As Introduced

127th General Assembly
Regular Session **S. B. No. 194**
2007-2008

Senator Miller, R.

Cosponsors: Senators Fedor, Cafaro, Miller, D., Roberts, Sawyer

A B I L L

To amend sections 9.231, 9.239, 9.24, 101.39, 101.391, 103.144, 109.572, 109.85, 117.10, 119.01, 121.02, 121.03, 122.15, 124.30, 124.301, 124.821, 127.16, 131.23, 145.27, 145.58, 149.431, 169.02, 173.14, 173.20, 173.21, 173.26, 173.35, 173.394, 173.40, 173.42, 173.45, 173.47, 173.50, 173.71, 173.72, 173.721, 173.722, 173.723, 173.724, 173.73, 173.731, 173.732, 173.74, 173.741, 173.742, 173.75, 173.751, 173.752, 173.753, 173.76, 173.77, 173.771, 173.772, 173.773, 173.78, 173.79, 173.791, 173.80, 173.801, 173.802, 173.803, 173.81, 173.811, 173.812, 173.813, 173.814, 173.815, 173.82, 173.83, 173.831, 173.832, 173.833, 173.84, 173.85, 173.86, 173.861, 173.87, 173.88, 173.89, 173.891, 173.892, 173.90, 173.91, 173.99, 317.08, 317.36, 323.01, 329.04, 329.051, 329.06, 329.14, 340.03, 340.091, 340.16, 341.192, 505.84, 742.41, 955.201, 1337.11, 1347.08, 1731.04, 1739.061, 1751.01, 1751.04, 1751.05, 1751.11, 1751.111, 1751.12, 1751.13, 1751.15, 1751.16, 1751.17, 1751.18, 1751.20, 1751.271, 1751.31, 1751.34, 1751.53, 1751.60, 1751.88, 1751.89, 2108.01, 2113.041, 2113.06,

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(5168.06), to enact sections 117.54, 117.55, 117.56, 117.57, 329.043, 5160.01, 5160.02, 5160.03, 5160.05, 5160.06, 5160.08, 5160.10, 5160.101, 5160.12, 5160.13, 5160.15, 5160.151, 5160.152, 5160.16, 5160.17, 5160.18, 5160.19, 5160.191, 5160.192, 5160.20, 5160.21, 5160.211, 5160.22, 5160.23, 5160.24, 5160.26, 5160.261, 5160.262, 5160.28, 5160.29, 5160.30, 5160.32, 5160.34, 5160.341, 5160.41, 5160.43, 5160.44, 5160.45, 5160.46, 5160.50, 5160.51, 5160.52, 5160.53, 5160.54, 5160.55, 5160.56, 5160.57, 5160.58, 5160.59, 5160.60, 5160.61, 5160.62, 5160.63, 5160.64, 5160.65, 5160.70, 5160.71, 5160.75, 5160.99, 5161.01, 5161.03, 5162.02, 5162.03, 5162.17, 5163.04, 5163.05, 5164.051, 5165.01, 5165.02, 5165.04, 5165.06, 5165.08, 5165.17, 5165.18, 5167.01, 5168.03, 5168.04, 5168.08, 5168.09, 5168.10, and 5169.99, and to repeal section 5111.012 of the Revised Code; to amend Section 7 of Am. Sub. H.B. 468 of the 126th General Assembly; to create the Department of Health Care Administration; to transfer the Medicaid Program, Children's Health Insurance Program Parts I and II, Hospital Care Assurance Program, Disability Medical Assistance Program, Ohio's Best Rx Program, and Residential State Supplement Program to the new department; to require the new department to create a central pharmaceutical purchasing office; and to make an appropriation.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF OHIO:

Section 1. That sections 9.231, 9.239, 9.24, 101.39, 101.391, 103.144, 109.572, 109.85, 117.10, 119.01, 121.02, 121.03, 122.15, 124.30, 124.301, 124.821, 127.16, 131.23, 145.27, 145.58, 149.431, 169.02, 173.14, 173.20, 173.21, 173.26, 173.35, 173.394, 173.40, 173.42, 173.45, 173.47, 173.50, 173.71, 173.72, 173.721, 173.722, 173.723, 173.724, 173.73, 173.731, 173.732, 173.74, 173.741, 173.742, 173.75, 173.751, 173.752, 173.753, 173.76, 173.77, 173.771, 173.772, 173.773, 173.78, 173.79, 173.791, 173.80, 173.801, 173.802, 173.803, 173.81, 173.811, 173.812, 173.813, 173.814, 173.815, 173.82, 173.83, 173.831, 173.832, 173.833, 173.84, 173.85, 173.86, 173.861, 173.87, 173.88, 173.89, 173.891, 173.892, 173.90, 173.91, 173.99, 317.08, 317.36, 323.01, 329.04, 329.051, 329.06, 329.14, 340.03, 340.091, 340.16, 341.192, 505.84, 742.41, 955.201, 1337.11, 1347.08, 1731.04, 1739.061, 1751.01, 1751.04, 1751.05, 1751.11, 1751.111, 1751.12, 1751.13, 1751.15, 1751.16, 1751.17, 1751.18, 1751.20, 1751.271, 1751.31, 1751.34, 1751.53, 1751.60, 1751.88, 1751.89, 2108.01, 2113.041, 2113.06, 2117.061, 2117.25, 2133.01, 2151.3514, 2305.234, 2307.65, 2335.39, 2505.02, 2705.02, 2744.05, 2903.33, 2913.40, 2913.401, 2921.01, 2921.13, 2945.401, 3101.051, 3107.083, 3111.04, 3111.72, 3119.54, 3121.441, 3121.898, 3125.36, 3307.20, 3309.22, 3313.714, 3313.715, 3317.023, 3323.021, 3599.45, 3701.023, 3701.024, 3701.027, 3701.043, 3701.132, 3701.243, 3701.507, 3701.74, 3701.741, 3701.881, 3702.30, 3702.31, 3702.51, 3702.522, 3702.62, 3702.63, 3702.74, 3702.91, 3712.07, 3712.09, 3721.01, 3721.011, 3721.021, 3721.022, 3721.024, 3721.026, 3721.071, 3721.08, 3721.10, 3721.12, 3721.121, 3721.13, 3721.15, 3721.16, 3721.17, 3721.19, 3721.21, 3721.28, 3721.32, 3721.50, 3721.51, 3721.52, 3721.53, 3721.54, 3721.541, 3721.55, 3721.56, 3721.561, 3721.57, 3721.58, 3722.10, 3722.16, 3727.02, 3742.30, 3742.51, 3793.07, 3901.3814, 3903.14, 3916.06, 3923.122, 3923.27, 3923.281, 3923.33, 3923.38, 3923.49, 3923.50, 3923.58, 3923.601, 3923.70, 3923.79, 3923.83, 3924.41,

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(5162.26), 5111.16 (5165.03), 5111.161 (5165.19), 5111.162 (5165.14), 5111.163 (5165.15), 5111.17 (5165.05), 5111.171 (5165.07), 5111.172 (5165.09), 5111.173 (5165.10), 5111.174 (5165.12), 5111.175 (5165.13), 5111.176 (5166.60), 5111.177 (5165.11), 5111.178 (5165.16), 5111.18 (5162.43), 5111.181 (5162.30), 5111.19 (5163.23), 5111.191 (5163.231), 5111.20 (5164.01), 5111.201 (5164.011), 5111.202 (5164.45), 5111.203 (5164.46), 5111.204 (5164.47), 5111.21 (5164.02), 5111.211 (5164.14), 5111.22 (5164.03), 5111.221 (5164.40), 5111.222 (5164.18), 5111.223 (5164.031), 5111.23 (5164.05), 5111.231 (5164.19), 5111.232 (5164.191), 5111.235 (5164.06), 5111.24 (5164.20), 5111.241 (5164.07), 5111.242 (5164.21), 5111.243 (5164.22), 5111.244 (5164.23), 5111.25 (5164.24), 5111.251 (5164.08), 5111.254 (5164.32), 5111.255 (5164.12), 5111.257 (5164.27), 5111.258 (5164.34), 5111.26 (5164.37), 5111.261 (5164.10), 5111.263 (5164.26), 5111.264 (5164.372), 5111.265 (5164.28), 5111.266 (5164.371), 5111.27 (5164.38), 5111.28 (5164.39), 5111.29 (5164.41), 5111.291 (5164.13), 5111.30 (5164.032), 5111.31 (5164.033), 5111.32 (5164.034), 5111.33 (5164.35), 5111.34 (5164.30), 5111.35 (5164.50), 5111.36 (5164.51), 5111.37 (5164.52), 5111.38 (5164.53), 5111.39 (5164.54), 5111.40 (5164.55), 5111.41 (5164.56), 5111.411 (5164.57), 5111.42 (5164.58), 5111.43 (5164.59), 5111.44 (5164.60), 5111.45 (5164.61), 5111.46 (5164.62), 5111.47 (5164.63), 5111.48 (5164.64), 5111.49 (5164.65), 5111.50 (5164.66), 5111.51 (5164.67), 5111.52 (5164.68), 5111.53 (5164.69), 5111.54 (5164.70), 5111.55 (5164.71), 5111.56 (5164.72), 5111.57 (5164.73), 5111.58 (5164.74), 5111.59 (5164.75), 5111.60 (5164.76), 5111.61 (5164.77), 5111.62 (5164.78), 5111.63 (5164.79), 5111.65 (5164.82), 5111.651 (5164.821), 5111.66 (5164.83), 5111.67 (5164.84), 5111.671 (5164.841), 5111.672 (5164.842), 5111.673 (5164.843), 5111.674 (5164.844), 5111.675 (5164.845), 5111.676 (5164.846), 5111.677

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that sections 117.54, 117.55, 117.56, 117.57, 329.043, 5160.01, 5160.02, 5160.03, 5160.05, 5160.06, 5160.08, 5160.10, 5160.101, 5160.12, 5160.13, 5160.15, 5160.151, 5160.152, 5160.16, 5160.17, 5160.18, 5160.19, 5160.191, 5160.192, 5160.20, 5160.21, 5160.211, 5160.22, 5160.23, 5160.24, 5160.26, 5160.261, 5160.262, 5160.28, 5160.29, 5160.30, 5160.32, 5160.34, 5160.341, 5160.41, 5160.43, 5160.44, 5160.45, 5160.46, 5160.50, 5160.51, 5160.52, 5160.53, 5160.54, 5160.55, 5160.56, 5160.57, 5160.58, 5160.59, 5160.60, 5160.61, 5160.62, 5160.63, 5160.64, 5160.65, 5160.70, 5160.71, 5160.75, 5160.99, 5161.01, 5161.03, 5162.02, 5162.03, 5162.17, 5163.04, 5163.05, 5164.051, 5165.01, 5165.02, 5165.04, 5165.06, 5165.08, 5165.17, 5165.18, 5167.01, 5168.03, 5168.04, 5168.08, 5168.09, 5168.10, and 5169.99 of the Revised Code be enacted to read as follows:

Sec. 9.231. (A)(1) Subject to divisions (A)(2) and (3) of this section, a governmental entity shall not disburse money totaling twenty-five thousand dollars or more to any person for the provision of services for the primary benefit of individuals or the public and not for the primary benefit of a governmental entity or the employees of a governmental entity, unless the contracting authority of the governmental entity first enters into a written contract with the person that is signed by the person or by an officer or agent of the person authorized to legally bind the person and that embodies all of the requirements and conditions set forth in sections 9.23 to 9.236 of the Revised Code. If the disbursement of money occurs over the course of a governmental entity's fiscal year, rather than in a lump sum, the contracting authority of the governmental entity shall enter into the written contract with the person at the point during the governmental entity's fiscal year that at least seventy-five thousand dollars has been disbursed by the governmental entity to the person. Thereafter, the contracting authority of the

governmental entity shall enter into the written contract with the person at the beginning of the governmental entity's fiscal year, if, during the immediately preceding fiscal year, the governmental entity disbursed to that person an aggregate amount totaling at least seventy-five thousand dollars.

(2) If the money referred to in division (A)(1) of this section is disbursed by or through more than one state agency to the person for the provision of services to the same population, the contracting authorities of those agencies shall determine which one of them will enter into the written contract with the person.

(3) The requirements and conditions set forth in divisions (A), (B), (C), and (F) of section 9.232, divisions (A)(1) and (2) and (B) of section 9.234, divisions (A)(2) and (B) of section 9.235, and sections 9.233 and 9.236 of the Revised Code do not apply with respect to the following:

(a) Contracts to which all of the following apply:

(i) The amount received for the services is a set fee for each time the services are provided, is determined in accordance with a fixed rate per unit of time or per service, or is a capitated rate, and the fee or rate is established by competitive bidding or by a market rate survey of similar services provided in a defined market area. The market rate survey may be one conducted by or on behalf of the governmental entity or an independent survey accepted by the governmental entity as statistically valid and reliable.

(ii) The services are provided in accordance with standards established by state or federal law, or by rules or regulations adopted thereunder, for their delivery, which standards are enforced by the federal government, a governmental entity, or an accrediting organization recognized by the federal government or a

governmental entity.

(iii) Payment for the services is made after the services are delivered and upon submission to the governmental entity of an invoice or other claim for payment as required by any applicable local, state, or federal law or, if no such law applies, by the terms of the contract.

(b) Contracts under which the services are reimbursed through or in a manner consistent with a federal program that meets all of the following requirements:

(i) The program calculates the reimbursement rate on the basis of the previous year's experience or in accordance with an alternative method set forth in rules adopted by the Ohio department of job and family services.

(ii) The reimbursement rate is derived from a breakdown of direct and indirect costs.

(iii) The program's guidelines describe types of expenditures that are allowable and not allowable under the program and delineate which costs are acceptable as direct costs for purposes of calculating the reimbursement rate.

(iv) The program includes a uniform cost reporting system with specific audit requirements.

(c) Contracts under which the services are reimbursed through or in a manner consistent with a federal program that calculates the reimbursement rate on a fee for service basis in compliance with United States office of management and budget Circular A-87, as revised May 10, 2004.

(d) Contracts for services that are paid pursuant to the earmarking of an appropriation made by the general assembly for that purpose.

(B) Division (A) of this section does not apply if the money

is disbursed to a person pursuant to a contract with the United States or a governmental entity under any of the following circumstances:

(1) The person receives the money directly or indirectly from the United States, and no governmental entity exercises any oversight or control over the use of the money.

(2) The person receives the money solely in return for the performance of one or more of the following types of services:

(a) Medical, therapeutic, or other health-related services provided by a person if the amount received is a set fee for each time the person provides the services, is determined in accordance with a fixed rate per unit of time, or is a capitated rate, and the fee or rate is reasonable and customary in the person's trade or profession;

(b) Medicaid-funded services, including administrative and management services, provided pursuant to a contract or medicaid provider agreement that meets the requirements of the medicaid program ~~established under Chapter 5111. of the Revised Code~~.

(c) Services, other than administrative or management services or any of the services described in division (B)(2)(a) or (b) of this section, that are commonly purchased by the public at an hourly rate or at a set fee for each time the services are provided, unless the services are performed for the benefit of children, persons who are eligible for the services by reason of advanced age, medical condition, or financial need, or persons who are confined in a detention facility as defined in section 2921.01 of the Revised Code, and the services are intended to help promote the health, safety, or welfare of those children or persons;

(d) Educational services provided by a school to children eligible to attend that school. For purposes of division (B)(2)(d) of this section, "school" means any school operated by a school

district board of education, any community school established under Chapter 3314. of the Revised Code, or any nonpublic school for which the state board of education prescribes minimum education standards under section 3301.07 of the Revised Code.

(e) Services provided by a foster home as defined in section 5103.02 of the Revised Code;

(f) "Routine business services other than administrative or management services," as that term is defined by the attorney general by rule adopted in accordance with Chapter 119. of the Revised Code;

(g) Services to protect the environment or promote environmental education that are provided by a nonprofit entity or services to protect the environment that are funded with federal grants or revolving loan funds and administered in accordance with federal law.

(3) The person receives the money solely in return for the performance of services intended to help preserve public health or safety under circumstances requiring immediate action as a result of a natural or man-made emergency.

(C) With respect to a nonprofit association, corporation, or organization established for the purpose of providing educational, technical, consulting, training, financial, or other services to its members in exchange for membership dues and other fees, any of the services provided to a member that is a governmental entity shall, for purposes of this section, be considered services "for the primary benefit of a governmental entity or the employees of a governmental entity."

Sec. 9.239. (A) There is hereby created the government contracting advisory council. The attorney general and auditor of state shall consult with the council on the performance of their

rule-making functions under sections 9.237 and 9.238 of the Revised Code and shall consider any recommendations of the council. ~~The director of job and family services shall annually report to the council the cost methodology of the medicaid-funded services described in division (A)(3)(d) of section 9.231 of the Revised Code.~~ The council shall consist of the following members or their designees:

(1) The attorney general;

(2) The auditor of state;

(3) The director of administrative services;

(4) The director of aging;

(5) The director of alcohol and drug addiction services;

(6) The director of budget and management;

(7) The director of development;

(8) The director of job and family services;

(9) The director of mental health;

(10) The director of mental retardation and developmental disabilities;

(11) The director of rehabilitation and correction;

(12) The administrator of workers' compensation;

(13) The executive director of the county commissioners' association of Ohio;

(14) The president of the Ohio grantmakers forum;

(15) The president of the Ohio chamber of commerce;

(16) The president of the Ohio state bar association;

(17) The president of the Ohio society of certified public accountants;

(18) The executive director of the Ohio association of nonprofit organizations;

(19) The president of the Ohio united way;

(20) One additional member appointed by the attorney general;

(21) One additional member appointed by the auditor of state.

(B) If an agency or organization represented on the council ceases to exist in the form it has on ~~the effective date of this section~~ September 29, 2005, the successor agency or organization shall be represented in its place. If there is no successor agency or organization, or if it is not clear what agency or organization is the successor, the attorney general shall designate an agency or organization to be represented in place of the agency or organization originally represented on the council.

(C) The two members appointed to the council shall serve three-year terms. Original appointments shall be made not later than sixty days after ~~the effective date of this section~~ September 29, 2005. Vacancies on the council shall be filled in the same manner as the original appointment.

(D) The attorney general or the attorney general's designee shall be the chairperson of the council. The council shall meet at least once every two years to review the rules adopted under sections 9.237 and 9.238 of the Revised Code and to make recommendations to the attorney general and auditor of state regarding the adoption, amendment, or repeal of those rules. The council shall also meet at other times as requested by the attorney general or auditor of state.

(E) Members of the council shall serve without compensation or reimbursement.

(F) The office of the attorney general shall provide necessary staff, facilities, supplies, and services to the

council.

(G) Sections 101.82 to 101.87 of the Revised Code do not apply to the council.

Sec. 9.24. (A) Except as may be allowed under division (F) of this section, no state agency and no political subdivision shall award a contract as described in division (G)(1) of this section for goods, services, or construction, paid for in whole or in part with state funds, to a person against whom a finding for recovery has been issued by the auditor of state on and after January 1, 2001, if the finding for recovery is unresolved.

A contract is considered to be awarded when it is entered into or executed, irrespective of whether the parties to the contract have exchanged any money.

(B) For purposes of this section, a finding for recovery is unresolved unless one of the following criteria applies:

(1) The money identified in the finding for recovery is paid in full to the state agency or political subdivision to whom the money was owed;

(2) The debtor has entered into a repayment plan that is approved by the attorney general and the state agency or political subdivision to whom the money identified in the finding for recovery is owed. A repayment plan may include a provision permitting a state agency or political subdivision to withhold payment to a debtor for goods, services, or construction provided to or for the state agency or political subdivision pursuant to a contract that is entered into with the debtor after the date the finding for recovery was issued.

(3) The attorney general waives a repayment plan described in division (B)(2) of this section for good cause;

(4) The debtor and state agency or political subdivision to

whom the money identified in the finding for recovery is owed have agreed to a payment plan established through an enforceable settlement agreement.

(5) The state agency or political subdivision desiring to enter into a contract with a debtor certifies, and the attorney general concurs, that all of the following are true:

(a) Essential services the state agency or political subdivision is seeking to obtain from the debtor cannot be provided by any other person besides the debtor;

(b) Awarding a contract to the debtor for the essential services described in division (B)(5)(a) of this section is in the best interest of the state;

(c) Good faith efforts have been made to collect the money identified in the finding of recovery.

(6) The debtor has commenced an action to contest the finding for recovery and a final determination on the action has not yet been reached.

(C) The attorney general shall submit an initial report to the auditor of state, not later than December 1, 2003, indicating the status of collection for all findings for recovery issued by the auditor of state for calendar years 2001, 2002, and 2003. Beginning on January 1, 2004, the attorney general shall submit to the auditor of state, on the first day of every January, April, July, and October, a list of all findings for recovery that have been resolved in accordance with division (B) of this section during the calendar quarter preceding the submission of the list and a description of the means of resolution. The attorney general shall notify the auditor of state when a judgment is issued against an entity described in division (F)(1) of this section.

(D) The auditor of state shall maintain a database, accessible to the public, listing persons against whom an

unresolved finding for recovery has been issued, and the amount of the money identified in the unresolved finding for recovery. The auditor of state shall have this database operational on or before January 1, 2004. The initial database shall contain the information required under this division for calendar years 2001, 2002, and 2003.

Beginning January 15, 2004, the auditor of state shall update the database by the fifteenth day of every January, April, July, and October to reflect resolved findings for recovery that are reported to the auditor of state by the attorney general on the first day of the same month pursuant to division (C) of this section.

(E) Before awarding a contract as described in division (G)(1) of this section for goods, services, or construction, paid for in whole or in part with state funds, a state agency or political subdivision shall verify that the person to whom the state agency or political subdivision plans to award the contract has no unresolved finding for recovery issued against the person. A state agency or political subdivision shall verify that the person does not appear in the database described in division (D) of this section or shall obtain other proof that the person has no unresolved finding for recovery issued against the person.

(F) The prohibition of division (A) of this section and the requirement of division (E) of this section do not apply with respect to the companies or agreements described in divisions (F)(1) and (2) of this section, or in the circumstance described in division (F)(3) of this section.

(1) A bonding company or a company authorized to transact the business of insurance in this state, a self-insurance pool, joint self-insurance pool, risk management program, or joint risk management program, unless a court has entered a final judgment against the company and the company has not yet satisfied the

final judgment.

(2) To ~~medicaid~~ provider agreements under ~~Chapter 5111. of the Revised Code~~ the medicaid program or payments or provider agreements under the disability assistance medical assistance ~~established under Chapter 5115. of the Revised Code~~ program.

(3) When federal law dictates that a specified entity provide the goods, services, or construction for which a contract is being awarded, regardless of whether that entity would otherwise be prohibited from entering into the contract pursuant to this section.

(G)(1) This section applies only to contracts for goods, services, or construction that satisfy the criteria in either division (G)(1)(a) or (b) of this section. This section may apply to contracts for goods, services, or construction that satisfy the criteria in division (G)(1)(c) of this section, provided that the contracts also satisfy the criteria in either division (G)(1)(a) or (b) of this section.

(a) The cost for the goods, services, or construction provided under the contract is estimated to exceed twenty-five thousand dollars.

(b) The aggregate cost for the goods, services, or construction provided under multiple contracts entered into by the particular state agency and a single person or the particular political subdivision and a single person within the fiscal year preceding the fiscal year within which a contract is being entered into by that same state agency and the same single person or the same political subdivision and the same single person, exceeded fifty thousand dollars.

(c) The contract is a renewal of a contract previously entered into and renewed pursuant to that preceding contract.

(2) This section does not apply to employment contracts.

(H) As used in this section:

(1) "State agency" has the same meaning as in section 9.66 of the Revised Code.

(2) "Political subdivision" means a political subdivision as defined in section 9.82 of the Revised Code that has received more than fifty thousand dollars of state money in the current fiscal year or the preceding fiscal year.

(3) "Finding for recovery" means a determination issued by the auditor of state, contained in a report the auditor of state gives to the attorney general pursuant to section 117.28 of the Revised Code, that public money has been illegally expended, public money has been collected but not been accounted for, public money is due but has not been collected, or public property has been converted or misappropriated.

(4) "Debtor" means a person against whom a finding for recovery has been issued.

(5) "Person" means the person named in the finding for recovery.

(6) "State money" does not include funds the state receives from another source and passes through to a political subdivision.

Sec. 101.39. (A) There is hereby created the joint legislative committee on health care oversight. The committee may review or study any matter related to the provision of health care services that it considers of significance to the citizens of this state, including the availability of health care, the quality of health care, the effectiveness and efficiency of managed care systems, and the operation of the ~~medical assistance~~ medicaid program ~~established under Chapter 5111. of the Revised Code~~ or other government health programs.

The department of health care administration, department of

job and family services, department of health, department of aging, department of mental health, department of mental retardation and developmental disabilities, department of alcohol and drug addiction services, and other state agencies shall cooperate with the committee in its study and review of health care issues. On request, the departments shall provide the committee with reports and other information sufficient for the committee to fulfill its duties.

The committee may issue recommendations as it determines appropriate. The recommendations may be made to the general assembly, state agencies, private industry, or any other entity.

(B) The committee shall consist of the following members of the general assembly: the chairperson of the senate's standing committee with primary responsibility for health legislation, the chairperson of the house of representatives' standing committee with primary responsibility for health legislation, four members of the house of representatives appointed by the speaker of the house of representatives, and four members of the senate appointed by the president of the senate. Not more than two members appointed by the speaker of the house of representatives and not more than two members appointed by the president of the senate may be of the same political party. Except in 1995, appointments shall be made not later than fifteen days after the commencement of the first regular session of each general assembly. The chairpersons of the standing committees with primary responsibility for health legislation shall serve as co-chairpersons of the committee.

Each member of the committee shall hold office during the general assembly in which the member is appointed and until a successor has been appointed, notwithstanding the adjournment sine die of the general assembly in which the member was appointed or the expiration of the member's term as a member of the general

assembly. Any vacancies occurring among the members of the committee shall be filled in the manner of the original appointment.

The committee shall meet at least quarterly and at the call of the co-chairpersons. The co-chairpersons shall determine the time, place, and agenda for each meeting of the committee.

The committee has the same powers as other standing or select committees of the general assembly. The committee may request assistance from the legislative service commission ~~and the legislative budget office of the legislative service commission~~.

Sec. 101.391. (A) There is hereby created the joint legislative committee on medicaid technology and reform. The committee may review or study any matter that it considers relevant to the operation of the medicaid program ~~established under Chapter 5111. of the Revised Code~~, with priority given to the study or review of mechanisms to enhance the program's effectiveness through improved technology systems and program reform.

(B) The committee shall consist of five members of the house of representatives appointed by the speaker of the house of representatives and five members of the senate appointed by the president of the senate. Not more than three members appointed by the speaker of the house of representatives and not more than three members appointed by the president of the senate may be of the same political party.

Each member of the committee shall hold office during the general assembly in which the member is appointed and until a successor has been appointed, notwithstanding the adjournment sine die of the general assembly in which the member was appointed or the expiration of the member's term as a member of the general assembly. Any vacancies occurring among the members of the

committee shall be filled in the manner of the original appointment.

(C) The committee has the same powers as other standing or select committees of the general assembly. The committee may employ an executive director.

Sec. 103.144. As used in sections 103.144 to 103.146 of the Revised Code:

(A) "Mandated benefit" means the following, when considered in the context of a sickness and accident insurance policy or a health insuring corporation policy, contract, or agreement:

(1) Any required coverage for a specific medical or health-related service, treatment, medication, or practice;

(2) Any required coverage for the services of specific health care providers;

(3) Any requirement that an insurer or health insuring corporation offer coverage to specific individuals or groups;

(4) Any requirement that an insurer or health insuring corporation offer specific medical or health-related services, treatments, medications, or practices to existing insureds or enrollees;

(5) Any required expansion of, or addition to, existing coverage;

(6) Any mandated reimbursement amount to specific health care providers.

(B) "Mandated benefit" does not include any required coverage or offer of coverage, any required expansion of, or addition to, existing coverage, or any mandated reimbursement amount to specific providers, as described in division (A) of this section, within the context of any public health benefits arrangement,

including but not limited to, the coverage of beneficiaries enrolled in ~~Title XVIII of~~ the ~~"Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended~~ medicare program, pursuant to a medicare risk contract or medicare cost contract, or to the coverage of ~~beneficiaries enrolled in Title XIX of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended, known as~~ recipients of the ~~medical assistance program or~~ medicaid~~,~~ ~~provided by the Ohio department of job and family services under Chapter 5111. of the Revised Code~~ program.

Sec. 109.572. (A)(1) Upon receipt of a request pursuant to section 121.08, 3301.32, 3301.541, 3319.39, 5104.012, or 5104.013 of the Revised Code, a completed form prescribed pursuant to division (C)(1) of this section, and a set of fingerprint impressions obtained in the manner described in division (C)(2) of this section, the superintendent of the bureau of criminal identification and investigation shall conduct a criminal records check in the manner described in division (B) of this section to determine whether any information exists that indicates that the person who is the subject of the request previously has been convicted of or pleaded guilty to any of the following:

(a) A violation of section 2903.01, 2903.02, 2903.03, 2903.04, 2903.11, 2903.12, 2903.13, 2903.16, 2903.21, 2903.34, 2905.01, 2905.02, 2905.05, 2907.02, 2907.03, 2907.04, 2907.05, 2907.06, 2907.07, 2907.08, 2907.09, 2907.21, 2907.22, 2907.23, 2907.25, 2907.31, 2907.32, 2907.321, 2907.322, 2907.323, 2911.01, 2911.02, 2911.11, 2911.12, 2919.12, 2919.22, 2919.24, 2919.25, 2923.12, 2923.13, 2923.161, 2925.02, 2925.03, 2925.04, 2925.05, 2925.06, or 3716.11 of the Revised Code, felonious sexual penetration in violation of former section 2907.12 of the Revised Code, a violation of section 2905.04 of the Revised Code as it existed prior to July 1, 1996, a violation of section 2919.23 of the Revised Code that would have been a violation of section

2905.04 of the Revised Code as it existed prior to July 1, 1996, had the violation been committed prior to that date, or a violation of section 2925.11 of the Revised Code that is not a minor drug possession offense;

(b) A violation of an existing or former law of this state, any other state, or the United States that is substantially equivalent to any of the offenses listed in division (A)(1)(a) of this section.

(2) On receipt of a request pursuant to section 5123.081 of the Revised Code with respect to an applicant for employment in any position with the department of mental retardation and developmental disabilities, pursuant to section 5126.28 of the Revised Code with respect to an applicant for employment in any position with a county board of mental retardation and developmental disabilities, or pursuant to section 5126.281 of the Revised Code with respect to an applicant for employment in a direct services position with an entity contracting with a county board for employment, a completed form prescribed pursuant to division (C)(1) of this section, and a set of fingerprint impressions obtained in the manner described in division (C)(2) of this section, the superintendent of the bureau of criminal identification and investigation shall conduct a criminal records check. The superintendent shall conduct the criminal records check in the manner described in division (B) of this section to determine whether any information exists that indicates that the person who is the subject of the request has been convicted of or pleaded guilty to any of the following:

(a) A violation of section 2903.01, 2903.02, 2903.03, 2903.04, 2903.11, 2903.12, 2903.13, 2903.16, 2903.21, 2903.34, 2903.341, 2905.01, 2905.02, 2905.04, 2905.05, 2907.02, 2907.03, 2907.04, 2907.05, 2907.06, 2907.07, 2907.08, 2907.09, 2907.12, 2907.21, 2907.22, 2907.23, 2907.25, 2907.31, 2907.32, 2907.321,

2907.322, 2907.323, 2911.01, 2911.02, 2911.11, 2911.12, 2919.12, 2919.22, 2919.24, 2919.25, 2923.12, 2923.13, 2923.161, 2925.02, 2925.03, or 3716.11 of the Revised Code;

(b) An existing or former municipal ordinance or law of this state, any other state, or the United States that is substantially equivalent to any of the offenses listed in division (A)(2)(a) of this section.

(3) On receipt of a request pursuant to section 173.27, 173.394, 3712.09, 3721.121, or 3722.151 of the Revised Code, a completed form prescribed pursuant to division (C)(1) of this section, and a set of fingerprint impressions obtained in the manner described in division (C)(2) of this section, the superintendent of the bureau of criminal identification and investigation shall conduct a criminal records check with respect to any person who has applied for employment in a position for which a criminal records check is required by those sections. The superintendent shall conduct the criminal records check in the manner described in division (B) of this section to determine whether any information exists that indicates that the person who is the subject of the request previously has been convicted of or pleaded guilty to any of the following:

(a) A violation of section 2903.01, 2903.02, 2903.03, 2903.04, 2903.11, 2903.12, 2903.13, 2903.16, 2903.21, 2903.34, 2905.01, 2905.02, 2905.11, 2905.12, 2907.02, 2907.03, 2907.05, 2907.06, 2907.07, 2907.08, 2907.09, 2907.12, 2907.25, 2907.31, 2907.32, 2907.321, 2907.322, 2907.323, 2911.01, 2911.02, 2911.11, 2911.12, 2911.13, 2913.02, 2913.03, 2913.04, 2913.11, 2913.21, 2913.31, 2913.40, 2913.43, 2913.47, 2913.51, 2919.25, 2921.36, 2923.12, 2923.13, 2923.161, 2925.02, 2925.03, 2925.11, 2925.13, 2925.22, 2925.23, or 3716.11 of the Revised Code;

(b) An existing or former law of this state, any other state, or the United States that is substantially equivalent to any of

the offenses listed in division (A)(3)(a) of this section.

(4) On receipt of a request pursuant to section 3701.881 of the Revised Code with respect to an applicant for employment with a home health agency as a person responsible for the care, custody, or control of a child, a completed form prescribed pursuant to division (C)(1) of this section, and a set of fingerprint impressions obtained in the manner described in division (C)(2) of this section, the superintendent of the bureau of criminal identification and investigation shall conduct a criminal records check. The superintendent shall conduct the criminal records check in the manner described in division (B) of this section to determine whether any information exists that indicates that the person who is the subject of the request previously has been convicted of or pleaded guilty to any of the following:

(a) A violation of section 2903.01, 2903.02, 2903.03, 2903.04, 2903.11, 2903.12, 2903.13, 2903.16, 2903.21, 2903.34, 2905.01, 2905.02, 2905.04, 2905.05, 2907.02, 2907.03, 2907.04, 2907.05, 2907.06, 2907.07, 2907.08, 2907.09, 2907.12, 2907.21, 2907.22, 2907.23, 2907.25, 2907.31, 2907.32, 2907.321, 2907.322, 2907.323, 2911.01, 2911.02, 2911.11, 2911.12, 2919.12, 2919.22, 2919.24, 2919.25, 2923.12, 2923.13, 2923.161, 2925.02, 2925.03, 2925.04, 2925.05, 2925.06, or 3716.11 of the Revised Code or a violation of section 2925.11 of the Revised Code that is not a minor drug possession offense;

(b) An existing or former law of this state, any other state, or the United States that is substantially equivalent to any of the offenses listed in division (A)(4)(a) of this section.

(5) On receipt of a request pursuant to section ~~5111.95~~ 5163.75 or ~~5111.96~~ 5163.76 of the Revised Code with respect to an applicant for employment with a waiver agency participating in a department of job and family services administered home and

community-based waiver program or an independent provider participating in a department administered home and community-based waiver program in a position that involves providing home and community-based waiver services to consumers with disabilities, a completed form prescribed pursuant to division (C)(1) of this section, and a set of fingerprint impressions obtained in the manner described in division (C)(2) of this section, the superintendent of the bureau of criminal identification and investigation shall conduct a criminal records check. The superintendent shall conduct the criminal records check in the manner described in division (B) of this section to determine whether any information exists that indicates that the person who is the subject of the request previously has been convicted of or pleaded guilty to any of the following:

(a) A violation of section 2903.01, 2903.02, 2903.03, 2903.04, 2903.041, 2903.11, 2903.12, 2903.13, 2903.16, 2903.21, 2903.34, 2905.01, 2905.02, 2905.05, 2905.11, 2905.12, 2907.02, 2907.03, 2907.04, 2907.05, 2907.06, 2907.07, 2907.08, 2907.09, 2907.21, 2907.22, 2907.23, 2907.25, 2907.31, 2907.32, 2907.321, 2907.322, 2907.323, 2911.01, 2911.02, 2911.11, 2911.12, 2911.13, 2913.02, 2913.03, 2913.04, 2913.11, 2913.21, 2913.31, 2913.40, 2913.43, 2913.47, 2913.51, 2919.12, 2919.24, 2919.25, 2921.36, 2923.12, 2923.13, 2923.161, 2925.02, 2925.03, 2925.04, 2925.05, 2925.06, 2925.11, 2925.13, 2925.22, 2925.23, or 3716.11 of the Revised Code, felonious sexual penetration in violation of former section 2907.12 of the Revised Code, a violation of section 2905.04 of the Revised Code as it existed prior to July 1, 1996, a violation of section 2919.23 of the Revised Code that would have been a violation of section 2905.04 of the Revised Code as it existed prior to July 1, 1996, had the violation been committed prior to that date;

(b) An existing or former law of this state, any other state,

or the United States that is substantially equivalent to any of the offenses listed in division (A)(5)(a) of this section.

(6) On receipt of a request pursuant to section 3701.881 of the Revised Code with respect to an applicant for employment with a home health agency in a position that involves providing direct care to an older adult, a completed form prescribed pursuant to division (C)(1) of this section, and a set of fingerprint impressions obtained in the manner described in division (C)(2) of this section, the superintendent of the bureau of criminal identification and investigation shall conduct a criminal records check. The superintendent shall conduct the criminal records check in the manner described in division (B) of this section to determine whether any information exists that indicates that the person who is the subject of the request previously has been convicted of or pleaded guilty to any of the following:

(a) A violation of section 2903.01, 2903.02, 2903.03, 2903.04, 2903.11, 2903.12, 2903.13, 2903.16, 2903.21, 2903.34, 2905.01, 2905.02, 2905.11, 2905.12, 2907.02, 2907.03, 2907.05, 2907.06, 2907.07, 2907.08, 2907.09, 2907.12, 2907.25, 2907.31, 2907.32, 2907.321, 2907.322, 2907.323, 2911.01, 2911.02, 2911.11, 2911.12, 2911.13, 2913.02, 2913.03, 2913.04, 2913.11, 2913.21, 2913.31, 2913.40, 2913.43, 2913.47, 2913.51, 2919.25, 2921.36, 2923.12, 2923.13, 2923.161, 2925.02, 2925.03, 2925.11, 2925.13, 2925.22, 2925.23, or 3716.11 of the Revised Code;

(b) An existing or former law of this state, any other state, or the United States that is substantially equivalent to any of the offenses listed in division (A)(6)(a) of this section.

(7) When conducting a criminal records check upon a request pursuant to section 3319.39 of the Revised Code for an applicant who is a teacher, in addition to the determination made under division (A)(1) of this section, the superintendent shall determine whether any information exists that indicates that the

person who is the subject of the request previously has been convicted of or pleaded guilty to any offense specified in section 3319.31 of the Revised Code.

(8) On a request pursuant to section 2151.86 of the Revised Code, a completed form prescribed pursuant to division (C)(1) of this section, and a set of fingerprint impressions obtained in the manner described in division (C)(2) of this section, the superintendent of the bureau of criminal identification and investigation shall conduct a criminal records check in the manner described in division (B) of this section to determine whether any information exists that indicates that the person who is the subject of the request previously has been convicted of or pleaded guilty to any of the following:

(a) A violation of section 2903.01, 2903.02, 2903.03, 2903.04, 2903.11, 2903.12, 2903.13, 2903.16, 2903.21, 2903.34, 2905.01, 2905.02, 2905.05, 2907.02, 2907.03, 2907.04, 2907.05, 2907.06, 2907.07, 2907.08, 2907.09, 2907.21, 2907.22, 2907.23, 2907.25, 2907.31, 2907.32, 2907.321, 2907.322, 2907.323, 2909.02, 2909.03, 2911.01, 2911.02, 2911.11, 2911.12, 2919.12, 2919.22, 2919.24, 2919.25, 2923.12, 2923.13, 2923.161, 2925.02, 2925.03, 2925.04, 2925.05, 2925.06, or 3716.11 of the Revised Code, a violation of section 2905.04 of the Revised Code as it existed prior to July 1, 1996, a violation of section 2919.23 of the Revised Code that would have been a violation of section 2905.04 of the Revised Code as it existed prior to July 1, 1996, had the violation been committed prior to that date, a violation of section 2925.11 of the Revised Code that is not a minor drug possession offense, or felonious sexual penetration in violation of former section 2907.12 of the Revised Code;

(b) A violation of an existing or former law of this state, any other state, or the United States that is substantially equivalent to any of the offenses listed in division (A)(8)(a) of

this section.

(9) When conducting a criminal records check on a request pursuant to section 5104.013 of the Revised Code for a person who is an owner, licensee, or administrator of a child day-care center or type A family day-care home, an authorized provider of a certified type B family day-care home, or an adult residing in a type A or certified type B home, or when conducting a criminal records check or a request pursuant to section 5104.012 of the Revised Code for a person who is an applicant for employment in a center, type A home, or certified type B home, the superintendent, in addition to the determination made under division (A)(1) of this section, shall determine whether any information exists that indicates that the person has been convicted of or pleaded guilty to any of the following:

(a) A violation of section 2913.02, 2913.03, 2913.04, 2913.041, 2913.05, 2913.06, 2913.11, 2913.21, 2913.31, 2913.32, 2913.33, 2913.34, 2913.40, 2913.41, 2913.42, 2913.43, 2913.44, 2913.441, 2913.45, 2913.46, 2913.47, 2913.48, 2913.49, 2921.11, 2921.13, or 2923.01 of the Revised Code, a violation of section 2923.02 or 2923.03 of the Revised Code that relates to a crime specified in this division or division (A)(1)(a) of this section, or a second violation of section 4511.19 of the Revised Code within five years of the date of application for licensure or certification.

(b) A violation of an existing or former law of this state, any other state, or the United States that is substantially equivalent to any of the offenses or violations described in division (A)(9)(a) of this section.

(10) Upon receipt of a request pursuant to section 5153.111 of the Revised Code, a completed form prescribed pursuant to division (C)(1) of this section, and a set of fingerprint impressions obtained in the manner described in division (C)(2) of

this section, the superintendent of the bureau of criminal identification and investigation shall conduct a criminal records check in the manner described in division (B) of this section to determine whether any information exists that indicates that the person who is the subject of the request previously has been convicted of or pleaded guilty to any of the following:

(a) A violation of section 2903.01, 2903.02, 2903.03, 2903.04, 2903.11, 2903.12, 2903.13, 2903.16, 2903.21, 2903.34, 2905.01, 2905.02, 2905.05, 2907.02, 2907.03, 2907.04, 2907.05, 2907.06, 2907.07, 2907.08, 2907.09, 2907.21, 2907.22, 2907.23, 2907.25, 2907.31, 2907.32, 2907.321, 2907.322, 2907.323, 2909.02, 2909.03, 2911.01, 2911.02, 2911.11, 2911.12, 2919.12, 2919.22, 2919.24, 2919.25, 2923.12, 2923.13, 2923.161, 2925.02, 2925.03, 2925.04, 2925.05, 2925.06, or 3716.11 of the Revised Code, felonious sexual penetration in violation of former section 2907.12 of the Revised Code, a violation of section 2905.04 of the Revised Code as it existed prior to July 1, 1996, a violation of section 2919.23 of the Revised Code that would have been a violation of section 2905.04 of the Revised Code as it existed prior to July 1, 1996, had the violation been committed prior to that date, or a violation of section 2925.11 of the Revised Code that is not a minor drug possession offense;

(b) A violation of an existing or former law of this state, any other state, or the United States that is substantially equivalent to any of the offenses listed in division (A)(10)(a) of this section.

(11) On receipt of a request for a criminal records check from an individual pursuant to section 4749.03 or 4749.06 of the Revised Code, accompanied by a completed copy of the form prescribed in division (C)(1) of this section and a set of fingerprint impressions obtained in a manner described in division (C)(2) of this section, the superintendent of the bureau of

criminal identification and investigation shall conduct a criminal records check in the manner described in division (B) of this section to determine whether any information exists indicating that the person who is the subject of the request has been convicted of or pleaded guilty to a felony in this state or in any other state. If the individual indicates that a firearm will be carried in the course of business, the superintendent shall require information from the federal bureau of investigation as described in division (B)(2) of this section. The superintendent shall report the findings of the criminal records check and any information the federal bureau of investigation provides to the director of public safety.

(12) On receipt of a request pursuant to section 1322.03, 1322.031, or 4763.05 of the Revised Code, a completed form prescribed pursuant to division (C)(1) of this section, and a set of fingerprint impressions obtained in the manner described in division (C)(2) of this section, the superintendent of the bureau of criminal identification and investigation shall conduct a criminal records check with respect to any person who has applied for a license, permit, or certification from the department of commerce or a division in the department. The superintendent shall conduct the criminal records check in the manner described in division (B) of this section to determine whether any information exists that indicates that the person who is the subject of the request previously has been convicted of or pleaded guilty to any of the following: a violation of section 2913.02, 2913.11, 2913.31, 2913.51, or 2925.03 of the Revised Code; any other criminal offense involving theft, receiving stolen property, embezzlement, forgery, fraud, passing bad checks, money laundering, or drug trafficking, or any criminal offense involving money or securities, as set forth in Chapters 2909., 2911., 2913., 2915., 2921., 2923., and 2925. of the Revised Code; or any existing or former law of this state, any other state, or the

United States that is substantially equivalent to those offenses.

(13) Not later than thirty days after the date the superintendent receives the request, completed form, and fingerprint impressions, the superintendent shall send the person, board, or entity that made the request any information, other than information the dissemination of which is prohibited by federal law, the superintendent determines exists with respect to the person who is the subject of the request that indicates that the person previously has been convicted of or pleaded guilty to any offense listed or described in division (A)(1), (2), (3), (4), (5), (6), (7), (8), (9), (10), (11), or (12) of this section, as appropriate. The superintendent shall send the person, board, or entity that made the request a copy of the list of offenses specified in division (A)(1), (2), (3), (4), (5), (6), (7), (8), (9), (10), (11), or (12) of this section, as appropriate. If the request was made under section 3701.881 of the Revised Code with regard to an applicant who may be both responsible for the care, custody, or control of a child and involved in providing direct care to an older adult, the superintendent shall provide a list of the offenses specified in divisions (A)(4) and (6) of this section.

(B) The superintendent shall conduct any criminal records check requested under section 121.08, 173.27, 173.394, 1322.03, 1322.031, 2151.86, 3301.32, 3301.541, 3319.39, 3701.881, 3712.09, 3721.121, 3722.151, 4749.03, 4749.06, 4763.05, 5104.012, 5104.013, ~~5111.95, 5111.96,~~ 5123.081, 5126.28, 5126.281, ~~or~~ 5153.111, 5163.75, or 5163.76 of the Revised Code as follows:

(1) The superintendent shall review or cause to be reviewed any relevant information gathered and compiled by the bureau under division (A) of section 109.57 of the Revised Code that relates to the person who is the subject of the request, including any relevant information contained in records that have been sealed

under section 2953.32 of the Revised Code;

(2) If the request received by the superintendent asks for information from the federal bureau of investigation, the superintendent shall request from the federal bureau of investigation any information it has with respect to the person who is the subject of the request and shall review or cause to be reviewed any information the superintendent receives from that bureau.

(3) The superintendent or the superintendent's designee may request criminal history records from other states or the federal government pursuant to the national crime prevention and privacy compact set forth in section 109.571 of the Revised Code.

(C)(1) The superintendent shall prescribe a form to obtain the information necessary to conduct a criminal records check from any person for whom a criminal records check is required by section 121.08, 173.27, 173.394, 1322.03, 1322.031, 2151.86, 3301.32, 3301.541, 3319.39, 3701.881, 3712.09, 3721.121, 3722.151, 4749.03, 4749.06, 4763.05, 5104.012, 5104.013, ~~5111.95, 5111.96,~~ 5123.081, 5126.28, 5126.281, ~~or~~ 5153.111, 5163.75, or 5163.76 of the Revised Code. The form that the superintendent prescribes pursuant to this division may be in a tangible format, in an electronic format, or in both tangible and electronic formats.

(2) The superintendent shall prescribe standard impression sheets to obtain the fingerprint impressions of any person for whom a criminal records check is required by section 121.08, 173.27, 173.394, 1322.03, 1322.031, 2151.86, 3301.32, 3301.541, 3319.39, 3701.881, 3712.09, 3721.121, 3722.151, 4749.03, 4749.06, 4763.05, 5104.012, 5104.013, ~~5111.95, 5111.96,~~ 5123.081, 5126.28, 5126.281, ~~or~~ 5153.111, 5163.75, or 5163.76 of the Revised Code. Any person for whom a records check is required by any of those sections shall obtain the fingerprint impressions at a county sheriff's office, municipal police department, or any other entity

with the ability to make fingerprint impressions on the standard impression sheets prescribed by the superintendent. The office, department, or entity may charge the person a reasonable fee for making the impressions. The standard impression sheets the superintendent prescribes pursuant to this division may be in a tangible format, in an electronic format, or in both tangible and electronic formats.

(3) Subject to division (D) of this section, the superintendent shall prescribe and charge a reasonable fee for providing a criminal records check requested under section 121.08, 173.27, 173.394, 1322.03, 1322.031, 2151.86, 3301.32, 3301.541, 3319.39, 3701.881, 3712.09, 3721.121, 3722.151, 4749.03, 4749.06, 4763.05, 5104.012, 5104.013, ~~5111.95, 5111.96,~~ 5123.081, 5126.28, 5126.281, ~~or~~ 5153.111, 5163.75, or 5163.76 of the Revised Code. The person making a criminal records request under section 121.08, 173.27, 173.394, 1322.03, 1322.031, 2151.86, 3301.32, 3301.541, 3319.39, 3701.881, 3712.09, 3721.121, 3722.151, 4749.03, 4749.06, 4763.05, 5104.012, 5104.013, ~~5111.95, 5111.96,~~ 5123.081, 5126.28, 5126.281, ~~or~~ 5153.111, 5163.75, or 5163.76 of the Revised Code shall pay the fee prescribed pursuant to this division. A person making a request under section 3701.881 of the Revised Code for a criminal records check for an applicant who may be both responsible for the care, custody, or control of a child and involved in providing direct care to an older adult shall pay one fee for the request.

(4) The superintendent of the bureau of criminal identification and investigation may prescribe methods of forwarding fingerprint impressions and information necessary to conduct a criminal records check, which methods shall include, but not be limited to, an electronic method.

(D) A determination whether any information exists that indicates that a person previously has been convicted of or

pleaded guilty to any offense listed or described in division (A)(1)(a) or (b), (A)(2)(a) or (b), (A)(3)(a) or (b), (A)(4)(a) or (b), (A)(5)(a) or (b), (A)(6)(a) or (b), (A)(7), (A)(8)(a) or (b), (A)(9)(a) or (b), (A)(10)(a) or (b), or (A)(12) of this section that is made by the superintendent with respect to information considered in a criminal records check in accordance with this section is valid for the person who is the subject of the criminal records check for a period of one year from the date upon which the superintendent makes the determination. During the period in which the determination in regard to a person is valid, if another request under this section is made for a criminal records check for that person, the superintendent shall provide the information that is the basis for the superintendent's initial determination at a lower fee than the fee prescribed for the initial criminal records check.

(E) As used in this section:

(1) "Criminal records check" means any criminal records check conducted by the superintendent of the bureau of criminal identification and investigation in accordance with division (B) of this section.

(2) "Home and community-based waiver services" and "waiver agency" have the same meanings as in section ~~5111.95~~ 5163.75 of the Revised Code.

(3) "Independent provider" has the same meaning as in section ~~5111.96~~ 5163.76 of the Revised Code.

(4) "Minor drug possession offense" has the same meaning as in section 2925.01 of the Revised Code.

(5) "Older adult" means a person age sixty or older.

Sec. 109.85. (A) Upon the written request of the governor, the general assembly, the auditor of state, the director of ~~job~~

~~and family services~~ health care administration, the director of health, or the director of budget and management, or upon the attorney general's becoming aware of criminal or improper activity related to Chapter 3721. and the ~~medical assistance~~ medicaid program ~~established under section 5111.01 of the Revised Code~~, the attorney general shall investigate any criminal or civil violation of law related to Chapter 3721. of the Revised Code or the ~~medical assistance~~ medicaid program.

(B) When it appears to the attorney general, as a result of an investigation under division (A) of this section, that there is cause to prosecute for the commission of a crime or to pursue a civil remedy, the attorney general may refer the evidence to the prosecuting attorney having jurisdiction of the matter, or to a regular grand jury drawn and impaneled pursuant to sections 2939.01 to 2939.24 of the Revised Code, or to a special grand jury drawn and impaneled pursuant to section 2939.17 of the Revised Code, or the attorney general may initiate and prosecute any necessary criminal or civil actions in any court or tribunal of competent jurisdiction in this state. When proceeding under this section, the attorney general, and any assistant or special counsel designated by the attorney general for that purpose, have all rights, privileges, and powers of prosecuting attorneys. The attorney general shall have exclusive supervision and control of all investigations and prosecutions initiated by the attorney general under this section. The forfeiture provisions of Chapter 2981. of the Revised Code apply in relation to any such criminal action initiated and prosecuted by the attorney general.

(C) Nothing in this section shall prevent a county prosecuting attorney from investigating and prosecuting criminal activity related to Chapter 3721. of the Revised Code and the ~~medical assistance~~ medicaid program ~~established under section 5111.01 of the Revised Code~~. The forfeiture provisions of Chapter

2981. of the Revised Code apply in relation to any prosecution of criminal activity related to the ~~medical assistance~~ medicaid program undertaken by the prosecuting attorney.

Sec. 117.10. The auditor of state shall audit all public offices as provided in this chapter. The auditor of state also may audit the accounts of private institutions, associations, boards, and corporations receiving public money for their use and may require of them annual reports in such form as the auditor of state prescribes.

If the auditor of state performs or contracts for the performance of an audit, including a special audit, of the public employees retirement system, school employees retirement system, state teachers retirement system, state highway patrol retirement system, or Ohio police and fire pension fund, the auditor of state shall make a timely report of the results of the audit to the Ohio retirement study council.

The auditor of state may audit the accounts of any provider as defined in section ~~5111.06~~ 5163.01 of the Revised Code.

If a public office has been audited by an agency of the United States government, the auditor of state may, if satisfied that the federal audit has been conducted according to principles and procedures not contrary to those of the auditor of state, use and adopt the federal audit and report in lieu of an audit by the auditor of state's own office.

Within thirty days after the creation or dissolution or the winding up of the affairs of any public office, that public office shall notify the auditor of state in writing that this action has occurred.

Sec. 117.54. The auditor of state may enter into agreements with the director of health care administration, director of job

and family services, and comparable officers of other states for the exchange of names, current or most recent addresses, and social security numbers of medicaid recipients and participants and recipients of Title IV-A programs as defined in section 5101.80 of the Revised Code.

Sec. 117.55. The auditor of state shall retain, for not less than two years, at least one copy of all materials containing information received under sections 117.54, 117.56, 145.27, 742.41, 3307.21, 3309.22, 4123.27, 5101.181, 5101.182, 5160.43, 5160.44, and 5505.04 of the Revised Code. The auditor of state shall review the information to determine whether overpayments were made to participants and recipients of public assistance under Chapters 5107., 5108., and 5115. of the Revised Code and whether benefits were incorrectly paid on behalf of medicaid recipients and disability medical assistance recipients. The auditor of state shall initiate action leading to prosecution, where warranted, of participants and recipients who received overpayments or had benefits incorrectly paid on their behalf by forwarding the name of each such participant or recipient, together with other pertinent information, to the following:

(A) The attorney general;

(B) The director of job and family services or director of health care administration, as appropriate;

(C) In the case of public assistance under Chapters 5107., 5108., and 5115. of the Revised Code, the district director of job and family services of the district through which the public assistance was received;

(D) The county director of job and family services and county prosecutor of the county through which the public assistance, medicaid, or disability medical assistance was received.

Sec. 117.56. The auditor of state and the attorney general and persons acting at their direction may examine any records, whether in computer or printed format, in the possession of the department of health care administration, the department of job and family services, or a county department of job and family services. The auditor of state and attorney general shall provide safeguards that restrict access to the records to purposes directly connected with an audit or investigation, prosecution, or criminal or civil proceeding conducted in connection with the administration of the medicaid program, the disability medical assistance program, or a public assistance program under Chapter 5107., 5108., or 5115. of the Revised Code. Persons acting under this section shall comply with the rules of the director of job and family services restricting the disclosure of information regarding participants and recipients of public assistance and rules of the director of health care administration restricting the disclosure of information regarding medicaid and disability medical assistance recipients. A person determined to have failed to comply with these rules shall thereafter be disqualified from acting as an agent or employee or in any other capacity under appointment or employment of any state board, commission, or agency.

Sec. 117.57. The auditor of state is responsible for the costs incurred by the auditor of state in carrying out the auditor of state's duties under sections 117.55 and 117.56 of the Revised Code.

Sec. 119.01. As used in sections 119.01 to 119.13 of the Revised Code:

(A)(1) "Agency" means, except as limited by this division, any official, board, or commission having authority to promulgate

rules or make adjudications in the civil service commission, the division of liquor control, the department of taxation, the industrial commission, the bureau of workers' compensation, the functions of any administrative or executive officer, department, division, bureau, board, or commission of the government of the state specifically made subject to sections 119.01 to 119.13 of the Revised Code, and the licensing functions of any administrative or executive officer, department, division, bureau, board, or commission of the government of the state having the authority or responsibility of issuing, suspending, revoking, or canceling licenses.

Except as otherwise provided in division (I) of this section, sections 119.01 to 119.13 of the Revised Code do not apply to the public utilities commission. Sections 119.01 to 119.13 of the Revised Code do not apply to the utility radiological safety board; to the controlling board; to actions of the superintendent of financial institutions and the superintendent of insurance in the taking possession of, and rehabilitation or liquidation of, the business and property of banks, savings and loan associations, savings banks, credit unions, insurance companies, associations, reciprocal fraternal benefit societies, and bond investment companies; to any action taken by the division of securities under section 1707.201 of the Revised Code; or to any action that may be taken by the superintendent of financial institutions under section 1113.03, 1121.06, 1121.10, 1125.09, 1125.12, 1125.18, 1157.01, 1157.02, 1157.10, 1165.01, 1165.02, 1165.10, 1349.33, 1733.35, 1733.361, 1733.37, or 1761.03 of the Revised Code.

Sections 119.01 to 119.13 of the Revised Code do not apply to actions of the industrial commission or the bureau of workers' compensation under sections 4123.01 to 4123.94 of the Revised Code with respect to all matters of adjudication, and to the actions of the industrial commission and bureau of workers' compensation

under division (D) of section 4121.32, sections 4123.29, 4123.34, 4123.341, 4123.342, 4123.40, 4123.411, 4123.44, and 4123.442, and divisions (B), (C), and (E) of section 4131.14 of the Revised Code.

(2) "Agency" also means any official or work unit having authority to promulgate rules or make adjudications in the department of job and family services, but only with respect to both of the following:

(a) The adoption, amendment, or rescission of rules that section 5101.09 of the Revised Code requires be adopted in accordance with this chapter;

(b) The issuance, suspension, revocation, or cancellation of licenses.

(B) "License" means any license, permit, certificate, commission, or charter issued by any agency. "License" does not include any arrangement whereby a person, institution, or entity 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. 301, as amended~~ health care administration.

(C) "Rule" means any rule, regulation, or standard, having a general and uniform operation, adopted, promulgated, and enforced by any agency under the authority of the laws governing such agency, and includes any appendix to a rule. "Rule" does not include any internal management rule of an agency unless the internal management rule affects private rights and does not include any guideline adopted pursuant to section 3301.0714 of the Revised Code.

(D) "Adjudication" means the determination by the highest or ultimate authority of an agency of the rights, duties, privileges, benefits, or legal relationships of a specified person, but does

not include the issuance of a license in response to an application with respect to which no question is raised, nor other acts of a ministerial nature.

(E) "Hearing" means a public hearing by any agency in compliance with procedural safeguards afforded by sections 119.01 to 119.13 of the Revised Code.

(F) "Person" means a person, firm, corporation, association, or partnership.

(G) "Party" means the person whose interests are the subject of an adjudication by an agency.

(H) "Appeal" means the procedure by which a person, aggrieved by a finding, decision, order, or adjudication of any agency, invokes the jurisdiction of a court.

(I) "Rule-making agency" means any board, commission, department, division, or bureau of the government of the state that is required to file proposed rules, amendments, or rescissions under division (D) of section 111.15 of the Revised Code and any agency that is required to file proposed rules, amendments, or rescissions under divisions (B) and (H) of section 119.03 of the Revised Code. "Rule-making agency" includes the public utilities commission. "Rule-making agency" does not include any state-supported college or university.

(J) "Substantive revision" means any addition to, elimination from, or other change in a rule, an amendment of a rule, or a rescission of a rule, whether of a substantive or procedural nature, that changes any of the following:

(1) That which the rule, amendment, or rescission permits, authorizes, regulates, requires, prohibits, penalizes, rewards, or otherwise affects;

(2) The scope or application of the rule, amendment, or

rescission.

(K) "Internal management rule" means any rule, regulation, or standard governing the day-to-day staff procedures and operations within an agency.

Sec. 121.02. The following administrative departments and their respective directors are hereby created:

(A) The office of budget and management, which shall be administered by the director of budget and management;

(B) The department of commerce, which shall be administered by the director of commerce;

(C) The department of administrative services, which shall be administered by the director of administrative services;

(D) The department of transportation, which shall be administered by the director of transportation;

(E) The department of agriculture, which shall be administered by the director of agriculture;

(F) The department of natural resources, which shall be administered by the director of natural resources;

(G) The department of health, which shall be administered by the director of health;

(H) The department of job and family services, which shall be administered by the director of job and family services;

(I) Until July 1, 1997, the department of liquor control, which shall be administered by the director of liquor control;

(J) The department of public safety, which shall be administered by the director of public safety;

(K) The department of mental health, which shall be administered by the director of mental health;

(L) The department of mental retardation and developmental disabilities, which shall be administered by the director of mental retardation and developmental disabilities;

(M) The department of insurance, which shall be administered by the superintendent of insurance as director thereof;

(N) The department of development, which shall be administered by the director of development;

(O) The department of youth services, which shall be administered by the director of youth services;

(P) The department of rehabilitation and correction, which shall be administered by the director of rehabilitation and correction;

(Q) The environmental protection agency, which shall be administered by the director of environmental protection;

(R) The department of aging, which shall be administered by the director of aging;

(S) The department of alcohol and drug addiction services, which shall be administered by the director of alcohol and drug addiction services.

(T) The department of health care administration, which shall be administered by the director of health care administration.

The director of each department shall exercise the powers and perform the duties vested by law in such department.

Sec. 121.03. The following administrative department heads shall be appointed by the governor, with the advice and consent of the senate, and shall hold their offices during the term of the appointing governor, and are subject to removal at the pleasure of the governor.

(A) The director of budget and management;

(B) The director of commerce;

(C) The director of transportation;

(D) The director of agriculture;

(E) The director of job and family services;

(F) Until July 1, 1997, the director of liquor control;

(G) The director of public safety;

(H) The superintendent of insurance;

(I) The director of development;

(J) The tax commissioner;

(K) The director of administrative services;

(L) The director of natural resources;

(M) The director of mental health;

(N) The director of mental retardation and developmental disabilities;

(O) The director of health;

(P) The director of youth services;

(Q) The director of rehabilitation and correction;

(R) The director of environmental protection;

(S) The director of aging;

(T) The director of alcohol and drug addiction services;

(U) The administrator of workers' compensation who meets the qualifications required under division (A) of section 4121.121 of the Revised Code.

(V) The director of health care administration.

Sec. 122.15. As used in sections 122.15 to 122.154 of the Revised Code:

(A) "Edison center" means a cooperative research and development facility that receives funding through the Thomas Alva Edison grant program under division (C) of section 122.33 of the Revised Code.

(B) "Ohio entity" means any corporation, limited liability company, or unincorporated business organization, including a general or limited partnership, that has its principal place of business located in this state and has at least fifty per cent of its gross assets and fifty per cent of its employees located in this state. If a corporation, limited liability company, or unincorporated business organization is a member of an affiliated group, the gross assets and the number of employees of all of the members of that affiliated group, wherever those assets and employees are located, shall be included for the purpose of determining the percentage of the corporation's, company's, or organization's gross assets and employees that are located in this state.

(C) "Qualified trade or business" means any trade or business that primarily involves research and development, technology transfer, bio-technology, information technology, or the application of new technology developed through research and development or acquired through technology transfer. "Qualified trade or business" does not include any of the following:

(1) Any trade or business involving the performance of services in the field of law, engineering, architecture, accounting, actuarial science, performing arts, consulting, athletics, financial services, or brokerage services, or any trade or business where the principal asset of the trade or business is the reputation or skill of one or more of its employees;

(2) Any banking, insurance, financing, leasing, rental, investing, or similar business;

(3) Any farming business, including the business of raising or harvesting trees;

(4) Any business involving the production or extraction of products of a character with respect to which a deduction is allowable under section 611, 613, or 613A of the "Internal Revenue Code of 1986," 100 Stat. 2085, 26 U.S.C.A. 611, 613, or 613A;

(5) Any business of operating a hotel, motel, restaurant, or similar business;

(6) Any trade or business involving a hospital, a private office of a licensed health care professional, a group practice of licensed health care professionals, or a nursing home. As used in division (C)(6) of this section:

(a) "Nursing home" has the same meaning as in section ~~3721.50~~ 5166.20 of the Revised Code.

(b) "Hospital" has the same meaning as in section 3727.01 of the Revised Code.

(D) "Information technology" means the branch of technology devoted to the study and application of data and the processing thereof; the automatic acquisition, storage, manipulation or transformation, management, movement, control, display, switching, interchange, transmission or reception of data, and the development or use of hardware, software, firmware, and procedures associated with this processing. Information technology includes matters concerned with the furtherance of computer science and technology, design, development, installation and implementation of information systems and applications that in turn will be licensed or sold to a specific target market. Information technology does not include the creation of a distribution method for existing products and services.

(E) "Insider" means an individual who owns, controls, or holds power to vote five per cent or more of the outstanding

securities of a business. For purposes of determining whether an investor is an insider, the percentage of voting power in the Ohio entity held by a person related to the investor shall be added to the investor's percentage of voting power in the same Ohio entity, if the investor claimed the person related to the investor as a dependent or a spouse on the investor's federal income tax return for the previous tax year.

(F) "Related to" means being the spouse, parent, child, or sibling of an individual.

(G) "Research and development" means designing, creating, or formulating new or enhanced products, equipment, or processes, and conducting scientific or technological inquiry and experimentation in the physical sciences with the goal of increasing scientific knowledge that may reveal the bases for new or enhanced products, equipment, or processes.

(H) "State tax liability" means any tax liability incurred under division (D) of section 5707.03, section 5727.24, 5727.38, or 5747.02, or Chapter 5733. of the Revised Code.

(I) "Technology transfer" means the transfer of technology from one sector of the economy to another, including the transfer of military technology to civilian applications, civilian technology to military applications, or technology from public or private research laboratories to military or civilian applications.

(J) "Affiliated group" means two or more persons related in such a way that one of the persons owns or controls the business operations of another of those persons. In the case of a corporation issuing capital stock, one corporation owns or controls the business operations of another corporation if it owns more than fifty per cent of the other corporation's capital stock with voting rights. In the case of a limited liability company,

one person owns or controls the business operations of the company if that person's membership interest, as defined in section 1705.01 of the Revised Code, is greater than fifty per cent of combined membership interest of all persons owning such interests in the company. In the case of an unincorporated business organization, one person owns or controls the business operations of the organization if, under the articles of organization or other instrument governing the affairs of the organization, that person has a beneficial interest in the organization's profits, surpluses, losses, or other distributions greater than fifty per cent of the combined beneficial interests of all persons having such an interest in the organization.

(K) "Money" means United States currency, or a check, draft, or cashier's check for United States currency, payable on demand and drawn on a bank.

(L) "EDGE business enterprise" means an Ohio entity certified by the director of administrative services as a participant in the encouraging diversity, growth, and equity program established by the governor's executive order 2002-17T.

(M) "Distressed area" has the same meaning as in section 122.23 of the Revised Code.

Sec. 124.30. (A) Positions in the classified service may be filled without competition as follows:

(1) Whenever there are urgent reasons for filling a vacancy in any position in the classified service and the director of administrative services is unable to certify to the appointing authority, upon its request, a list of persons eligible for appointment to the position after a competitive examination, the appointing authority may fill the position by noncompetitive examination.

A temporary appointment may be made without regard to the rules of sections 124.01 to 124.64 of the Revised Code. Except as otherwise provided in this division, the temporary appointment may not continue longer than one hundred twenty days, and in no case shall successive temporary appointments be made. A temporary appointment longer than one hundred twenty days may be made if necessary by reason of sickness, disability, or other approved leave of absence of regular officers or employees, in which case it may continue during the period of sickness, disability, or other approved leave of absence, subject to the rules of the director.

(2) In case of a vacancy in a position in the classified service where peculiar and exceptional qualifications of a scientific, managerial, professional, or educational character are required, and upon satisfactory evidence that for specified reasons competition in this special case is impracticable and that the position can best be filled by a selection of some designated person of high and recognized attainments in those qualities, the director may suspend the provisions of sections 124.01 to 124.64 of the Revised Code that require competition in this special case, but no suspension shall be general in its application. All such cases of suspension shall be reported in the annual report of the director with the reasons for each suspension. The director shall suspend the provisions when the director of job and family services <u>or director of health care administration</u> provides the certification under section 5101.051 <u>or 5160.05</u> of the Revised Code that a position with the department of job and family services <u>or department of health care administration</u> can best be filled if the provisions are suspended.

(3) The acceptance or refusal by an eligible person of a temporary appointment shall not affect the person's standing on the eligible list for permanent appointment, nor shall the period

of temporary service be counted as a part of the probationary service in case of subsequent appointment to a permanent position.

(B) Persons who receive temporary or intermittent appointments are in the unclassified civil service and serve at the pleasure of their appointing authority.

Sec. 124.301. The director of administrative services shall waive any residency requirement for the civil service established by a rule adopted under division (A) of section 124.09 of the Revised Code if the director of job and family services or director of health care administration provides the director certification under section 5101.051 or 5160.05 of the Revised Code that a position with the department of job and family services or department of health care administration can best be filled if the residency requirement is waived.

Sec. 124.821. Each state agency shall pay the monthly enrollee premium for medical insurance coverage under Part B of ~~"The Social Security Amendments of 1965," 79 Stat. 301, 42 U.S.C. 1395j, as amended,~~ the medicare program for state employees and elected state officials who are employed by or serve in the agency, are paid directly by warrant of the director of budget and management, are sixty-five years of age or older, and are participating in the medicare program ~~of health insurance for the aged under Title XVIII of the "Social Security Act," 79 Stat. 286, 42 U.S.C. 1395, as amended~~. The cost of the premiums shall not be deducted from any employee's or official's wage or salary.

The director of administrative services shall uniformly administer this section and shall, by rule, establish procedures for carrying out such administration.

Sec. 127.16. (A) Upon the request of either a state agency or the director of budget and management and after the controlling

board determines that an emergency or a sufficient economic reason exists, the controlling board may approve the making of a purchase without competitive selection as provided in division (B) of this section.

(B) Except as otherwise provided in this section, no state agency, using money that has been appropriated to it directly, shall:

(1) Make any purchase from a particular supplier, that would amount to fifty thousand dollars or more when combined with both the amount of all disbursements to the supplier during the fiscal year for purchases made by the agency and the amount of all outstanding encumbrances for purchases made by the agency from the supplier, unless the purchase is made by competitive selection or with the approval of the controlling board;

(2) Lease real estate from a particular supplier, if the lease would amount to seventy-five thousand dollars or more when combined with both the amount of all disbursements to the supplier during the fiscal year for real estate leases made by the agency and the amount of all outstanding encumbrances for real estate leases made by the agency from the supplier, unless the lease is made by competitive selection or with the approval of the controlling board.

(C) Any person who authorizes a purchase in violation of division (B) of this section shall be liable to the state for any state funds spent on the purchase, and the attorney general shall collect the amount from the person.

(D) Nothing in division (B) of this section shall be construed as:

(1) A limitation upon the authority of the director of transportation as granted in sections 5501.17, 5517.02, and 5525.14 of the Revised Code;

(2) Applying to medicaid provider agreements under Chapter ~~5111.~~ 5163. or 5164. of the Revised Code or payments or provider agreements under the disability medical assistance program established under Chapter ~~5115.~~ 5168. of the Revised Code;

(3) Applying to the purchase of examinations from a sole supplier by a state licensing board under Title XLVII of the Revised Code;

(4) Applying to entertainment contracts for the Ohio state fair entered into by the Ohio expositions commission, provided that the controlling board has given its approval to the commission to enter into such contracts and has approved a total budget amount for such contracts as agreed upon by commission action, and that the commission causes to be kept itemized records of the amounts of money spent under each contract and annually files those records with the clerk of the house of representatives and the clerk of the senate following the close of the fair;

(5) Limiting the authority of the chief of the division of mineral resources management to contract for reclamation work with an operator mining adjacent land as provided in section 1513.27 of the Revised Code;

(6) Applying to investment transactions and procedures of any state agency, except that the agency shall file with the board the name of any person with whom the agency contracts to make, broker, service, or otherwise manage its investments, as well as the commission, rate, or schedule of charges of such person with respect to any investment transactions to be undertaken on behalf of the agency. The filing shall be in a form and at such times as the board considers appropriate.

(7) Applying to purchases made with money for the per cent for arts program established by section 3379.10 of the Revised Code;

(8) Applying to purchases made by the rehabilitation services commission of services, or supplies, that are provided to persons with disabilities, or to purchases made by the commission in connection with the eligibility determinations it makes for applicants of programs administered by the social security administration;

(9) Applying to payments by the department of ~~job and family services~~ health care administration under section ~~5111.13~~ 5165.30 of the Revised Code for group health plan premiums, deductibles, coinsurance, and other cost-sharing expenses;

(10) Applying to any agency of the legislative branch of the state government;

(11) Applying to agreements or contracts entered into under section 5101.11, 5101.20, 5101.201, 5101.21, ~~or~~ 5101.214, 5160.13, 5160.15, or 5160.17 of the Revised Code;

(12) Applying to purchases of services by the adult parole authority under section 2967.14 of the Revised Code or by the department of youth services under section 5139.08 of the Revised Code;

(13) Applying to dues or fees paid for membership in an organization or association;

(14) Applying to purchases of utility services pursuant to section 9.30 of the Revised Code;

(15) Applying to purchases made in accordance with rules adopted by the department of administrative services of motor vehicle, aviation, or watercraft fuel, or emergency repairs of such vehicles;

(16) Applying to purchases of tickets for passenger air transportation;

(17) Applying to purchases necessary to provide public

notifications required by law or to provide notifications of job openings;

(18) Applying to the judicial branch of state government;

(19) Applying to purchases of liquor for resale by the division of liquor control;

(20) Applying to purchases of motor courier and freight services made in accordance with department of administrative services rules;

(21) Applying to purchases from the United States postal service and purchases of stamps and postal meter replenishment from vendors at rates established by the United States postal service;

(22) Applying to purchases of books, periodicals, pamphlets, newspapers, maintenance subscriptions, and other published materials;

(23) Applying to purchases from other state agencies, including state-assisted institutions of higher education;

(24) Limiting the authority of the director of environmental protection to enter into contracts under division (D) of section 3745.14 of the Revised Code to conduct compliance reviews, as defined in division (A) of that section;

(25) Applying to purchases from a qualified nonprofit agency pursuant to sections 125.60 to 125.6012 or 4115.31 to 4115.35 of the Revised Code;

(26) Applying to payments by the department of job and family services to the United States department of health and human services for printing and mailing notices pertaining to the tax refund offset program of the internal revenue service of the United States department of the treasury;

(27) Applying to contracts entered into by the department of

mental retardation and developmental disabilities under sections 5123.18, 5123.182, and 5123.199 of the Revised Code;

(28) Applying to payments made by the department of mental health under a physician recruitment program authorized by section 5119.101 of the Revised Code;

(29) Applying to contracts entered into with persons by the director of commerce for unclaimed funds collection and remittance efforts as provided in division (F) of section 169.03 of the Revised Code. The director shall keep an itemized accounting of unclaimed funds collected by those persons and amounts paid to them for their services.

(30) Applying to purchases made by a state institution of higher education in accordance with the terms of a contract between the vendor and an inter-university purchasing group comprised of purchasing officers of state institutions of higher education;

(31) Applying to the department of ~~job and family services'~~ health care administration's purchases of health assistance services under the children's health insurance program ~~part I provided for under section 5101.50 of the Revised Code or the children's health insurance program part II provided for under section 5101.51 of the Revised Code~~;

(32) Applying to payments by the attorney general from the reparations fund to hospitals and other emergency medical facilities for performing medical examinations to collect physical evidence pursuant to section 2907.28 of the Revised Code;

(33) Applying to contracts with a contracting authority or administrative receiver under division (B) of section 5126.056 of the Revised Code;

(34) Applying to reimbursements paid to the United States department of veterans affairs for pharmaceutical and patient

supply purchases made on behalf of the Ohio veterans' home agency;

(35) Applying to agreements entered into with terminal distributors of dangerous drugs under section ~~173.79~~ 5169.09 of the Revised Code.

(E) Notwithstanding division (B)(1) of this section, the cumulative purchase threshold shall be seventy-five thousand dollars for the departments of mental retardation and developmental disabilities, mental health, rehabilitation and correction, and youth services.

(F) When determining whether a state agency has reached the cumulative purchase thresholds established in divisions (B)(1), (B)(2), and (E) of this section, all of the following purchases by such agency shall not be considered:

(1) Purchases made through competitive selection or with controlling board approval;

(2) Purchases listed in division (D) of this section;

(3) For the purposes of the thresholds of divisions (B)(1) and (E) of this section only, leases of real estate.

(G) As used in this section, "competitive selection," "purchase," "supplies," and "services" have the same meanings as in section 125.01 of the Revised Code.

Sec. 131.23. The various political subdivisions of this state may issue bonds, and any indebtedness created by that issuance shall not be subject to the limitations or included in the calculation of indebtedness prescribed by sections 133.05, 133.06, 133.07, and 133.09 of the Revised Code, but the bonds may be issued only under the following conditions:

(A) The subdivision desiring to issue the bonds shall obtain from the county auditor a certificate showing the total amount of delinquent taxes due and unpayable to the subdivision at the last

semiannual tax settlement.

(B) The fiscal officer of that subdivision shall prepare a statement, from the books of the subdivision, verified by the fiscal officer under oath, which shall contain the following facts of the subdivision:

(1) The total bonded indebtedness;

(2) The aggregate amount of notes payable or outstanding accounts of the subdivision, incurred prior to the commencement of the current fiscal year, which shall include all evidences of indebtedness issued by the subdivision except notes issued in anticipation of bond issues and the indebtedness of any nontax-supported public utility;

(3) Except in the case of school districts, the aggregate current year's requirement for disability financial assistance ~~and disability medical assistance~~ provided under Chapter ~~5115.~~ 5168. of the Revised Code and the disability medical assistance program that the subdivision is unable to finance except by the issue of bonds;

(4) The indebtedness outstanding through the issuance of any bonds or notes pledged or obligated to be paid by any delinquent taxes;

(5) The total of any other indebtedness;

(6) The net amount of delinquent taxes unpledged to pay any bonds, notes, or certificates, including delinquent assessments on improvements on which the bonds have been paid;

(7) The budget requirements for the fiscal year for bond and note retirement;

(8) The estimated revenue for the fiscal year.

(C) The certificate and statement provided for in divisions (A) and (B) of this section shall be forwarded to the tax

commissioner together with a request for authority to issue bonds of the subdivision in an amount not to exceed seventy per cent of the net unobligated delinquent taxes and assessments due and owing to the subdivision, as set forth in division (B)(6) of this section.

(D) No subdivision may issue bonds under this section in excess of a sufficient amount to pay the indebtedness of the subdivision as shown by division (B)(2) of this section and, except in the case of school districts, to provide funds for disability financial assistance and disability medical assistance, as shown by division (B)(3) of this section.

(E) The tax commissioner shall grant to the subdivision authority requested by the subdivision as restricted by divisions (C) and (D) of this section and shall make a record of the certificate, statement, and grant in a record book devoted solely to such recording and which shall be open to inspection by the public.

(F) The commissioner shall immediately upon issuing the authority provided in division (E) of this section notify the proper authority having charge of the retirement of bonds of the subdivision by forwarding a copy of the grant of authority and of the statement provided for in division (B) of this section.

(G) Upon receipt of authority, the subdivision shall proceed according to law to issue the amount of bonds authorized by the commissioner, and authorized by the taxing authority, provided the taxing authority of that subdivision may submit, by resolution, to the electors of that subdivision the question of issuing the bonds. The resolution shall make the declarations and statements required by section 133.18 of the Revised Code. The county auditor and taxing authority shall thereupon proceed as set forth in divisions (C) and (D) of that section. The election on the question of issuing the bonds shall be held under divisions (E),

(F), and (G) of that section, except that publication of the notice of the election shall be made on two separate days prior to the election in one or more newspapers of general circulation in the subdivision, and, if the board of elections operates and maintains a web site, notice of the election also shall be posted on that web site for thirty days prior to the election. The bonds may be exchanged at their face value with creditors of the subdivision in liquidating the indebtedness described and enumerated in division (B)(2) of this section or may be sold as provided in Chapter 133. of the Revised Code, and in either event shall be uncontestable.

(H) The per cent of delinquent taxes and assessments collected for and to the credit of the subdivision after the exchange or sale of bonds as certified by the commissioner shall be paid to the authority having charge of the sinking fund of the subdivision, which money shall be placed in a separate fund for the purpose of retiring the bonds so issued. The proper authority of the subdivisions shall provide for the levying of a tax sufficient in amount to pay the debt charges on all such bonds issued under this section.

(I) This section is for the sole purpose of assisting the various subdivisions in paying their unsecured indebtedness, and providing funds for disability financial assistance and the disability medical assistance program. The bonds issued under authority of this section shall not be used for any other purpose, and any exchange for other purposes, or the use of the money derived from the sale of the bonds by the subdivision for any other purpose, is misapplication of funds.

(J) The bonds authorized by this section shall be redeemable or payable in not to exceed ten years from date of issue and shall not be subject to or considered in calculating the net indebtedness of the subdivision. The budget commission of the

county in which the subdivision is located shall annually allocate such portion of the then delinquent levy due the subdivision which is unpledged for other purposes to the payment of debt charges on the bonds issued under authority of this section.

(K) The issue of bonds under this section shall be governed by Chapter 133. of the Revised Code, respecting the terms used, forms, manner of sale, and redemption except as otherwise provided in this section.

The board of county commissioners of any county may issue bonds authorized by this section and distribute the proceeds of the bond issues to any or all of the cities and townships of the county, according to their relative needs for disability financial assistance and the disability medical assistance program as determined by the county.

All sections of the Revised Code inconsistent with or prohibiting the exercise of the authority conferred by this section are inoperative respecting bonds issued under this section.

Sec. 145.27. (A)(1) As used in this division, "personal history record" means information maintained by the public employees retirement board on an individual who is a member, former member, contributor, former contributor, retirant, or beneficiary that includes the address, telephone number, social security number, record of contributions, correspondence with the public employees retirement system, or other information the board determines to be confidential.

(2) The records of the board shall be open to public inspection, except that the following shall be excluded, except with the written authorization of the individual concerned:

(a) The individual's statement of previous service and other

information as provided for in section 145.16 of the Revised Code;

(b) The amount of a monthly allowance or benefit paid to the individual;

(c) The individual's personal history record.

(B) All medical reports and recommendations required by this chapter are privileged, except that copies of such medical reports or recommendations shall be made available to the personal physician, attorney, or authorized agent of the individual concerned upon written release from the individual or the individual's agent, or when necessary for the proper administration of the fund, to the board assigned physician.

(C) Any person who is a member or contributor of the system shall be furnished with a statement of the amount to the credit of the individual's account upon written request. The board is not required to answer more than one such request of a person in any one year. The board may issue annual statements of accounts to members and contributors.

(D) Notwithstanding the exceptions to public inspection in division (A)(2) of this section, the board may furnish the following information:

(1) If a member, former member, contributor, former contributor, or retirant is subject to an order issued under section 2907.15 of the Revised Code or is convicted of or pleads guilty to a violation of section 2921.41 of the Revised Code, on written request of a prosecutor as defined in section 2935.01 of the Revised Code, the board shall furnish to the prosecutor the information requested from the individual's personal history record.

(2) Pursuant to a court or administrative order issued pursuant to Chapter 3119., 3121., 3123., or 3125. of the Revised Code, the board shall furnish to a court or child support

enforcement agency the information required under that section.

(3) At the written request of any person, the board shall provide to the person a list of the names and addresses of members, former members, contributors, former contributors, retirants, or beneficiaries. The costs of compiling, copying, and mailing the list shall be paid by such person.

(4) Within fourteen days after receiving ~~from the director of job and family services~~ a list of the names and social security numbers of recipients of public assistance pursuant to section 5101.181 of the Revised Code or a list of the names and social security numbers of public medical assistance recipients pursuant to section 5160.43 of the Revised Code, the board shall inform the auditor of state of the name, current or most recent employer address, and social security number of each member whose name and social security number are the same as that of a person whose name or social security number ~~was submitted by the director~~ is included on the list. The board and its employees shall, except for purposes of furnishing the auditor of state with information required by this section, preserve the confidentiality of recipients of public assistance in compliance with ~~division (A) of~~ section 5101.181 of the Revised Code and preserve the confidentiality of public medical assistance recipients with section 5160.43 of the Revised Code.

(5) The system shall comply with orders issued under section 3105.87 of the Revised Code.

On the written request of an alternate payee, as defined in section 3105.80 of the Revised Code, the system shall furnish to the alternate payee information on the amount and status of any amounts payable to the alternate payee under an order issued under section 3105.171 or 3105.65 of the Revised Code.

(6) At the request of any person, the board shall make

available to the person copies of all documents, including resumes, in the board's possession regarding filling a vacancy of an employee member or retirant member of the board. The person who made the request shall pay the cost of compiling, copying, and mailing the documents. The information described in this division is a public record.

(E) A statement that contains information obtained from the system's records that is signed by the executive director or an officer of the system and to which the system's official seal is affixed, or copies of the system's records to which the signature and seal are attached, shall be received as true copies of the system's records in any court or before any officer of this state.

Sec. 145.58. (A) As used in this section, "ineligible individual" means all of the following:

(1) A former member receiving benefits pursuant to section 145.32, 145.33, 145.331, 145.34, or 145.46 of the Revised Code for whom eligibility is established more than five years after June 13, 1981, and who, at the time of establishing eligibility, has accrued less than ten years' service credit, exclusive of credit obtained pursuant to section 145.297 or 145.298 of the Revised Code, credit obtained after January 29, 1981, pursuant to section 145.293 or 145.301 of the Revised Code, and credit obtained after May 4, 1992, pursuant to section 145.28 of the Revised Code;

(2) The spouse of the former member;

(3) The beneficiary of the former member receiving benefits pursuant to section 145.46 of the Revised Code.

(B) The public employees retirement board may enter into agreements with insurance companies, health insuring corporations, or government agencies authorized to do business in the state for issuance of a policy or contract of health, medical, hospital, or

surgical benefits, or any combination thereof, for those individuals receiving age and service retirement or a disability or survivor benefit subscribing to the plan, or for PERS retirants employed under section 145.38 of the Revised Code, for coverage of benefits in accordance with division (D)(2) of section 145.38 of the Revised Code. Notwithstanding any other provision of this chapter, the policy or contract may also include coverage for any eligible individual's spouse and dependent children and for any of the individual's sponsored dependents as the board determines appropriate. If all or any portion of the policy or contract premium is to be paid by any individual receiving age and service retirement or a disability or survivor benefit, the individual shall, by written authorization, instruct the board to deduct the premium agreed to be paid by the individual to the company, corporation, or agency.

The board may contract for coverage on the basis of part or all of the cost of the coverage to be paid from appropriate funds of the public employees retirement system. The cost paid from the funds of the system shall be included in the employer's contribution rate provided by sections 145.48 and 145.51 of the Revised Code. The board may by rule provide coverage to ineligible individuals if the coverage is provided at no cost to the retirement system. The board shall not pay or reimburse the cost for coverage under this section or section 145.325 of the Revised Code for any ineligible individual.

The board may provide for self-insurance of risk or level of risk as set forth in the contract with the companies, corporations, or agencies, and may provide through the self-insurance method specific benefits as authorized by rules of the board.

(C) The board shall, beginning the month following receipt of satisfactory evidence of the payment for coverage, pay monthly to

each recipient of service retirement, or a disability or survivor benefit under the public employees retirement system who is eligible for medical insurance coverage under part B of ~~Title XVIII of "The Social Security Act," 79 Stat. 301 (1965), 42 U.S.C.A. 1395j, as amended~~ the medicare program, an amount equal to the basic premium for such coverage, except that the board shall make no such payment to any ineligible individual.

(D) The board shall establish by rule requirements for the coordination of any coverage, payment, or benefit provided under this section or section 145.325 of the Revised Code with any similar coverage, payment, or benefit made available to the same individual by the Ohio police and fire pension fund, state teachers retirement system, school employees retirement system, or state highway patrol retirement system.

(E) The board shall make all other necessary rules pursuant to the purpose and intent of this section.

Sec. 149.431. (A) Any governmental entity or agency and any nonprofit corporation or association, except a corporation organized pursuant to Chapter 1719. of the Revised Code prior to January 1, 1980 or organized pursuant to Chapter 3941. of the Revised Code, that enters into a contract or other agreement with the federal government, a unit of state government, or a political subdivision or taxing unit of this state for the provision of services shall keep accurate and complete financial records of any moneys expended in relation to the performance of the services pursuant to such contract or agreement according to generally accepted accounting principles. Such contract or agreement and such financial records shall be deemed to be public records as defined in division (A)(1) of section 149.43 of the Revised Code and are subject to the requirements of division (B) of that section, except that:

(1) Any information directly or indirectly identifying a present or former individual patient or client or ~~his~~ such an individual patient's or client's diagnosis, prognosis, or medical treatment, treatment for a mental or emotional disorder, treatment for mental retardation or a developmental disability, treatment for drug abuse or alcoholism, or counseling for personal or social problems is not a public record;

(2) If disclosure of the contract or agreement or financial records is requested at a time when confidential professional services are being provided to a patient or client whose confidentiality might be violated if disclosure were made at that time, disclosure may be deferred if reasonable times are established when the contract or agreement or financial records will be disclosed.

(3) Any nonprofit corporation or association that receives both public and private funds in fulfillment of any such contract or other agreement is not required to keep as public records the financial records of any private funds expended in relation to the performance of services pursuant to the contract or agreement.

(B) Any nonprofit corporation or association that receives more than fifty per cent of its gross receipts excluding moneys received pursuant to ~~Title XVIII of~~ the ~~"Social Security Act," 49 Stat. 620 (1935), 42 U.S.C. 301, as amended~~ medicare program, in a calendar year in fulfillment of a contract or other agreement for services with a governmental entity shall maintain information setting forth the compensation of any individual serving the nonprofit corporation or association in an executive or administrative capacity. Such information shall be deemed to be public records as defined in division (A)(1) of section 149.43 of the Revised Code and is subject to the requirements of division (B) of that section.

Nothing in this section shall be construed to otherwise limit

the provisions of section 149.43 of the Revised Code.

Sec. 169.02. Subject to division (B) of section 169.01 of the Revised Code, the following constitute unclaimed funds:

(A) Except as provided in division (R) of this section, any demand, savings, or matured time deposit account, or matured certificate of deposit, together with any interest or dividend on it, less any lawful claims, that is held or owed by a holder which is a financial organization, unclaimed for a period of five years;

(B) Any funds paid toward the purchase of withdrawable shares or other interest in a financial organization, and any interest or dividends on them, less any lawful claims, that is held or owed by a holder which is a financial organization, unclaimed for a period of five years;

(C) Except as provided in division (A) of section 3903.45 of the Revised Code, moneys held or owed by a holder, including a fraternal association, providing life insurance, including annuity or endowment coverage, unclaimed for three years after becoming payable as established from the records of such holder under any life or endowment insurance policy or annuity contract that has matured or terminated. An insurance policy, the proceeds of which are payable on the death of the insured, not matured by proof of death of the insured is deemed matured and the proceeds payable if such policy was in force when the insured attained the limiting age under the mortality table on which the reserve is based.

Moneys otherwise payable according to the records of such holder are deemed payable although the policy or contract has not been surrendered as required.

(D) Any deposit made to secure payment or any sum paid in advance for utility services of a public utility and any amount refundable from rates or charges collected by a public utility for

utility services held or owed by a holder, less any lawful claims, that has remained unclaimed for one year after the termination of the services for which the deposit or advance payment was made or one year from the date the refund was payable, whichever is earlier;

(E) Except as provided in division (R) of this section, any certificates, securities as defined in section 1707.01 of the Revised Code, nonwithdrawable shares, other instruments evidencing ownership, or rights to them or funds paid toward the purchase of them, or any dividend, capital credit, profit, distribution, interest, or payment on principal or other sum, held or owed by a holder, including funds deposited with a fiscal agent or fiduciary for payment of them, and instruments representing an ownership interest, unclaimed for five years. Any underlying share or other intangible instrument representing an ownership interest in a business association, in which the issuer has recorded on its books the issuance of the share but has been unable to deliver the certificate to the shareholder, constitutes unclaimed funds if such underlying share is unclaimed for five years. In addition, an underlying share constitutes unclaimed funds if a dividend, distribution, or other sum payable as a result of the underlying share has remained unclaimed by the owner for five years.

This division shall not prejudice the rights of fiscal agents or fiduciaries for payment to return the items described in this division to their principals, according to the terms of an agency or fiduciary agreement, but such a return shall constitute the principal as the holder of the items and shall not interrupt the period for computing the time for which the items have remained unclaimed.

In the case of any such funds accruing and held or owed by a corporation under division (E) of section 1701.24 of the Revised Code, such corporation shall comply with this chapter, subject to

the limitation contained in section 1701.34 of the Revised Code. The period of time for which such funds have gone unclaimed specified in section 1701.34 of the Revised Code shall be computed, with respect to dividends or distributions, commencing as of the dates when such dividends or distributions would have been payable to the shareholder had such shareholder surrendered the certificates for cancellation and exchange by the date specified in the order relating to them.

Capital credits of a cooperative which after January 1, 1972, have been allocated to members and which by agreement are expressly required to be paid if claimed after death of the owner are deemed payable, for the purpose of this chapter, fifteen years after either the termination of service by the cooperative to the owner or upon the nonactivity as provided in division (B) of section 169.01 of the Revised Code, whichever occurs later, provided that this provision does not apply if the payment is not mandatory.

(F) Any sum payable on certified checks or other written instruments certified or issued and representing funds held or owed by a holder, less any lawful claims, that are unclaimed for five years from the date payable or from the date of issuance if payable on demand; except that the unclaimed period for money orders that are not third party bank checks is seven years, and the unclaimed period for traveler's checks is fifteen years, from the date payable or from the date of issuance if payable on demand.

As used in this division, "written instruments" include, but are not limited to, certified checks, cashier's checks, bills of exchange, letters of credit, drafts, money orders, and traveler's checks.

If there is no address of record for the owner or other person entitled to the funds, such address is presumed to be the

address where the instrument was certified or issued.

(G) Except as provided in division (R) of this section, all moneys, rights to moneys, or other intangible property, arising out of the business of engaging in the purchase or sale of securities, or otherwise dealing in intangibles, less any lawful claims, that are held or owed by a holder and are unclaimed for five years from the date of transaction.

(H) Except as provided in division (A) of section 3903.45 of the Revised Code, all moneys, rights to moneys, and other intangible property distributable in the course of dissolution or liquidation of a holder that are unclaimed for one year after the date set by the holder for distribution;

(I) All moneys, rights to moneys, or other intangible property removed from a safe-deposit box or other safekeeping repository located in this state or removed from a safe-deposit box or other safekeeping repository of a holder, on which the lease or rental period has expired, or any amount arising from the sale of such property, less any lawful claims, that are unclaimed for three years from the date on which the lease or rental period expired;

(J) Subject to division (M)(2) of this section, all moneys, rights to moneys, or other intangible property, and any income or increment on them, held or owed by a holder which is a fiduciary for the benefit of another, or a fiduciary or custodian of a qualified retirement plan or individual retirement arrangement under section 401 or 408 of the Internal Revenue Code, unclaimed for three years after the final date for distribution;

(K) All moneys, rights to moneys, or other intangible property held or owed in this state or held for or owed to an owner whose last known address is within this state, by the United States government or any state, as those terms are described in

division (E) of section 169.01 of the Revised Code, unclaimed by the owner for three years, excluding any property in the control of any court in a proceeding in which a final adjudication has not been made;

(L) Amounts payable pursuant to the terms of any policy of insurance, other than life insurance, or any refund available under such a policy, held or owed by any holder, unclaimed for three years from the date payable or distributable;

(M)(1) Subject to division (M)(2) of this section, any funds constituting rents or lease payments due, any deposit made to secure payment of rents or leases, or any sum paid in advance for rents, leases, possible damage to property, unused services, performance requirements, or any other purpose, held or owed by a holder unclaimed for one year;

(2) Any escrow funds, security deposits, or other moneys that are received by a licensed broker in a fiduciary capacity and that, pursuant to division (A)(26) of section 4735.18 of the Revised Code, are required to be deposited into and maintained in a special or trust, noninterest-bearing bank account separate and distinct from any personal or other account of the licensed broker, held or owed by the licensed broker unclaimed for two years.

(N) Any sum greater than fifty dollars payable as wages, any sum payable as salaries or commissions, any sum payable for services rendered, funds owed or held as royalties, oil and mineral proceeds, funds held for or owed to suppliers, and moneys owed under pension and profit-sharing plans, held or owed by any holder unclaimed for one year from date payable or distributable, and all other credits held or owed, or to be refunded to a retail customer, by any holder unclaimed for three years from date payable or distributable;

(O) Amounts held in respect of or represented by lay-aways sold after January 1, 1972, less any lawful claims, when such lay-aways are unclaimed for three years after the sale of them;

(P) All moneys, rights to moneys, and other intangible property not otherwise constituted as unclaimed funds by this section, including any income or increment on them, less any lawful claims, which are held or owed by any holder, other than a holder which holds a permit issued pursuant to Chapter 3769. of the Revised Code, and which have remained unclaimed for three years after becoming payable or distributable;

(Q) All moneys that arise out of a sale held pursuant to section 5322.03 of the Revised Code, that are held by a holder for delivery on demand to the appropriate person pursuant to division (I) of that section, and that are unclaimed for two years after the date of the sale.

(R)(1) Any funds that are subject to an agreement between the holder and owner providing for automatic reinvestment and that constitute dividends, distributions, or other sums held or owed by a holder in connection with a security as defined in section 1707.01 of the Revised Code, an ownership interest in an investment company registered under the "Investment Company Act of 1940," 54 Stat. 789, 15 U.S.C. 80a-1, as amended, or a certificate of deposit, unclaimed for a period of five years.

(2) The five-year period under division (R)(1) of this section commences from the date a second shareholder notification or communication mailing to the owner of the funds is returned to the holder as undeliverable by the United States postal service or other carrier. The notification or communication mailing by the holder shall be no less frequent than quarterly.

All moneys in a personal allowance account, as defined by rules adopted by the director of ~~job and family services~~ health

care administration, up to and including the maximum resource limitation, of a medicaid patient who has died after receiving care in a long-term care facility, and for whom there is no identifiable heir or sponsor, are not subject to this chapter.

Sec. 173.14. As used in sections 173.14 to 173.27 of the Revised Code:

(A)(1) Except as otherwise provided in division (A)(2) of this section, "long-term care facility" includes any residential facility that provides personal care services for more than twenty-four hours for two or more unrelated adults, including all of the following:

(a) A "nursing home," "residential care facility," or "home for the aging" as defined in section 3721.01 of the Revised Code;

(b) A facility authorized to provide extended care services under ~~Title XVIII of~~ the ~~"Social Security Act," 49 Stat. 620 (1935), 42 U.S.C. 301, as amended~~ medicare program;

(c) A county home or district home operated pursuant to Chapter 5155. of the Revised Code;

(d) An "adult care facility" as defined in section 3722.01 of the Revised Code;

(e) A facility approved by the veterans administration under section 104(a) of the "Veterans Health Care Amendments of 1983," 97 Stat. 993, 38 U.S.C. 630, as amended, and used exclusively for the placement and care of veterans;

(f) An adult foster home certified under section 173.36 of the Revised Code.

(2) "Long-term care facility" does not include a "residential facility" as defined in section 5119.22 of the Revised Code or a "residential facility" as defined in section 5123.19 of the Revised Code.

(B) "Resident" means a resident of a long-term care facility and, where appropriate, includes a prospective, previous, or deceased resident of a long-term care facility.

(C) "Community-based long-term care services" means health and social services provided to persons in their own homes or in community care settings, and includes any of the following:

(1) Case management;

(2) Home health care;

(3) Homemaker services;

(4) Chore services;

(5) Respite care;

(6) Adult day care;

(7) Home-delivered meals;

(8) Personal care;

(9) Physical, occupational, and speech therapy;

(10) Transportation;

(11) Any other health and social services provided to persons that allow them to retain their independence in their own homes or in community care settings.

(D) "Recipient" means a recipient of community-based long-term care services and, where appropriate, includes a prospective, previous, or deceased recipient of community-based long-term care services.

(E) "Sponsor" means an adult relative, friend, or guardian who has an interest in or responsibility for the welfare of a resident or a recipient.

(F) "Personal care services" has the same meaning as in section 3721.01 of the Revised Code.

(G) "Regional long-term care ombudsperson program" means an entity, either public or private and nonprofit, designated as a regional long-term care ombudsperson program by the state long-term care ombudsperson.

(H) "Representative of the office of the state long-term care ombudsperson program" means the state long-term care ombudsperson or a member of the ombudsperson's staff, or a person certified as a representative of the office under section 173.21 of the Revised Code.

(I) "Area agency on aging" means an area agency on aging established under the "Older Americans Act of 1965," 79 Stat. 219, 42 U.S.C.A. 3001, as amended.

Sec. 173.20. (A) If consent is given and unless otherwise prohibited by law, a representative of the office of the state long-term care ~~ombudsman~~ ombudsperson program shall have access to any records, including medical records, of a resident or a recipient that are reasonably necessary for investigation of a complaint. Consent may be given in any of the following ways:

(1) In writing by the resident or recipient;

(2) Orally by the resident or recipient, witnessed in writing at the time it is given by one other person, and, if the records involved are being maintained by a long-term care provider, also by an employee of the long-term care provider designated under division (E)(1) of this section;

(3) In writing by the guardian of the resident or recipient;

(4) In writing by the attorney in fact of the resident or recipient, if the resident or recipient has authorized the attorney in fact to give such consent;

(5) In writing by the executor or administrator of the estate of a deceased resident or recipient.

(B) If consent to access to records is not refused by a resident or recipient or ~~his~~ the resident's or recipient's legal representative but cannot be obtained and any of the following circumstances exist, a representative of the office of the state long-term care ~~ombudsman~~ ombudsperson program, on approval of the state long-term care ~~ombudsman~~ ombudsperson, may inspect the records of a resident or a recipient, including medical records, that are reasonably necessary for investigation of a complaint:

(1) The resident or recipient is unable to express written or oral consent and there is no guardian or attorney in fact;

(2) There is a guardian or attorney in fact, but ~~he~~ the guardian or attorney in fact cannot be contacted within three working days;

(3) There is a guardianship or durable power of attorney, but its existence is unknown by the long-term care provider and the representative of the office at the time of the investigation;

(4) There is no executor or administrator of the estate of a deceased resident or recipient.

(C) If a representative of the office of the state long-term care ~~ombudsman~~ ombudsperson program has been refused access to records by a guardian or attorney in fact, but has reasonable cause to believe that the guardian or attorney in fact is not acting in the best interests of the resident or recipient, the representative may, on approval of the state long-term care ~~ombudsman~~ ombudsperson, inspect the records of the resident or recipient, including medical records, that are reasonably necessary for investigation of a complaint.

(D) A representative of the office of the state long-term care ~~ombudsman~~ ombudsperson program shall have access to any records of a long-term care provider reasonably necessary to an investigation conducted under this section, including but not

limited to: incident reports, dietary records, policies and procedures of a facility required to be maintained under section ~~5111.21~~ 5164.02 of the Revised Code, admission agreements, staffing schedules, any document depicting the actual staffing pattern of the provider, any financial records that are matters of public record, resident council and grievance committee minutes, and any waiting list maintained by a facility in accordance with section ~~5111.31~~ 5164.033 of the Revised Code, or any similar records or lists maintained by a provider of community-based long-term care services. Pursuant to division (E)(2) of this section, a representative shall be permitted to make or obtain copies of any of these records after giving the long-term care provider twenty-four hours' notice. A long-term care provider may impose a charge for providing copies of records under this division that does not exceed the actual and necessary expense of making the copies.

The state ~~ombudsman~~ ombudsperson shall take whatever action is necessary to ensure that any copy of a record made or obtained under this division is returned to the long-term care provider no later than three years after the date the investigation for which the copy was made or obtained is completed.

(E)(1) Each long-term care provider shall designate one or more of its employees to be responsible for witnessing the giving of oral consent under division (A) of this section. In the event that a designated employee is not available when a resident or recipient attempts to give oral consent, the provider shall designate another employee to witness the consent.

(2) Each long-term care provider shall designate one or more of its employees to be responsible for releasing records for copying to representatives of the office of the long-term care ~~ombudsman~~ ombudsperson program who request permission to make or obtain copies of records specified in division (D) of this

section. In the event that a designated employee is not available when a representative of the office makes the request, the long-term care provider shall designate another employee to release the records for copying.

(F) A long-term care provider or any employee of such a provider is immune from civil or criminal liability or action taken pursuant to a professional disciplinary procedure for the release or disclosure of records to a representative of the office pursuant to this section.

(G) A state or local government agency or entity with records relevant to a complaint or investigation being conducted by a representative of the office shall provide the representative access to the records.

(H) The state ~~ombudsman~~ ombudsperson, with the approval of the director of aging, may issue a subpoena to compel any person ~~he~~ the ombudsperson reasonably believes may be able to provide information to appear before ~~him~~ the ombudsperson or ~~his~~ the ombudsperson's designee and give sworn testimony and to produce documents, books, records, papers, or other evidence the state ~~ombudsman~~ ombudsperson believes is relevant to the investigation. On the refusal of a witness to be sworn or to answer any question put to ~~him~~ the witness, or if a person disobeys a subpoena, the ~~ombudsman~~ ombudsperson shall apply to the Franklin county court of common pleas for a contempt order, as in the case of disobedience of the requirements of a subpoena issued from the court, or a refusal to testify in the court.

(I) The state ~~ombudsman~~ ombudsperson may petition the court of common pleas in the county in which a long-term care facility is located to issue an injunction against any long-term care facility in violation of sections 3721.10 to 3721.17 of the Revised Code.

(J) Any suspected violation of Chapter 3721. of the Revised Code discovered during the course of an investigation may be reported to the department of health. Any suspected criminal violation discovered during the course of an investigation shall be reported to the attorney general or other appropriate law enforcement authorities.

(K) The department of aging shall adopt rules in accordance with Chapter 119. of the Revised Code for referral by the state ~~ombudsman~~ ombudsperson and regional long-term care ~~ombudsman~~ ombudsperson programs of complaints to other public agencies or entities. A public agency or entity to which a complaint is referred shall keep the state ~~ombudsman~~ ombudsperson or regional program handling the complaint advised and notified in writing in a timely manner of the disposition of the complaint to the extent permitted by law.

Sec. 173.21. (A) The office of the state long-term care ~~ombudsman~~ ombudsperson program, through the state long-term care ~~ombudsman~~ ombudsperson and the regional long-term care ~~ombudsman~~ ombudsperson programs, shall require each representative of the office to complete a training and certification program in accordance with this section and to meet the continuing education requirements established under this section.

(B) The department of aging shall adopt rules under Chapter 119. of the Revised Code specifying the content of training programs for representatives of the office of the state long-term care ~~ombudsman~~ ombudsperson program. Training for representatives other than those who are volunteers providing services through regional long-term care ~~ombudsman~~ ombudsperson programs shall include instruction regarding federal, state, and local laws, rules, and policies on long-term care facilities and community-based long-term care services; investigative techniques;

and other topics considered relevant by the department and shall consist of the following:

(1) A minimum of forty clock hours of basic instruction, which shall be completed before the trainee is permitted to handle complaints without the supervision of a representative of the office certified under this section;

(2) An additional sixty clock hours of instruction, which shall be completed within the first fifteen months of employment;

(3) An internship of twenty clock hours, which shall be completed within the first twenty-four months of employment, including instruction in, and observation of, basic nursing care and long-term care provider operations and procedures. The internship shall be performed at a site that has been approved as an internship site by the state long-term care ~~ombudsman~~ ombudsperson.

(4) One of the following, which shall be completed within the first twenty-four months of employment:

(a) Observation of a survey conducted by the director of health to certify a facility to receive funds under sections ~~5111.20~~ 5164.01 to ~~5111.32~~ 5164.35 of the Revised Code;

(b) Observation of an inspection conducted by the director of health to license an adult care facility under section 3722.04 of the Revised Code.

(5) Any other training considered appropriate by the department.

(C) Persons who for a period of at least six months prior to June 11, 1990, served as ombudsmen through the long-term care ~~ombudsman~~ ombudsperson program established by the department of aging under division (M) of section 173.01 of the Revised Code shall not be required to complete a training program. These

persons and persons who complete a training program shall take an examination administered by the department of aging. On attainment of a passing score, the person shall be certified by the department as a representative of the office. The department shall issue the person an identification card, which the representative shall show at the request of any person with whom ~~he~~ the representative deals while performing ~~his~~ the representative's duties and which ~~he~~ shall ~~surrender~~ be surrendered at the time ~~he~~ the representative separates from the office.

(D) The state ~~ombudsman~~ ombudsperson and each regional program shall conduct training programs for volunteers on their respective staffs in accordance with the rules of the department of aging adopted under division (B) of this section. Training programs may be conducted that train volunteers to complete some, but not all, of the duties of a representative of the office. Each regional office shall bear the cost of training its representatives who are volunteers. On completion of a training program, the representative shall take an examination administered by the department of aging. On attainment of a passing score, ~~he~~ a volunteer shall be certified by the department as a representative authorized to perform services specified in the certification. The department shall issue an identification card, which the representative shall show at the request of any person with whom ~~he~~ the representative deals while performing ~~his~~ the representative's duties and which ~~he~~ shall ~~surrender~~ be surrendered at the time ~~he~~ the representative separates from the office. Except as a supervised part of a training program, no volunteer shall perform any duty unless he is certified as a representative having received appropriate training for that duty.

(E) The state ~~ombudsman~~ ombudsperson shall provide technical assistance to regional programs conducting training programs for volunteers and shall monitor the training programs.

(F) Prior to scheduling an observation of a certification survey or licensing inspection for purposes of division (B)(4) of this section, the state ~~ombudsman~~ ombudsperson shall obtain permission to have the survey or inspection observed from both the director of health and the long-term care facility at which the survey or inspection is to take place.

(G) The department of aging shall establish continuing education requirements for representatives of the office.

Sec. 173.26. (A) Each of the following facilities shall annually pay to the department of aging six dollars for each bed maintained by the facility for use by a resident during any part of the previous year:

(1) Nursing homes, residential care facilities, and homes for the aging as defined in section 3721.01 of the Revised Code;

(2) Facilities authorized to provide extended care services under ~~Title XVIII of~~ the ~~"Social Security Act," 49 Stat. 620 (1935), 42 U.S.C. 301, as amended~~ medicare program;

(3) County homes and district homes operated pursuant to Chapter 5155. of the Revised Code;

(4) Adult care facilities as defined in section 3722.01 of the Revised Code;

(5) Facilities approved by the Veterans Administration under Section 104(a) of the "Veterans Health Care Amendments of 1983," 97 Stat. 993, 38 U.S.C. 630, as amended, and used exclusively for the placement and care of veterans.

The department shall, by rule adopted in accordance with Chapter 119. of the Revised Code, establish deadlines for payments required by this section. A facility that fails, within ninety days after the established deadline, to pay a payment required by this section shall be assessed at two times the original invoiced

payment.

(B) All money collected under this section shall be deposited in the state treasury to the credit of the office of the state long-term care ombudsperson program fund, which is hereby created. Money credited to the fund shall be used solely to pay the costs of operating the regional long-term care ombudsperson programs.

(C) The state long-term care ombudsperson and the regional programs may solicit and receive contributions to support the operation of the office or a regional program, except that no contribution shall be solicited or accepted that would interfere with the independence or objectivity of the office or program.

Sec. 173.394. (A) As used in this section:

(1) "Applicant" means a person who is under final consideration for employment with a community-based long-term care agency in a full-time, part-time, or temporary position that involves providing direct care to an individual. "Applicant" does not include a person who provides direct care as a volunteer without receiving or expecting to receive any form of remuneration other than reimbursement for actual expenses.

(2) "Criminal records check" has the same meaning as in section 109.572 of the Revised Code.

(B)(1) Except as provided in division (I) of this section, the chief administrator of a community-based long-term care agency shall request that the superintendent of the bureau of criminal identification and investigation conduct a criminal records check with respect to each applicant. If an applicant for whom a criminal records check request is required under this division does not present proof of having been a resident of this state for the five-year period immediately prior to the date the criminal records check is requested or provide evidence that within that

five-year period the superintendent has requested information about the applicant from the federal bureau of investigation in a criminal records check, the chief administrator shall request that the superintendent obtain information from the federal bureau of investigation as part of the criminal records check of the applicant. Even if an applicant for whom a criminal records check request is required under this division presents proof of having been a resident of this state for the five-year period, the chief administrator may request that the superintendent include information from the federal bureau of investigation in the criminal records check.

(2) A person required by division (B)(1) of this section to request a criminal records check shall do both of the following:

(a) Provide to each applicant for whom a criminal records check request is required under that division a copy of the form prescribed pursuant to division (C)(1) of section 109.572 of the Revised Code and a standard fingerprint impression sheet prescribed pursuant to division (C)(2) of that section, and obtain the completed form and impression sheet from the applicant;

(b) Forward the completed form and impression sheet to the superintendent of the bureau of criminal identification and investigation.

(3) An applicant provided the form and fingerprint impression sheet under division (B)(2)(a) of this section who fails to complete the form or provide fingerprint impressions shall not be employed in any position for which a criminal records check is required by this section.

(C)(1) Except as provided in rules adopted by the department of aging in accordance with division (F) of this section and subject to division (C)(2) of this section, no community-based long-term care agency shall employ a person in a position that

involves providing direct care to an individual if the person has been convicted of or pleaded guilty to any of the following:

(a) A violation of section 2903.01, 2903.02, 2903.03, 2903.04, 2903.11, 2903.12, 2903.13, 2903.16, 2903.21, 2903.34, 2905.01, 2905.02, 2905.11, 2905.12, 2907.02, 2907.03, 2907.05, 2907.06, 2907.07, 2907.08, 2907.09, 2907.12, 2907.25, 2907.31, 2907.32, 2907.321, 2907.322, 2907.323, 2911.01, 2911.02, 2911.11, 2911.12, 2911.13, 2913.02, 2913.03, 2913.04, 2913.11, 2913.21, 2913.31, 2913.40, 2913.43, 2913.47, 2913.51, 2919.25, 2921.36, 2923.12, 2923.13, 2923.161, 2925.02, 2925.03, 2925.11, 2925.13, 2925.22, 2925.23, or 3716.11 of the Revised Code.

(b) A violation of an existing or former law of this state, any other state, or the United States that is substantially equivalent to any of the offenses listed in division (C)(1)(a) of this section.

(2)(a) A community-based long-term care agency may employ conditionally an applicant for whom a criminal records check request is required under division (B) of this section prior to obtaining the results of a criminal records check regarding the individual, provided that the agency shall request a criminal records check regarding the individual in accordance with division (B)(1) of this section not later than five business days after the individual begins conditional employment. In the circumstances described in division (I)(2) of this section, a community-based long-term care agency may employ conditionally an applicant who has been referred to the agency by an employment service that supplies full-time, part-time, or temporary staff for positions involving the direct care of individuals and for whom, pursuant to that division, a criminal records check is not required under division (B) of this section.

(b) A community-based long-term care agency that employs an individual conditionally under authority of division (C)(2)(a) of

this section shall terminate the individual's employment if the results of the criminal records check request under division (B) of this section or described in division (I)(2) of this section, other than the results of any request for information from the federal bureau of investigation, are not obtained within the period ending sixty days after the date the request is made. Regardless of when the results of the criminal records check are obtained, if the results indicate that the individual has been convicted of or pleaded guilty to any of the offenses listed or described in division (C)(1) of this section, the agency shall terminate the individual's employment unless the agency chooses to employ the individual pursuant to division (F) of this section. Termination of employment under this division shall be considered just cause for discharge for purposes of division (D)(2) of section 4141.29 of the Revised Code if the individual makes any attempt to deceive the agency about the individual's criminal record.

(D)(1) Each community-based long-term care agency shall pay to the bureau of criminal identification and investigation the fee prescribed pursuant to division (C)(3) of section 109.572 of the Revised Code for each criminal records check conducted pursuant to a request made under division (B) of this section.

(2) A community-based long-term care agency may charge an applicant a fee not exceeding the amount the agency pays under division (D)(1) of this section. An agency may collect a fee only if both of the following apply:

(a) The agency notifies the person at the time of initial application for employment of the amount of the fee and that, unless the fee is paid, the person will not be considered for employment;

(b) The medicaid program ~~established under Chapter 5111. of the Revised Code~~ does not reimburse the agency the fee it pays

under division (D)(1) of this section.

(E) The report of any criminal records check conducted pursuant to a request made under this section is not a public record for the purposes of section 149.43 of the Revised Code and shall not be made available to any person other than the following:

(1) The individual who is the subject of the criminal records check or the individual's representative;

(2) The chief administrator of the agency requesting the criminal records check or the administrator's representative;

(3) The administrator of any other facility, agency, or program that provides direct care to individuals that is owned or operated by the same entity that owns or operates the community-based long-term care agency;

(4) The director of aging or a person authorized by the director to monitor a community-based long-term care agency's compliance with this section;

(5) A court, hearing officer, or other necessary individual involved in a case dealing with a denial of employment of the applicant or dealing with employment or unemployment benefits of the applicant;

(6) Any person to whom the report is provided pursuant to, and in accordance with, division (I)(1) or (2) of this section.

(F) The department of aging shall adopt rules in accordance with Chapter 119. of the Revised Code to implement this section. The rules shall specify circumstances under which a community-based long-term care agency may employ a person who has been convicted of or pleaded guilty to an offense listed or described in division (C)(1) of this section but meets personal character standards set by the department.

(G) The chief administrator of a community-based long-term care agency shall inform each person, at the time of initial application for a position that involves providing direct care to an individual, that the person is required to provide a set of fingerprint impressions and that a criminal records check is required to be conducted if the person comes under final consideration for employment.

(H) In a tort or other civil action for damages that is brought as the result of an injury, death, or loss to person or property caused by an individual who a community-based long-term care agency employs in a position that involves providing direct care to individuals, all of the following shall apply:

(1) If the agency employed the individual in good faith and reasonable reliance on the report of a criminal records check requested under this section, the agency shall not be found negligent solely because of its reliance on the report, even if the information in the report is determined later to have been incomplete or inaccurate;

(2) If the agency employed the individual in good faith on a conditional basis pursuant to division (C)(2) of this section, the agency shall not be found negligent solely because it employed the individual prior to receiving the report of a criminal records check requested under this section;

(3) If the agency in good faith employed the individual according to the personal character standards established in rules adopted under division (F) of this section, the agency shall not be found negligent solely because the individual prior to being employed had been convicted of or pleaded guilty to an offense listed or described in division (C)(1) of this section.

(I)(1) The chief administrator of a community-based long-term care agency is not required to request that the superintendent of

the bureau of criminal identification and investigation conduct a criminal records check of an applicant if the applicant has been referred to the agency by an employment service that supplies full-time, part-time, or temporary staff for positions involving the direct care of individuals and both of the following apply:

(a) The chief administrator receives from the employment service or the applicant a report of the results of a criminal records check regarding the applicant that has been conducted by the superintendent within the one-year period immediately preceding the applicant's referral;

(b) The report of the criminal records check demonstrates that the person has not been convicted of or pleaded guilty to an offense listed or described in division (C)(1) of this section, or the report demonstrates that the person has been convicted of or pleaded guilty to one or more of those offenses, but the community-based long-term care agency chooses to employ the individual pursuant to division (F) of this section.

(2) The chief administrator of a community-based long-term care agency is not required to request that the superintendent of the bureau of criminal identification and investigation conduct a criminal records check of an applicant and may employ the applicant conditionally as described in this division, if the applicant has been referred to the agency by an employment service that supplies full-time, part-time, or temporary staff for positions involving the direct care of individuals and if the chief administrator receives from the employment service or the applicant a letter from the employment service that is on the letterhead of the employment service, dated, and signed by a supervisor or another designated official of the employment service and that states that the employment service has requested the superintendent to conduct a criminal records check regarding

the applicant, that the requested criminal records check will include a determination of whether the applicant has been convicted of or pleaded guilty to any offense listed or described in division (C)(1) of this section, that, as of the date set forth on the letter, the employment service had not received the results of the criminal records check, and that, when the employment service receives the results of the criminal records check, it promptly will send a copy of the results to the community-based long-term care agency. If a community-based long-term care agency employs an applicant conditionally in accordance with this division, the employment service, upon its receipt of the results of the criminal records check, promptly shall send a copy of the results to the community-based long-term care agency, and division (C)(2)(b) of this section applies regarding the conditional employment.

Sec. 173.40. There is hereby created a medicaid waiver component, as defined in section ~~5111.85~~ 5163.50 of the Revised Code, to be known as the preadmission screening system providing options and resources today program, or PASSPORT. The PASSPORT program shall provide home and community-based services as an alternative to nursing facility placement for aged and disabled medicaid recipients. The program shall be operated pursuant to a home and community-based waiver granted by the United States secretary of health and human services under ~~section 1915 of the "Social Security Act," 49 Stat. 620 (1935),~~ 42 U.S.C. 1396n~~, as amended~~. The department of aging shall administer the program through a contract entered into with the department of ~~job and family services~~ health care administration under section ~~5111.91~~ 5161.05 of the Revised Code. The director of ~~job and family services~~ health care administration shall adopt rules under section ~~5111.85~~ 5163.50 of the Revised Code and the director of aging shall adopt rules in accordance with Chapter 119. of the

Revised Code to implement the program.

Sec. 173.42. (A) As used in this section:

(1) "Area agency on aging" means a public or private nonprofit entity designated under section 173.011 of the Revised Code to administer programs on behalf of the department of aging.

(2) "Long-term care consultation" means the process used to provide services under the long-term care consultation program established pursuant to this section, including, but not limited to, such services as the provision of information about long-term care options and costs, the assessment of an individual's functional capabilities, and the conduct of all or part of the reviews, assessments, and determinations specified in sections ~~5111.202, 5111.204,~~ 5119.061, ~~and~~ 5123.021, 5164.45, and 5164.47 of the Revised Code and the rules adopted under those sections.

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

~~(4)~~ "Nursing facility" has the same meaning as in section ~~5111.20~~ 5164.01 of the Revised Code.

~~(5)~~(4) "Representative" means a person acting on behalf of an individual seeking a long-term care consultation, applying for admission to a nursing facility, or residing in a nursing facility. A representative may be a family member, attorney, hospital social worker, or any other person chosen to act on behalf of the individual.

(B) The department of aging shall develop a long-term care consultation program whereby individuals or their representatives are provided with long-term care consultations and receive through these professional consultations information about options available to meet long-term care needs and information about factors to consider in making long-term care decisions. The

long-term care consultations provided under the program may be provided at any appropriate time, as permitted or required under this section and the rules adopted under it, including either prior to or after the individual who is the subject of a consultation has been admitted to a nursing facility.

(C) The long-term care consultation program shall be administered by the department of aging, except that the department may enter into a contract with an area agency on aging or other entity selected by the department under which the program for a particular area is administered by the area agency on aging or other entity pursuant to the contract.

(D) The long-term care consultations provided for purposes of the program shall be provided by individuals certified by the department under section 173.43 of the Revised Code.

(E) The information provided through a long-term care consultation shall be appropriate to the individual's needs and situation and shall address all of the following:

(1) The availability of any long-term care options open to the individual;

(2) Sources and methods of both public and private payment for long-term care services;

(3) Factors to consider when choosing among the available programs, services, and benefits;

(4) Opportunities and methods for maximizing independence and self-reliance, including support services provided by the individual's family, friends, and community.

(F) An individual's long-term care consultation may include an assessment of the individual's functional capabilities. The consultation may incorporate portions of the determinations required under sections ~~5111.202,~~ 5119.061, ~~and~~ 5123.021, and

5164.45 of the Revised Code and may be provided concurrently with the assessment required under section ~~5111.204~~ 5164.47 of the Revised Code.

(G)(1) Unless an exemption specified in division (I) of this section is applicable, each individual in the following categories shall be provided with a long-term care consultation:

(a) Individuals who apply or indicate an intention to apply for admission to a nursing facility, regardless of the source of payment to be used for their care in a nursing facility;

(b) Nursing facility residents who apply or indicate an intention to apply for medicaid;

(c) Nursing facility residents who are likely to spend down their resources within six months after admission to a nursing facility to a level at which they are financially eligible for medicaid;

(d) Individuals who request a long-term care consultation.

(2) In addition to the individuals included in the categories specified in division (G)(1) of this section, long-term care consultations may be provided to nursing facility residents who have not applied and have not indicated an intention to apply for medicaid. The purpose of the consultations provided to these individuals shall be to determine continued need for nursing facility services, to provide information on alternative services, and to make referrals to alternative services.

(H)(1) When a long-term care consultation is required to be provided pursuant to division (G)(1) of this section, the consultation shall be provided as follows or pursuant to division (H)(2) or (3) of this section:

(a) If the individual for whom the consultation is being provided has applied for medicaid and the consultation is being

provided concurrently with the assessment required under section 5111.204 of the Revised Code, the consultation shall be completed in accordance with the applicable time frames specified in that section for providing a level of care determination based on the assessment.

(b) In all other cases, the consultation shall be provided not later than five calendar days after the department or the program administrator under contract with the department receives notice of the reason for which the consultation is required to be provided pursuant to division (G)(1) of this section.

(2) An individual or the individual's representative may request that a long-term care consultation be provided on a date that is later than the date required under division (H)(1)(a) or (b) of this section.

(3) If a long-term care consultation cannot be completed within the number of days required by division (H)(1) or (2) of this section, the department or the program administrator under contract with the department may do any of the following:

(a) Exempt the individual from the consultation pursuant to rules that may be adopted under division (L) of this section;

(b) In the case of an applicant for admission to a nursing facility, provide the consultation after the individual is admitted to the nursing facility;

(c) In the case of a resident of a nursing facility, provide the consultation as soon as practicable.

(I) An individual is not required to be provided a long-term care consultation under this section if any of the following apply:

(1) The individual or the individual's representative chooses to forego participation in the consultation pursuant to criteria

specified in rules adopted under division (L) of this section;

(2) The individual is to receive care in a nursing facility under a contract for continuing care as defined in section 173.13 of the Revised Code;

(3) The individual has a contractual right to admission to a nursing facility operated as part of a system of continuing care in conjunction with one or more facilities that provide a less intensive level of services, including a residential care facility licensed under Chapter 3721. of the Revised Code, an adult care facility licensed under Chapter 3722. of the Revised Code, or an independent living arrangement;

(4) The individual is to receive continual care in a home for the aged exempt from taxation under section 5701.13 of the Revised Code;

(5) The individual is seeking admission to a facility that is not a nursing facility with a provider agreement under section ~~5111.22~~ 5164.03 of the Revised Code;

(6) The individual is to be transferred from another nursing facility;

(7) The individual is to be readmitted to a nursing facility following a period of hospitalization;

(8) The individual is exempted from the long-term care consultation requirement by the department or the program administrator pursuant to rules that may be adopted under division (L) of this section.

(J) At the conclusion of an individual's long-term care consultation, the department or the program administrator under contract with the department shall provide the individual or individual's representative with a written summary of options and resources available to meet the individual's needs. Even though

the summary may specify that a source of long-term care other than care in a nursing facility is appropriate and available, the individual is not required to seek an alternative source of long-term care and may be admitted to or continue to reside in a nursing facility.

(K) No nursing facility for which an operator has a provider agreement under section ~~5111.22~~ 5164.03 of the Revised Code shall admit or retain any individual as a resident, unless the nursing facility has received evidence that a long-term care consultation has been completed for the individual or division (I) of this section is applicable to the individual.

(L) The director of aging may adopt any rules the director considers necessary for the implementation and administration of this section. The rules shall be adopted in accordance with Chapter 119. of the Revised Code and may specify any or all of the following:

(1) Procedures for providing long-term care consultations pursuant to this section;

(2) Information to be provided through long-term care consultations regarding long-term care services that are available;

(3) Criteria under which an individual or the individual's representative may choose to forego participation in a long-term care consultation;

(4) Criteria for exempting individuals from the long-term care consultation requirement;

(5) Circumstances under which it may be appropriate to provide an individual's long-term care consultation after the individual's admission to a nursing facility rather than before admission;

(6) Criteria for identifying nursing facility residents who would benefit from the provision of a long-term care consultation.

(M) The director of aging may fine a nursing facility an amount determined by rules the director shall adopt in accordance with Chapter 119. of the Revised Code if the nursing facility admits or retains an individual, without evidence that a long-term care consultation has been provided, as required by this section.

In accordance with section ~~5111.62~~ 5164.78 of the Revised Code, all fines collected under this division shall be deposited into the state treasury to the credit of the residents protection fund.

Sec. 173.45. As used in this section and in sections 173.46 to 173.49 of the Revised Code:

(A) "Long-term care facility" means a nursing home or residential care facility.

(B) "Nursing home" and "residential care facility" have the same meanings as in section 3721.01 of the Revised Code.

(C) "Nursing facility" has the same meaning as in section ~~5111.20~~ 5164.01 of the Revised Code.

Sec. 173.47. (A) For purposes of publishing the Ohio long-term care consumer guide, the department of aging shall conduct or provide for the conduct of an annual customer satisfaction survey of each long-term care facility. The results of the surveys may include information obtained from long-term care facility residents, their families, or both.

(B)(1) The department may charge fees for the conduct of annual customer satisfaction surveys. The department may contract with any person or government entity to collect the fees on its behalf. All fees collected under this section shall be deposited

in accordance with section 173.48 of the Revised Code.

(2) The fees charged under this section shall not exceed the following amounts:

(a) Four hundred dollars for the customer satisfaction survey of a long-term care facility that is a nursing home;

(b) Three hundred dollars for the customer satisfaction survey pertaining to a long-term care facility that is a residential care facility.

(3) Fees paid by a long-term care facility that is a nursing facility shall be reimbursed through the medicaid program ~~operated under Chapter 5111. of the Revised Code~~.

(C) Each long-term care facility shall cooperate in the conduct of its annual customer satisfaction survey.

Sec. 173.50. (A) Pursuant to a contract entered into with the department of ~~job and family services~~ health care administration as an interagency agreement under section ~~5111.91~~ 5161.05 of the Revised Code, the department of aging shall carry out the day-to-day administration of the component of the medicaid program ~~established under Chapter 5111. of the Revised Code~~ known as the program of all-inclusive care for the elderly or PACE. The department of aging shall carry out its PACE administrative duties in accordance with the provisions of the interagency agreement and all applicable federal laws, including the "Social Security Act," 79 Stat. 286 (1965), 42 U.S.C. 1396u-4, as amended.

(B) The department of aging may adopt rules in accordance with Chapter 119. of the Revised Code regarding the PACE program, subject to both of the following:

(1) The rules shall be authorized by rules adopted by the department of job and family services.

(2) The rules shall address only those issues that are not

addressed in rules adopted by the department of job and family services for the PACE program.

Sec. 173.99. (A) A long-term care provider, person employed by a long-term care provider, other entity, or employee of such other entity that violates division (C) of section 173.24 of the Revised Code is subject to a fine not to exceed one thousand dollars for each violation.

(B) Whoever violates division (C) of section 173.23 of the Revised Code is guilty of registering a false complaint, a misdemeanor of the first degree.

(C) A long-term care provider, other entity, or person employed by a long-term care provider or other entity that violates division (E) of section 173.19 of the Revised Code by denying a representative of the office of the state long-term care ombudsperson program the access required by that division is subject to a fine not to exceed five hundred dollars for each violation.

(D) Whoever violates division (C) of section 173.44 of the Revised Code is subject to a fine of one hundred dollars.

~~(E) Whoever violates division (B) of section 173.90 of the Revised Code is guilty of a misdemeanor of the first degree.~~

Sec. 317.08. (A) Except as provided in divisions (C) and (D) of this section, the county recorder shall keep six separate sets of records as follows:

(1) A record of deeds, in which shall be recorded all deeds and other instruments of writing for the absolute and unconditional sale or conveyance of lands, tenements, and hereditaments; all notices as provided in sections 5301.47 to 5301.56 of the Revised Code; all judgments or decrees in actions brought under section 5303.01 of the Revised Code; all

declarations and bylaws, and all amendments to declarations and bylaws, as provided in Chapter 5311. of the Revised Code; affidavits as provided in sections 5301.252 and 5301.56 of the Revised Code; all certificates as provided in section 5311.17 of the Revised Code; all articles dedicating archaeological preserves accepted by the director of the Ohio historical society under section 149.52 of the Revised Code; all articles dedicating nature preserves accepted by the director of natural resources under section 1517.05 of the Revised Code; all agreements for the registration of lands as archaeological or historic landmarks under section 149.51 or 149.55 of the Revised Code; all conveyances of conservation easements and agricultural easements under section 5301.68 of the Revised Code; all instruments extinguishing agricultural easements under section 901.21 or 5301.691 of the Revised Code or pursuant to terms of such an easement granted to a charitable organization under section 5301.68 of the Revised Code; all instruments or orders described in division (B)(2)(b) of section 5301.56 of the Revised Code; all no further action letters issued under section 122.654 or 3746.11 of the Revised Code; all covenants not to sue issued under section 3746.12 of the Revised Code, including all covenants not to sue issued pursuant to section 122.654 of the Revised Code; any restrictions on the use of property contained in a no further action letter issued under section 122.654 of the Revised Code, any restrictions on the use of property identified pursuant to division (C)(3)(a) of section 3746.10 of the Revised Code, and any restrictions on the use of property contained in a deed or other instrument as provided in division (E) or (F) of section 3737.882 of the Revised Code; any easement executed or granted under section 3734.22, 3734.24, 3734.25, or 3734.26 of the Revised Code; any environmental covenant entered into in accordance with sections 5301.80 to 5301.92 of the Revised Code; all memoranda of trust, as described in division (A) of section 5301.255 of the

Revised Code, that describe specific real property; and all agreements entered into under division (A) of section 1521.26 of the Revised Code;

(2) A record of mortgages, in which shall be recorded all of the following:

(a) All mortgages, including amendments, supplements, modifications, and extensions of mortgages, or other instruments of writing by which lands, tenements, or hereditaments are or may be mortgaged or otherwise conditionally sold, conveyed, affected, or encumbered;

(b) All executory installment contracts for the sale of land executed after September 29, 1961, that by their terms are not required to be fully performed by one or more of the parties to them within one year of the date of the contracts;

(c) All options to purchase real estate, including supplements, modifications, and amendments of the options, but no option of that nature shall be recorded if it does not state a specific day and year of expiration of its validity;

(d) Any tax certificate sold under section 5721.33 of the Revised Code, or memorandum of it, that is presented for filing of record.

(3) A record of powers of attorney, including all memoranda of trust, as described in division (A) of section 5301.255 of the Revised Code, that do not describe specific real property;

(4) A record of plats, in which shall be recorded all plats and maps of town lots, of the subdivision of town lots, and of other divisions or surveys of lands, any center line survey of a highway located within the county, the plat of which shall be furnished by the director of transportation or county engineer, and all drawings and amendments to drawings, as provided in Chapter 5311. of the Revised Code;

(5) A record of leases, in which shall be recorded all leases, memoranda of leases, and supplements, modifications, and amendments of leases and memoranda of leases;

(6) A record of declarations executed pursuant to section 2133.02 of the Revised Code and durable powers of attorney for health care executed pursuant to section 1337.12 of the Revised Code.

(B) All instruments or memoranda of instruments entitled to record shall be recorded in the proper record in the order in which they are presented for record. The recorder may index, keep, and record in one volume unemployment compensation liens, internal revenue tax liens and other liens in favor of the United States as described in division (A) of section 317.09 of the Revised Code, personal tax liens, mechanic's liens, agricultural product liens, notices of liens, certificates of satisfaction or partial release of estate tax liens, discharges of recognizances, excise and franchise tax liens on corporations, broker's liens, and liens provided for in sections 1513.33, 1513.37, 3752.13, ~~5111.022~~ 5163.08, and 5311.18 of the Revised Code.

The recording of an option to purchase real estate, including any supplement, modification, and amendment of the option, under this section shall serve as notice to any purchaser of an interest in the real estate covered by the option only during the period of the validity of the option as stated in the option.

(C) In lieu of keeping the six separate sets of records required in divisions (A)(1) to (6) of this section and the records required in division (D) of this section, a county recorder may record all the instruments required to be recorded by this section in two separate sets of record books. One set shall be called the "official records" and shall contain the instruments listed in divisions (A)(1), (2), (3), (5), and (6) and (D) of this section. The second set of records shall contain the instruments

listed in division (A)(4) of this section.

(D) Except as provided in division (C) of this section, the county recorder shall keep a separate set of records containing all corrupt activity lien notices filed with the recorder pursuant to section 2923.36 of the Revised Code and a separate set of records containing all medicaid fraud lien notices filed with the recorder pursuant to section 2933.75 of the Revised Code.

Sec. 317.36. (A) The county recorder shall collect the low- and moderate-income housing trust fund fee as specified in sections 317.32, 1563.42, 1702.59, 2505.13, 4141.23, 4509.60, ~~5111.022~~ 5163.08, 5310.15, 5719.07, 5727.56, 5733.18, 5733.22, 6101.09, and 6115.09 of the Revised Code. The amount of any housing trust fund fee the recorder is authorized to collect is equal to the amount of any base fee the recorder is authorized to collect for services. The housing trust fund fee shall be collected in addition to the base fee.

(B) The recorder shall certify the amounts collected as housing trust fund fees pursuant to division (A) of this section into the county treasury as housing trust fund fees to be paid to the treasurer of state pursuant to section 319.63 of the Revised Code.

Sec. 323.01. Except as otherwise provided, as used in Chapter 323. of the Revised Code:

(A) "Subdivision" means any county, township, school district, or municipal corporation.

(B) "Municipal corporation" includes charter municipalities.

(C) "Taxes" means the total amount of all charges against an entry appearing on a tax list and the duplicate thereof that was prepared and certified in accordance with section 319.28 of the Revised Code, including taxes levied against real estate; taxes on

property whose value is certified pursuant to section 5727.23 of the Revised Code; recoupment charges applied pursuant to section 5713.35 of the Revised Code; all assessments; penalties and interest charged pursuant to section 323.121 of the Revised Code; charges added pursuant to section 319.35 of the Revised Code; and all of such charges which remain unpaid from any previous tax year.

(D) "Current taxes" means all taxes charged against an entry on the general tax list and duplicate of real and public utility property that have not appeared on such list and duplicate for any prior tax year and any penalty thereon charged by division (A) of section 323.121 of the Revised Code. Current taxes, whether or not they have been certified delinquent, become delinquent taxes if they remain unpaid after the last day prescribed for payment of the second installment of current taxes without penalty.

(E) "Delinquent taxes" means:

(1) Any taxes charged against an entry on the general tax list and duplicate of real and public utility property that were charged against an entry on such list and duplicate for a prior tax year and any penalties and interest charged against such taxes.

(2) Any current taxes charged on the general tax list and duplicate of real and public utility property that remain unpaid after the last day prescribed for payment of the second installment of such taxes without penalty, whether or not they have been certified delinquent, and any penalties and interest charged against such taxes.

(F) "Current tax year" means, with respect to particular taxes, the calendar year in which the first installment of taxes is due prior to any extension granted under section 323.17 of the Revised Code.

(G) "Liquidated claim" means:

(1) Any sum of money due and payable, upon a written contractual obligation executed between the subdivision and the taxpayer, but excluding any amount due on general and special assessment bonds and notes;

(2) Any sum of money due and payable, for disability financial assistance ~~or disability medical assistance~~ provided under Chapter 5115. of the Revised Code or the disability medical assistance program that is furnished to or in behalf of a subdivision, provided that such claim is recognized by a resolution or ordinance of the legislative body of such subdivision;

(3) Any sum of money advanced and paid to or received and used by a subdivision, pursuant to a resolution or ordinance of such subdivision or its predecessor in interest, and the moral obligation to repay which sum, when in funds, shall be recognized by resolution or ordinance by the subdivision.

Sec. 329.04. (A) The county department of job and family services shall have, exercise, and perform the following powers and duties:

(1) Perform any duties assigned by the state department of job and family services regarding the provision of public family services, including the provision of the following services to prevent or reduce economic or personal dependency and to strengthen family life:

(a) Services authorized by a Title IV-A program, as defined in section 5101.80 of the Revised Code;

(b) Social services authorized by Title XX of the "Social Security Act" and provided for by section 5101.46 or 5101.461 of the Revised Code;

(c) If the county department is designated as the child support enforcement agency, services authorized by Title IV-D of the "Social Security Act" and provided for by Chapter 3125. of the Revised Code. The county department may perform the services itself or contract with other government entities, and, pursuant to division (C) of section 2301.35 and section 2301.42 of the Revised Code, private entities, to perform the Title IV-D services.

(d) Duties assigned under section ~~5111.98~~ 5161.02 of the Revised Code.

(2) Administer disability financial assistance, as required by the state department of job and family services under section 5115.03 of the Revised Code;

(3) Administer disability medical assistance program, as required by the ~~state~~ department of ~~job and family services under section 5115.13 of the Revised Code~~ health care administration;

(4) Administer burials insofar as the administration of burials was, prior to September 12, 1947, imposed upon the board of county commissioners and if otherwise required by state law;

(5) Cooperate with state and federal authorities in any matter relating to family services and to act as the agent of such authorities;

(6) Submit an annual account of its work and expenses to the board of county commissioners and to the state department of job and family services at the close of each fiscal year;

(7) Exercise any powers and duties relating to family services duties or workforce development activities imposed upon the county department of job and family services by law, by resolution of the board of county commissioners, or by order of the governor, when authorized by law, to meet emergencies during war or peace;

(8) ~~Determine the~~ Make eligibility determinations for ~~medical assistance of recipients of aid under Title XVI of the "Social Security Act"~~ the medicaid program in accordance with rules adopted by the director of health care administration under section 5162.20 of the Revised Code;

(9) If assigned by the ~~state~~ director of ~~job and family services~~ health care administration under section ~~5101.515~~ 5167.15 of the Revised Code, determine applicants' eligibility for health assistance under the children's health insurance program part II;

(10) Enter into a plan of cooperation with the board of county commissioners under section 307.983, consult with the board in the development of the transportation work plan developed under section 307.985, establish with the board procedures under section 307.986 for providing services to children whose families relocate frequently, and comply with the contracts the board enters into under sections 307.981 and 307.982 of the Revised Code that affect the county department;

(11) For the purpose of complying with a fiscal agreement the board of county commissioners enters into under section 307.98 of the Revised Code, exercise the powers and perform the duties the fiscal agreement assigns to the county department;

(12) If the county department is designated as the workforce development agency, provide the workforce development activities specified in the contract required by section 330.05 of the Revised Code.

(B) The powers and duties of a county department of job and family services are, and shall be exercised and performed, under the control and direction of the board of county commissioners. The board may assign to the county department any power or duty of the board regarding family services duties and workforce development activities. If the new power or duty necessitates the

state department of job and family services changing its federal cost allocation plan, the county department may not implement the power or duty unless the United States department of health and human services approves the changes.

Sec. 329.043. 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:

(A) Identify applicants and recipients who might be eligible for benefits under the supplemental security income program;

(B) 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 of job and family services or county department has contracted under section 5115.20 of the Revised Code;

(C) Inform applicants and recipients of available sources of representation, which may include a person or government entity with which the department of job and family services or county department has contracted under section 5115.20 of the Revised Code, 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 disability financial assistance or disability medical 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 section 5115.20 of the Revised Code.

(D) Require applicants and recipients who, in the judgment of the county department, are or may be aged, blind, or disabled, to apply for the medicaid program, make determinations when appropriate as to eligibility for medicaid, and refer their applications when necessary to the disability determination unit established in accordance with section 5162.17 of the Revised Code for expedited review;

(E) Require each applicant and recipient who in the judgment of the department of job and family services 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, director of health care administration, or either director's designee an amount sufficient to reimburse the state and county shares of interim assistance furnished to the individual. For the purposes of this division, "benefits" and "interim assistance" have the meanings given in Title XVI of the "Social Security Act of 1935."

Sec. 329.051. The county department of job and family services shall make voter registration applications as prescribed by the secretary of state under section 3503.10 of the Revised Code available to persons who are applying for, receiving assistance from, or participating in any of the following:

(A) The disability financial assistance program established under Chapter 5115. of the Revised Code;

(B) The disability medical assistance program ~~established under Chapter 5115. of the Revised Code~~;

(C) The ~~medical assistance~~ medicaid program ~~established under Chapter 5111. of the Revised Code~~;

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

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

Sec. 329.06. (A) Except as provided in division (C) of this section and section 6301.08 of the Revised Code, the board of county commissioners shall establish a county family services planning committee. The board shall appoint a member to represent the county department of job and family services; an employee in the classified civil service of the county department of job and family services, if there are any such employees; and a member to represent the public. The board shall appoint other individuals to the committee in such a manner that the committee's membership is broadly representative of the groups of individuals and the public and private entities that have an interest in the family services provided in the county. The board shall make appointments in a manner that reflects the ethnic and racial composition of the county. The following groups and entities may be represented on the committee:

(1) Consumers of family services;

(2) The public children services agency;

(3) The child support enforcement agency;

(4) The county family and children first council;

(5) Public and private colleges and universities;

(6) Public entities that provide family services, including boards of health, boards of education, the county board of mental retardation and developmental disabilities, and the board of alcohol, drug addiction, and mental health services that serves the county;

(7) Private nonprofit and for-profit entities that provide

family services in the county or that advocate for consumers of family services in the county, including entities that provide services to or advocate for victims of domestic violence;

(8) Labor organizations;

(9) Any other group or entity that has an interest in the family services provided in the county, including groups or entities that represent any of the county's business, urban, and rural sectors.

(B) The county family services planning committee shall do all of the following:

(1) Serve as an advisory body to the board of county commissioners with regard to the family services provided in the county, including assistance under Chapters 5107. and 5108. of the Revised Code, publicly funded child care under Chapter 5104. of the Revised Code, and social services provided under section 5101.46 of the Revised Code;

(2) At least once a year, review and analyze the county department of job and family services' implementation of the programs established under Chapters 5107. and 5108. of the Revised Code. In its review, the committee shall use information available to it to examine all of the following:

(a) Return of assistance groups to participation in either program after ceasing to participate;

(b) Teen pregnancy rates among the programs' participants;

(c) The other types of assistance the programs' participants receive, including ~~medical assistance under Chapter 5111. of the Revised Code~~ medicaid, publicly funded child care under Chapter 5104. of the Revised Code, food stamp benefits under section 5101.54 of the Revised Code, and energy assistance under Chapter 5117. of the Revised Code;

(d) Other issues the committee considers appropriate.

The committee shall make recommendations to the board of county commissioners and county department of job and family services regarding the committee's findings.

(3) Conduct public hearings on proposed county profiles for the provision of social services under section 5101.46 of the Revised Code;

(4) At the request of the board, make recommendations and provide assistance regarding the family services provided in the county;

(5) At any other time the committee considers appropriate, consult with the board and make recommendations regarding the family services provided in the county. The committee's recommendations may address the following:

(a) Implementation and administration of family service programs;

(b) Use of federal, state, and local funds available for family service programs;

(c) Establishment of goals to be achieved by family service programs;

(d) Evaluation of the outcomes of family service programs;

(e) Any other matter the board considers relevant to the provision of family services.

(C) If there is a committee in existence in a county on October 1, 1997, that the board of county commissioners determines is capable of fulfilling the responsibilities of a county family services planning committee, the board may designate the committee as the county's family services planning committee and the committee shall serve in that capacity.

Sec. 329.14. (A) An individual whose household income does not exceed one hundred fifty per cent of the federal poverty line is eligible to participate in an individual development account program established by the county department of job and family services of the county in which the individual resides. An eligible individual seeking to be a participant in the program shall enter into an agreement with the fiduciary organization administering the program. The agreement shall specify the terms and conditions of uses of funds deposited, financial documentation required to be maintained by the participant, expectations and responsibilities of the participant, and services to be provided by the fiduciary organization.

(B) A participant may deposit earned income, as defined in 26 U.S.C. 911(d)(2), as amended, into the account. The fiduciary organization may deposit into the account an amount not exceeding twice the amount deposited by the participant except that a fiduciary organization may not, pursuant to an agreement with an employer, deposit an amount into an account held by a participant who is employed by the employer. An account may have no more than ten thousand dollars in it at any time.

(C) Notwithstanding eligibility requirements established in or pursuant to Chapter 5107.~~,~~ or 5108.~~, or 5111.~~ of the Revised Code or for the medicaid program, to the extent permitted by federal statutes and regulations, money in an individual development account, including interest, is exempt from consideration in determining whether the participant or a member of the participant's assistance group is eligible for assistance under Chapter 5107.~~,~~ or 5108.~~, or 5111.~~ of the Revised Code or the medicaid program and the amount of assistance the participant or assistance group is eligible to receive.

(D)(1) Except as provided in division (D)(2) of this section,

an individual development account program participant may use money in the account only for the following purposes:

(a) Postsecondary educational expenses paid directly from the account to an eligible education institution or vendor;

(b) Qualified acquisition expenses of a principal residence, as defined in 26 U.S.C. 1034, as amended, paid directly from the account to the person or government entity to which the expenses are due;

(c) Qualified business capitalization expenses made in accordance with a qualified business plan that has been approved by a financial institution or by a nonprofit microenterprise program having demonstrated business expertise and paid directly from the account to the person to whom the expenses are due.

(2) A fiduciary organization shall permit a participant to withdraw money deposited by the participant if it is needed to deal with a personal emergency of the participant or a member of the participant's family or household. Withdrawal shall result in the loss of any matching funds in an amount equal to the amount of the withdrawal.

(3) Regardless of the reason for the withdrawal, a withdrawal from an individual development account may be made only with the approval of the fiduciary organization.

Sec. 340.03. (A) Subject to rules issued by the director of mental health after consultation with relevant constituencies as required by division (A)(11) of section 5119.06 of the Revised Code, with regard to mental health services, the board of alcohol, drug addiction, and mental health services shall:

(1) Serve as the community mental health planning agency for the county or counties under its jurisdiction, and in so doing it shall:

(a) Evaluate the need for facilities and community mental health services;

(b) In cooperation with other local and regional planning and funding bodies and with relevant ethnic organizations, assess the community mental health needs, set priorities, and develop plans for the operation of facilities and community mental health services;

(c) In accordance with guidelines issued by the director of mental health after consultation with board representatives, develop and submit to the department of mental health, no later than six months prior to the conclusion of the fiscal year in which the board's current plan is scheduled to expire, a community mental health plan listing community mental health needs, including the needs of all residents of the district now residing in state mental institutions and severely mentally disabled adults, children, and adolescents; all children subject to a determination made pursuant to section 121.38 of the Revised Code; and all the facilities and community mental health services that are or will be in operation or provided during the period for which the plan will be in operation in the service district to meet such needs.

The plan shall include, but not be limited to, a statement of which of the services listed in section 340.09 of the Revised Code the board intends to make available. The board must include crisis intervention services for individuals in an emergency situation in the plan and explain how the board intends to make such services available. The plan must also include an explanation of how the board intends to make any payments that it may be required to pay under section 5119.62 of the Revised Code, a statement of the inpatient and community-based services the board proposes that the department operate, an assessment of the number and types of residential facilities needed, such other information as the

department requests, and a budget for moneys the board expects to receive. The board shall also submit an allocation request for state and federal funds. Within sixty days after the department's determination that the plan and allocation request are complete, the department shall approve or disapprove the plan and request, in whole or in part, according to the criteria developed pursuant to section 5119.61 of the Revised Code. The department's statement of approval or disapproval shall specify the inpatient and the community-based services that the department will operate for the board.

Eligibility for state and federal funding shall be contingent upon an approved plan or relevant part of a plan. The department may provide state and federal funding for services included in a plan only if the services are for individuals whose focus of treatment or prevention is a mental disorder according to the edition of the American psychiatric association's diagnostic and statistical manual of mental disorders that is current at the time the funding is provided. This shall include such services for individuals who have a mental disorder and a co-occurring substance use disorder, substance-induced disorder, chronic dementing organic mental disorder, mental retardation, or developmental disability. The department may not provide state or federal funding under a plan for a service for individuals whose focus of treatment or prevention is solely a substance use disorder, substance-induced disorder, chronic dementing organic mental disorder, mental retardation, or developmental disability.

If the director disapproves all or part of any plan, 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 provide the board an opportunity to present its case on behalf of the plan. The director shall give the board a reasonable time in which to meet the criteria, and

shall offer the board technical assistance 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.

If a board determines that it is necessary to amend a plan or an allocation request that has been approved under division (A)(1)(c) of this section, the board shall submit a proposed amendment to the director. The director may approve or disapprove all or part of the amendment. If the director does not approve all or part of the amendment within thirty days after it is submitted, the amendment or part of it shall be considered to have been approved. The director shall inform the board of the reasons for disapproval of all or part of an amendment and of the criteria that must be met before the amendment may be approved. The director shall provide the board an opportunity to present its case on behalf of the amendment. The director shall give the board a reasonable time in which to meet the criteria, and shall offer the board technical assistance to help it meet the criteria.

The board shall implement the plan approved by the department.

(d) Receive, compile, and transmit to the department of mental health applications for state reimbursement;

(e) Promote, arrange, and implement working agreements with social agencies, both public and private, and with judicial agencies.

(2) Investigate, or request another agency to investigate, any complaint alleging abuse or neglect of any person receiving services from a community mental health agency as defined in section 5122.01 of the Revised Code, or from a residential facility licensed under section 5119.22 of the Revised Code. If the investigation substantiates the charge of abuse or neglect, the board shall take whatever action it determines is necessary to correct the situation, including notification of the appropriate authorities. Upon request, the board shall provide information about such investigations to the department.

(3) For the purpose of section 5119.611 of the Revised Code, cooperate with the director of mental health in visiting and evaluating whether the services of a community mental health agency satisfy the certification standards established by rules adopted under that section;

(4) In accordance with criteria established under division (G) of section 5119.61 of the Revised Code, review and evaluate the quality, effectiveness, and efficiency of services provided through its community mental health plan and submit its findings and recommendations to the department of mental health;

(5) In accordance with section 5119.22 of the Revised Code, review applications for residential facility licenses and recommend to the department of mental health approval or disapproval of applications;

(6) Audit, in accordance with rules adopted by the auditor of state pursuant to section 117.20 of the Revised Code, at least annually all programs and services provided under contract with the board. In so doing, the board may contract for or employ the

services of private auditors. A copy of the fiscal audit report shall be provided to the director of mental health, the auditor of state, and the county auditor of each county in the board's district.

(7) Recruit and promote local financial support for mental health programs from private and public sources;

(8)(a) Enter into contracts with public and private facilities for the operation of facility services included in the board's community mental health plan and enter into contracts with public and private community mental health agencies for the provision of community mental health services that are listed in section 340.09 of the Revised Code and included in the board's community mental health plan. The board may not contract with a community mental health agency to provide community mental health services included in the board's community mental health plan unless the services are certified by the director of mental health under section 5119.611 of the Revised Code. Section 307.86 of the Revised Code does not apply to contracts entered into under this division. In contracting with a community mental health agency, a board shall consider the cost effectiveness of services provided by that agency and the quality and continuity of care, and may review cost elements, including salary costs, of the services to be provided. A utilization review process shall be established as part of the contract for services entered into between a board and a community mental health agency. The board may establish this process in a way that is most effective and efficient in meeting local needs. In the case of a contract with a community mental health facility, as defined in section ~~5111.023~~ 5163.20 of the Revised Code, to provide services listed in division (B) of that section, the contract shall provide for the facility to be paid in accordance with the contract entered into between the departments of ~~job and family services~~ health care administration and mental

health under section ~~5111.91~~ 5161.05 of the Revised Code and any rules adopted under division (A) of section 5119.61 of the Revised Code.

If either the board or a facility or community mental health agency with which the board contracts under division (A)(8)(a) of this section proposes not to renew the contract or proposes substantial changes in contract terms, the other party shall be given written notice at least one hundred twenty days before the expiration date of the contract. During the first sixty days of this one hundred twenty-day period, both parties shall attempt to resolve any dispute through good faith collaboration and negotiation in order to continue to provide services to persons in need. If the dispute has not been resolved sixty days before the expiration date of the contract, either party may notify the department of mental health of the unresolved dispute. The director may require both parties to submit the dispute to a third party with the cost to be shared by the board and the facility or community mental health agency. The third party shall issue to the board, the facility or agency, and the department recommendations on how the dispute may be resolved twenty days prior to the expiration date of the contract, unless both parties agree to a time extension. The director shall adopt rules establishing the procedures of this dispute resolution process.

(b) With the prior approval of the director of mental health, a board may operate a facility or provide a community mental health service as follows, if there is no other qualified private or public facility or community mental health agency that is immediately available and willing to operate such a facility or provide the service:

(i) In an emergency situation, any board may operate a facility or provide a community mental health service in order to provide essential services for the duration of the emergency;

(ii) In a service district with a population of at least one hundred thousand but less than five hundred thousand, a board may operate a facility or provide a community mental health service for no longer than one year;

(iii) In a service district with a population of less than one hundred thousand, a board may operate a facility or provide a community mental health service for no longer than one year, except that such a board may operate a facility or provide a community mental health service for more than one year with the prior approval of the director and the prior approval of the board of county commissioners, or of a majority of the boards of county commissioners if the district is a joint-county district.

The director shall not give a board approval to operate a facility or provide a community mental health service under division (A)(8)(b)(ii) or (iii) of this section unless the director determines that it is not feasible to have the department operate the facility or provide the service.

The director shall not give a board approval to operate a facility or provide a community mental health service under division (A)(8)(b)(iii) of this section unless the director determines that the board will provide greater administrative efficiency and more or better services than would be available if the board contracted with a private or public facility or community mental health agency.

The director shall not give a board approval to operate a facility previously operated by a person or other government entity unless the board has established to the director's satisfaction that the person or other government entity cannot effectively operate the facility or that the person or other government entity has requested the board to take over operation of the facility. The director shall not give a board approval to provide a community mental health service previously provided by a

community mental health agency unless the board has established to the director's satisfaction that the agency cannot effectively provide the service or that the agency has requested the board take over providing the service.

The director shall review and evaluate a board's operation of a facility and provision of community mental health service under division (A)(8)(b) of this section.

Nothing in division (A)(8)(b) of this section authorizes a board to administer or direct the daily operation of any facility or community mental health agency, but a facility or agency may contract with a board to receive administrative services or staff direction from the board under the direction of the governing body of the facility or agency.

(9) Approve fee schedules and related charges or adopt a unit cost schedule or other methods of payment for contract services provided by community mental health agencies in accordance with guidelines issued by the department as necessary to comply with state and federal laws pertaining to financial assistance;

(10) Submit to the director and the county commissioners of the county or counties served by the board, and make available to the public, an annual report of the programs under the jurisdiction of the board, including a fiscal accounting;

(11) Establish, to the extent resources are available, a community support system, which provides for treatment, support, and rehabilitation services and opportunities. The essential elements of the system include, but are not limited to, the following components in accordance with section 5119.06 of the Revised Code:

(a) To locate persons in need of mental health services to inform them of available services and benefits mechanisms;

(b) Assistance for clients to obtain services necessary to

meet basic human needs for food, clothing, shelter, medical care, personal safety, and income;

(c) Mental health care, including, but not limited to, outpatient, partial hospitalization, and, where appropriate, inpatient care;

(d) Emergency services and crisis intervention;

(e) Assistance for clients to obtain vocational services and opportunities for jobs;

(f) The provision of services designed to develop social, community, and personal living skills;

(g) Access to a wide range of housing and the provision of residential treatment and support;

(h) Support, assistance, consultation, and education for families, friends, consumers of mental health services, and others;

(i) Recognition and encouragement of families, friends, neighborhood networks, especially networks that include racial and ethnic minorities, churches, community organizations, and meaningful employment as natural supports for consumers of mental health services;

(j) Grievance procedures and protection of the rights of consumers of mental health services;

(k) Case management, which includes continual individualized assistance and advocacy to ensure that needed services are offered and procured.

(12) Designate the treatment program, agency, or facility for each person involuntarily committed to the board pursuant to Chapter 5122. of the Revised Code and authorize payment for such treatment. The board shall provide the least restrictive and most appropriate alternative that is available for any person

involuntarily committed to it and shall assure that the services listed in section 340.09 of the Revised Code are available to severely mentally disabled persons residing within its service district. The board shall establish the procedure for authorizing payment for services, which may include prior authorization in appropriate circumstances. The board may provide for services directly to a severely mentally disabled person when life or safety is endangered and when no community mental health agency is available to provide the service.

(13) Establish a method for evaluating referrals for involuntary commitment and affidavits filed pursuant to section 5122.11 of the Revised Code in order to assist the probate division of the court of common pleas in determining whether there is probable cause that a respondent is subject to involuntary hospitalization and what alternative treatment is available and appropriate, if any;

(14) Ensure that apartments or rooms built, subsidized, renovated, rented, owned, or leased by the board or a community mental health agency have been approved as meeting minimum fire safety standards and that persons residing in the rooms or apartments are receiving appropriate and necessary services, including culturally relevant services, from a community mental health agency. This division does not apply to residential facilities licensed pursuant to section 5119.22 of the Revised Code.

(15) Establish a mechanism for involvement of consumer recommendation and advice on matters pertaining to mental health services in the alcohol, drug addiction, and mental health service district;

(16) Perform the duties under section 3722.18 of the Revised Code required by rules adopted under section 5119.61 of the Revised Code regarding referrals by the board or mental health

agencies under contract with the board 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 board is accountable in the manner specified in the rules for ensuring that the ongoing mental health services are effectively arranged for the individuals.

(B) The board shall establish such rules, operating procedures, standards, and bylaws, and perform such other duties as may be necessary or proper to carry out the purposes of this chapter.

(C) A board of alcohol, drug addiction, and mental health services may receive by gift, grant, devise, or bequest any moneys, lands, or property for the benefit of the purposes for which the board is established, and may hold and apply it according to the terms of the gift, grant, or bequest. All money received, including accrued interest, by gift, grant, or bequest shall be deposited in the treasury of the county, the treasurer of which is custodian of the alcohol, drug addiction, and mental health services funds to the credit of the board and shall be available for use by the board for purposes stated by the donor or grantor.

(D) No board member or employee of a board of alcohol, drug addiction, and mental health services shall be liable for injury or damages caused by any action or inaction taken within the scope of the board member's official duties or the employee's employment, whether or not such action or inaction is expressly authorized by this section, section 340.033, or any other section of the Revised Code, unless such action or inaction constitutes willful or wanton misconduct. Chapter 2744. of the Revised Code applies to any action or inaction by a board member or employee of a board taken within the scope of the board member's official duties or employee's employment. For the purposes of this

division, the conduct of a board member or employee shall not be considered willful or wanton misconduct if the board member or employee acted in good faith and in a manner that the board member or employee reasonably believed was in or was not opposed to the best interests of the board and, with respect to any criminal action or proceeding, had no reasonable cause to believe the conduct was unlawful.

(E) The meetings held by any committee established by a board of alcohol, drug addiction, and mental health services shall be considered to be meetings of a public body subject to section 121.22 of the Revised Code.

Sec. 340.091. Each board of alcohol, drug addiction, and mental health services shall contract with a community mental health agency under division (A)(8)(a) of section 340.03 of the Revised Code for the agency to do all of the following in accordance with rules adopted under section 5119.61 of the Revised Code for an individual referred to the agency under division (C)(2) of section ~~173.35~~ 5160.80 of the Revised Code:

(A) Assess the individual to determine whether to recommend that a PASSPORT administrative agency determine that the environment in which the individual will be living while receiving residential state supplement payments is appropriate for the individual's needs and, if it determines the environment is appropriate, issue the recommendation to the PASSPORT administrative agency;

(B) Provide ongoing monitoring to ensure that services provided under section 340.09 of the Revised Code are available to the individual;

(C) Provide discharge planning to ensure the individual's earliest possible transition to a less restrictive environment.

Sec. 340.16. Not later than ninety days after September 5, 2001, the department of mental health and the department of job and family services shall adopt rules that establish requirements and procedures for prior notification and service coordination between public children services agencies and boards of alcohol, drug addiction, and mental health services when a public children services agency refers a child in its custody to a board for services funded by the board. The rules shall be adopted in accordance with Chapter 119. of the Revised Code.

The department of mental health and department of ~~job and family services~~ health care administration shall collaborate in formulating a plan that delineates the funding responsibilities of public children services agencies and boards of alcohol, drug addiction, and mental health services for services provided under section ~~5111.023~~ 5163.20 of the Revised Code to children in the custody of public children services agencies. ~~The departments shall complete the plan not later than ninety days after September 5, 2001.~~

Sec. 341.192. (A) As used in this section:

(1) ~~"Medical assistance program" has the same meaning as in section 2913.40 of the Revised Code.~~

~~(2)~~ "Medical provider" means a physician, hospital, laboratory, pharmacy, or other health care provider that is not employed by or under contract to a county or the department of rehabilitation and correction to provide medical services to persons confined in the county jail or a state correctional institution.

~~(3)~~(2) "Necessary care" means medical care of a nonelective nature that cannot be postponed until after the period of confinement of a person who is confined in a county jail or a

state correctional institution or is in the custody of a law enforcement officer without endangering the life or health of the person.

(B) If a physician employed by or under contract to a county or the department of rehabilitation and correction to provide medical services to persons confined in the county jail or state correctional institution determines that a person who is confined in the county jail or a state correctional institution or who is in the custody of a law enforcement officer prior to the person's confinement in the county jail or a state correctional institution requires necessary care that the physician cannot provide, the necessary care shall be provided by a medical provider. The county or the department of rehabilitation and correction shall pay a medical provider for necessary care an amount not exceeding the authorized reimbursement rate for the same service established by the department of ~~job and family services~~ health care administration under the ~~medical assistance~~ medicaid program.

Sec. 505.84. As used in this section, "authorized medicare reimbursement rate" means such rate established for the locality under ~~Title XVIII of~~ the ~~"Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended~~ medicare program.

A board of township trustees may establish reasonable charges for the use of fire and rescue services, ambulance services, or emergency medical services. The board may establish different charges for township residents and nonresidents, and may, in its discretion, waive all or part of the charge for any resident. The charge for ambulance transportation for nonresidents shall be an amount not less than the authorized medicare reimbursement rate, except that, if prior to September 9, 1988, the board had different charges for residents and nonresidents and the charge for nonresidents was less than the authorized medicare

reimbursement rate, the board may charge nonresidents less than the authorized medicare reimbursement rate.

Charges collected under this section shall be kept in a separate fund designated as "the fire and rescue services, ambulance services, and emergency medical services fund," and shall be appropriated and administered by the board. The fund shall be used for the payment of the costs of the management, maintenance, and operation of fire and rescue services, ambulance services, and emergency medical services in the township. If the fire and rescue services, ambulance services, and emergency medical services are discontinued in the township, any balance remaining in the fund shall be paid into the general fund of the township.

Sec. 742.41. (A) As used in this section:

(1) "Other system retirant" has the same meaning as in section 742.26 of the Revised Code.

(2) "Personal history record" includes a member's, former member's, or other system retirant's name, address, telephone number, social security number, record of contributions, correspondence with the Ohio police and fire pension fund, status of any application for benefits, and any other information deemed confidential by the trustees of the fund.

(B) The treasurer of state shall furnish annually to the board of trustees of the fund a sworn statement of the amount of the funds in the treasurer of state's custody belonging to the Ohio police and fire pension fund. The records of the fund shall be open for public inspection except for the following, which shall be excluded, except with the written authorization of the individual concerned:

(1) The individual's personal history record;

(2) Any information identifying, by name and address, the amount of a monthly allowance or benefit paid to the individual.

(C) All medical reports and recommendations required are privileged, except that copies of such medical reports or recommendations shall be made available to the personal physician, attorney, or authorized agent of the individual concerned upon written release received from the individual or the individual's agent or, when necessary for the proper administration of the fund, to the board-assigned physician.

(D) Any person who is a member of the fund or an other system retirant shall be furnished with a statement of the amount to the credit of the person's individual account upon the person's written request. The fund need not answer more than one such request of a person in any one year.

(E) Notwithstanding the exceptions to public inspection in division (B) of this section, the fund may furnish the following information:

(1) If a member, former member, or other system retirant is subject to an order issued under section 2907.15 of the Revised Code or is convicted of or pleads guilty to a violation of section 2921.41 of the Revised Code, on written request of a prosecutor as defined in section 2935.01 of the Revised Code, the fund shall furnish to the prosecutor the information requested from the individual's personal history record.

(2) Pursuant to a court order issued pursuant to Chapter 3119., 3121., 3123., or 3125. of the Revised Code, the fund shall furnish to a court or child support enforcement agency the information required under that section.

(3) At the request of any organization or association of members of the fund, the fund shall provide a list of the names and addresses of members of the fund and other system retirants.

The fund shall comply with the request of such organization or association at least once a year and may impose a reasonable charge for the list.

(4) Within fourteen days after receiving ~~from the director of job and family services~~ a list of the names and social security numbers of recipients of public assistance pursuant to section 5101.181 of the Revised Code or a list of the names and social security numbers of public medical assistance program recipients pursuant to section 5160.43 of the Revised Code, the fund shall inform the auditor of state of the name, current or most recent employer address, and social security number of each member or other system retirant whose name and social security number are the same as that of a person whose name or social security number ~~was submitted by the director~~ is included on the list. The fund and its employees shall, except for purposes of furnishing the auditor of state with information required by this section, preserve the confidentiality of recipients of public assistance in compliance with ~~division (A) of~~ section 5101.181 of the Revised Code and preserve the confidentiality of public medical assistance program recipients in compliance with section 5160.43 of the Revised Code.

(5) The fund shall comply with orders issued under section 3105.87 of the Revised Code.

On the written request of an alternate payee, as defined in section 3105.80 of the Revised Code, the fund shall furnish to the alternate payee information on the amount and status of any amounts payable to the alternate payee under an order issued under section 3105.171 or 3105.65 of the Revised Code.

(6) At the request of any person, the fund shall make available to the person copies of all documents, including resumes, in the fund's possession regarding filling a vacancy of a police officer employee member, firefighter employee member,

police retirant member, or firefighter retirant member of the board of trustees. The person who made the request shall pay the cost of compiling, copying, and mailing the documents. The information described in this division is a public record.

(F) A statement that contains information obtained from the fund's records that is signed by the secretary of the board of trustees of the Ohio police and fire pension fund and to which the board's official seal is affixed, or copies of the fund's records to which the signature and seal are attached, shall be received as true copies of the fund's records in any court or before any officer of this state.

Sec. 955.201. (A) As used in this section and in section 955.202 of the Revised Code, "Ohio pet fund" means a nonprofit corporation organized by that name under Chapter 1702. of the Revised Code that consists of humane societies, veterinarians, animal shelters, companion animal breeders, dog wardens, and similar individuals and entities.

(B) The Ohio pet fund shall do all of the following:

(1) Establish eligibility criteria for organizations that may receive financial assistance from the pets program funding board created in section 955.202 of the Revised Code. Those organizations may include any of the following:

(a) An animal shelter as defined in section 4729.01 of the Revised Code;

(b) A local nonprofit veterinary association that operates a program for the sterilization of dogs and cats;

(c) A charitable organization that is exempt from federal income taxation under subsection 501(c)(3) of the Internal Revenue Code and the primary purpose of which is to support programs for the sterilization of dogs and cats and educational programs

concerning the proper veterinary care of those animals.

(2) Establish procedures for applying for financial assistance from the pets program funding board. Application procedures shall require eligible organizations to submit detailed proposals that outline the intended uses of the moneys sought.

(3) Establish eligibility criteria for sterilization and educational programs for which moneys from the pets program funding board may be used and, consistent with division (C) of this section, establish eligibility criteria for individuals who seek sterilization for their dogs and cats from eligible organizations;

(4) Establish procedures for the disbursement of moneys the pets program funding board receives from license plate contributions pursuant to division (C) of section 4503.551 of the Revised Code;

(5) Advertise or otherwise provide notification of the availability of financial assistance from the pets program funding board for eligible organizations;

(6) Design markings to be inscribed on "pets" license plates under section 4503.551 of the Revised Code.

(C)(1) The owner of a dog or cat is eligible for dog or cat sterilization services from an eligible organization when those services are subsidized in whole or in part by money from the pets program funding board if any of the following applies:

(a) The income of the owner's family does not exceed one hundred fifty per cent of the federal poverty guideline.

(b) The owner, or any member of the owner's family who resides with the owner, is a recipient or beneficiary of one of the following government assistance programs:

(i) Low-income housing assistance under the "United States

Housing Act of 1937," 42 U.S.C.A. 1437f, as amended, known as the federal section 8 housing program;

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

(iii) ~~Title XIX of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended, known as the medical assistance program or~~ The medicaid~~, provided by the department of job and family services under Chapter 5111. of the Revised Code~~ program;

(iv) A program or law administered by the United States department of veterans' affairs or veterans' administration for any service-connected disability;

(v) The food stamp program established under the "Food Stamp Act of 1977," 91 Stat. 958, 7 U.S.C.A. 2011, as amended, administered by the department of job and family services under section 5101.54 of the Revised Code;

(vi) The "special supplemental nutrition program for women, infants, and children" established under the "Child Nutrition Act of 1966," 80 Stat. 885, 42 U.S.C. 1786, as amended, administered by the department of health under section 3701.132 of the Revised Code;

(vii) Supplemental security income ~~under Title XVI of the "Social Security Act," 86 Stat. 1475 (1972), 42 U.S.C.A. 1383, as amended~~;

(viii) Social security disability insurance benefits provided under Title II of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 401, as amended.

(c) The owner of the dog or cat submits to the eligible organization operating the sterilization program either of the following:

(i) A certificate of adoption showing that the dog or cat was adopted from a licensed animal shelter, a municipal, county, or regional pound, or a holding and impoundment facility that contracts with a municipal corporation;

(ii) A certificate of adoption showing that the dog or cat was adopted through a nonprofit corporation operating an animal adoption referral service whose holding facility, if any, is licensed in accordance with state law or a municipal ordinance.

(2) The Ohio pet fund shall determine the type of documentary evidence that must be presented by the owner of a dog or cat to show that the income of the owner's family does not exceed one hundred fifty per cent of the federal poverty guideline or that the owner is eligible under division (C)(1)(b) of this section.

(D) As used in division (C) of this section, "federal poverty guideline" means the official poverty guideline 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.

Sec. 1337.11. As used in sections 1337.11 to 1337.17 of the Revised Code:

(A) "Adult" means a person who is eighteen years of age or older.

(B) "Attending physician" means the physician to whom a principal or the family of a principal has assigned primary responsibility for the treatment or care of the principal or, if the responsibility has not been assigned, the physician who has accepted that responsibility.

(C) "Comfort care" means any of the following:

(1) Nutrition when administered to diminish the pain or discomfort of a principal, but not to postpone death;

(2) Hydration when administered to diminish the pain or discomfort of a principal, but not to postpone death;

(3) Any other medical or nursing procedure, treatment, intervention, or other measure that is taken to diminish the pain or discomfort of a principal, but not to postpone death.

(D) "Consulting physician" means a physician who, in conjunction with the attending physician of a principal, makes one or more determinations that are required to be made by the attending physician, or to be made by the attending physician and one other physician, by an applicable provision of sections 1337.11 to 1337.17 of the Revised Code, to a reasonable degree of medical certainty and in accordance with reasonable medical standards.

(E) "Declaration for mental health treatment" has the same meaning as in section 2135.01 of the Revised Code.

(F) "Guardian" means a person appointed by a probate court pursuant to Chapter 2111. of the Revised Code to have the care and management of the person of an incompetent.

(G) "Health care" means any care, treatment, service, or procedure to maintain, diagnose, or treat an individual's physical or mental condition or physical or mental health.

(H) "Health care decision" means informed consent, refusal to give informed consent, or withdrawal of informed consent to health care.

(I) "Health care facility" means any of the following:

(1) A hospital;

(2) A hospice care program or other institution that specializes in comfort care of patients in a terminal condition or

in a permanently unconscious state;

(3) A nursing home;

(4) A home health agency;

(5) An intermediate care facility for the mentally retarded;

(6) A regulated community mental health organization.

(J) "Health care personnel" means physicians, nurses, physician assistants, emergency medical technicians-basic, emergency medical technicians-intermediate, emergency medical technicians-paramedic, medical technicians, dietitians, other authorized persons acting under the direction of an attending physician, and administrators of health care facilities.

(K) "Home health agency" has the same meaning as in section ~~5101.61~~ 3701.881 of the Revised Code.

(L) "Hospice care program" has the same meaning as in section 3712.01 of the Revised Code.

(M) "Hospital" has the same meanings as in sections 2108.01, 3701.01, and 5122.01 of the Revised Code.

(N) "Hydration" means fluids that are artificially or technologically administered.

(O) "Incompetent" has the same meaning as in section 2111.01 of the Revised Code.

(P) "Intermediate care facility for the mentally retarded" has the same meaning as in section ~~5111.20~~ 5164.01 of the Revised Code.

(Q) "Life-sustaining treatment" means any medical procedure, treatment, intervention, or other measure that, when administered to a principal, will serve principally to prolong the process of dying.

(R) "Medical claim" has the same meaning as in section

2305.113 of the Revised Code.

(S) "Mental health treatment" has the same meaning as in section 2135.01 of the Revised Code.

(T) "Nursing home" has the same meaning as in section 3721.01 of the Revised Code.

(U) "Nutrition" means sustenance that is artificially or technologically administered.

(V) "Permanently unconscious state" means a state of permanent unconsciousness in a principal that, to a reasonable degree of medical certainty as determined in accordance with reasonable medical standards by the principal's attending physician and one other physician who has examined the principal, is characterized by both of the following:

(1) Irreversible unawareness of one's being and environment.

(2) Total loss of cerebral cortical functioning, resulting in the principal having no capacity to experience pain or suffering.

(W) "Person" has the same meaning as in section 1.59 of the Revised Code and additionally includes political subdivisions and governmental agencies, boards, commissions, departments, institutions, offices, and other instrumentalities.

(X) "Physician" means a person who is authorized under Chapter 4731. of the Revised Code to practice medicine and surgery or osteopathic medicine and surgery.

(Y) "Political subdivision" and "state" have the same meanings as in section 2744.01 of the Revised Code.

(Z) "Professional disciplinary action" means action taken by the board or other entity that regulates the professional conduct of health care personnel, including the state medical board and the board of nursing.

(AA) "Regulated community mental health organization" means a

residential facility as defined and licensed under section 5119.22 of the Revised Code or a community mental health agency as defined in section 5122.01 of the Revised Code.

(BB) "Terminal condition" means an irreversible, incurable, and untreatable condition caused by disease, illness, or injury from which, to a reasonable degree of medical certainty as determined in accordance with reasonable medical standards by a principal's attending physician and one other physician who has examined the principal, both of the following apply:

(1) There can be no recovery.

(2) Death is likely to occur within a relatively short time if life-sustaining treatment is not administered.

(CC) "Tort action" means a civil action for damages for injury, death, or loss to person or property, other than a civil action for damages for a breach of contract or another agreement between persons.

Sec. 1347.08. (A) Every state or local agency that maintains a personal information system, upon the request and the proper identification of any person who is the subject of personal information in the system, shall:

(1) Inform the person of the existence of any personal information in the system of which the person is the subject;

(2) Except as provided in divisions (C) and (E)(2) of this section, permit the person, the person's legal guardian, or an attorney who presents a signed written authorization made by the person, to inspect all personal information in the system of which the person is the subject;

(3) Inform the person about the types of uses made of the personal information, including the identity of any users usually granted access to the system.

(B) Any person who wishes to exercise a right provided by this section may be accompanied by another individual of the person's choice.

(C)(1) A state or local agency, upon request, shall disclose medical, psychiatric, or psychological information to a person who is the subject of the information or to the person's legal guardian, unless a physician, psychiatrist, or psychologist determines for the agency that the disclosure of the information is likely to have an adverse effect on the person, in which case the information shall be released to a physician, psychiatrist, or psychologist who is designated by the person or by the person's legal guardian.

(2) Upon the signed written request of either a licensed attorney at law or a licensed physician designated by the inmate, together with the signed written request of an inmate of a correctional institution under the administration of the department of rehabilitation and correction, the department shall disclose medical information to the designated attorney or physician as provided in division (C) of section 5120.21 of the Revised Code.

(D) If an individual who is authorized to inspect personal information that is maintained in a personal information system requests the state or local agency that maintains the system to provide a copy of any personal information that the individual is authorized to inspect, the agency shall provide a copy of the personal information to the individual. Each state and local agency may establish reasonable fees for the service of copying, upon request, personal information that is maintained by the agency.

(E)(1) This section regulates access to personal information that is maintained in a personal information system by persons who are the subject of the information, but does not limit the

authority of any person, including a person who is the subject of personal information maintained in a personal information system, to inspect or have copied, pursuant to section 149.43 of the Revised Code, a public record as defined in that section.

(2) This section does not provide a person who is the subject of personal information maintained in a personal information system, the person's legal guardian, or an attorney authorized by the person, with a right to inspect or have copied, or require an agency that maintains a personal information system to permit the inspection of or to copy, a confidential law enforcement investigatory record or trial preparation record, as defined in divisions (A)(2) and (4) of section 149.43 of the Revised Code.

(F) This section does not apply to any of the following:

(1) The contents of an adoption file maintained by the department of health under section 3705.12 of the Revised Code;

(2) Information contained in the putative father registry established by section 3107.062 of the Revised Code, regardless of whether the information is held by the department of job and family services or, pursuant to section 3111.69 of the Revised Code, the office of child support in the department or a child support enforcement agency;

(3) Papers, records, and books that pertain to an adoption and that are subject to inspection in accordance with section 3107.17 of the Revised Code;

(4) Records listed in division (A) of section 3107.42 of the Revised Code or specified in division (A) of section 3107.52 of the Revised Code;

(5) Records that identify an individual described in division (A)(1) of section 3721.031 of the Revised Code, or that would tend to identify such an individual;

(6) Files and records that have been expunged under division (D)(1) of section 3721.23 of the Revised Code;

(7) Records that identify an individual described in division (A)(1) of section 3721.25 of the Revised Code, or that would tend to identify such an individual;

(8) Records that identify an individual described in division (A)(1) of section ~~5111.61~~ 5164.77 of the Revised Code, or that would tend to identify such an individual;

(9) Test materials, examinations, or evaluation tools used in an examination for licensure as a nursing home administrator that the board of examiners of nursing home administrators administers under section 4751.04 of the Revised Code or contracts under that section with a private or government entity to administer;

(10) Information contained in a database established and maintained pursuant to section 5101.13 of the Revised Code.

Sec. 1731.04. (A) An agreement between an alliance and an insurer referred to in division (B) of section 1731.01 of the Revised Code shall contain at least the following:

(1) A provision requiring the insurer to offer and sell to small employers served or to be served by an alliance one or more health benefit plan options for coverage of their eligible employees and the eligible dependents and members of the families of the eligible employees and, if applicable, such members' eligible retirees and the eligible dependents and members of the families of the retirees, subject to such conditions and restrictions as may be set forth or incorporated into the agreement;

(2) A brief description of each type of health benefit plan option that is to be so offered and the conditions for the modification, continuation, and termination of the coverage and

benefits thereunder;

(3) A statement of the eligibility requirements that an employee or retiree must meet in order for the employee or retiree to be eligible to obtain and retain coverage under any health benefit plan option so offered and, if one of such requirements is that an employee must regularly work for a minimum number of hours per week, a statement of such minimum number of hours, which minimum shall not exceed twenty-five hours per week;

(4) A description of any pre-existing condition and waiting period rules;

(5) A statement of the premium rates or other charges that apply to each health benefit plan option or a formula or method of determining the rates or charges;

(6) A provision prescribing the minimum employer contribution toward premiums or other charges required in order to permit a small employer to obtain coverage under a health benefit plan option offered under an alliance program;

(7) A provision requiring that each health benefit plan under the alliance program must provide for the continuation of coverage of participants of an enrolled small employer so long as the small employer determines that such person is a qualified beneficiary entitled to such coverage pursuant to Part 6 of Title I of the "Federal Employee Retirement Income Security Act of 1974," 88 Stat. 832, 29 U.S.C.A. 1001, and the laws of this state, and regulations or rulings interpreting such provisions. Such coverage provided by the insurer under the plan to participants shall comply with the "Federal Employee Retirement Income Security Act of 1974" and the relevant statutes, regulations, and rulings interpreting that act, including provisions regarding types of coverage to be provided, apportionments of limitations on coverage, apportionments of deductibles, and the rights of

qualified beneficiaries to elect coverage options relating to types of coverage and otherwise.

(B) An agreement between an alliance and an insurer referred to in division (B) of section 1731.01 of the Revised Code may contain provisions relating to, but not limited to, any of the following:

(1) The application and enrollment process for a small employer and related provisions pertaining to historical experience, health statements, and underwriting standards;

(2) The minimum number of those employees eligible to be participants that are required to participate in order to permit a small employer to obtain coverage under a health benefit plan option offered under the alliance program, which may vary with the number of employees or those eligible to be participants in respect of the small employer;

(3) A procedure for allowing an enrolled small employer to change from one plan option to another under the alliance program, subject to qualifying by size or otherwise under the alliance program;

(4) The application of any risk-related pooling or grouping programs and related premiums, conditions, reviews, and alternatives offered by the insurer;

(5) The availability of a medicare supplement coverage option for eligible participants who are covered by Parts A and B of the medicare~~, Title XVIII of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301~~ program;

(6) Relevant experience periods, enrollment periods, and contract periods;

(7) Effective dates for coverage of eligible participants;

(8) Conditions under which denial or withdrawal of coverage

of participants or small employers and their employees may occur by reason of falsification or misrepresentation of material facts or criminal conduct toward the insurer, small employer, or alliance under the program;

(9) Premium rate structures, which may be uniform or make provision for age-specific rates, differentials based on number of participants of an enrolled small employer, products and plan options selected, and other factors, rate adjustments based on consumer price indices, utilization, or other relevant factors, notification of rate adjustments, and arbitration;

(10) Any responsibilities of the alliance for billing, collection, and transmittal of premiums;

(11) Inclusion under the alliance program of small employers that are members of other organizations described in division (A)(1) of section 1731.01 of the Revised Code that contract with the alliance for this purpose, and conditions pertaining to those small employer members and to their employees and retirees, and dependents and family members of those employees or retirees, as applicable under the alliance program;

(12) The agreement of the insurer to offer and sell one or more health benefit plans to small employer members of another small employer health care alliance that contracts with the alliance for this purpose;

(13) Use of the health benefit plan options of the insurer in the alliance program and use of the names of the alliance and the insurer;

(14) Indemnification from claims and liability by reason of acts or omissions of others;

(15) Ownership, use, availability, and maintenance of confidentiality of data and records relating to the alliance program;

(16) Utilization reports to be provided to the alliance by the insurer;

(17) Such other provisions as may be agreed upon by the alliance and the insurer to better provide for the articulation, promotion, financing, and operation of the alliance program or a health benefit plan under the program in furtherance of the public purposes stated in section 1731.02 of the Revised Code.

(C) Neither an alliance program nor an agreement between an alliance and an insurer is itself a policy or contract of insurance, or a certificate, indorsement, rider, or application forming any part of a policy, contract, or certificate of insurance. Chapters 3905., 3933., and 3959. of the Revised Code do not apply to an alliance program or to an agreement between an alliance and an insurer thereunder, as such, or to the functions of the alliance under an alliance program.

Sec. 1739.061. (A)(1) This section applies to both of the following:

(a) A multiple employer welfare arrangement that issues or requires the use of a standardized identification card or an electronic technology for submission and routing of prescription drug claims;

(b) A person or entity that a multiple employer welfare arrangement contracts with to issue a standardized identification card or an electronic technology described in division (A)(1)(a) of this section.

(2) Notwithstanding division (A)(1) of this section, this section does not apply to the issuance or required use of a standardized identification card or an electronic technology for the submission and routing of prescription drug claims in connection with any of the following:

(a) Any program or arrangement covering only accident, credit, dental, disability income, long-term care, hospital indemnity, medicare supplement, medicare, tricare, specified disease, or vision care; coverage under a one-time-limited-duration policy of not longer than six months; coverage issued as a supplement to liability insurance; insurance arising out of workers' compensation or similar law; automobile medical payment insurance; or insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(b) Coverage provided under the medicaid~~, as defined in section 5111.01 of the Revised Code~~ program.

(c) Coverage provided under an employer's self-insurance plan or by any of its administrators, as defined in section 3959.01 of the Revised Code, to the extent that federal law supersedes, preempts, prohibits, or otherwise precludes the application of this section to the plan and its administrators.

(B) A standardized identification card or an electronic technology issued or required to be used as provided in division (A)(1) of this section shall contain uniform prescription drug information in accordance with either division (B)(1) or (2) of this section.

(1) The standardized identification card or the electronic technology shall be in a format and contain information fields approved by the national council for prescription drug programs or a successor organization, as specified in the council's or successor organization's pharmacy identification card implementation guide in effect on the first day of October most immediately preceding the issuance or required use of the standardized identification card or the electronic technology.

(2) If the multiple employer welfare arrangement or person under contract with it to issue a standardized identification card or an electronic technology requires the information for the submission and routing of a claim, the standardized identification card or the electronic technology shall contain any of the following information:

(a) The name of the multiple employer welfare arrangement;

(b) The individual's name, group number, and identification number;

(c) A telephone number to inquire about pharmacy-related issues;

(d) The issuer's international identification number, labeled as "ANSI BIN" or "RxBIN";

(e) The processor's control number, labeled as "RxPCN";

(f) The individual's pharmacy benefits group number if different from the insured's medical group number, labeled as "RxGrp."

(C) If the standardized identification card or the electronic technology issued or required to be used as provided in division (A)(1) of this section is also used for submission and routing of nonpharmacy claims, the designation "Rx" is required to be included as part of the labels identified in divisions (B)(2)(d) and (e) of this section if the issuer's international identification number or the processor's control number is different for medical and pharmacy claims.

(D) Each multiple employer welfare arrangement described in division (A) of this section shall annually file a certificate with the superintendent of insurance certifying that it or any person it contracts with to issue a standardized identification card or electronic technology for submission and routing of

prescription drug claims complies with this section.

(E)(1) Except as provided in division (E)(2) of this section, if there is a change in the information contained in the standardized identification card or the electronic technology issued to an individual, the multiple employer welfare arrangement or person under contract with it to issue a standardized identification card or an electronic technology shall issue a new card or electronic technology to the individual.

(2) A multiple employer welfare arrangement or person under contract with it is not required under division (E)(1) of this section to issue a new card or electronic technology to an individual more than once during a twelve-month period.

(F) Nothing in this section shall be construed as requiring a multiple employer welfare arrangement to produce more than one standardized identification card or one electronic technology for use by individuals accessing health care benefits provided under a multiple employer welfare arrangement.

Sec. 1751.01. As used in this chapter:

(A)(1) "Basic health care services" means the following services when medically necessary:

(a) Physician's services, except when such services are supplemental under division (B) of this section;

(b) Inpatient hospital services;

(c) Outpatient medical services;

(d) Emergency health services;

(e) Urgent care services;

(f) Diagnostic laboratory services and diagnostic and therapeutic radiologic services;

(g) Diagnostic and treatment services, other than

prescription drug services, for biologically based mental illnesses;

(h) Preventive health care services, including, but not limited to, voluntary family planning services, infertility services, periodic physical examinations, prenatal obstetrical care, and well-child care.

"Basic health care services" does not include experimental procedures.

Except as provided by divisions (A)(2) and (3) of this section in connection with the offering of coverage for diagnostic and treatment services for biologically based mental illnesses, a health insuring corporation shall not offer coverage for a health care service, defined as a basic health care service by this division, unless it offers coverage for all listed basic health care services. However, this requirement does not apply to the coverage of beneficiaries enrolled in ~~Title XVIII of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended,~~ the medicare program pursuant to a medicare contract, or to the coverage of beneficiaries enrolled in the federal employee health benefits program pursuant to 5 U.S.C.~~A.~~ 8905, or to the coverage of ~~beneficiaries enrolled in Title XIX~~ recipients of the ~~"Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended, known as the medical assistance program or~~ medicaid~~, provided by the department of job and family services under Chapter 5111. of the Revised Code~~ program, or to the coverage of beneficiaries under any federal health care program regulated by a federal regulatory body, or to the coverage of beneficiaries under any contract covering officers or employees of the state that has been entered into by the department of administrative services.

(2) A health insuring corporation may offer coverage for diagnostic and treatment services for biologically based mental illnesses without offering coverage for all other basic health

care services. A health insuring corporation may offer coverage for diagnostic and treatment services for biologically based mental illnesses alone or in combination with one or more supplemental health care services. However, a health insuring corporation that offers coverage for any other basic health care service shall offer coverage for diagnostic and treatment services for biologically based mental illnesses in combination with the offer of coverage for all other listed basic health care services.

(3) A health insuring corporation that offers coverage for basic health care services is not required to offer coverage for diagnostic and treatment services for biologically based mental illnesses in combination with the offer of coverage for all other listed basic health care services if all of the following apply:

(a) The health insuring corporation submits documentation certified by an independent member of the American academy of actuaries to the superintendent of insurance showing that incurred claims for diagnostic and treatment services for biologically based mental illnesses for a period of at least six months independently caused the health insuring corporation's costs for claims and administrative expenses for the coverage of basic health care services to increase by more than one per cent per year.

(b) The health insuring corporation submits a signed letter from an independent member of the American academy of actuaries to the superintendent of insurance opining that the increase in costs described in division (A)(3)(a) of this section could reasonably justify an increase of more than one per cent in the annual premiums or rates charged by the health insuring corporation for the coverage of basic health care services.

(c) The superintendent of insurance makes the following determinations from the documentation and opinion submitted pursuant to divisions (A)(3)(a) and (b) of this section:

(i) Incurred claims for diagnostic and treatment services for biologically based mental illnesses for a period of at least six months independently caused the health insuring corporation's costs for claims and administrative expenses for the coverage of basic health care services to increase by more than one per cent per year.

(ii) The increase in costs reasonably justifies an increase of more than one per cent in the annual premiums or rates charged by the health insuring corporation for the coverage of basic health care services.

Any determination made by the superintendent under this division is subject to Chapter 119. of the Revised Code.

(B)(1) "Supplemental health care services" means any health care services other than basic health care services that a health insuring corporation may offer, alone or in combination with either basic health care services or other supplemental health care services, and includes:

(a) Services of facilities for intermediate or long-term care, or both;

(b) Dental care services;

(c) Vision care and optometric services including lenses and frames;

(d) Podiatric care or foot care services;

(e) Mental health services, excluding diagnostic and treatment services for biologically based mental illnesses;

(f) Short-term outpatient evaluative and crisis-intervention mental health services;

(g) Medical or psychological treatment and referral services for alcohol and drug abuse or addiction;

(h) Home health services;

(i) Prescription drug services;

(j) Nursing services;

(k) Services of a dietitian licensed under Chapter 4759. of the Revised Code;

(l) Physical therapy services;

(m) Chiropractic services;

(n) Any other category of services approved by the superintendent of insurance.

(2) If a health insuring corporation offers prescription drug services under this division, the coverage shall include prescription drug services for the treatment of biologically based mental illnesses on the same terms and conditions as other physical diseases and disorders.

(C) "Specialty health care services" means one of the supplemental health care services listed in division (B) of this section, when provided by a health insuring corporation on an outpatient-only basis and not in combination with other supplemental health care services.

(D) "Biologically based mental illnesses" means schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, and panic disorder, as these terms are defined in the most recent edition of the diagnostic and statistical manual of mental disorders published by the American psychiatric association.

(E) "Closed panel plan" means a health care plan that requires enrollees to use participating providers.

(F) "Compensation" means remuneration for the provision of health care services, determined on other than a fee-for-service or discounted-fee-for-service basis.

(G) "Contractual periodic prepayment" means the formula for determining the premium rate for all subscribers of a health insuring corporation.

(H) "Corporation" means a corporation formed under Chapter 1701. or 1702. of the Revised Code or the similar laws of another state.

(I) "Emergency health services" means those health care services that must be available on a seven-days-per-week, twenty-four-hours-per-day basis in order to prevent jeopardy to an enrollee's health status that would occur if such services were not received as soon as possible, and includes, where appropriate, provisions for transportation and indemnity payments or service agreements for out-of-area coverage.

(J) "Enrollee" means any natural person who is entitled to receive health care benefits provided by a health insuring corporation.

(K) "Evidence of coverage" means any certificate, agreement, policy, or contract issued to a subscriber that sets out the coverage and other rights to which such person is entitled under a health care plan.

(L) "Health care facility" means any facility, except a health care practitioner's office, that provides preventive, diagnostic, therapeutic, acute convalescent, rehabilitation, mental health, mental retardation, intermediate care, or skilled nursing services.

(M) "Health care services" means basic, supplemental, and specialty health care services.

(N) "Health delivery network" means any group of providers or health care facilities, or both, or any representative thereof, that have entered into an agreement to offer health care services in a panel rather than on an individual basis.

(O) "Health insuring corporation" means a corporation, as defined in division (H) of this section, that, pursuant to a policy, contract, certificate, or agreement, pays for, reimburses, or provides, delivers, arranges for, or otherwise makes available, basic health care services, supplemental health care services, or specialty health care services, or a combination of basic health care services and either supplemental health care services or specialty health care services, through either an open panel plan or a closed panel plan.

"Health insuring corporation" does not include a limited liability company formed pursuant to Chapter 1705. of the Revised Code, an insurer licensed under Title XXXIX of the Revised Code if that insurer offers only open panel plans under which all providers and health care facilities participating receive their compensation directly from the insurer, a corporation formed by or on behalf of a political subdivision or a department, office, or institution of the state, or a public entity formed by or on behalf of a board of county commissioners, a county board of mental retardation and developmental disabilities, an alcohol and drug addiction services board, a board of alcohol, drug addiction, and mental health services, or a community mental health board, as those terms are used in Chapters 340. and 5126. of the Revised Code. Except as provided by division (D) of section 1751.02 of the Revised Code, or as otherwise provided by law, no board, commission, agency, or other entity under the control of a political subdivision may accept insurance risk in providing for health care services. However, nothing in this division shall be construed as prohibiting such entities from purchasing the services of a health insuring corporation or a third-party administrator licensed under Chapter 3959. of the Revised Code.

(P) "Intermediary organization" means a health delivery network or other entity that contracts with licensed health

insuring corporations or self-insured employers, or both, to provide health care services, and that enters into contractual arrangements with other entities for the provision of health care services for the purpose of fulfilling the terms of its contracts with the health insuring corporations and self-insured employers.

(Q) "Intermediate care" means residential care above the level of room and board for patients who require personal assistance and health-related services, but who do not require skilled nursing care.

(R) "Medical record" means the personal information that relates to an individual's physical or mental condition, medical history, or medical treatment.

(S)(1) "Open panel plan" means a health care plan that provides incentives for enrollees to use participating providers and that also allows enrollees to use providers that are not participating providers.

(2) No health insuring corporation may offer an open panel plan, unless the health insuring corporation is also licensed as an insurer under Title XXXIX of the Revised Code, the health insuring corporation, on June 4, 1997, holds a certificate of authority or license to operate under Chapter 1736. or 1740. of the Revised Code, or an insurer licensed under Title XXXIX of the Revised Code is responsible for the out-of-network risk as evidenced by both an evidence of coverage filing under section 1751.11 of the Revised Code and a policy and certificate filing under section 3923.02 of the Revised Code.

(T) "Panel" means a group of providers or health care facilities that have joined together to deliver health care services through a contractual arrangement with a health insuring corporation, employer group, or other payor.

(U) "Person" has the same meaning as in section 1.59 of the

Revised Code, and, unless the context otherwise requires, includes any insurance company holding a certificate of authority under Title XXXIX of the Revised Code, any subsidiary and affiliate of an insurance company, and any government agency.

(V) "Premium rate" means any set fee regularly paid by a subscriber to a health insuring corporation. A "premium rate" does not include a one-time membership fee, an annual administrative fee, or a nominal access fee, paid to a managed health care system under which the recipient of health care services remains solely responsible for any charges accessed for those services by the provider or health care facility.

(W) "Primary care provider" means a provider that is designated by a health insuring corporation to supervise, coordinate, or provide initial care or continuing care to an enrollee, and that may be required by the health insuring corporation to initiate a referral for specialty care and to maintain supervision of the health care services rendered to the enrollee.

(X) "Provider" means any natural person or partnership of natural persons who are licensed, certified, accredited, or otherwise authorized in this state to furnish health care services, or any professional association organized under Chapter 1785. of the Revised Code, provided that nothing in this chapter or other provisions of law shall be construed to preclude a health insuring corporation, health care practitioner, or organized health care group associated with a health insuring corporation from employing certified nurse practitioners, certified nurse anesthetists, clinical nurse specialists, certified nurse midwives, dietitians, physician assistants, dental assistants, dental hygienists, optometric technicians, or other allied health personnel who are licensed, certified, accredited, or otherwise authorized in this state to furnish health care services.

(Y) "Provider sponsored organization" means a corporation, as defined in division (H) of this section, that is at least eighty per cent owned or controlled by one or more hospitals, as defined in section 3727.01 of the Revised Code, or one or more physicians licensed to practice medicine or surgery or osteopathic medicine and surgery under Chapter 4731. of the Revised Code, or any combination of such physicians and hospitals. Such control is presumed to exist if at least eighty per cent of the voting rights or governance rights of a provider sponsored organization are directly or indirectly owned, controlled, or otherwise held by any combination of the physicians and hospitals described in this division.

(Z) "Solicitation document" means the written materials provided to prospective subscribers or enrollees, or both, and used for advertising and marketing to induce enrollment in the health care plans of a health insuring corporation.

(AA) "Subscriber" means a person who is responsible for making payments to a health insuring corporation for participation in a health care plan, or an enrollee whose employment or other status is the basis of eligibility for enrollment in a health insuring corporation.

(BB) "Urgent care services" means those health care services that are appropriately provided for an unforeseen condition of a kind that usually requires medical attention without delay but that does not pose a threat to the life, limb, or permanent health of the injured or ill person, and may include such health care services provided out of the health insuring corporation's approved service area pursuant to indemnity payments or service agreements.

Sec. 1751.04. (A) Except as provided by division (F) of this section, upon the receipt by the superintendent of insurance of a

complete application for a certificate of authority to establish or operate a health insuring corporation, which application sets forth or is accompanied by the information and documents required by division (A) of section 1751.03 of the Revised Code, the superintendent shall transmit copies of the application and accompanying documents to the director of health.

(B) The director shall review the application and accompanying documents and make findings as to whether the applicant for a certificate of authority has done all of the following with respect to any basic health care services and supplemental health care services to be furnished:

(1) Demonstrated the willingness and potential ability to ensure that all basic health care services and supplemental health care services described in the evidence of coverage will be provided to all its enrollees as promptly as is appropriate and in a manner that assures continuity;

(2) Made effective arrangements to ensure that its enrollees have reliable access to qualified providers in those specialties that are generally available in the geographic area or areas to be served by the applicant and that are necessary to provide all basic health care services and supplemental health care services described in the evidence of coverage;

(3) Made appropriate arrangements for the availability of short-term health care services in emergencies within the geographic area or areas to be served by the applicant, twenty-four hours per day, seven days per week, and for the provision of adequate coverage whenever an out-of-area emergency arises;

(4) Made appropriate arrangements for an ongoing evaluation and assurance of the quality of health care services provided to enrollees, including, if applicable, the development of a quality

assurance program complying with the requirements of sections 1751.73 to 1751.75 of the Revised Code, and the adequacy of the personnel, facilities, and equipment by or through which the services are rendered;

(5) Developed a procedure to gather and report statistics relating to the cost and effectiveness of its operations, the pattern of utilization of its services, and the quality, availability, and accessibility of its services.

(C) Within ninety days of the director's receipt of the application for issuance of a certificate of authority, the director shall certify to the superintendent whether or not the applicant meets the requirements of division (B) of this section and sections 3702.51 to 3702.62 of the Revised Code. If the director certifies that the applicant does not meet these requirements, the director shall specify in what respects it is deficient. However, the director shall not certify that the requirements of this section are not met unless the applicant has been given an opportunity for a hearing.

(D) If the applicant requests a hearing, the director shall hold a hearing before certifying that the applicant does not meet the requirements of this section. The hearing shall be held in accordance with Chapter 119. of the Revised Code.

(E) The ninety-day review period provided for under division (C) of this section shall cease to run as of the date on which the notice of the applicant's right to request a hearing is mailed and shall remain suspended until the director issues a final certification order.

(F) Nothing in this section requires the director to review or make findings with regard to an application and accompanying documents to establish or operate a health insuring corporation to cover solely recipients of assistance under the medicaid program

~~operated pursuant to Chapter 5111. of the Revised Code~~, a health insuring corporation to cover solely recipients of assistance under the ~~federal~~ medicare program ~~under Title XVIII of the "Social Security Act," 49 Stat. 62 (1935), 42 U.S.C. 301, as amended~~, or a health insuring corporation to cover solely recipients of assistance under both the medicaid and medicare programs.

Sec. 1751.05. (A) The superintendent of insurance shall issue or deny a certificate of authority to health insuring corporations within the deadlines specified as follows:

(1) For a health insuring corporation filing an application pursuant to section 1751.03 of the Revised Code, forty-five days from the superintendent's receipt of the certification from the director of health under division (C) of section 1751.04 of the Revised Code;

(2) For a health insuring corporation that covers solely recipients of ~~assistance under~~ the medicaid program ~~operated pursuant to Chapter 5111. of the Revised Code~~, one hundred thirty-five days from the superintendent's receipt of a complete application and accompanying documents.

(B) A certificate of authority shall be issued upon payment of the application fee prescribed in section 1751.44 of the Revised Code if the superintendent is satisfied that the following conditions are met:

(1) The persons responsible for the conduct of the affairs of the applicant are competent, trustworthy, and possess good reputations.

(2) The director certifies, in accordance with division (C) of section 1751.04 of the Revised Code, that the organization's proposed plan of operation meets the requirements of division (B)

of that section and sections 3702.51 to 3702.62 of the Revised Code. If, after the director has certified compliance, the application is amended in a manner that affects its approval under section 1751.04 of the Revised Code, the superintendent shall request the director to review and recertify the amended plan of operation. Within forty-five days of receipt of the amended plan from the superintendent, the director shall certify to the superintendent, pursuant to section 1751.04 of the Revised Code, whether or not the amended plan meets the requirements of section 1751.04 of the Revised Code. The superintendent's forty-five-day review period shall cease to run as of the date on which the amended plan is transmitted to the director and shall remain suspended until the superintendent receives a new certification from the director.

(3) The applicant constitutes an appropriate mechanism to effectively provide or arrange for the provision of the basic health care services, supplemental health care services, or specialty health care services to be provided to enrollees.

(4) The applicant is financially responsible, complies with section 1751.28 of the Revised Code, and may reasonably be expected to meet its obligations to enrollees and prospective enrollees. In making this determination, the superintendent may consider:

(a) The financial soundness of the applicant's arrangements for health care services, including the applicant's proposed contractual periodic prepayments or premiums and the use of copayments and deductibles;

(b) The adequacy of working capital;

(c) Any agreement with an insurer, a government, or any other person for insuring the payment of the cost of health care services or providing for automatic applicability of an

alternative coverage in the event of discontinuance of the health insuring corporation's operations;

(d) Any agreement with providers or health care facilities for the provision of health care services;

(e) Any deposit of securities submitted in accordance with section 1751.27 of the Revised Code as a guarantee that the obligations will be performed.

(5) The applicant has submitted documentation of an arrangement to provide health care services to its enrollees until the expiration of the enrollees' contracts with the applicant if a health care plan or the operations of the health insuring corporation are discontinued prior to the expiration of the enrollees' contracts. An arrangement to provide health care services may be made by using any one, or any combination, of the following methods:

(a) The maintenance of insolvency insurance;

(b) A provision in contracts with providers and health care facilities, but no health insuring corporation shall rely solely on such a provision for more than thirty days;

(c) An agreement with other health insuring corporations or insurers, providing enrollees with automatic conversion rights upon the discontinuation of a health care plan or the health insuring corporation's operations;

(d) Such other methods as approved by the superintendent.

(6) Nothing in the applicant's proposed method of operation, as shown by the information submitted pursuant to section 1751.03 of the Revised Code or by independent investigation, will cause harm to an enrollee or to the public at large, as determined by the superintendent.

(7) Any deficiencies certified by the director have been

corrected.

(8) The applicant has deposited securities as set forth in section 1751.27 of the Revised Code.

(C) If an applicant elects to fulfill the requirements of division (A)(5) of this section through an agreement with other health insuring corporations or insurers, the agreement shall require those health insuring corporations or insurers to give thirty days' notice to the superintendent prior to cancellation or discontinuation of the agreement for any reason.

(D) A certificate of authority shall be denied only after compliance with the requirements of section 1751.36 of the Revised Code.

Sec. 1751.11. (A) Every subscriber of a health insuring corporation is entitled to an evidence of coverage for the health care plan under which health care benefits are provided.

(B) Every subscriber of a health insuring corporation that offers basic health care services is entitled to an identification card or similar document that specifies the health insuring corporation's name as stated in its articles of incorporation, and any trade or fictitious names used by the health insuring corporation. The identification card or document shall list at least one toll-free telephone number that provides the subscriber with access, to information on a twenty-four-hours-per-day, seven-days-per-week basis, as to how health care services may be obtained. The identification card or document shall also list at least one toll-free number that, during normal business hours, provides the subscriber with access to information on the coverage available under the subscriber's health care plan and information on the health care plan's internal and external review processes.

(C) No evidence of coverage, or amendment to the evidence of

coverage, shall be delivered, issued for delivery, renewed, or used, until the form of the evidence of coverage or amendment has been filed by the health insuring corporation with the superintendent of insurance. If the superintendent does not disapprove the evidence of coverage or amendment within sixty days after it is filed it shall be deemed approved, unless the superintendent sooner gives approval for the evidence of coverage or amendment. With respect to an amendment to an approved evidence of coverage, the superintendent only may disapprove provisions amended or added to the evidence of coverage. If the superintendent determines within the sixty-day period that any evidence of coverage or amendment fails to meet the requirements of this section, the superintendent shall so notify the health insuring corporation and it shall be unlawful for the health insuring corporation to use such evidence of coverage or amendment. At any time, the superintendent, upon at least thirty days' written notice to a health insuring corporation, may withdraw an approval, deemed or actual, of any evidence of coverage or amendment on any of the grounds stated in this section. Such disapproval shall be effected by a written order, which shall state the grounds for disapproval and shall be issued in accordance with Chapter 119. of the Revised Code.

(D) No evidence of coverage or amendment shall be delivered, issued for delivery, renewed, or used:

(1) If it contains provisions or statements that are inequitable, untrue, misleading, or deceptive;

(2) Unless it contains a clear, concise, and complete statement of the following:

(a) The health care services and insurance or other benefits, if any, to which an enrollee is entitled under the health care plan;

(b) Any exclusions or limitations on the health care services, type of health care services, benefits, or type of benefits to be provided, including copayments and deductibles;

(c) An enrollee's personal financial obligation for noncovered services;

(d) Where and in what manner general information and information as to how health care services may be obtained is available, including a toll-free telephone number;

(e) The premium rate with respect to individual and conversion contracts, and relevant copayment and deductible provisions with respect to all contracts. The statement of the premium rate, however, may be contained in a separate insert.

(f) The method utilized by the health insuring corporation for resolving enrollee complaints;

(g) The utilization review, internal review, and external review procedures established under sections 1751.77 to 1751.85 of the Revised Code.

(3) Unless it provides for the continuation of an enrollee's coverage, in the event that the enrollee's coverage under the group policy, contract, certificate, or agreement terminates while the enrollee is receiving inpatient care in a hospital. This continuation of coverage shall terminate at the earliest occurrence of any of the following:

(a) The enrollee's discharge from the hospital;

(b) The determination by the enrollee's attending physician that inpatient care is no longer medically indicated for the enrollee; however, nothing in division (D)(3)(b) of this section precludes a health insuring corporation from engaging in utilization review as described in the evidence of coverage.

(c) The enrollee's reaching the limit for contractual

benefits;

(d) The effective date of any new coverage.

(4) Unless it contains a provision that states, in substance, that the health insuring corporation is not a member of any guaranty fund, and that in the event of the health insuring corporation's insolvency, an enrollee is protected only to the extent that the hold harmless provision required by section 1751.13 of the Revised Code applies to the health care services rendered;

(5) Unless it contains a provision that states, in substance, that in the event of the insolvency of the health insuring corporation, an enrollee may be financially responsible for health care services rendered by a provider or health care facility that is not under contract to the health insuring corporation, whether or not the health insuring corporation authorized the use of the provider or health care facility.

(E) Notwithstanding divisions (C) and (D) of this section, a health insuring corporation may use an evidence of coverage that provides for the coverage of beneficiaries enrolled in ~~Title XVIII of~~ the ~~"Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended~~ medicare program, pursuant to a medicare contract, or an evidence of coverage that provides for the coverage of beneficiaries enrolled in the federal employees health benefits program pursuant to 5 U.S.C.~~A.~~ 8905, or an evidence of coverage that provides for the coverage of ~~beneficiaries enrolled in Title XIX~~ recipients of the ~~"Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended, known as the medical assistance program or~~ medicaid~~, provided by the Ohio department of job and family services under Chapter 5111. of the Revised Code~~ program, or an evidence of coverage that provides for the coverage of beneficiaries under any other federal health care program regulated by a federal regulatory body, or an evidence of coverage

that provides for the coverage of beneficiaries under any contract covering officers or employees of the state that has been entered into by the department of administrative services, if both of the following apply:

(1) The evidence of coverage has been approved by the United States department of health and human services, the United States office of personnel management, the ~~Ohio~~ department of ~~job and family services~~ health care administration, or the department of administrative services.

(2) The evidence of coverage is filed with the superintendent of insurance prior to use and is accompanied by documentation of approval from the United States department of health and human services, the United States office of personnel management, the ~~Ohio~~ department of ~~job and family services~~ health care administration, or the department of administrative services.

Sec. 1751.111. (A)(1) This section applies to both of the following:

(a) A health insuring corporation that issues or requires the use of a standardized identification card or an electronic technology for submission and routing of prescription drug claims pursuant to a policy, contract, or agreement for health care services;

(b) A person or entity that a health insuring corporation contracts with to issue a standardized identification card or an electronic technology described in division (A)(1)(a) of this section.

(2) Notwithstanding division (A)(1) of this section, this section does not apply to the issuance or required use of a standardized identification card or an electronic technology for submission and routing of prescription drug claims in connection

with any of the following:

(a) Coverage provided under the medicare advantage program operated pursuant to Part C of ~~Title XVIII of~~ the ~~"Social Security Act," 49 Stat. 62 (1935), 42 U.S.C. 301, as amended~~ medicare program.

(b) Coverage provided under the medicaid~~, as defined in section 5111.01 of the Revised Code~~ program.

(c) Coverage provided under an employer's self-insurance plan or by any of its administrators, as defined in section 3959.01 of the Revised Code, to the extent that federal law supersedes, preempts, prohibits, or otherwise precludes the application of this section to the plan and its administrators.

(B) A standardized identification card or an electronic technology issued or required to be used as provided in division (A)(1) of this section shall contain uniform prescription drug information in accordance with either division (B)(1) or (2) of this section.

(1) The standardized identification card or the electronic technology shall be in a format and contain information fields approved by the national council for prescription drug programs or a successor organization, as specified in the council's or successor organization's pharmacy identification card implementation guide in effect on the first day of October most immediately preceding the issuance or required use of the standardized identification card or the electronic technology.

(2) If the health insuring corporation or the person under contract with the corporation to issue a standardized identification card or an electronic technology requires the information for the submission and routing of a claim, the standardized identification card or the electronic technology shall contain any of the following information:

(a) The health insuring corporation's name;

(b) The subscriber's name, group number, and identification number;

(c) A telephone number to inquire about pharmacy-related issues;

(d) The issuer's international identification number, labeled as "ANSI BIN" or "RxBIN";

(e) The processor's control number, labeled as "RxPCN";

(f) The subscriber's pharmacy benefits group number if different from the subscriber's medical group number, labeled as "RxGrp."

(C) If the standardized identification card or the electronic technology issued or required to be used as provided in division (A)(1) of this section is also used for submission and routing of nonpharmacy claims, the designation "Rx" is required to be included as part of the labels identified in divisions (B)(2)(d) and (e) of this section if the issuer's international identification number or the processor's control number is different for medical and pharmacy claims.

(D) Each health insuring corporation described in division (A) of this section shall annually file a certificate with the superintendent of insurance certifying that it or any person it contracts with to issue a standardized identification card or electronic technology for submission and routing of prescription drug claims complies with this section.

(E)(1) Except as provided in division (E)(2) of this section, if there is a change in the information contained in the standardized identification card or the electronic technology issued to a subscriber, the health insuring corporation or person under contract with the corporation to issue a standardized

identification card or an electronic technology shall issue a new card or electronic technology to the subscriber.

(2) A health insuring corporation or person under contract with the corporation is not required under division (E)(1) of this section to issue a new card or electronic technology to a subscriber more than once during a twelve-month period.

(F) Nothing in this section shall be construed as requiring a health insuring corporation to produce more than one standardized identification card or one electronic technology for use by subscribers accessing health care benefits provided under a policy, contract, or agreement for health care services.

Sec. 1751.12. (A)(1) No contractual periodic prepayment and no premium rate for nongroup and conversion policies for health care services, or any amendment to them, may be used by any health insuring corporation at any time until the contractual periodic prepayment and premium rate, or amendment, have been filed with the superintendent of insurance, and shall not be effective until the expiration of sixty days after their filing unless the superintendent sooner gives approval. The filing shall be accompanied by an actuarial certification in the form prescribed by the superintendent. The superintendent shall disapprove the filing, if the superintendent determines within the sixty-day period that the contractual periodic prepayment or premium rate, or amendment, is not in accordance with sound actuarial principles or is not reasonably related to the applicable coverage and characteristics of the applicable class of enrollees. The superintendent shall notify the health insuring corporation of the disapproval, and it shall thereafter be unlawful for the health insuring corporation to use the contractual periodic prepayment or premium rate, or amendment.

(2) No contractual periodic prepayment for group policies for

health care services shall be used until the contractual periodic prepayment has been filed with the superintendent. The filing shall be accompanied by an actuarial certification in the form prescribed by the superintendent. The superintendent may reject a filing made under division (A)(2) of this section at any time, with at least thirty days' written notice to a health insuring corporation, if the contractual periodic prepayment is not in accordance with sound actuarial principles or is not reasonably related to the applicable coverage and characteristics of the applicable class of enrollees.

(3) At any time, the superintendent, upon at least thirty days' written notice to a health insuring corporation, may withdraw the approval given under division (A)(1) of this section, deemed or actual, of any contractual periodic prepayment or premium rate, or amendment, based on information that either of the following applies:

(a) The contractual periodic prepayment or premium rate, or amendment, is not in accordance with sound actuarial principles.

(b) The contractual periodic prepayment or premium rate, or amendment, is not reasonably related to the applicable coverage and characteristics of the applicable class of enrollees.

(4) Any disapproval under division (A)(1) of this section, any rejection of a filing made under division (A)(2) of this section, or any withdrawal of approval under division (A)(3) of this section, shall be effected by a written notice, which shall state the specific basis for the disapproval, rejection, or withdrawal and shall be issued in accordance with Chapter 119. of the Revised Code.

(B) Notwithstanding division (A) of this section, a health insuring corporation may use a contractual periodic prepayment or premium rate for policies used for the coverage of beneficiaries

enrolled in ~~Title XVIII of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended,~~ the medicare program pursuant to a medicare risk contract or medicare cost contract, or for policies used for the coverage of beneficiaries enrolled in the federal employees health benefits program pursuant to 5 U.S.C.~~A.~~ 8905, or for policies used for the coverage of ~~beneficiaries enrolled in Title XIX~~ recipients of the ~~"Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended, known as the medical assistance program or~~ medicaid~~, provided by the department of job and family services under Chapter 5111. of the Revised Code~~ program, or for policies used for the coverage of beneficiaries under any other federal health care program regulated by a federal regulatory body, or for policies used for the coverage of beneficiaries under any contract covering officers or employees of the state that has been entered into by the department of administrative services, if both of the following apply:

(1) The contractual periodic prepayment or premium rate has been approved by the United States department of health and human services, the United States office of personnel management, the department of ~~job and family services~~ health care administration, or the department of administrative services.

(2) The contractual periodic prepayment or premium rate is filed with the superintendent prior to use and is accompanied by documentation of approval from the United States department of health and human services, the United States office of personnel management, the department of ~~job and family services~~ health care administration, or the department of administrative services.

(C) The administrative expense portion of all contractual periodic prepayment or premium rate filings submitted to the superintendent for review must reflect the actual cost of administering the product. The superintendent may require that the administrative expense portion of the filings be itemized and

supported.

(D)(1) Copayments must be reasonable and must not be a barrier to the necessary utilization of services by enrollees.

(2) A health insuring corporation, in order to ensure that copayments are reasonable and not a barrier to the necessary utilization of basic health care services by enrollees, may do one of the following:

(a) Impose copayment charges on any single covered basic health care service that does not exceed forty per cent of the average cost to the health insuring corporation of providing the service;

(b) Impose copayment charges that annually do not exceed twenty per cent of the total annual cost to the health insuring corporation of providing all covered basic health care services, including physician office visits, urgent care services, and emergency health services, when aggregated as to all persons covered under the filed product in question. In addition, annual copayment charges as to each enrollee shall not exceed twenty per cent of the total annual cost to the health insuring corporation of providing all covered basic health care services, including physician office visits, urgent care services, and emergency health services, as to such enrollee. The total annual cost of providing a health care service is the cost to the health insuring corporation of providing the health care service to its enrollees as reduced by any applicable provider discount.

(3) To ensure that copayments are reasonable and not a barrier to the utilization of basic health care services, a health insuring corporation may not impose, in any contract year, on any subscriber or enrollee, copayments that exceed two hundred per cent of the average annual premium rate to subscribers or enrollees.

(4) For purposes of division (D) of this section, both of the following apply:

(a) Copayments imposed by health insuring corporations in connection with a high deductible health plan that is linked to a health savings account are reasonable and are not a barrier to the necessary utilization of services by enrollees.

(b) Divisions (D)(2) and (3) of this section do not apply to a high deductible health plan that is linked to a health savings account.

(E) A health insuring corporation shall not impose lifetime maximums on basic health care services. However, a health insuring corporation may establish a benefit limit for inpatient hospital services that are provided pursuant to a policy, contract, certificate, or agreement for supplemental health care services.

(F) A health insuring corporation may require that an enrollee pay an annual deductible that does not exceed one thousand dollars per enrollee or two thousand dollars per family, except that:

(1) A health insuring corporation may impose higher deductibles for high deductible health plans that are linked to health savings accounts;

(2) The superintendent may adopt rules allowing different annual deductible amounts for plans with a medical savings account, health reimbursement arrangement, flexible spending account, or similar account;

(3) A health insuring corporation may impose higher deductibles under health plans if requested by the group contract, policy, certificate, or agreement holder, or an individual seeking coverage under an individual health plan. This shall not be construed as requiring the health insuring corporation to create customized health plans for group contract holders or individuals.

(G) As used in this section, "health savings account" and "high deductible health plan" have the same meanings as in the "Internal Revenue Code of 1986," 100 Stat. 2085, 26 U.S.C. 223, as amended.

Sec. 1751.13. (A)(1)(a) A health insuring corporation shall, either directly or indirectly, enter into contracts for the provision of health care services with a sufficient number and types of providers and health care facilities to ensure that all covered health care services will be accessible to enrollees from a contracted provider or health care facility.

(b) A health insuring corporation shall not refuse to contract with a physician for the provision of health care services or refuse to recognize a physician as a specialist on the basis that the physician attended an educational program or a residency program approved or certified by the American osteopathic association. A health insuring corporation shall not refuse to contract with a health care facility for the provision of health care services on the basis that the health care facility is certified or accredited by the American osteopathic association or that the health care facility is an osteopathic hospital as defined in section 3702.51 of the Revised Code.

(c) Nothing in division (A)(1)(b) of this section shall be construed to require a health insuring corporation to make a benefit payment under a closed panel plan to a physician or health care facility with which the health insuring corporation does not have a contract, provided that none of the bases set forth in that division are used as a reason for failing to make a benefit payment.

(2) When a health insuring corporation is unable to provide a covered health care service from a contracted provider or health care facility, the health insuring corporation must provide that

health care service from a noncontracted provider or health care facility consistent with the terms of the enrollee's policy, contract, certificate, or agreement. The health insuring corporation shall either ensure that the health care service be provided at no greater cost to the enrollee than if the enrollee had obtained the health care service from a contracted provider or health care facility, or make other arrangements acceptable to the superintendent of insurance.

(3) Nothing in this section shall prohibit a health insuring corporation from entering into contracts with out-of-state providers or health care facilities that are licensed, certified, accredited, or otherwise authorized in that state.

(B)(1) A health insuring corporation shall, either directly or indirectly, enter into contracts with all providers and health care facilities through which health care services are provided to its enrollees.

(2) A health insuring corporation, upon written request, shall assist its contracted providers in finding stop-loss or reinsurance carriers.

(C) A health insuring corporation shall file an annual certificate with the superintendent certifying that all provider contracts and contracts with health care facilities through which health care services are being provided contain the following:

(1) A description of the method by which the provider or health care facility will be notified of the specific health care services for which the provider or health care facility will be responsible, including any limitations or conditions on such services;

(2) The specific hold harmless provision specifying protection of enrollees set forth as follows:

"[Provider/Health Care Facility] agrees that in no event,

including but not limited to nonpayment by the health insuring corporation, insolvency of the health insuring corporation, or breach of this agreement, shall [Provider/Health Care Facility] bill, charge, collect a deposit from, seek remuneration or reimbursement from, or have any recourse against, a subscriber, enrollee, person to whom health care services have been provided, or person acting on behalf of the covered enrollee, for health care services provided pursuant to this agreement. This does not prohibit [Provider/Health Care Facility] from collecting co-insurance, deductibles, or copayments as specifically provided in the evidence of coverage, or fees for uncovered health care services delivered on a fee-for-service basis to persons referenced above, nor from any recourse against the health insuring corporation or its successor."

(3) Provisions requiring the provider or health care facility to continue to provide covered health care services to enrollees in the event of the health insuring corporation's insolvency or discontinuance of operations. The provisions shall require the provider or health care facility to continue to provide covered health care services to enrollees as needed to complete any medically necessary procedures commenced but unfinished at the time of the health insuring corporation's insolvency or discontinuance of operations. The completion of a medically necessary procedure shall include the rendering of all covered health care services that constitute medically necessary follow-up care for that procedure. If an enrollee is receiving necessary inpatient care at a hospital, the provisions may limit the required provision of covered health care services relating to that inpatient care in accordance with division (D)(3) of section 1751.11 of the Revised Code, and may also limit such required provision of covered health care services to the period ending thirty days after the health insuring corporation's insolvency or discontinuance of operations.

The provisions required by division (C)(3) of this section shall not require any provider or health care facility to continue to provide any covered health care service after the occurrence of any of the following:

(a) The end of the thirty-day period following the entry of a liquidation order under Chapter 3903. of the Revised Code;

(b) The end of the enrollee's period of coverage for a contractual prepayment or premium;

(c) The enrollee obtains equivalent coverage with another health insuring corporation or insurer, or the enrollee's employer obtains such coverage for the enrollee;

(d) The enrollee or the enrollee's employer terminates coverage under the contract;

(e) A liquidator effects a transfer of the health insuring corporation's obligations under the contract under division (A)(8) of section 3903.21 of the Revised Code.

(4) A provision clearly stating the rights and responsibilities of the health insuring corporation, and of the contracted providers and health care facilities, with respect to administrative policies and programs, including, but not limited to, payments systems, utilization review, quality assurance, assessment, and improvement programs, credentialing, confidentiality requirements, and any applicable federal or state programs;

(5) A provision regarding the availability and confidentiality of those health records maintained by providers and health care facilities to monitor and evaluate the quality of care, to conduct evaluations and audits, and to determine on a concurrent or retrospective basis the necessity of and appropriateness of health care services provided to enrollees. The provision shall include terms requiring the provider or health

care facility to make these health records available to appropriate state and federal authorities involved in assessing the quality of care or in investigating the grievances or complaints of enrollees, and requiring the provider or health care facility to comply with applicable state and federal laws related to the confidentiality of medical or health records.

(6) A provision that states that contractual rights and responsibilities may not be assigned or delegated by the provider or health care facility without the prior written consent of the health insuring corporation;

(7) A provision requiring the provider or health care facility to maintain adequate professional liability and malpractice insurance. The provision shall also require the provider or health care facility to notify the health insuring corporation not more than ten days after the provider's or health care facility's receipt of notice of any reduction or cancellation of such coverage.

(8) A provision requiring the provider or health care facility to observe, protect, and promote the rights of enrollees as patients;

(9) A provision requiring the provider or health care facility to provide health care services without discrimination on the basis of a patient's participation in the health care plan, age, sex, ethnicity, religion, sexual preference, health status, or disability, and without regard to the source of payments made for health care services rendered to a patient. This requirement shall not apply to circumstances when the provider or health care facility appropriately does not render services due to limitations arising from the provider's or health care facility's lack of training, experience, or skill, or due to licensing restrictions.

(10) A provision containing the specifics of any obligation

on the primary care provider to provide, or to arrange for the provision of, covered health care services twenty-four hours per day, seven days per week;

(11) A provision setting forth procedures for the resolution of disputes arising out of the contract;

(12) A provision stating that the hold harmless provision required by division (C)(2) of this section shall survive the termination of the contract with respect to services covered and provided under the contract during the time the contract was in effect, regardless of the reason for the termination, including the insolvency of the health insuring corporation;

(13) A provision requiring those terms that are used in the contract and that are defined by this chapter, be used in the contract in a manner consistent with those definitions.

This division does not apply to the coverage of beneficiaries enrolled in ~~Title XVIII of~~ the ~~"Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended~~ medicare program, pursuant to a medicare risk contract or medicare cost contract, or to the coverage of beneficiaries enrolled in the federal employee health benefits program pursuant to 5 U.S.C.~~A.~~ 8905, or to the coverage of ~~beneficiaries enrolled in Title XIX~~ recipients of the ~~"Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended, known as the medical assistance program or~~ medicaid~~, provided by the department of job and family services under Chapter 5111. of the Revised Code~~ program, or to the coverage of beneficiaries under any federal health care program regulated by a federal regulatory body, or to the coverage of beneficiaries under any contract covering officers or employees of the state that has been entered into by the department of administrative services.

(D)(1) No health insuring corporation contract with a provider or health care facility shall contain any of the

following:

(a) A provision that directly or indirectly offers an inducement to the provider or health care facility to reduce or limit medically necessary health care services to a covered enrollee;

(b) A provision that penalizes a provider or health care facility that assists an enrollee to seek a reconsideration of the health insuring corporation's decision to deny or limit benefits to the enrollee;

(c) A provision that limits or otherwise restricts the provider's or health care facility's ethical and legal responsibility to fully advise enrollees about their medical condition and about medically appropriate treatment options;

(d) A provision that penalizes a provider or health care facility for principally advocating for medically necessary health care services;

(e) A provision that penalizes a provider or health care facility for providing information or testimony to a legislative or regulatory body or agency. This shall not be construed to prohibit a health insuring corporation from penalizing a provider or health care facility that provides information or testimony that is libelous or slanderous or that discloses trade secrets which the provider or health care facility has no privilege or permission to disclose.

(2) Nothing in this division shall be construed to prohibit a health insuring corporation from doing either of the following:

(a) Making a determination not to reimburse or pay for a particular medical treatment or other health care service;

(b) Enforcing reasonable peer review or utilization review protocols, or determining whether a particular provider or health

care facility has complied with these protocols.

(E) Any contract between a health insuring corporation and an intermediary organization shall clearly specify that the health insuring corporation must approve or disapprove the participation of any provider or health care facility with which the intermediary organization contracts.

(F) If an intermediary organization that is not a health delivery network contracting solely with self-insured employers subcontracts with a provider or health care facility, the subcontract with the provider or health care facility shall do all of the following:

(1) Contain the provisions required by divisions (C) and (G) of this section, as made applicable to an intermediary organization, without the inclusion of inducements or penalties described in division (D) of this section;

(2) Acknowledge that the health insuring corporation is a third-party beneficiary to the agreement;

(3) Acknowledge the health insuring corporation's role in approving the participation of the provider or health care facility, pursuant to division (E) of this section.

(G) Any provider contract or contract with a health care facility shall clearly specify the health insuring corporation's statutory responsibility to monitor and oversee the offering of covered health care services to its enrollees.

(H)(1) A health insuring corporation shall maintain its provider contracts and its contracts with health care facilities at one or more of its places of business in this state, and shall provide copies of these contracts to facilitate regulatory review upon written notice by the superintendent of insurance.

(2) Any contract with an intermediary organization that

accepts compensation shall include provisions requiring the intermediary organization to provide the superintendent with regulatory access to all books, records, financial information, and documents related to the provision of health care services to subscribers and enrollees under the contract. The contract shall require the intermediary organization to maintain such books, records, financial information, and documents at its principal place of business in this state and to preserve them for at least three years in a manner that facilitates regulatory review.

(I)(1) A health insuring corporation shall notify its affected enrollees of the termination of a contract for the provision of health care services between the health insuring corporation and a primary care physician or hospital, by mail, within thirty days after the termination of the contract.

(a) Notice shall be given to subscribers of the termination of a contract with a primary care physician if the subscriber, or a dependent covered under the subscriber's health care coverage, has received health care services from the primary care physician within the previous twelve months or if the subscriber or dependent has selected the physician as the subscriber's or dependent's primary care physician within the previous twelve months.

(b) Notice shall be given to subscribers of the termination of a contract with a hospital if the subscriber, or a dependent covered under the subscriber's health care coverage, has received health care services from that hospital within the previous twelve months.

(2) The health insuring corporation shall pay, in accordance with the terms of the contract, for all covered health care services rendered to an enrollee by a primary care physician or hospital between the date of the termination of the contract and five days after the notification of the contract termination is

mailed to a subscriber at the subscriber's last known address.

(J) Divisions (A) and (B) of this section do not apply to any health insuring corporation that, on June 4, 1997, holds a certificate of authority or license to operate under Chapter 1740. of the Revised Code.

(K) Nothing in this section shall restrict the governing body of a hospital from exercising the authority granted it pursuant to section 3701.351 of the Revised Code.

Sec. 1751.15. (A) After a health insuring corporation has furnished, directly or indirectly, basic health care services for a period of twenty-four months, and if it currently meets the financial requirements set forth in section 1751.28 of the Revised Code and had net income as reported to the superintendent of insurance for at least one of the preceding four calendar quarters, it shall hold an annual open enrollment period of not less than thirty days during its month of licensure for individuals who are not federally eligible individuals at the time they apply for enrollment.

(B) During the open enrollment period described in division (A) of this section, the health insuring corporation shall accept applicants and their dependents in the order in which they apply for enrollment and in accordance with any of the following:

(1) Up to its capacity, as determined by the health insuring corporation subject to review by the superintendent;

(2) If less than its capacity, one per cent of the health insuring corporation's total number of subscribers residing in this state as of the immediately preceding thirty-first day of December.

(C) Where a health insuring corporation demonstrates to the satisfaction of the superintendent that such open enrollment would

jeopardize its economic viability, the superintendent may do any of the following:

(1) Waive the requirement for open enrollment;

(2) Impose a limit on the number of applicants and their dependents that must be enrolled;

(3) Authorize such underwriting restrictions upon open enrollment as are necessary to do any of the following:

(a) Preserve its financial stability;

(b) Prevent excessive adverse selection;

(c) Avoid unreasonably high or unmarketable charges for coverage of health care services.

(D)(1) A request to the superintendent under division (C) of this section for any restriction, limit, or waiver during an open enrollment period must be accompanied by supporting documentation, including financial data. In reviewing the request, the superintendent may consider various factors, including the size of the health insuring corporation, the health insuring corporation's net worth and profitability, the health insuring corporation's delivery system structure, and the effect on profitability of prior open enrollments.

(2) Any action taken by the superintendent under division (C) of this section shall be effective for a period of not more than one year. At the expiration of such time, a new demonstration of the health insuring corporation's need for the restriction, limit, or waiver shall be made before a new restriction, limit, or waiver is granted by the superintendent.

(3) Irrespective of the granting of any restriction, limit, or waiver by the superintendent, a health insuring corporation may reject an applicant or a dependent of the applicant during its open enrollment period if the applicant or dependent:

(a) Was eligible for and was covered under any employer-sponsored health care coverage, or if employer-sponsored health care coverage was available at the time of open enrollment;

(b) Is eligible for continuation coverage under state or federal law;

(c) Is eligible for medicare, and the health insuring corporation does not have an agreement on appropriate payment mechanisms with the governmental agency administering the medicare program.

(E) A health insuring corporation shall not be required either to enroll applicants or their dependents who are confined to a health care facility because of chronic illness, permanent injury, or other infirmity that would cause economic impairment to the health insuring corporation if such applicants or their dependents were enrolled or to make the effective date of benefits for applicants or their dependents enrolled under this section earlier than ninety days after the date of enrollment.

(F) A health insuring corporation shall not be required to cover the fees or costs, or both, for any basic health care service related to a transplant of a body organ if the transplant occurs within one year after the effective date of an enrollee's coverage under this section. This limitation on coverage does not apply to a newly born child who meets the requirements for coverage under section 1751.61 of the Revised Code.

(G) Each health insuring corporation required to hold an open enrollment pursuant to division (A) of this section shall file with the superintendent, not later than sixty days prior to the commencement of the proposed open enrollment period, the following documents:

(1) The proposed public notice of open enrollment;

(2) The evidence of coverage approved pursuant to section

1751.11 of the Revised Code that will be used during open enrollment;

(3) The contractual periodic prepayment and premium rate approved pursuant to section 1751.12 of the Revised Code that will be applicable during open enrollment;

(4) Any solicitation document approved pursuant to section 1751.31 of the Revised Code to be sent to applicants, including the application form that will be used during open enrollment;

(5) A list of the proposed dates of publication of the public notice, and the names of the newspapers in which the notice will appear;

(6) Any request for a restriction, limit, or waiver with respect to the open enrollment period, along with any supporting documentation.

(H)(1) An open enrollment period shall not satisfy the requirements of this section unless the health insuring corporation provides adequate public notice in accordance with divisions (H)(2) and (3) of this section. No public notice shall be used until the form of the public notice has been filed by the health insuring corporation with the superintendent. If the superintendent does not disapprove the public notice within sixty days after it is filed, it shall be deemed approved, unless the superintendent sooner gives approval for the public notice. If the superintendent determines within this sixty-day period that the public notice fails to meet the requirements of this section, the superintendent shall so notify the health insuring corporation and it shall be unlawful for the health insuring corporation to use the public notice. Such disapproval shall be effected by a written order, which shall state the grounds for disapproval and shall be issued in accordance with Chapter 119. of the Revised Code.

(2) A public notice pursuant to division (H)(1) of this

section shall be published in at least one newspaper of general circulation in each county in the health insuring corporation's service area, at least once in each of the two weeks immediately preceding the month in which the open enrollment is to occur and in each week of that month, or until the enrollment limitation is reached, whichever occurs first. The notice published during the last week of open enrollment shall appear not less than five days before the end of the open enrollment period. It shall be at least two newspaper columns wide or two and one-half inches wide, whichever is larger. The first two lines of the text shall be published in not less than twelve-point, boldface type. The remainder of the text of the notice shall be published in not less than eight-point type. The entire public notice shall be surrounded by a continuous black line not less than one-eighth of an inch wide.

(3) The following information shall be included in the public notice provided under division (H)(2) of this section:

(a) The dates that open enrollment will be held and the date coverage obtained under the open enrollment will become effective;

(b) Notice that an applicant or the applicant's dependents will not be denied coverage during open enrollment because of a preexisting health condition, but that some limitations and restrictions may apply;

(c) The address where a person may obtain an application;

(d) The telephone number that a person may call to request an application or to ask questions;

(e) The date the first payment will be due;

(f) The actual rates or range of rates that will be applicable for applicants;

(g) Any limitation granted by the superintendent on the

number of applications that will be accepted by the health insuring corporation.

(4) Within thirty days after the end of an open enrollment period, the health insuring corporation shall submit to the superintendent proof of publication for the public notices, and shall report the total number of applicants and their dependents enrolled during the open enrollment period.

(I)(1) No health insuring corporation may employ any scheme, plan, or device that restricts the ability of any person to enroll during open enrollment.

(2) No health insuring corporation may require enrollment to be made in person. Every health insuring corporation shall permit application for coverage by mail. A representative of the health insuring corporation may visit an applicant who has submitted an application by mail, in order to explain the operations of the health insuring corporation and to answer any questions the applicant may have. Every health insuring corporation shall make open enrollment applications and solicitation documents readily available to any potential applicant who requests such material.

(J) An application postmarked on the last day of an open enrollment period shall qualify as a valid application, regardless of the date on which it is received by the health insuring corporation.

(K) This section does not apply to any health insuring corporation that offers only supplemental health care services or specialty health care services, or to any health insuring corporation that offers plans only through ~~Title XVIII or Title XIX of~~ the ~~"Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended~~ medicare program or medicaid program, and that has no other commercial enrollment, or to any health insuring corporation that offers plans only through other federal health

care programs regulated by federal regulatory bodies and that has no other commercial enrollment, or to any health insuring corporation that offers plans only through contracts covering officers or employees of the state that have been entered into by the department of administrative services and that has no other commercial enrollment.

(L) Each health insuring corporation shall accept federally eligible individuals for open enrollment coverage as provided in section 3923.581 of the Revised Code. A health insuring corporation may reinsure coverage of any federally eligible individual acquired under that section with the open enrollment reinsurance program in accordance with division (G) of section 3924.11 of the Revised Code. Fixed periodic prepayment rates charged for coverage reinsured by the program shall be established in accordance with section 3924.12 of the Revised Code.

(M) As used in this section, "federally eligible individual" means an eligible individual as defined in 45 C.F.R. 148.103.

Sec. 1751.16. (A) Except as provided in division (F) of this section, every group contract issued by a health insuring corporation shall provide an option for conversion to an individual contract issued on a direct-payment basis to any subscriber covered by the group contract who terminates employment or membership in the group, unless:

(1) Termination of the conversion option or contract is based upon nonpayment of premium after reasonable notice in writing has been given by the health insuring corporation to the subscriber.

(2) The subscriber is, or is eligible to be, covered for benefits at least comparable to the group contract under any of the following:

(a) ~~Title XVIII of the "Social Security Act," 49 Stat. 620~~

~~(1935), 42 U.S.C.A. 301, as amended~~ The medicare program;

(b) Any act of congress or law under this or any other state of the United States providing coverage at least comparable to the benefits under division (A)(2)(a) of this section;

(c) Any policy of insurance or health care plan providing coverage at least comparable to the benefits under division (A)(2)(a) of this section.

(B)(1) The direct-payment contract offered by the health insuring corporation pursuant to division (A) of this section shall provide the following:

(a) In the case of an individual who is not a federally eligible individual, benefits comparable to benefits in any of the individual contracts then being issued to individual subscribers by the health insuring corporation;

(b) In the case of a federally eligible individual, a basic and standard plan established by the board of directors of the Ohio health reinsurance program or plans substantially similar to the basic and standard plan in benefit design and scope of covered services. For purposes of division (B)(1)(b) of this section, the superintendent of insurance shall determine whether a plan is substantially similar to the basic or standard plan in benefit design and scope of covered services. The contractual periodic prepayments charged for such plans may not exceed an amount that is two times the midpoint of the standard rate charged any other individual of a group to which the organization is currently accepting new business and for which similar copayments and deductibles are applied.

(2) The direct payment contract offered pursuant to division (A) of this section may include a coordination of benefits provision as approved by the superintendent.

(3) For purposes of division (B) of this section "federally

eligible individual" means an eligible individual as defined in 45 C.F.R. 148.103.

(C) The option for conversion shall be available:

(1) Upon the death of the subscriber, to the surviving spouse with respect to such of the spouse and dependents as are then covered by the group contract;

(2) To a child solely with respect to the child upon the child's attaining the limiting age of coverage under the group contract while covered as a dependent under the contract;

(3) Upon the divorce, dissolution, or annulment of the marriage of the subscriber, to the divorced spouse, or, in the event of annulment, to the former spouse of the subscriber.

(D) No health insuring corporation shall use age as the basis for refusing to renew a converted contract.

(E) Written notice of the conversion option provided by this section shall be given to the subscriber by the health insuring corporation by mail. The notice shall be sent to the subscriber's address in the records of the employer upon receipt of notice from the employer of the event giving rise to the conversion option. If the subscriber has not received notice of the conversion privilege at least fifteen days prior to the expiration of the thirty-day conversion period, then the subscriber shall have an additional period within which to exercise the privilege. This additional period shall expire fifteen days after the subscriber receives notice, but in no event shall the period extend beyond sixty days after the expiration of the thirty-day conversion period.

(F) This section does not apply to any group contract offering only supplemental health care services or specialty health care services.

Sec. 1751.17. (A) As used in this section, "nongroup

contract" means a contract issued by a health insuring corporation to an individual who makes direct application for coverage under the contract and who, if required by the health insuring corporation, submits to medical underwriting. "Nongroup contract" does not include group conversion coverage, coverage obtained through open enrollment, or coverage issued on the basis of membership in a group.

(B) Except as provided in division (C) of this section, every nongroup contract that is issued by a health insuring corporation and that makes available basic health care services shall provide an option for conversion to a contract issued on a direct-payment basis to an enrollee covered by the nongroup contract. The option for conversion shall be available:

(1) Upon the death of the subscriber, to the surviving spouse with respect to the spouse or dependents who were then covered by the nongroup contract;

(2) Upon the divorce, dissolution, or annulment of the marriage of the subscriber, to the divorced spouse, or, in the event of annulment, to the former spouse of the subscriber;

(3) To a child solely with respect to the child, upon the child's attaining the limiting age of coverage under the nongroup contract while covered as a dependent under the contract.

(C) The direct payment contract offered pursuant to division (B) of this section shall not be made available to an enrollee if any of the following applies:

(1) The enrollee is, or is eligible to be, covered for benefits at least comparable to the nongroup contract under any of the following:

(a) The ~~medical assistance~~ medicaid program ~~under Chapter 5111. of the Revised Code~~;

(b) ~~Title XVIII of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended~~ The medicare program;

(c) Any act of congress or law under this or any other state of the United States providing coverage at least comparable to the benefits offered under division (C)(1)(a) or (b) of this section.

(2) The nongroup contract under which the enrollee was covered was terminated due to nonpayment of a premium rate.

(3) The enrollee is eligible for group coverage provided by, or available through, an employer or association and the group coverage provides benefits comparable to the benefits provided under a direct payment contract.

(D) The direct payment contract offered pursuant to division (B) of this section shall provide benefits that are at least comparable to the benefits provided by the nongroup contract under which the enrollee was covered at the time of the occurrence of any of the events set forth in division (B) of this section. The coverage provided under the direct payment contract shall be continuous, provided that the enrollee makes the required premium rate payment within the thirty-day period immediately following the occurrence of the event, and may be terminated for nonpayment of any required premium rate payment.

(E) The evidence of coverage of every nongroup contract shall contain notice that an option for conversion to a contract issued on a direct-payment basis is available, in accordance with this section, to any enrollee covered by the contract.

(F) Benefits otherwise payable to an enrollee under a direct payment contract shall be reduced by the amount of any benefits available to the enrollee under any applicable group health insuring corporation contract or group sickness and accident insurance policy.

(G) Nothing in this section shall be construed as requiring a

health insuring corporation to offer nongroup contracts.

(H) This section does not apply to any nongroup contract offering only supplemental health care services or specialty health care services.

Sec. 1751.18. (A)(1) No health insuring corporation shall cancel or fail to renew the coverage of a subscriber or enrollee because of any health status-related factor in relation to the subscriber or enrollee, the subscriber's or enrollee's requirements for health care services, or for any other reason designated under rules adopted by the superintendent of insurance.

(2) Unless otherwise required by state or federal law, no health insuring corporation, or health care facility or provider through which the health insuring corporation has made arrangements to provide health care services, shall discriminate against any individual with regard to enrollment, disenrollment, or the quality of health care services rendered, on the basis of the individual's race, color, sex, age, religion, or status as a recipient of medicare or ~~medical assistance under Title XVIII or XIX of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended~~ medicaid, or any health status-related factor in relation to the individual. However, a health insuring corporation shall not be required to accept a recipient of medicare or ~~medical assistance~~ medicaid, if an agreement has not been reached on appropriate payment mechanisms between the health insuring corporation and the governmental agency administering these programs. Further, except during a period of open enrollment under section 1751.15 of the Revised Code, a health insuring corporation may reject an applicant for nongroup enrollment on the basis of any health status-related factor in relation to the applicant.

(B) A health insuring corporation may cancel or decide not to renew the coverage of an enrollee if the enrollee has performed an

act or practice that constitutes fraud or intentional misrepresentation of material fact under the terms of the coverage and if the cancellation or nonrenewal is not based, either directly or indirectly, on any health status-related factor in relation to the enrollee.

(C) An enrollee may appeal any action or decision of a health insuring corporation taken pursuant to section 2742(b) to (e) of the "Health Insurance Portability and Accountability Act of 1996," Pub. L. No. 104-191, 110 Stat. 1955, 42 U.S.C.A. 300gg-42, as amended. To appeal, the enrollee may submit a written complaint to the health insuring corporation pursuant to section 1751.19 of the Revised Code. The enrollee may, within thirty days after receiving a written response from the health insuring corporation, appeal the health insuring corporation's action or decision to the superintendent.

(D) As used in this section, "health status-related factor" means any of the following:

(1) Health status;

(2) Medical condition, including both physical and mental illnesses;

(3) Claims experience;

(4) Receipt of health care;

(5) Medical history;

(6) Genetic information;

(7) Evidence of insurability, including conditions arising out of acts of domestic violence;

(8) Disability.

Sec. 1751.20. (A) No health insuring corporation, or agent, employee, or representative of a health insuring corporation,

shall use any advertisement or solicitation document, or shall engage in any activity, that is unfair, untrue, misleading, or deceptive.

(B) No health insuring corporation shall use a name that is deceptively similar to the name or description of any insurance or surety corporation doing business in this state.

(C) All solicitation documents, advertisements, evidences of coverage, and enrollee identification cards used by a health insuring corporation shall contain the health insuring corporation's name. The use of a trade name, an insurance group designation, the name of a parent company, the name of a division of an affiliated insurance company, a service mark, a slogan, a symbol, or other device, without the name of the health insuring corporation as stated in its articles of incorporation, shall not satisfy this requirement if the usage would have the capacity and tendency to mislead or deceive persons as to the true identity of the health insuring corporation.

(D) No solicitation document or advertisement used by a health insuring corporation shall contain any words, symbols, or physical materials that are so similar in content, phraseology, shape, color, or other characteristic to those used by an agency of the federal government or this state, that prospective enrollees may be led to believe that the solicitation document or advertisement is connected with an agency of the federal government or this state.

(E) A health insuring corporation that provides basic health care services may use the phrase "health maintenance organization" or the abbreviation "HMO" in its marketing name, advertising, solicitation documents, or marketing literature, or in reference to the phrase "doing business as" or the abbreviation "DBA."

(F) This section does not apply to the coverage of

beneficiaries enrolled in ~~Title XVIII of~~ the ~~"Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended~~ medicare program, pursuant to a medicare risk contract or medicare cost contract, or to the coverage of beneficiaries enrolled in the federal employee health benefits program pursuant to 5 U.S.C.~~A.~~ 8905, or to the coverage of ~~beneficiaries enrolled in Title XIX~~ recipients of the ~~"Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended, known as the medical assistance program or~~ medicaid~~, provided by the Ohio department of job and family services under Chapter 5111. of the Revised Code~~ program, or to the coverage of beneficiaries under any federal health care program regulated by a federal regulatory body, or to the coverage of beneficiaries under any contract covering officers or employees of the state that has been entered into by the department of administrative services.

Sec. 1751.271. (A) Each health insuring corporation that provides coverage to medicaid recipients shall post a performance bond in the amount of three million dollars as security to fulfill the obligations of the health insuring corporation to pay claims of contracted providers for covered health care services provided to medicaid recipients. The bond shall be payable to the department of insurance in the event that the health insuring corporation is placed in rehabilitation or liquidation proceedings under Chapter 3903. of the Revised Code, and shall become a special deposit subject to section 3903.14 or 3903.421 of the Revised Code, as applicable. In lieu of the performance bond, a medicaid health insuring corporation may deposit securities with the superintendent of insurance, acceptable to the superintendent, in the amount of three million dollars, to satisfy the bonding requirements of this section. Upon rehabilitation or liquidation, the securities shall become a special deposit subject to sections 3903.14 and 3903.421 of the Revised Code, as applicable. The

health insuring corporation shall receive the interest on the deposited securities as long as the health insuring corporation remains solvent.

(B) The bond shall be issued by a surety company licensed with the department of insurance. The bond or deposit, or any replacement bond or deposit, shall be in a form acceptable to the superintendent, and shall remain in effect during the duration of the medicaid health insuring corporation's license and thereafter until all claims against the medicaid health insuring corporation have been paid in full.

(C) Documentation of the bond acceptable to the superintendent of insurance shall be filed with the superintendent prior to the issuance of a certificate of authority. Annually, thirty days prior to the renewal of its certificate of authority, every medicaid health insuring corporation shall furnish the superintendent of insurance with evidence that the required bond is still in effect.

(D) As used in this section:

(1) "Contracted provider" means a provider that has a contract with a medicaid health insuring corporation to provide covered health care services to medicaid recipients.

(2) "Medicaid health insuring corporation" means a health insuring corporation that provides health insurance coverage or otherwise assumes claims liabilities for medicaid recipients.

(3) "Medicaid recipient" means a person eligible for medical assistance under the medicaid program ~~operated pursuant to Chapter 5111. of the Revised Code~~.

Sec. 1751.31. (A) Any changes in a health insuring corporation's solicitation document shall be filed with the superintendent of insurance. The superintendent, within sixty days

of filing, may disapprove any solicitation document or amendment to it on any of the grounds stated in this section. Such disapproval shall be effected by written notice to the health insuring corporation. The notice shall state the grounds for disapproval and shall be issued in accordance with Chapter 119. of the Revised Code.

(B) The solicitation document shall contain all information necessary to enable a consumer to make an informed choice as to whether or not to enroll in the health insuring corporation. The information shall include a specific description of the health care services to be available and the approximate number and type of full-time equivalent medical practitioners. The information shall be presented in the solicitation document in a manner that is clear, concise, and intelligible to prospective applicants in the proposed service area.

(C) Every potential applicant whose subscription to a health care plan is solicited shall receive, at or before the time of solicitation, a solicitation document approved by the superintendent.

(D) Notwithstanding division (A) of this section, a health insuring corporation may use a solicitation document that the corporation uses in connection with policies for beneficiaries of ~~Title XVIII of~~ the ~~"Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended~~ medicare program, pursuant to a medicare risk contract or medicare cost contract, or for policies for beneficiaries of the federal employees health benefits program pursuant to 5 U.S.C.~~A.~~ 8905, or for policies for ~~beneficiaries of Title XIX~~ recipients of the ~~"Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended, known as the medical assistance program or~~ medicaid~~, provided by the department of job and family services under Chapter 5111. of the Revised Code~~ program, or for policies for beneficiaries of any other federal

health care program regulated by a federal regulatory body, or for policies for beneficiaries of contracts covering officers or employees of the state entered into by the department of administrative services, if both of the following apply:

(1) The solicitation document has been approved by the United States department of health and human services, the United States office of personnel management, the department of ~~job and family services~~ health care administration, or the department of administrative services.

(2) The solicitation document is filed with the superintendent of insurance prior to use and is accompanied by documentation of approval from the United States department of health and human services, the United States office of personnel management, the department of ~~job and family services~~ health care administration, or the department of administrative services.

(E) No health insuring corporation, or its agents or representatives, shall use monetary or other valuable consideration, engage in misleading or deceptive practices, or make untrue, misleading, or deceptive representations to induce enrollment. Nothing in this division shall prohibit incentive forms of remuneration such as commission sales programs for the health insuring corporation's employees and agents.

(F) Any person obligated for any part of a premium rate in connection with an enrollment agreement, in addition to any right otherwise available to revoke an offer, may cancel such agreement within seventy-two hours after having signed the agreement or offer to enroll. Cancellation occurs when written notice of the cancellation is given to the health insuring corporation or its agents or other representatives. A notice of cancellation mailed to the health insuring corporation shall be considered to have been filed on its postmark date.

(G) Nothing in this section shall prohibit healthy lifestyle programs.

Sec. 1751.34. (A) Each health insuring corporation and each applicant for a certificate of authority under this chapter shall be subject to examination by the superintendent of insurance in accordance with section 3901.07 of the Revised Code. Section 3901.07 of the Revised Code shall govern every aspect of the examination, including the circumstances under and frequency with which it is conducted, the authority of the superintendent and any examiner or other person appointed by the superintendent, the liability for the assessment of expenses incurred in conducting the examination, and the remittance of the assessment to the superintendent's examination fund.

(B) The director of health shall make an examination concerning the matters subject to the director's consideration in section 1751.04 of the Revised Code as often as the director considers it necessary for the protection of the interests of the people of this state, but not less frequently than once every three years. The expenses of such examinations shall be assessed against the health insuring corporation being examined in the manner in which expenses of examinations are assessed against an insurance company under section 3901.07 of the Revised Code. Nothing in this division requires the director to make an examination of a health insuring corporation that covers solely recipients of assistance under the medicaid program ~~operated pursuant to Chapter 5111. of the Revised Code~~, a health insuring corporation that covers solely recipients of assistance under the ~~federal~~ medicare program ~~under Title XVIII of the "Social Security Act," 49 Stat. 62 (1935), 42 U.S.C. 301, as amended~~, or a health insuring corporation that covers solely recipients of assistance under both the medicaid and medicare programs.

(C) An examination, pursuant to section 3901.07 of the Revised Code, of an insurance company holding a certificate of authority under this chapter to organize and operate a health insuring corporation shall include an examination of the health insuring corporation pursuant to this section and the examination shall satisfy the requirements of divisions (A) and (B) of this section.

(D) The superintendent may conduct market conduct examinations pursuant to section 3901.011 of the Revised Code of any health insuring corporation as often as the superintendent considers it necessary for the protection of the interests of subscribers and enrollees. The expenses of such market conduct examinations shall be assessed against the health insuring corporation being examined. All costs, assessments, or fines collected under this division shall be paid into the state treasury to the credit of the department of insurance operating fund.

Sec. 1751.53. (A) As used in this section:

(1) "Group contract" means a group health insuring corporation contract covering employees that meets either of the following conditions:

(a) The contract was issued by an entity that, on ~~the effective date of this section~~ June 4, 1997, holds a certificate of authority or license to operate under Chapter 1738. or 1742. of the Revised Code, and covers an employee at the time the employee's employment is terminated.

(b) The contract is delivered, issued for delivery, or renewed in this state after ~~the effective date of this section~~ June 4, 1997, and covers an employee at the time the employee's employment is terminated.

(2) "Eligible employee" means an employee to whom all of the following apply:

(a) The employee has been continuously covered under a group contract or under the contract and any prior similar group coverage replaced by the contract, during the entire three-month period preceding the termination of the employee's employment.

(b) The employee is entitled, at the time of the termination of this employment, to unemployment compensation benefits under Chapter 4141. of the Revised Code.

(c) The employee is not, and does not become, covered by or eligible for coverage by medicare ~~under Title XVIII of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended~~.

(d) The employee is not, and does not become, covered by or eligible for coverage by any other insured or uninsured arrangement that provides hospital, surgical, or medical coverage for individuals in a group and under which the employee was not covered immediately prior to the termination of employment. A person eligible for continuation of coverage under this section, who is also eligible for coverage under section 3923.123 of the Revised Code, may elect either coverage, but not both. A person who elects continuation of coverage may elect any coverage available under section 3923.123 of the Revised Code upon the termination of the continuation of coverage.

(B) A group contract shall provide that any eligible employee may continue the coverage under the contract, for the employee and the employee's eligible dependents, for a period of six months after the date that the group coverage would otherwise terminate by reason of the termination of the employee's employment. Each certificate of coverage issued to employees under the contract shall include a notice of the employee's privilege of continuation.

(C) All of the following apply to the continuation of group coverage required under division (B) of this section:

(1) Continuation need not include any supplemental health care services benefits or specialty health care services benefits provided by the group contract.

(2) The employer shall notify the employee of the right of continuation at the time the employer notifies the employee of the termination of employment. The notice shall inform the employee of the amount of contribution required by the employer under division (C)(4) of this section.

(3) The employee shall file a written election of continuation with the employer and pay the employer the first contribution required under division (C)(4) of this section. The request and payment must be received by the employer no later than the earlier of any of the following dates:

(a) Thirty-one days after the date on which the employee's coverage would otherwise terminate;

(b) Ten days after the date on which the employee's coverage would otherwise terminate, if the employer has notified the employee of the right of continuation prior to this date;

(c) Ten days after the employer notifies the employee of the right of continuation, if the notice is given after the date on which the employee's coverage would otherwise terminate.

(4) The employee must pay to the employer, on a monthly basis, in advance, the amount of contribution required by the employer. The amount required shall not exceed the group rate for the insurance being continued under the policy on the due date of each payment.

(5) The employee's privilege to continue coverage and the coverage under any continuation ceases if any of the following

occurs:

(a) The employee ceases to be an eligible employee under division (A)(2)(c) or (d) of this section;

(b) A period of six months expires after the date that the employee's coverage under the group contract would otherwise have terminated because of the termination of employment;

(c) The employee fails to make a timely payment of a required contribution, in which event the coverage shall cease at the end of the coverage for which contributions were made;

(d) The group contract is terminated, or the employer terminates participation under the contract, unless the employer replaces the coverage by similar coverage under another contract or other group health arrangement. If the employer replaces the contract with similar group health coverage, all of the following apply:

(i) The member shall be covered under the replacement coverage, for the balance of the period that the member would have remained covered under the terminated coverage if it had not been terminated.

(ii) The minimum level of benefits under the replacement coverage shall be the applicable level of benefits of the contract replaced reduced by any benefits payable under the contract replaced.

(iii) The contract replaced shall continue to provide benefits to the extent of its accrued liabilities and extensions of benefits as if the replacement had not occurred.

(D) This section does not apply to any group contract offering only supplemental health care services or specialty health care services.

Sec. 1751.60. (A) Except as provided for in divisions (E) and

(F) of this section, every provider or health care facility that contracts with a health insuring corporation to provide health care services to the health insuring corporation's enrollees or subscribers shall seek compensation for covered services solely from the health insuring corporation and not, under any circumstances, from the enrollees or subscribers, except for approved copayments and deductibles.

(B) No subscriber or enrollee of a health insuring corporation is liable to any contracting provider or health care facility for the cost of any covered health care services, if the subscriber or enrollee has acted in accordance with the evidence of coverage.

(C) Except as provided for in divisions (E) and (F) of this section, every contract between a health insuring corporation and provider or health care facility shall contain a provision approved by the superintendent of insurance requiring the provider or health care facility to seek compensation solely from the health insuring corporation and not, under any circumstances, from the subscriber or enrollee, except for approved copayments and deductibles.

(D) Nothing in this section shall be construed as preventing a provider or health care facility from billing the enrollee or subscriber of a health insuring corporation for noncovered services.

(E) Upon application by a health insuring corporation and a provider or health care facility, the superintendent may waive the requirements of divisions (A) and (C) of this section when, in addition to the reserve requirements contained in section 1751.28 of the Revised Code, the health insuring corporation provides sufficient assurances to the superintendent that the provider or health care facility has been provided with financial guarantees. No waiver of the requirements of divisions (A) and (C) of this

section is effective as to enrollees or subscribers for whom the health insuring corporation is compensated under a provider agreement or risk contract entered into pursuant to Chapter ~~5111. or~~ 5115. or 5168. of the Revised Code.

(F) The requirements of divisions (A) to (C) of this section apply only to health care services provided to an enrollee or subscriber prior to the effective date of a termination of a contract between the health insuring corporation and the provider or health care facility.

Sec. 1751.88. Consistent with the Rules of Evidence, a written decision or opinion prepared by or for an independent review organization under section 1751.84 or 1751.85 of the Revised Code shall be admissible in any civil action related to the coverage decision that was the subject of the decision or opinion. The independent review organization's decision or opinion shall be presumed to be a scientifically valid and accurate description of the state of medical knowledge at the time it was written.

Consistent with the Rules of Evidence, any party to a civil action related to a health insuring corporation's coverage decision involving an investigational or experimental drug, device, or treatment may introduce into evidence any applicable medicare reimbursement standards established under ~~Title XVIII of~~ the ~~"Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended~~ medicare program.

Sec. 1751.89. Sections 1751.77 to 1751.85 of the Revised Code do not apply to either of the following:

(A) Coverage provided to beneficiaries enrolled in the medicare~~...~~+choice program operated under ~~Title XVIII of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as~~

~~amended~~ the medicare program;

(B) Coverage provided to recipients of medical assistance under the medicaid program ~~operated pursuant to Chapter 5111. of the Revised Code~~.

Sec. 2108.01. As used in sections 2108.01 to 2108.12 of the Revised Code:

(A) "Anatomical gift" means a donation of all or part of a human body to take effect upon or after death.

(B) "Decedent" means a deceased individual and includes a stillborn infant or fetus.

(C) If a will or other document by which an anatomical gift is made includes a valid specification of the intended donee, "donee" means the specified person or entity; otherwise, "donee" means, in the case of organs, an organ procurement organization that serves the region of the state where the body of the donor is located or, in the case of tissue or eyes, an organization entitled by law to recover the tissue or eyes from the donor's body.

(D) "Donor" means an individual who makes an anatomical gift.

(E) "Hospital" means any hospital operated in this state that is certified under ~~Title XVIII of~~ the ~~"Social Security Act," 49 Stat. 620 (1935), 42 U.S.C. 301, as amended~~ medicare program, or accredited by the joint commission on accreditation of healthcare organizations or the American osteopathic association. "Hospital" also means a facility licensed, accredited, registered, or approved as a hospital under the laws of any state, and includes a facility operated as a hospital by a state or a subdivision of the state, although not required to be licensed under state laws.

(F) "Identification card" means an identification card issued under sections 4507.50 and 4507.51 of the Revised Code.

(G) "Part" means any portion of a human body.

(H) "Tissue" means any body part other than an organ or eye.

(I) "Person" has the same meaning as in section 1.59 of the Revised Code and also includes a government or governmental subdivision or agency.

(J) "Physician" or "surgeon" means an individual who is licensed or authorized to practice medicine and surgery or osteopathic medicine and surgery under the laws of any state.

(K) "Recovery agency" means a nonprofit organization incorporated under Chapter 1702. of the Revised Code that is one of the following:

(1) An organ procurement organization designated by the secretary of health and human services pursuant to ~~Title XVIII of~~ the ~~"Social Security Act," 49 Stat. 620 (1935), 42 U.S.C. 301, 1320b-8, as amended~~ medicare program;

(2) An eye bank that is accredited by the eye bank association of America or that has applied for accreditation, is in substantial compliance with accreditation standards of the association, and since applying for accreditation has been in operation for not longer than one year;

(3) A tissue bank that is certified by the American association of tissue banks or that has applied for certification, is in substantial compliance with certification standards of the association, and since applying for certification has been in operation for not longer than one year.

Sec. 2113.041. (A) The administrator of the estate recovery program established pursuant to section ~~5111.11~~ 5162.40 of the Revised Code may present an affidavit to a financial institution requesting that the financial institution release account proceeds to recover the cost of services correctly provided to a medicaid

recipient who is subject to the estate recovery program. The affidavit shall include all of the following information:

(1) The name of the decedent;

(2) The name of any person who gave notice that the decedent was a medicaid recipient and that person's relationship to the decedent;

(3) The name of the financial institution;

(4) The account number;

(5) A description of the claim for estate recovery;

(6) The amount of funds to be recovered.

(B) A financial institution may release account proceeds to the administrator of the estate recovery program if all of the following apply:

(1) The decedent held an account at the financial institution that was in the decedent's name only.

(2) No estate has been, and it is reasonable to assume that no estate will be, opened for the decedent.

(3) The decedent has no outstanding debts known to the administrator of the estate recovery program.

(4) The financial institution has received no objections or has determined that no valid objections to release of proceeds have been received.

(C) If proceeds have been released pursuant to division (B) of this section and the department of ~~job and family services~~ health care administration receives notice of a valid claim to the proceeds that has a higher priority under section 2117.25 of the Revised Code than the claim of the estate recovery program, the department may refund the proceeds to the financial institution or pay them to the person or government entity with the claim.

Sec. 2113.06. Administration of the estate of an intestate shall be granted to persons mentioned in this section, in the following order:

(A) To the surviving spouse of the deceased, if resident of the state;

(B) To one of the next of kin of the deceased, resident of the state.

If the persons entitled to administer the estate fail to take or renounce administration voluntarily, they shall be cited by the probate court for that purpose.

If there are no persons entitled to administration, or if they are for any reason unsuitable for the discharge of the trust, or if without sufficient cause they neglect to apply within a reasonable time for the administration of the estate, their right to priority shall be lost, and the court shall commit the administration to some suitable person who is a resident of the state, or to the attorney general or the attorney general's designee, if the department of ~~job and family services~~ health care administration is seeking to recover ~~medical assistance~~ medicaid costs from the deceased pursuant to section ~~5111.11~~ 5162.40 or ~~5111.111~~ 5162.41 of the Revised Code. Such person may be a creditor of the estate.

This section applies to the appointment of an administrator de bonis non.

Sec. 2117.061. (A) As used in this section:

(1) "Medicaid estate recovery program" means the program instituted under section ~~5111.11~~ 5162.40 of the Revised Code.

(2) "Permanently institutionalized individual" has the same meaning as in section ~~5111.11~~ 5162.40 of the Revised Code.

(3) "Person responsible for the estate" means the executor, administrator, commissioner, or person who filed pursuant to section 2113.03 of the Revised Code for release from administration of an estate.

(B) If a decedent, at the time of death, was fifty-five years of age or older or a permanently institutionalized individual, the person responsible for the decedent's estate shall determine whether the decedent was, at any time during the decedent's life, a medicaid recipient ~~under Chapter 5111. of the Revised Code~~. If the decedent was a medicaid recipient, the person responsible for the estate shall submit a properly completed medicaid estate recovery reporting form prescribed under division (D) of this section to the administrator of the medicaid estate recovery program not later than thirty days after the occurrence of any of the following:

(1) The granting of letters testamentary;

(2) The administration of the estate;

(3) The filing of an application for release from administration or summary release from administration.

(C) The person responsible for the estate shall mark the appropriate box on the appropriate probate form to indicate compliance with the requirements of division (B) of this section.

The probate court shall send a copy of the completed probate form to the administrator of the medicaid estate recovery program.

(D) The administrator of the estate recovery program shall prescribe a medicaid estate recovery reporting form for the purpose of division (B) of this section. The form shall require, at a minimum, that the person responsible for the estate list all of the decedent's real and personal property and other assets that are part of the decedent's estate as defined in section ~~5111.11~~ 5162.40 of the Revised Code. The administrator shall include on

the form a statement printed in bold letters informing the person responsible for the estate that knowingly making a false statement on the form is falsification under section 2921.13 of the Revised Code, a misdemeanor of the first degree.

(E) The estate recovery program administrator shall present a claim for estate recovery to the person responsible for the estate or the person's legal representative not later than ninety days after the date on which the medicaid estate recovery reporting form is received under division (B) of this section or one year after the decedent's death, whichever is later.

Sec. 2117.25. (A) Every executor or administrator shall proceed with diligence to pay the debts of the decedent and shall apply the assets in the following order:

(1) Costs and expenses of administration;

(2) An amount, not exceeding four thousand dollars, for funeral expenses that are included in the bill of a funeral director, funeral expenses other than those in the bill of a funeral director that are approved by the probate court, and an amount, not exceeding three thousand dollars, for burial and cemetery expenses, including that portion of the funeral director's bill allocated to cemetery expenses that have been paid to the cemetery by the funeral director.

For purposes of this division, burial and cemetery expenses shall be limited to the following:

(a) The purchase of a right of interment;

(b) Monuments or other markers;

(c) The outer burial container;

(d) The cost of opening and closing the place of interment;

(e) The urn.

(3) The allowance for support made to the surviving spouse, minor children, or both under section 2106.13 of the Revised Code;

(4) Debts entitled to a preference under the laws of the United States;

(5) Expenses of the last sickness of the decedent;

(6) If the total bill of a funeral director for funeral expenses exceeds four thousand dollars, then, in addition to the amount described in division (A)(2) of this section, an amount, not exceeding two thousand dollars, for funeral expenses that are included in the bill and that exceed four thousand dollars;

(7) Personal property taxes, claims made under the estate recovery program instituted pursuant to section ~~5111.11~~ 5162.40 of the Revised Code, and obligations for which the decedent was personally liable to the state or any of its subdivisions;

(8) Debts for manual labor performed for the decedent within twelve months preceding the decedent's death, not exceeding three hundred dollars to any one person;

(9) Other debts for which claims have been presented and finally allowed.

(B) The part of the bill of a funeral director that exceeds the total of six thousand dollars as described in divisions (A)(2) and (6) of this section, and the part of a claim included in division (A)(8) of this section that exceeds three hundred dollars shall be included as a debt under division (A)(9) of this section, depending upon the time when the claim for the additional amount is presented.

(C) Any natural person or fiduciary who pays a claim of any creditor described in division (A) of this section shall be subrogated to the rights of that creditor proportionate to the amount of the payment and shall be entitled to reimbursement for

that amount in accordance with the priority of payments set forth in that division.

(D)(1) Chapters 2113. to 2125. of the Revised Code, relating to the manner in which and the time within which claims shall be presented, shall apply to claims set forth in divisions (A)(2), (6), and (8) of this section. Claims for an expense of administration or for the allowance for support need not be presented. The executor or administrator shall pay debts included in divisions (A)(4) and (7) of this section, of which the executor or administrator has knowledge, regardless of presentation.

(2) The giving of written notice to an executor or administrator of a motion or application to revive an action pending against the decedent at the date of death shall be equivalent to the presentation of a claim to the executor or administrator for the purpose of determining the order of payment of any judgment rendered or decree entered in such an action.

(E) No payments shall be made to creditors of one class until all those of the preceding class are fully paid or provided for. If the assets are insufficient to pay all the claims of one class, the creditors of that class shall be paid ratably.

(F) If it appears at any time that the assets have been exhausted in paying prior or preferred charges, allowances, or claims, those payments shall be a bar to an action on any claim not entitled to that priority or preference.

Sec. 2133.01. Unless the context otherwise requires, as used in sections 2133.01 to 2133.15 of the Revised Code:

(A) "Adult" means an individual who is eighteen years of age or older.

(B) "Attending physician" means the physician to whom a declarant or other patient, or the family of a declarant or other

patient, has assigned primary responsibility for the treatment or care of the declarant or other patient, or, if the responsibility has not been assigned, the physician who has accepted that responsibility.

(C) "Comfort care" means any of the following:

(1) Nutrition when administered to diminish the pain or discomfort of a declarant or other patient, but not to postpone the declarant's or other patient's death;

(2) Hydration when administered to diminish the pain or discomfort of a declarant or other patient, but not to postpone the declarant's or other patient's death;

(3) Any other medical or nursing procedure, treatment, intervention, or other measure that is taken to diminish the pain or discomfort of a declarant or other patient, but not to postpone the declarant's or other patient's death.

(D) "Consulting physician" means a physician who, in conjunction with the attending physician of a declarant or other patient, makes one or more determinations that are required to be made by the attending physician, or to be made by the attending physician and one other physician, by an applicable provision of this chapter, to a reasonable degree of medical certainty and in accordance with reasonable medical standards.

(E) "Declarant" means any adult who has executed a declaration in accordance with section 2133.02 of the Revised Code.

(F) "Declaration" means a written document executed in accordance with section 2133.02 of the Revised Code.

(G) "Durable power of attorney for health care" means a document created pursuant to sections 1337.11 to 1337.17 of the Revised Code.

(H) "Guardian" means a person appointed by a probate court pursuant to Chapter 2111. of the Revised Code to have the care and management of the person of an incompetent.

(I) "Health care facility" means any of the following:

(1) A hospital;

(2) A hospice care program or other institution that specializes in comfort care of patients in a terminal condition or in a permanently unconscious state;

(3) A nursing home or residential care facility, as defined in section 3721.01 of the Revised Code;

(4) A home health agency and any residential facility where a person is receiving care under the direction of a home health agency;

(5) An intermediate care facility for the mentally retarded.

(J) "Health care personnel" means physicians, nurses, physician assistants, emergency medical technicians-basic, emergency medical technicians-intermediate, emergency medical technicians-paramedic, medical technicians, dietitians, other authorized persons acting under the direction of an attending physician, and administrators of health care facilities.

(K) "Home health agency" has the same meaning as in section 3701.881 of the Revised Code.

(L) "Hospice care program" has the same meaning as in section 3712.01 of the Revised Code.

(M) "Hospital" has the same meanings as in sections 2108.01, 3701.01, and 5122.01 of the Revised Code.

(N) "Hydration" means fluids that are artificially or technologically administered.

(O) "Incompetent" has the same meaning as in section 2111.01

of the Revised Code.

(P) "Intermediate care facility for the mentally retarded" has the same meaning as in section ~~5111.20~~ 5164.01 of the Revised Code.

(Q) "Life-sustaining treatment" means any medical procedure, treatment, intervention, or other measure that, when administered to a qualified patient or other patient, will serve principally to prolong the process of dying.

(R) "Nurse" means a person who is licensed to practice nursing as a registered nurse or to practice practical nursing as a licensed practical nurse pursuant to Chapter 4723. of the Revised Code.

(S) "Nursing home" has the same meaning as in section 3721.01 of the Revised Code.

(T) "Nutrition" means sustenance that is artificially or technologically administered.

(U) "Permanently unconscious state" means a state of permanent unconsciousness in a declarant or other patient that, to a reasonable degree of medical certainty as determined in accordance with reasonable medical standards by the declarant's or other patient's attending physician and one other physician who has examined the declarant or other patient, is characterized by both of the following:

(1) Irreversible unawareness of one's being and environment.

(2) Total loss of cerebral cortical functioning, resulting in the declarant or other patient having no capacity to experience pain or suffering.

(V) "Person" has the same meaning as in section 1.59 of the Revised Code and additionally includes political subdivisions and governmental agencies, boards, commissions, departments,

institutions, offices, and other instrumentalities.

(W) "Physician" means a person who is authorized under Chapter 4731. of the Revised Code to practice medicine and surgery or osteopathic medicine and surgery.

(X) "Political subdivision" and "state" have the same meanings as in section 2744.01 of the Revised Code.

(Y) "Professional disciplinary action" means action taken by the board or other entity that regulates the professional conduct of health care personnel, including the state medical board and the board of nursing.

(Z) "Qualified patient" means an adult who has executed a declaration and has been determined to be in a terminal condition or in a permanently unconscious state.

(AA) "Terminal condition" means an irreversible, incurable, and untreatable condition caused by disease, illness, or injury from which, to a reasonable degree of medical certainty as determined in accordance with reasonable medical standards by a declarant's or other patient's attending physician and one other physician who has examined the declarant or other patient, both of the following apply:

(1) There can be no recovery.

(2) Death is likely to occur within a relatively short time if life-sustaining treatment is not administered.

(BB) "Tort action" means a civil action for damages for injury, death, or loss to person or property, other than a civil action for damages for breach of a contract or another agreement between persons.

Sec. 2151.3514. (A) As used in this section:

(1) "Alcohol and drug addiction program" has the same meaning

as in section 3793.01 of the Revised Code;

(2) "Chemical dependency" means either of the following:

(a) The chronic and habitual use of alcoholic beverages to the extent that the user no longer can control the use of alcohol or endangers the user's health, safety, or welfare or that of others;

(b) The use of a drug of abuse to the extent that the user becomes physically or psychologically dependent on the drug or endangers the user's health, safety, or welfare or that of others.

(3) "Drug of abuse" has the same meaning as in section 3719.011 of the Revised Code.

~~(4) "Medicaid" means the program established under Chapter 5111. of the Revised Code.~~

(B) If the juvenile court issues an order of temporary custody or protective supervision under division (A) of section 2151.353 of the Revised Code with respect to a child adjudicated to be an abused, neglected, or dependent child and the alcohol or other drug addiction of a parent or other caregiver of the child was the basis for the adjudication of abuse, neglect, or dependency, the court shall issue an order requiring the parent or other caregiver to submit to an assessment and, if needed, treatment from an alcohol and drug addiction program certified by the department of alcohol and drug addiction services. The court may order the parent or other caregiver to submit to alcohol or other drug testing during, after, or both during and after, the treatment. The court shall send any order issued pursuant to this division to the public children services agency that serves the county in which the court is located for use as described in section 340.15 of the Revised Code.

(C) Any order requiring alcohol or other drug testing that is issued pursuant to division (B) of this section shall require one

alcohol or other drug test to be conducted each month during a period of twelve consecutive months beginning the month immediately following the month in which the order for alcohol or other drug testing is issued. Arrangements for administering the alcohol or other drug tests, as well as funding the costs of the tests, shall be locally determined in accordance with sections 340.033 and 340.15 of the Revised Code. If a parent or other caregiver required to submit to alcohol or other drug tests under this section is not a recipient of medicaid, the agency that refers the parent or caregiver for the tests may require the parent or caregiver to reimburse the agency for the cost of conducting the tests.

(D) The certified alcohol and drug addiction program that conducts any alcohol or other drug tests ordered in accordance with divisions (B) and (C) of this section shall send the results of the tests, along with the program's recommendations as to the benefits of continued treatment, to the court and to the public children services agency providing services to the involved family, according to federal regulations set forth in 42 C.F.R. Part 2, and division (B) of section 340.15 of the Revised Code. The court shall consider the results and the recommendations sent to it under this division in any adjudication or review by the court, according to section 2151.353, 2151.414, or 2151.419 of the Revised Code.

Sec. 2305.234. (A) As used in this section:

(1) "Chiropractic claim," "medical claim," and "optometric claim" have the same meanings as in section 2305.113 of the Revised Code.

(2) "Dental claim" has the same meaning as in section 2305.113 of the Revised Code, except that it does not include any claim arising out of a dental operation or any derivative claim

for relief that arises out of a dental operation.

(3) "Governmental health care program" has the same meaning as in section 4731.65 of the Revised Code.

(4) "Health care facility or location" means a hospital, clinic, ambulatory surgical facility, office of a health care professional or associated group of health care professionals, training institution for health care professionals, or any other place where medical, dental, or other health-related diagnosis, care, or treatment is provided to a person.

(5) "Health care professional" means any of the following who provide medical, dental, or other health-related diagnosis, care, or treatment:

(a) Physicians authorized under Chapter 4731. of the Revised Code to practice medicine and surgery or osteopathic medicine and surgery;

(b) Registered nurses and licensed practical nurses licensed under Chapter 4723. of the Revised Code and individuals who hold a certificate of authority issued under that chapter that authorizes the practice of nursing as a certified registered nurse anesthetist, clinical nurse specialist, certified nurse-midwife, or certified nurse practitioner;

(c) Physician assistants authorized to practice under Chapter 4730. of the Revised Code;

(d) Dentists and dental hygienists licensed under Chapter 4715. of the Revised Code;

(e) Physical therapists, physical therapist assistants, occupational therapists, and occupational therapy assistants licensed under Chapter 4755. of the Revised Code;

(f) Chiropractors licensed under Chapter 4734. of the Revised Code;

(g) Optometrists licensed under Chapter 4725. of the Revised Code;

(h) Podiatrists authorized under Chapter 4731. of the Revised Code to practice podiatry;

(i) Dietitians licensed under Chapter 4759. of the Revised Code;

(j) Pharmacists licensed under Chapter 4729. of the Revised Code;

(k) Emergency medical technicians-basic, emergency medical technicians-intermediate, and emergency medical technicians-paramedic, certified under Chapter 4765. of the Revised Code;

(l) Respiratory care professionals licensed under Chapter 4761. of the Revised Code;

(m) Speech-language pathologists and audiologists licensed under Chapter 4753. of the Revised Code.

(6) "Health care worker" means a person other than a health care professional who provides medical, dental, or other health-related care or treatment under the direction of a health care professional with the authority to direct that individual's activities, including medical technicians, medical assistants, dental assistants, orderlies, aides, and individuals acting in similar capacities.

(7) "Indigent and uninsured person" means a person who meets all of the following requirements:

(a) The person's income is not greater than two hundred per cent of the current poverty line as defined by the United States office of management and budget and revised in accordance with section 673(2) of the "Omnibus Budget Reconciliation Act of 1981," 95 Stat. 511, 42 U.S.C. 9902, as amended.

(b) The person is ~~not eligible to receive medical assistance under Chapter 5111.~~ ineligible for the medicaid program, the disability medical assistance ~~under Chapter 5115. of the Revised Code or~~ program, and assistance under any other governmental health care program.

(c) Either of the following applies:

(i) The person is not a policyholder, certificate holder, insured, contract holder, subscriber, enrollee, member, beneficiary, or other covered individual under a health insurance or health care policy, contract, or plan.

(ii) The person is a policyholder, certificate holder, insured, contract holder, subscriber, enrollee, member, beneficiary, or other covered individual under a health insurance or health care policy, contract, or plan, but the insurer, policy, contract, or plan denies coverage or is the subject of insolvency or bankruptcy proceedings in any jurisdiction.

(8) "Nonprofit health care referral organization" means an entity that is not operated for profit and refers patients to, or arranges for the provision of, health-related diagnosis, care, or treatment by a health care professional or health care worker.

(9) "Operation" means any procedure that involves cutting or otherwise infiltrating human tissue by mechanical means, including surgery, laser surgery, ionizing radiation, therapeutic ultrasound, or the removal of intraocular foreign bodies. "Operation" does not include the administration of medication by injection, unless the injection is administered in conjunction with a procedure infiltrating human tissue by mechanical means other than the administration of medicine by injection. "Operation" does not include routine dental restorative procedures, the scaling of teeth, or extractions of teeth that are not impacted.

(10) "Tort action" means a civil action for damages for injury, death, or loss to person or property other than a civil action for damages for a breach of contract or another agreement between persons or government entities.

(11) "Volunteer" means an individual who provides any medical, dental, or other health-care related diagnosis, care, or treatment without the expectation of receiving and without receipt of any compensation or other form of remuneration from an indigent and uninsured person, another person on behalf of an indigent and uninsured person, any health care facility or location, any nonprofit health care referral organization, or any other person or government entity.

(12) "Community control sanction" has the same meaning as in section 2929.01 of the Revised Code.

(13) "Deep sedation" means a drug-induced depression of consciousness during which a patient cannot be easily aroused but responds purposefully following repeated or painful stimulation, a patient's ability to independently maintain ventilatory function may be impaired, a patient may require assistance in maintaining a patent airway and spontaneous ventilation may be inadequate, and cardiovascular function is usually maintained.

(14) "General anesthesia" means a drug-induced loss of consciousness during which a patient is not arousable, even by painful stimulation, the ability to independently maintain ventilatory function is often impaired, a patient often requires assistance in maintaining a patent airway, positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function, and cardiovascular function may be impaired.

(B)(1) Subject to divisions (F) and (G)(3) of this section, a health care professional who is a volunteer and complies with

division (B)(2) of this section is not liable in damages to any person or government entity in a tort or other civil action, including an action on a medical, dental, chiropractic, optometric, or other health-related claim, for injury, death, or loss to person or property that allegedly arises from an action or omission of the volunteer in the provision to an indigent and uninsured person of medical, dental, or other health-related diagnosis, care, or treatment, including the provision of samples of medicine and other medical products, unless the action or omission constitutes willful or wanton misconduct.

(2) To qualify for the immunity described in division (B)(1) of this section, a health care professional shall do all of the following prior to providing diagnosis, care, or treatment:

(a) Determine, in good faith, that the indigent and uninsured person is mentally capable of giving informed consent to the provision of the diagnosis, care, or treatment and is not subject to duress or under undue influence;

(b) Inform the person of the provisions of this section, including notifying the person that, by giving informed consent to the provision of the diagnosis, care, or treatment, the person cannot hold the health care professional liable for damages in a tort or other civil action, including an action on a medical, dental, chiropractic, optometric, or other health-related claim, unless the action or omission of the health care professional constitutes willful or wanton misconduct;

(c) Obtain the informed consent of the person and a written waiver, signed by the person or by another individual on behalf of and in the presence of the person, that states that the person is mentally competent to give informed consent and, without being subject to duress or under undue influence, gives informed consent to the provision of the diagnosis, care, or treatment subject to the provisions of this section. A written waiver under division

(B)(2)(c) of this section shall state clearly and in conspicuous type that the person or other individual who signs the waiver is signing it with full knowledge that, by giving informed consent to the provision of the diagnosis, care, or treatment, the person cannot bring a tort or other civil action, including an action on a medical, dental, chiropractic, optometric, or other health-related claim, against the health care professional unless the action or omission of the health care professional constitutes willful or wanton misconduct.

(3) A physician or podiatrist who is not covered by medical malpractice insurance, but complies with division (B)(2) of this section, is not required to comply with division (A) of section 4731.143 of the Revised Code.

(C) Subject to divisions (F) and (G)(3) of this section, health care workers who are volunteers are not liable in damages to any person or government entity in a tort or other civil action, including an action upon a medical, dental, chiropractic, optometric, or other health-related claim, for injury, death, or loss to person or property that allegedly arises from an action or omission of the health care worker in the provision to an indigent and uninsured person of medical, dental, or other health-related diagnosis, care, or treatment, unless the action or omission constitutes willful or wanton misconduct.

(D) Subject to divisions (F) and (G)(3) of this section, a nonprofit health care referral organization is not liable in damages to any person or government entity in a tort or other civil action, including an action on a medical, dental, chiropractic, optometric, or other health-related claim, for injury, death, or loss to person or property that allegedly arises from an action or omission of the nonprofit health care referral organization in referring indigent and uninsured persons to, or arranging for the provision of, medical, dental, or other

health-related diagnosis, care, or treatment by a health care professional described in division (B)(1) of this section or a health care worker described in division (C) of this section, unless the action or omission constitutes willful or wanton misconduct.

(E) Subject to divisions (F) and (G)(3) of this section and to the extent that the registration requirements of section 3701.071 of the Revised Code apply, a health care facility or location associated with a health care professional described in division (B)(1) of this section, a health care worker described in division (C) of this section, or a nonprofit health care referral organization described in division (D) of this section is not liable in damages to any person or government entity in a tort or other civil action, including an action on a medical, dental, chiropractic, optometric, or other health-related claim, for injury, death, or loss to person or property that allegedly arises from an action or omission of the health care professional or worker or nonprofit health care referral organization relative to the medical, dental, or other health-related diagnosis, care, or treatment provided to an indigent and uninsured person on behalf of or at the health care facility or location, unless the action or omission constitutes willful or wanton misconduct.

(F)(1) Except as provided in division (F)(2) of this section, the immunities provided by divisions (B), (C), (D), and (E) of this section are not available to a health care professional, health care worker, nonprofit health care referral organization, or health care facility or location if, at the time of an alleged injury, death, or loss to person or property, the health care professionals or health care workers involved are providing one of the following:

(a) Any medical, dental, or other health-related diagnosis, care, or treatment pursuant to a community service work order

entered by a court under division (B) of section 2951.02 of the Revised Code or imposed by a court as a community control sanction;

(b) Performance of an operation to which any one of the following applies:

(i) The operation requires the administration of deep sedation or general anesthesia.

(ii) The operation is a procedure that is not typically performed in an office.

(iii) The individual involved is a health care professional, and the operation is beyond the scope of practice or the education, training, and competence, as applicable, of the health care professional.

(c) Delivery of a baby or any other purposeful termination of a human pregnancy.

(2) Division (F)(1) of this section does not apply when a health care professional or health care worker provides medical, dental, or other health-related diagnosis, care, or treatment that is necessary to preserve the life of a person in a medical emergency.

(G)(1) This section does not create a new cause of action or substantive legal right against a health care professional, health care worker, nonprofit health care referral organization, or health care facility or location.

(2) This section does not affect any immunities from civil liability or defenses established by another section of the Revised Code or available at common law to which a health care professional, health care worker, nonprofit health care referral organization, or health care facility or location may be entitled in connection with the provision of emergency or other medical,

dental, or other health-related diagnosis, care, or treatment.

(3) This section does not grant an immunity from tort or other civil liability to a health care professional, health care worker, nonprofit health care referral organization, or health care facility or location for actions that are outside the scope of authority of health care professionals or health care workers.

(4) This section does not affect any legal responsibility of a health care professional, health care worker, or nonprofit health care referral organization to comply with any applicable law of this state or rule of an agency of this state.

(5) This section does not affect any legal responsibility of a health care facility or location to comply with any applicable law of this state, rule of an agency of this state, or local code, ordinance, or regulation that pertains to or regulates building, housing, air pollution, water pollution, sanitation, health, fire, zoning, or safety.

Sec. 2307.65. (A) The attorney general may bring a civil action in the Franklin county court of common pleas on behalf of the department of ~~job and family services~~ health care administration, and the prosecuting attorney of the county in which a violation of division (B) of section 2913.401 of the Revised Code occurs may bring a civil action in the court of common pleas of that county on behalf of the county department of job and family services, against a person who violates division (B) of section 2913.401 of the Revised Code for the recovery of the amount of benefits paid on behalf of a person that either department would not have paid but for the violation minus any amounts paid in restitution under division (C)(2) of section 2913.401 of the Revised Code and for reasonable attorney's fees and all other fees and costs of litigation.

(B) In a civil action brought under division (A) of this

section, if the defendant failed to disclose a transfer of property in violation of division (B)(3) of section 2913.401 of the Revised Code, the court may also grant any of the following relief to the extent permitted by 42 U.S.C. 1396p:

(1) Avoidance of the transfer of property that was not disclosed in violation of division (B)(3) of section 2913.401 of the Revised Code to the extent of the amount of benefits the department would not have paid but for the violation;

(2) An order of attachment or garnishment against the property in accordance with Chapter 2715. or 2716. of the Revised Code;

(3) An injunction against any further disposition by the transferor or transferee, or both, of the property the transfer of which was not disclosed in violation of division (B)(3) of section 2913.401 of the Revised Code or against the disposition of other property by the transferor or transferee;

(4) Appointment of a receiver to take charge of the property transferred or of other property of the transferee;

(5) Any other relief that the court considers just and equitable.

(C) To the extent permitted by 42 U.S.C. 1396p, the department of ~~job and family services~~ health care administration or the county department of job and family services may enforce a judgment obtained under this section by levying on property the transfer of which was not disclosed in violation of division (B)(3) of section 2913.401 of the Revised Code or on the proceeds of the transfer of that property in accordance with Chapter 2329. of the Revised Code.

(D) The remedies provided in divisions (B) and (C) of this section do not apply if the transferee of the property the transfer of which was not disclosed in violation of division

(B)(3) of section 2913.401 of the Revised Code acquired the property in good faith and for fair market value.

(E) The remedies provided in this section are not exclusive and do not preclude the use of any other criminal or civil remedy for any act that is in violation of section 2913.401 of the Revised Code.

(F) Amounts of medicaid benefits paid and recovered in an action brought under this section shall be credited to the general revenue fund, and any applicable federal share shall be returned to the appropriate agency or department of the United States.

Sec. 2335.39. (A) As used in this section:

(1) "Court" means any court of record.

(2) "Eligible party" means a party to an action or appeal involving the state, other than the following:

(a) The state;

(b) An individual whose net worth exceeded one million dollars at the time the action or appeal was filed;

(c) A sole owner of an unincorporated business that had, or a partnership, corporation, association, or organization that had, a net worth exceeding five million dollars at the time the action or appeal was filed, except that an organization that is described in subsection 501(c)(3) and is tax exempt under subsection 501(a) of the Internal Revenue Code shall not be excluded as an eligible party under this division because of its net worth;

(d) A sole owner of an unincorporated business that employed, or a partnership, corporation, association, or organization that employed, more than five hundred persons at the time the action or appeal was filed.

(3) "Fees" means reasonable attorney's fees, in an amount not

to exceed seventy-five dollars per hour or a higher hourly fee approved by the court.

(4) "Internal Revenue Code" means the "Internal Revenue Code of 1954," 68A Stat. 3, 26 U.S.C. 1, as amended.

(5) "Prevailing eligible party" means an eligible party that prevails in an action or appeal involving the state.

(6) "State" has the same meaning as in section 2743.01 of the Revised Code.

(B)(1) Except as provided in divisions (B)(2) and (F) of this section, in a civil action, or appeal of a judgment in a civil action, to which the state is a party, or in an appeal of an adjudication order of an agency pursuant to section 119.12 of the Revised Code, the prevailing eligible party is entitled, upon filing a motion in accordance with this division, to compensation for fees incurred by that party in connection with the action or appeal. Compensation, when payable to a prevailing eligible party under this section, is in addition to any other costs and expenses that may be awarded to that party by the court pursuant to law or rule.

A prevailing eligible party that desires an award of compensation for fees shall file a motion requesting the award with the court within thirty days after the court enters final judgment in the action or appeal. The motion shall do all of the following:

(a) Identify the party;

(b) Indicate that the party is the prevailing eligible party and is entitled to receive an award of compensation for fees;

(c) Include a statement that the state's position in initiating the matter in controversy was not substantially justified;

(d) Indicate the amount sought as an award;

(e) Itemize all fees sought in the requested award. The itemization shall include a statement from any attorney who represented the prevailing eligible party, that indicates the fees charged, the actual time expended, and the rate at which the fees were calculated.

(2) Upon the filing of a motion under this section, the court shall review the request for the award of compensation for fees and determine whether the position of the state in initiating the matter in controversy was substantially justified, whether special circumstances make an award unjust, and whether the prevailing eligible party engaged in conduct during the course of the action or appeal that unduly and unreasonably protracted the final resolution of the matter in controversy. The court shall issue an order, in writing, on the motion of the prevailing eligible party, which order shall include a statement indicating whether an award has been granted, the findings and conclusions underlying it, the reasons or bases for the findings and conclusions, and, if an award has been granted, its amount. The order shall be included in the record of the action or appeal, and the clerk of the court shall mail a certified copy of it to the state and the prevailing eligible party.

With respect to a motion under this section, the state has the burden of proving that its position in initiating the matter in controversy was substantially justified, that special circumstances make an award unjust, or that the prevailing eligible party engaged in conduct during the course of the action or appeal that unduly and unreasonably protracted the final resolution of the matter in controversy.

A court considering a motion under this section may deny an award entirely, or reduce the amount of an award that otherwise would be payable, to a prevailing eligible party only as follows:

(a) If the court determines that the state has sustained its burden of proof that its position in initiating the matter in controversy was substantially justified or that special circumstances make an award unjust, the motion shall be denied;

(b) If the court determines that the state has sustained its burden of proof that the prevailing eligible party engaged in conduct during the course of the action or appeal that unduly and unreasonably protracted the final resolution of the matter in controversy, the court may reduce the amount of an award, or deny an award, to that party to the extent of that conduct.

An order of a court considering a motion under this section is appealable as in other cases, by a prevailing eligible party that is denied an award or receives a reduced award. If the case is an appeal of the adjudication order of an agency pursuant to section 119.12 of the Revised Code, the agency may appeal an order granting an award. The order of the court may be modified by the appellate court only if it finds that the grant or the failure to grant an award, or the calculation of the amount of an award, involved an abuse of discretion.

(C) Compensation for fees awarded to a prevailing eligible party under this section may be paid by the specific branch of the state government or the state department, board, office, commission, agency, institution, or other instrumentality over which the party prevailed in the action or appeal from any funds available to it for payment of such compensation. If compensation is not paid from such funds or such funds are not available, upon the filing of the court's order in favor of the prevailing eligible party with the clerk of the court of claims, the order shall be treated as if it were a judgment under Chapter 2743. of the Revised Code and be payable in accordance with the procedures specified in section 2743.19 of the Revised Code, except that interest shall not be paid in relation to the award.

(D) If compensation for fees is awarded under this section to a prevailing eligible party that is appealing an agency adjudication order pursuant to section 119.12 of the Revised Code, it shall include the fees incurred in the appeal and, if requested in the motion, the fees incurred by the party in the adjudication hearing conducted under Chapter 119. of the Revised Code. A motion containing such a request shall itemize, in the manner described in division (B)(1)(e) of section 119.092 of the Revised Code, the fees, as defined in that section, that are sought in an award.

(E) Each court that orders during any fiscal year compensation for fees to be paid to a prevailing eligible party pursuant to this section shall prepare a report for that year. The report shall be completed no later than the first day of October of the fiscal year following the fiscal year covered by the report, and copies of it shall be filed with the general assembly. It shall contain the following information:

(1) The total amount and total number of awards of compensation for fees required to be paid to prevailing eligible parties;

(2) The amount and nature of each individual award ordered;

(3) Any other information that may aid the general assembly in evaluating the scope and impact of awards of compensation for fees.

(F) The provisions of this section do not apply in any of the following:

(1) Appropriation proceedings under Chapter 163. of the Revised Code;

(2) Civil actions or appeals of civil actions that involve torts;

(3) An appeal pursuant to section 119.12 of the Revised Code

that involves any of the following:

(a) An adjudication order entered after a hearing described in division (F) of section 119.092 of the Revised Code;

(b) A prevailing eligible party represented in the appeal by an attorney who was paid pursuant to an appropriation by the federal or state government or a local government;

(c) An administrative appeal decision made under section 5101.35 or 5160.34 of the Revised Code.

Sec. 2505.02. (A) As used in this section:

(1) "Substantial right" means a right that the United States Constitution, the Ohio Constitution, a statute, the common law, or a rule of procedure entitles a person to enforce or protect.

(2) "Special proceeding" means an action or proceeding that is specially created by statute and that prior to 1853 was not denoted as an action at law or a suit in equity.

(3) "Provisional remedy" means a proceeding ancillary to an action, including, but not limited to, a proceeding for a preliminary injunction, attachment, discovery of privileged matter, suppression of evidence, a prima-facie showing pursuant to section 2307.85 or 2307.86 of the Revised Code, a prima-facie showing pursuant to section 2307.92 of the Revised Code, or a finding made pursuant to division (A)(3) of section 2307.93 of the Revised Code.

(B) An order is a final order that may be reviewed, affirmed, modified, or reversed, with or without retrial, when it is one of the following:

(1) An order that affects a substantial right in an action that in effect determines the action and prevents a judgment;

(2) An order that affects a substantial right made in a

special proceeding or upon a summary application in an action after judgment;

(3) An order that vacates or sets aside a judgment or grants a new trial;

(4) An order that grants or denies a provisional remedy and to which both of the following apply:

(a) The order in effect determines the action with respect to the provisional remedy and prevents a judgment in the action in favor of the appealing party with respect to the provisional remedy.

(b) The appealing party would not be afforded a meaningful or effective remedy by an appeal following final judgment as to all proceedings, issues, claims, and parties in the action.

(5) An order that determines that an action may or may not be maintained as a class action;

(6) An order determining the constitutionality of any changes to the Revised Code made by Am. Sub. S.B. 281 of the 124th general assembly, including the amendment of sections 1751.67, 2117.06, 2305.11, 2305.15, 2305.234, 2317.02, 2317.54, 2323.56, 2711.21, 2711.22, 2711.23, 2711.24, 2743.02, 2743.43, 2919.16, 3923.63, 3923.64, 4705.15, and ~~5111.018~~ 5163.17, and the enactment of sections 2305.113, 2323.41, 2323.43, and 2323.55 of the Revised Code or any changes made by Sub. S.B. 80 of the 125th general assembly, including the amendment of sections 2125.02, 2305.10, 2305.131, 2315.18, 2315.19, and 2315.21 of the Revised Code.

(C) When a court issues an order that vacates or sets aside a judgment or grants a new trial, the court, upon the request of either party, shall state in the order the grounds upon which the new trial is granted or the judgment vacated or set aside.

(D) This section applies to and governs any action, including

an appeal, that is pending in any court on July 22, 1998, and all claims filed or actions commenced on or after July 22, 1998, notwithstanding any provision of any prior statute or rule of law of this state.

Sec. 2705.02. A person guilty of any of the following acts may be punished as for a contempt:

(A) Disobedience of, or resistance to, a lawful writ, process, order, rule, judgment, or command of a court or officer;

(B) Misbehavior of an officer of the court in the performance of official duties, or in official transactions;

(C) A failure to obey a subpoena duly served, or a refusal to be sworn or to answer as a witness, when lawfully required;

(D) The rescue, or attempted rescue, of a person or of property in the custody of an officer by virtue of an order or process of court held by the officer;

(E) A failure upon the part of a person recognized to appear as a witness in a court to appear in compliance with the terms of the person's recognizance;

(F) A failure to comply with an order issued pursuant to section 3109.19 or 3111.81 of the Revised Code;

(G) A failure to obey a subpoena issued by the department of job and family services or a child support enforcement agency pursuant to section 5101.37 of the Revised Code;

(H) A failure to obey a subpoena issued by the department of health care administration pursuant to section 5160.28 of the Revised Code;

(I) A willful failure to submit to genetic testing, or a willful failure to submit a child to genetic testing, as required by an order for genetic testing issued under section 3111.41 of

the Revised Code.

Sec. 2744.05. Notwithstanding any other provisions of the Revised Code or rules of a court to the contrary, in an action against a political subdivision to recover damages for injury, death, or loss to person or property caused by an act or omission in connection with a governmental or proprietary function:

(A) Punitive or exemplary damages shall not be awarded.

(B)(1) If a claimant receives or is entitled to receive benefits for injuries or loss allegedly incurred from a policy or policies of insurance or any other source, the benefits shall be disclosed to the court, and the amount of the benefits shall be deducted from any award against a political subdivision recovered by that claimant. No insurer or other person is entitled to bring an action under a subrogation provision in an insurance or other contract against a political subdivision with respect to those benefits.

The amount of the benefits shall be deducted from an award against a political subdivision under division (B)(1) of this section regardless of whether the claimant may be under an obligation to pay back the benefits upon recovery, in whole or in part, for the claim. A claimant whose benefits have been deducted from an award under division (B)(1) of this section is not considered fully compensated and shall not be required to reimburse a subrogated claim for benefits deducted from an award pursuant to division (B)(1) of this section.

(2) Nothing in division (B)(1) of this section shall be construed to do ~~either~~ any of the following:

(a) Limit the rights of a beneficiary under a life insurance policy or the rights of sureties under fidelity or surety bonds;

(b) Prohibit the department of ~~job and family services~~ health

care administration from recovering from the political subdivision, pursuant to section ~~5101.58~~ 5160.38 of the Revised Code, the cost of medical assistance benefits provided under ~~Chapter 5107., 5111., or 5115. of the Revised Code~~ the medicaid program or disability medical assistance program.

(C)(1) There shall not be any limitation on compensatory damages that represent the actual loss of the person who is awarded the damages. However, except in wrongful death actions brought pursuant to Chapter 2125. of the Revised Code, damages that arise from the same cause of action, transaction or occurrence, or series of transactions or occurrences and that do not represent the actual loss of the person who is awarded the damages shall not exceed two hundred fifty thousand dollars in favor of any one person. The limitation on damages that do not represent the actual loss of the person who is awarded the damages provided in this division does not apply to court costs that are awarded to a plaintiff, or to interest on a judgment rendered in favor of a plaintiff, in an action against a political subdivision.

(2) As used in this division, "the actual loss of the person who is awarded the damages" includes all of the following:

(a) All wages, salaries, or other compensation lost by the person injured as a result of the injury, including wages, salaries, or other compensation lost as of the date of a judgment and future expected lost earnings of the person injured;

(b) All expenditures of the person injured or another person on behalf of the person injured for medical care or treatment, for rehabilitation services, or for other care, treatment, services, products, or accommodations that were necessary because of the injury;

(c) All expenditures to be incurred in the future, as

determined by the court, by the person injured or another person on behalf of the person injured for medical care or treatment, for rehabilitation services, or for other care, treatment, services, products, or accommodations that will be necessary because of the injury;

(d) All expenditures of a person whose property was injured or destroyed or of another person on behalf of the person whose property was injured or destroyed in order to repair or replace the property that was injured or destroyed;

(e) All expenditures of the person injured or of the person whose property was injured or destroyed or of another person on behalf of the person injured or of the person whose property was injured or destroyed in relation to the actual preparation or presentation of the claim involved;

(f) Any other expenditures of the person injured or of the person whose property was injured or destroyed or of another person on behalf of the person injured or of the person whose property was injured or destroyed that the court determines represent an actual loss experienced because of the personal or property injury or property loss.

"The actual loss of the person who is awarded the damages" does not include any fees paid or owed to an attorney for any services rendered in relation to a personal or property injury or property loss, and does not include any damages awarded for pain and suffering, for the loss of society, consortium, companionship, care, assistance, attention, protection, advice, guidance, counsel, instruction, training, or education of the person injured, for mental anguish, or for any other intangible loss.

Sec. 2903.33. As used in sections 2903.33 to 2903.36 of the Revised Code:

(A) "Care facility" means any of the following:

(1) Any "home" as defined in section 3721.10 or ~~5111.20~~ 5164.01 of the Revised Code;

(2) Any "residential facility" as defined in section 5123.19 of the Revised Code;

(3) Any institution or facility operated or provided by the department of mental health or by the department of mental retardation and developmental disabilities pursuant to sections 5119.02 and 5123.03 of the Revised Code;

(4) Any "residential facility" as defined in section 5119.22 of the Revised Code;

(5) Any unit of any hospital, as defined in section 3701.01 of the Revised Code, that provides the same services as a nursing home, as defined in section 3721.01 of the Revised Code;

(6) Any institution, residence, or facility that provides, for a period of more than twenty-four hours, whether for a consideration or not, accommodations to one individual or two unrelated individuals who are dependent upon the services of others;

(7) Any "adult care facility" as defined in section 3722.01 of the Revised Code;

(8) Any adult foster home certified by the department of aging or its designee under section 173.36 of the Revised Code;

(9) Any "community alternative home" as defined in section 3724.01 of the Revised Code.

(B) "Abuse" means knowingly causing physical harm or recklessly causing serious physical harm to a person by physical contact with the person or by the inappropriate use of a physical or chemical restraint, medication, or isolation on the person.

(C)(1) "Gross neglect" means knowingly failing to provide a

person with any treatment, care, goods, or service that is necessary to maintain the health or safety of the person when the failure results in physical harm or serious physical harm to the person.

(2) "Neglect" means recklessly failing to provide a person with any treatment, care, goods, or service that is necessary to maintain the health or safety of the person when the failure results in serious physical harm to the person.

(D) "Inappropriate use of a physical or chemical restraint, medication, or isolation" means the use of physical or chemical restraint, medication, or isolation as punishment, for staff convenience, excessively, as a substitute for treatment, or in quantities that preclude habilitation and treatment.

Sec. 2913.40. (A) As used in this section:

(1) "Statement or representation" means any oral, written, electronic, electronic impulse, or magnetic communication that is used to identify an item of goods or a service for which reimbursement may be made under the ~~medical assistance~~ medicaid program or that states income and expense and is or may be used to determine a rate of reimbursement under the ~~medical assistance~~ medicaid program.

(2) ~~"Medical assistance program" means the program established by the department of job and family services to provide medical assistance under section 5111.01 of the Revised Code and the medicaid program of Title XIX of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C. 301, as amended.~~

~~(3)~~ "Provider" means any person who has signed a provider agreement with the department of ~~job and family services~~ health care administration to provide goods or services pursuant to the ~~medical assistance~~ medicaid program or any person who has signed

an agreement with a party to such a provider agreement under which the person agrees to provide goods or services that are reimbursable under the ~~medical assistance~~ medicaid program.

~~(4)~~(3) "Provider agreement" means an oral or written agreement between the department of ~~job and family services~~ health care administration and a person in which the person agrees to provide goods or services under the ~~medical assistance~~ medicaid program.

~~(5)~~(4) "Recipient" means any individual who receives goods or services from a provider under the ~~medical assistance~~ medicaid program.

~~(6)~~(5) "Records" means any medical, professional, financial, or business records relating to the treatment or care of any recipient, to goods or services provided to any recipient, or to rates paid for goods or services provided to any recipient and any records that are required by the rules of the director of ~~job and family services~~ health care administration to be kept for the ~~medical assistance~~ medicaid program.

(B) No person shall knowingly make or cause to be made a false or misleading statement or representation for use in obtaining reimbursement from the ~~medical assistance~~ medicaid program.

(C) No person, with purpose to commit fraud or knowing that the person is facilitating a fraud, shall do either of the following:

(1) Contrary to the terms of the person's provider agreement, charge, solicit, accept, or receive for goods or services that the person provides under the ~~medical assistance~~ medicaid program any property, money, or other consideration in addition to the amount of reimbursement under the ~~medical assistance~~ medicaid program and the person's provider agreement for the goods or services and any

deductibles or co-payments authorized by section ~~5111.0112~~ 5162.35 of the Revised Code or rules adopted pursuant to section ~~5111.01, 5111.011, or 5111.02~~ 5162.20 or 5163.15 of the Revised Code.

(2) Solicit, offer, or receive any remuneration, other than any deductibles or co-payments authorized by section ~~5111.0112~~ 5162.35 of the Revised Code or rules adopted under section ~~5111.01, 5111.011,~~ 5162.20 or ~~5111.02~~ 5163.15 of the Revised Code, in cash or in kind, including, but not limited to, a kickback or rebate, in connection with the furnishing of goods or services for which whole or partial reimbursement is or may be made under the ~~medical assistance~~ medicaid program.

(D) No person, having submitted a claim for or provided goods or services under the ~~medical assistance~~ medicaid program, shall do either of the following for a period of at least six years after a reimbursement pursuant to that claim, or a reimbursement for those goods or services, is received under the ~~medical assistance~~ medicaid program:

(1) Knowingly alter, falsify, destroy, conceal, or remove any records that are necessary to fully disclose the nature of all goods or services for which the claim was submitted, or for which reimbursement was received, by the person;

(2) Knowingly alter, falsify, destroy, conceal, or remove any records that are necessary to disclose fully all income and expenditures upon which rates of reimbursements were based for the person.

(E) Whoever violates this section is guilty of medicaid fraud. Except as otherwise provided in this division, medicaid fraud is a misdemeanor of the first degree. If the value of property, services, or funds obtained in violation of this section is five hundred dollars or more and is less than five thousand dollars, medicaid fraud is a felony of the fifth degree. If the

value of property, services, or funds obtained in violation of this section is five thousand dollars or more and is less than one hundred thousand dollars, medicaid fraud is a felony of the fourth degree. If the value of the property, services, or funds obtained in violation of this section is one hundred thousand dollars or more, medicaid fraud is a felony of the third degree.

(F) Upon application of the governmental agency, office, or other entity that conducted the investigation and prosecution in a case under this section, the court shall order any person who is convicted of a violation of this section for receiving any reimbursement for furnishing goods or services under the ~~medical assistance~~ medicaid program to which the person is not entitled to pay to the applicant its cost of investigating and prosecuting the case. The costs of investigation and prosecution that a defendant is ordered to pay pursuant to this division shall be in addition to any other penalties for the receipt of that reimbursement that are provided in this section, section ~~5111.03~~ 5163.03 of the Revised Code, or any other provision of law.

(G) The provisions of this section are not intended to be exclusive remedies and do not preclude the use of any other criminal or civil remedy for any act that is in violation of this section.

Sec. 2913.401. (A) As used in this section:

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

(2) "Property" means any real or personal property or other asset in which a person has any legal title or interest.

(B) No person shall knowingly do any of the following in an application for medicaid benefits or in a document that requires a

disclosure of assets for the purpose of determining eligibility to receive medicaid benefits:

(1) Make or cause to be made a false or misleading statement;

(2) Conceal an interest in property;

(3)(a) Except as provided in division (B)(3)(b) of this section, fail to disclose a transfer of property that occurred during the period beginning thirty-six months before submission of the application or document and ending on the date the application or document was submitted;

(b) Fail to disclose a transfer of property that occurred during the period beginning sixty months before submission of the application or document and ending on the date the application or document was submitted and that was made to an irrevocable trust a portion of which is not distributable to the applicant for medicaid benefits or the recipient of medicaid benefits or to a revocable trust.

(C)(1) Whoever violates this section is guilty of medicaid eligibility fraud. Except as otherwise provided in this division, a violation of this section is a misdemeanor of the first degree. If the value of the medicaid benefits paid as a result of the violation is five hundred dollars or more and is less than five thousand dollars, a violation of this section is a felony of the fifth degree. If the value of the medicaid benefits paid as a result of the violation is five thousand dollars or more and is less than one hundred thousand dollars, a violation of this section is a felony of the fourth degree. If the value of the medicaid benefits paid as a result of the violation is one hundred thousand dollars or more, a violation of this section is a felony of the third degree.

(2) In addition to imposing a sentence under division (C)(1) of this section, the court shall order that a person who is guilty

of medicaid eligibility fraud make restitution in the full amount of any medicaid benefits paid on behalf of an applicant for or recipient of medicaid benefits for which the applicant or recipient was not eligible, plus interest at the rate applicable to judgments on unreimbursed amounts from the date on which the benefits were paid to the date on which restitution is made.

(3) The remedies and penalties provided in this section are not exclusive and do not preclude the use of any other criminal or civil remedy for any act that is in violation of this section.

(D) This section does not apply to a person who fully disclosed in an application for medicaid benefits or in a document that requires a disclosure of assets for the purpose of determining eligibility to receive medicaid benefits all of the interests in property of the applicant for or recipient of medicaid benefits, all transfers of property by the applicant for or recipient of medicaid benefits, and the circumstances of all those transfers.

(E) Any amounts of medicaid benefits recovered as restitution under this section and any interest on those amounts shall be credited to the general revenue fund, and any applicable federal share shall be returned to the appropriate agency or department of the United States.

Sec. 2921.01. As used in sections 2921.01 to 2921.45 of the Revised Code:

(A) "Public official" means any elected or appointed officer, or employee, or agent of the state or any political subdivision, whether in a temporary or permanent capacity, and includes, but is not limited to, legislators, judges, and law enforcement officers.

(B) "Public servant" means any of the following:

(1) Any public official;

(2) Any person performing ad hoc a governmental function, including, but not limited to, a juror, member of a temporary commission, master, arbitrator, advisor, or consultant;

(3) A person who is a candidate for public office, whether or not the person is elected or appointed to the office for which the person is a candidate. A person is a candidate for purposes of this division if the person has been nominated according to law for election or appointment to public office, or if the person has filed a petition or petitions as required by law to have the person's name placed on the ballot in a primary, general, or special election, or if the person campaigns as a write-in candidate in any primary, general, or special election.

(C) "Party official" means any person who holds an elective or appointive post in a political party in the United States or this state, by virtue of which the person directs, conducts, or participates in directing or conducting party affairs at any level of responsibility.

(D) "Official proceeding" means any proceeding before a legislative, judicial, administrative, or other governmental agency or official authorized to take evidence under oath, and includes any proceeding before a referee, hearing examiner, commissioner, notary, or other person taking testimony or a deposition in connection with an official proceeding.

(E) "Detention" means arrest; confinement in any vehicle subsequent to an arrest; confinement in any public or private facility for custody of persons charged with or convicted of crime in this state or another state or under the laws of the United States or alleged or found to be a delinquent child or unruly child in this state or another state or under the laws of the United States; hospitalization, institutionalization, or confinement in any public or private facility that is ordered pursuant to or under the authority of section 2945.37, 2945.371,

2945.38, 2945.39, 2945.40, 2945.401, or 2945.402 of the Revised Code; confinement in any vehicle for transportation to or from any facility of any of those natures; detention for extradition or deportation; except as provided in this division, supervision by any employee of any facility of any of those natures that is incidental to hospitalization, institutionalization, or confinement in the facility but that occurs outside the facility; supervision by an employee of the department of rehabilitation and correction of a person on any type of release from a state correctional institution; or confinement in any vehicle, airplane, or place while being returned from outside of this state into this state by a private person or entity pursuant to a contract entered into under division (E) of section 311.29 of the Revised Code or division (B) of section 5149.03 of the Revised Code. For a person confined in a county jail who participates in a county jail industry program pursuant to section 5147.30 of the Revised Code, "detention" includes time spent at an assigned work site and going to and from the work site.

(F) "Detention facility" means any public or private place used for the confinement of a person charged with or convicted of any crime in this state or another state or under the laws of the United States or alleged or found to be a delinquent child or unruly child in this state or another state or under the laws of the United States.

(G) "Valuable thing or valuable benefit" includes, but is not limited to, a contribution. This inclusion does not indicate or imply that a contribution was not included in those terms before September 17, 1986.

(H) "Campaign committee," "contribution," "political action committee," "legislative campaign fund," "political party," and "political contributing entity" have the same meanings as in section 3517.01 of the Revised Code.

(I) "Provider agreement" ~~and "medical assistance program" have~~ has the same ~~meanings~~ meaning as in section 2913.40 of the Revised Code.

Sec. 2921.13. (A) No person shall knowingly make a false statement, or knowingly swear or affirm the truth of a false statement previously made, when any of the following applies:

(1) The statement is made in any official proceeding.

(2) The statement is made with purpose to incriminate another.

(3) The statement is made with purpose to mislead a public official in performing the public official's official function.

(4) The statement is made with purpose to secure the payment of unemployment compensation; Ohio works first; prevention, retention, and contingency benefits and services; disability financial assistance; retirement benefits; economic development assistance, as defined in section 9.66 of the Revised Code; or other benefits administered by a governmental agency or paid out of a public treasury.

(5) The statement is made with purpose to secure the issuance by a governmental agency of a license, permit, authorization, certificate, registration, release, or provider agreement.

(6) The statement is sworn or affirmed before a notary public or another person empowered to administer oaths.

(7) The statement is in writing on or in connection with a report or return that is required or authorized by law.

(8) The statement is in writing and is made with purpose to induce another to extend credit to or employ the offender, to confer any degree, diploma, certificate of attainment, award of excellence, or honor on the offender, or to extend to or bestow upon the offender any other valuable benefit or distinction, when

the person to whom the statement is directed relies upon it to that person's detriment.

(9) The statement is made with purpose to commit or facilitate the commission of a theft offense.

(10) The statement is knowingly made to a probate court in connection with any action, proceeding, or other matter within its jurisdiction, either orally or in a written document, including, but not limited to, an application, petition, complaint, or other pleading, or an inventory, account, or report.

(11) The statement is made on an account, form, record, stamp, label, or other writing that is required by law.

(12) The statement is made in connection with the purchase of a firearm, as defined in section 2923.11 of the Revised Code, and in conjunction with the furnishing to the seller of the firearm of a fictitious or altered driver's or commercial driver's license or permit, a fictitious or altered identification card, or any other document that contains false information about the purchaser's identity.

(13) The statement is made in a document or instrument of writing that purports to be a judgment, lien, or claim of indebtedness and is filed or recorded with the secretary of state, a county recorder, or the clerk of a court of record.

(14) The statement is made with purpose to obtain an Ohio's best Rx program enrollment card under section ~~173.773~~ 5169.073 of the Revised Code or a payment under section ~~173.801~~ 5169.101 of the Revised Code.

(15) The statement is made in an application filed with a county sheriff pursuant to section 2923.125 of the Revised Code in order to obtain or renew a license to carry a concealed handgun or is made in an affidavit submitted to a county sheriff to obtain a temporary emergency license to carry a concealed handgun under

section 2923.1213 of the Revised Code.

(16) The statement is required under section 5743.72 of the Revised Code in connection with the person's purchase of cigarettes or tobacco products in a delivery sale.

(B) No person, in connection with the purchase of a firearm, as defined in section 2923.11 of the Revised Code, shall knowingly furnish to the seller of the firearm a fictitious or altered driver's or commercial driver's license or permit, a fictitious or altered identification card, or any other document that contains false information about the purchaser's identity.

(C) No person, in an attempt to obtain a license to carry a concealed handgun under section 2923.125 of the Revised Code, shall knowingly present to a sheriff a fictitious or altered document that purports to be certification of the person's competence in handling a handgun as described in division (B)(3) of section 2923.125 of the Revised Code.

(D) It is no defense to a charge under division (A)(6) of this section that the oath or affirmation was administered or taken in an irregular manner.

(E) If contradictory statements relating to the same fact are made by the offender within the period of the statute of limitations for falsification, it is not necessary for the prosecution to prove which statement was false but only that one or the other was false.

(F)(1) Whoever violates division (A)(1), (2), (3), (4), (5), (6), (7), (8), (10), (11), (13), (14), or (16) of this section is guilty of falsification, a misdemeanor of the first degree.

(2) Whoever violates division (A)(9) of this section is guilty of falsification in a theft offense. Except as otherwise provided in this division, falsification in a theft offense is a misdemeanor of the first degree. If the value of the property or

services stolen is five hundred dollars or more and is less than five thousand dollars, falsification in a theft offense is a felony of the fifth degree. If the value of the property or services stolen is five thousand dollars or more and is less than one hundred thousand dollars, falsification in a theft offense is a felony of the fourth degree. If the value of the property or services stolen is one hundred thousand dollars or more, falsification in a theft offense is a felony of the third degree.

(3) Whoever violates division (A)(12) or (B) of this section is guilty of falsification to purchase a firearm, a felony of the fifth degree.

(4) Whoever violates division (A)(15) or (C) of this section is guilty of falsification to obtain a concealed handgun license, a felony of the fourth degree.

(G) A person who violates this section is liable in a civil action to any person harmed by the violation for injury, death, or loss to person or property incurred as a result of the commission of the offense and for reasonable attorney's fees, court costs, and other expenses incurred as a result of prosecuting the civil action commenced under this division. A civil action under this division is not the exclusive remedy of a person who incurs injury, death, or loss to person or property as a result of a violation of this section.

Sec. 2945.401. (A) A defendant found incompetent to stand trial and committed pursuant to section 2945.39 of the Revised Code or a person found not guilty by reason of insanity and committed pursuant to section 2945.40 of the Revised Code shall remain subject to the jurisdiction of the trial court pursuant to that commitment, and to the provisions of this section, until the final termination of the commitment as described in division (J)(1) of this section. If the jurisdiction is terminated under

this division because of the final termination of the commitment resulting from the expiration of the maximum prison term or term of imprisonment described in division (J)(1)(b) of this section, the court or prosecutor may file an affidavit for the civil commitment of the defendant or person pursuant to Chapter 5122. or 5123. of the Revised Code.

(B) A hearing conducted under any provision of sections 2945.37 to 2945.402 of the Revised Code shall not be conducted in accordance with Chapters 5122. and 5123. of the Revised Code. Any person who is committed pursuant to section 2945.39 or 2945.40 of the Revised Code shall not voluntarily admit the person or be voluntarily admitted to a hospital or institution pursuant to section 5122.02, 5122.15, 5123.69, or 5123.76 of the Revised Code. All other provisions of Chapters 5122. and 5123. of the Revised Code regarding hospitalization or institutionalization shall apply to the extent they are not in conflict with this chapter. A commitment under section 2945.39 or 2945.40 of the Revised Code shall not be terminated and the conditions of the commitment shall not be changed except as otherwise provided in division (D)(2) of this section with respect to a mentally retarded person subject to institutionalization by court order or except by order of the trial court.

(C) The hospital, facility, or program to which a defendant or person has been committed under section 2945.39 or 2945.40 of the Revised Code shall report in writing to the trial court, at the times specified in this division, as to whether the defendant or person remains a mentally ill person subject to hospitalization by court order or a mentally retarded person subject to institutionalization by court order and, in the case of a defendant committed under section 2945.39 of the Revised Code, as to whether the defendant remains incompetent to stand trial. The hospital, facility, or program shall make the reports after the

initial six months of treatment and every two years after the initial report is made. The trial court shall provide copies of the reports to the prosecutor and to the counsel for the defendant or person. Within thirty days after its receipt pursuant to this division of a report from a hospital, facility, or program, the trial court shall hold a hearing on the continued commitment of the defendant or person or on any changes in the conditions of the commitment of the defendant or person. The defendant or person may request a change in the conditions of confinement, and the trial court shall conduct a hearing on that request if six months or more have elapsed since the most recent hearing was conducted under this section.

(D)(1) Except as otherwise provided in division (D)(2) of this section, when a defendant or person has been committed under section 2945.39 or 2945.40 of the Revised Code, at any time after evaluating the risks to public safety and the welfare of the defendant or person, the chief clinical officer of the hospital, facility, or program to which the defendant or person is committed may recommend a termination of the defendant's or person's commitment or a change in the conditions of the defendant's or person's commitment.

Except as otherwise provided in division (D)(2) of this section, if the chief clinical officer recommends on-grounds unsupervised movement, off-grounds supervised movement, or nonsecured status for the defendant or person or termination of the defendant's or person's commitment, the following provisions apply:

(a) If the chief clinical officer recommends on-grounds unsupervised movement or off-grounds supervised movement, the chief clinical officer shall file with the trial court an application for approval of the movement and shall send a copy of the application to the prosecutor. Within fifteen days after

receiving the application, the prosecutor may request a hearing on the application and, if a hearing is requested, shall so inform the chief clinical officer. If the prosecutor does not request a hearing within the fifteen-day period, the trial court shall approve the application by entering its order approving the requested movement or, within five days after the expiration of the fifteen-day period, shall set a date for a hearing on the application. If the prosecutor requests a hearing on the application within the fifteen-day period, the trial court shall hold a hearing on the application within thirty days after the hearing is requested. If the trial court, within five days after the expiration of the fifteen-day period, sets a date for a hearing on the application, the trial court shall hold the hearing within thirty days after setting the hearing date. At least fifteen days before any hearing is held under this division, the trial court shall give the prosecutor written notice of the date, time, and place of the hearing. At the conclusion of each hearing conducted under this division, the trial court either shall approve or disapprove the application and shall enter its order accordingly.

(b) If the chief clinical officer recommends termination of the defendant's or person's commitment at any time or if the chief clinical officer recommends the first of any nonsecured status for the defendant or person, the chief clinical officer shall send written notice of this recommendation to the trial court and to the local forensic center. The local forensic center shall evaluate the committed defendant or person and, within thirty days after its receipt of the written notice, shall submit to the trial court and the chief clinical officer a written report of the evaluation. The trial court shall provide a copy of the chief clinical officer's written notice and of the local forensic center's written report to the prosecutor and to the counsel for the defendant or person. Upon the local forensic center's

submission of the report to the trial court and the chief clinical officer, all of the following apply:

(i) If the forensic center disagrees with the recommendation of the chief clinical officer, it shall inform the chief clinical officer and the trial court of its decision and the reasons for the decision. The chief clinical officer, after consideration of the forensic center's decision, shall either withdraw, proceed with, or modify and proceed with the recommendation. If the chief clinical officer proceeds with, or modifies and proceeds with, the recommendation, the chief clinical officer shall proceed in accordance with division (D)(1)(b)(iii) of this section.

(ii) If the forensic center agrees with the recommendation of the chief clinical officer, it shall inform the chief clinical officer and the trial court of its decision and the reasons for the decision, and the chief clinical officer shall proceed in accordance with division (D)(1)(b)(iii) of this section.

(iii) If the forensic center disagrees with the recommendation of the chief clinical officer and the chief clinical officer proceeds with, or modifies and proceeds with, the recommendation or if the forensic center agrees with the recommendation of the chief clinical officer, the chief clinical officer shall work with the board of alcohol, drug addiction, and mental health services or community mental health board serving the area, as appropriate, to develop a plan to implement the recommendation. If the defendant or person is on medication, the plan shall include, but shall not be limited to, a system to monitor the defendant's or person's compliance with the prescribed medication treatment plan. The system shall include a schedule that clearly states when the defendant or person shall report for a medication compliance check. The medication compliance checks shall be based upon the effective duration of the prescribed medication, taking into account the route by which it is taken,

and shall be scheduled at intervals sufficiently close together to detect a potential increase in mental illness symptoms that the medication is intended to prevent.

The chief clinical officer, after consultation with the board of alcohol, drug addiction, and mental health services or the community mental health board serving the area, shall send the recommendation and plan developed under division (D)(1)(b)(iii) of this section, in writing, to the trial court, the prosecutor and the counsel for the committed defendant or person. The trial court shall conduct a hearing on the recommendation and plan developed under division (D)(1)(b)(iii) of this section. Divisions (D)(1)(c) and (d) and (E) to (J) of this section apply regarding the hearing.

(c) If the chief clinical officer's recommendation is for nonsecured status or termination of commitment, the prosecutor may obtain an independent expert evaluation of the defendant's or person's mental condition, and the trial court may continue the hearing on the recommendation for a period of not more than thirty days to permit time for the evaluation.

The prosecutor may introduce the evaluation report or present other evidence at the hearing in accordance with the Rules of Evidence.

(d) The trial court shall schedule the hearing on a chief clinical officer's recommendation for nonsecured status or termination of commitment and shall give reasonable notice to the prosecutor and the counsel for the defendant or person. Unless continued for independent evaluation at the prosecutor's request or for other good cause, the hearing shall be held within thirty days after the trial court's receipt of the recommendation and plan.

(2)(a) Division (D)(1) of this section does not apply to

on-grounds unsupervised movement of a defendant or person who has been committed under section 2945.39 or 2945.40 of the Revised Code, who is a mentally retarded person subject to institutionalization by court order, and who is being provided residential habilitation, care, and treatment in a facility operated by the department of mental retardation and developmental disabilities.

(b) If, pursuant to section 2945.39 of the Revised Code, the trial court commits a defendant who is found incompetent to stand trial and who is a mentally retarded person subject to institutionalization by court order, if the defendant is being provided residential habilitation, care, and treatment in a facility operated by the department of mental retardation and developmental disabilities, if an individual who is conducting a survey for the department of health to determine the facility's compliance with the certification requirements of the medicaid program ~~under chapter 5111. of the Revised Code and Title XIX of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended,~~ cites the defendant's receipt of the residential habilitation, care, and treatment in the facility as being inappropriate under the certification requirements, if the defendant's receipt of the residential habilitation, care, and treatment in the facility potentially jeopardizes the facility's continued receipt of federal medicaid moneys, and if as a result of the citation the chief clinical officer of the facility determines that the conditions of the defendant's commitment should be changed, the department of mental retardation and developmental disabilities may cause the defendant to be removed from the particular facility and, after evaluating the risks to public safety and the welfare of the defendant and after determining whether another type of placement is consistent with the certification requirements, may place the defendant in another facility that the department selects as an appropriate facility

for the defendant's continued receipt of residential habilitation, care, and treatment and that is a no less secure setting than the facility in which the defendant had been placed at the time of the citation. Within three days after the defendant's removal and alternative placement under the circumstances described in division (D)(2)(b) of this section, the department of mental retardation and developmental disabilities shall notify the trial court and the prosecutor in writing of the removal and alternative placement.

The trial court shall set a date for a hearing on the removal and alternative placement, and the hearing shall be held within twenty-one days after the trial court's receipt of the notice from the department of mental retardation and developmental disabilities. At least ~~ten-days~~ ten days before the hearing is held, the trial court shall give the prosecutor, the department of mental retardation and developmental disabilities, and the counsel for the defendant written notice of the date, time, and place of the hearing. At the hearing, the trial court shall consider the citation issued by the individual who conducted the survey for the department of health to be prima-facie evidence of the fact that the defendant's commitment to the particular facility was inappropriate under the certification requirements of the medicaid program ~~under Chapter 5111. of the Revised Code and Title XIX of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended,~~ and potentially jeopardizes the particular facility's continued receipt of federal medicaid moneys. At the conclusion of the hearing, the trial court may approve or disapprove the defendant's removal and alternative placement. If the trial court approves the defendant's removal and alternative placement, the department of mental retardation and developmental disabilities may continue the defendant's alternative placement. If the trial court disapproves the defendant's removal and alternative placement, it shall enter an order modifying the defendant's

removal and alternative placement, but that order shall not require the department of mental retardation and developmental disabilities to replace the defendant for purposes of continued residential habilitation, care, and treatment in the facility associated with the citation issued by the individual who conducted the survey for the department of health.

(E) In making a determination under this section regarding nonsecured status or termination of commitment, the trial court shall consider all relevant factors, including, but not limited to, all of the following:

(1) Whether, in the trial court's view, the defendant or person currently represents a substantial risk of physical harm to the defendant or person or others;

(2) Psychiatric and medical testimony as to the current mental and physical condition of the defendant or person;

(3) Whether the defendant or person has insight into the dependant's or person's condition so that the defendant or person will continue treatment as prescribed or seek professional assistance as needed;

(4) The grounds upon which the state relies for the proposed commitment;

(5) Any past history that is relevant to establish the defendant's or person's degree of conformity to the laws, rules, regulations, and values of society;

(6) If there is evidence that the defendant's or person's mental illness is in a state of remission, the medically suggested cause and degree of the remission and the probability that the defendant or person will continue treatment to maintain the remissive state of the defendant's or person's illness should the defendant's or person's commitment conditions be altered.

(F) At any hearing held pursuant to division (C) or (D)(1) or (2) of this section, the defendant or the person shall have all the rights of a defendant or person at a commitment hearing as described in section 2945.40 of the Revised Code.

(G) In a hearing held pursuant to division (C) or (D)(1) of this section, the prosecutor has the burden of proof as follows:

(1) For a recommendation of termination of commitment, to show by clear and convincing evidence that the defendant or person remains a mentally ill person subject to hospitalization by court order or a mentally retarded person subject to institutionalization by court order;

(2) For a recommendation for a change in the conditions of the commitment to a less restrictive status, to show by clear and convincing evidence that the proposed change represents a threat to public safety or a threat to the safety of any person.

(H) In a hearing held pursuant to division (C) or (D)(1) or (2) of this section, the prosecutor shall represent the state or the public interest.

(I) At the conclusion of a hearing conducted under division (D)(1) of this section regarding a recommendation from the chief clinical officer of a hospital, program, or facility, the trial court may approve, disapprove, or modify the recommendation and shall enter an order accordingly.

(J)(1) A defendant or person who has been committed pursuant to section 2945.39 or 2945.40 of the Revised Code continues to be under the jurisdiction of the trial court until the final termination of the commitment. For purposes of division (J) of this section, the final termination of a commitment occurs upon the earlier of one of the following:

(a) The defendant or person no longer is a mentally ill person subject to hospitalization by court order or a mentally

retarded person subject to institutionalization by court order, as determined by the trial court;

(b) The expiration of the maximum prison term or term of imprisonment that the defendant or person could have received if the defendant or person had been convicted of the most serious offense with which the defendant or person is charged or in relation to which the defendant or person was found not guilty by reason of insanity;

(c) The trial court enters an order terminating the commitment under the circumstances described in division (J)(2)(a)(ii) of this section.

(2)(a) If a defendant is found incompetent to stand trial and committed pursuant to section 2945.39 of the Revised Code, if neither of the circumstances described in divisions (J)(1)(a) and (b) of this section applies to that defendant, and if a report filed with the trial court pursuant to division (C) of this section indicates that the defendant presently is competent to stand trial or if, at any other time during the period of the defendant's commitment, the prosecutor, the counsel for the defendant, or the chief clinical officer of the hospital, facility, or program to which the defendant is committed files an application with the trial court alleging that the defendant presently is competent to stand trial and requesting a hearing on the competency issue or the trial court otherwise has reasonable cause to believe that the defendant presently is competent to stand trial and determines on its own motion to hold a hearing on the competency issue, the trial court shall schedule a hearing on the competency of the defendant to stand trial, shall give the prosecutor, the counsel for the defendant, and the chief clinical officer notice of the date, time, and place of the hearing at least fifteen days before the hearing, and shall conduct the hearing within thirty days of the filing of the application or of

its own motion. If, at the conclusion of the hearing, the trial court determines that the defendant presently is capable of understanding the nature and objective of the proceedings against the defendant and of assisting in the defendant's defense, the trial court shall order that the defendant is competent to stand trial and shall be proceeded against as provided by law with respect to the applicable offenses described in division (C)(1) of section 2945.38 of the Revised Code and shall enter whichever of the following additional orders is appropriate:

(i) If the trial court determines that the defendant remains a mentally ill person subject to hospitalization by court order or a mentally retarded person subject to institutionalization by court order, the trial court shall order that the defendant's commitment to the hospital, facility, or program be continued during the pendency of the trial on the applicable offenses described in division (C)(1) of section 2945.38 of the Revised Code.

(ii) If the trial court determines that the defendant no longer is a mentally ill person subject to hospitalization by court order or a mentally retarded person subject to institutionalization by court order, the trial court shall order that the defendant's commitment to the hospital, facility, or program shall not be continued during the pendency of the trial on the applicable offenses described in division (C)(1) of section 2945.38 of the Revised Code. This order shall be a final termination of the commitment for purposes of division (J)(1)(c) of this section.

(b) If, at the conclusion of the hearing described in division (J)(2)(a) of this section, the trial court determines that the defendant remains incapable of understanding the nature and objective of the proceedings against the defendant or of assisting in the defendant's defense, the trial court shall order

that the defendant continues to be incompetent to stand trial, that the defendant's commitment to the hospital, facility, or program shall be continued, and that the defendant remains subject to the jurisdiction of the trial court pursuant to that commitment, and to the provisions of this section, until the final termination of the commitment as described in division (J)(1) of this section.

Sec. 3101.051. (A) Except as provided in division (B) of this section, a probate court shall make available to any person for inspection the records pertaining to the issuance of marriage licenses as provided under section 149.43 of the Revised Code.

(B) Before it makes available to a person any records pertaining to the issuance of a marriage license as described in division (A) of this section, subject to division (C) of this section, a probate court shall delete or otherwise remove any social security numbers of the parties to a marriage so that they are not available to the person inspecting the records.

(C) Division (B) of this section does not apply in any of the following circumstances:

(1) If the records in question are inspected by authorized personnel of the division of child support in the department of job and family services under section ~~5101.31~~ 5160.66 of the Revised Code;

(2) If the records in question are inspected by law enforcement personnel for purposes of a criminal investigation;

(3) If the records in question with the social security numbers are necessary for use in a civil or criminal trial and the release of the records with the social security numbers is ordered by a court with jurisdiction over the trial;

(4) If the records in question are inspected by either party

to the marriage to which the records pertain;

(5) If the court possessed the records in question prior to ~~the effective date of this section~~ February 12, 2001.

Sec. 3107.083. Not later than ninety days after June 20, 1996, the director of job and family services shall do all of the following:

(A)(1) For a parent of a child who, if adopted, will be an adopted person as defined in section 3107.45 of the Revised Code, prescribe a form that has the following six components:

(a) A component the parent signs under section 3107.071, 3107.081, or 5103.151 of the Revised Code to indicate the requirements of section 3107.082 or 5103.152 of the Revised Code have been met. The component shall be as follows:

"Statement Concerning Ohio Law and Adoption Materials

By signing this component of this form, I acknowledge that it has been explained to me, and I understand, that, if I check the space on the next component of this form that indicates that I authorize the release, the adoption file maintained by the Ohio Department of Health, which contains identifying information about me at the time of my child's birth, will be released, on request, to the adoptive parent when the adoptee is at least age eighteen but younger than age twenty-one and to the adoptee when he or she is age twenty-one or older. It has also been explained to me, and I understand, that I may prohibit the release of identifying information about me contained in the adoption file by checking the space on the next component of this form that indicates that I do not authorize the release of the identifying information. It has additionally been explained to me, and I understand, that I may change my mind regarding the decision I make on the next component of this form at any time and as many times as I desire by signing, dating, and having filed with the Ohio Department of

Health a denial of release form or authorization of release form prescribed and provided by the Department of Health and providing the Department two items of identification.

By signing this component of this form, I also acknowledge that I have been provided a copy of written materials about adoption prepared by the Ohio Department of Job and Family Services, the adoption process and ramifications of consenting to adoption or entering into a voluntary permanent custody surrender agreement have been discussed with me, and I have been provided the opportunity to review the materials and ask questions about the materials and discussion.

Signature of biological parent: .....

Signature of witness: .....

Date: ....."

(b) A component the parent signs under section 3107.071, 3107.081, or 5103.151 of the Revised Code regarding the parent's decision whether to allow identifying information about the parent contained in an adoption file maintained by the department of health to be released to the parent's child and adoptive parent pursuant to section 3107.47 of the Revised Code. The component shall be as follows:

"Statement Regarding Release of Identifying Information

The purpose of this component of this form is to allow a biological parent to decide whether to allow the Ohio Department of Health to provide an adoptee and adoptive parent identifying information about the adoptee's biological parent contained in an adoption file maintained by the Department. Please check one of the following spaces:

..... YES, I authorize the Ohio Department of Health to release identifying information about me, on request, to the adoptive parent when the adoptee is at least age eighteen but younger than age

twenty-one and to the adoptee when he or she is age twenty-one or older.

..... NO, I do not authorize the release of identifying information about me to the adoptive parent or adoptee.

Signature of biological parent: .....

Signature of witness: .....

Date: ....."

(c) A component the parent, if the mother of the child, completes and signs under section 3107.071, 3107.081, or 5103.151 of the Revised Code to indicate, to the extent of the mother's knowledge, all of the following:

(i) Whether the mother, during her pregnancy, was a recipient of the ~~medical assistance~~ medicaid program ~~established under Chapter 5111. of the Revised Code~~ or other public health insurance program and, if so, the dates her eligibility began and ended;

(ii) Whether the mother, during her pregnancy, was covered by private health insurance and, if so, the dates the coverage began and ended, the name of the insurance provider, the type of coverage, and the identification number of the coverage;

(iii) The name and location of the hospital, freestanding birth center, or other place where the mother gave birth and, if different, received medical care immediately after giving birth;

(iv) The expenses of the obstetrical and neonatal care;

(v) Whether the mother has been informed that the adoptive parent or the agency or attorney arranging the adoption are to pay expenses involved in the adoption, including expenses the mother has paid and expects to receive or has received reimbursement, and, if so, what expenses are to be or have been paid and an estimate of the expenses;

(vi) Any other information related to expenses the department

determines appropriate to be included in this component.

(d) A component the parent may sign to authorize the agency or attorney arranging the adoption to provide to the child or adoptive parent materials, other than photographs of the parent, that the parent requests be given to the child or adoptive parent pursuant to section 3107.68 of the Revised Code.

(e) A component the parent may sign to authorize the agency or attorney arranging the adoption to provide to the child or adoptive parent photographs of the parent pursuant to section 3107.68 of the Revised Code.

(f) A component the parent may sign to authorize the agency or attorney arranging the adoption to provide to the child or adoptive parent the first name of the parent pursuant to section 3107.68 of the Revised Code.

(2) State at the bottom of the form that the parent is to receive a copy of the form the parent signed.

(3) Provide copies of the form prescribed under this division to probate and juvenile courts, public children services agencies, private child placing agencies, private noncustodial agencies, attorneys, and persons authorized to take acknowledgments.

(B)(1) For a parent of a child who, if adopted, will become an adopted person as defined in section 3107.39 of the Revised Code, prescribe a form that has the following five components:

(a) A component the parent signs under section 3107.071, 3107.081, or 5103.151 of the Revised Code to attest that the requirement of division (A) of section 3107.082 or division (A) of section 5103.152 of the Revised Code has been met;

(b) A component the parent, if the mother of the child, completes and signs under section 3107.071, 3107.081, or 5103.151 of the Revised Code to indicate, to the extent of the mother's

knowledge, all of the following:

(i) Whether the mother, during her pregnancy, was a recipient of the ~~medical assistance~~ medicaid program ~~established under Chapter 5111. of the Revised Code~~ or other public health insurance program and, if so, the dates her eligibility began and ended;

(ii) Whether the mother, during her pregnancy, was covered by private health insurance and, if so, the dates the coverage began and ended, the name of the insurance provider, the type of coverage, and the identification number of the coverage;

(iii) The name and location of the hospital, freestanding birth center, or other place where the mother gave birth and, if different, received medical care immediately after giving birth;

(iv) The expenses of the obstetrical and neonatal care;

(v) Whether the mother has been informed that the adoptive parent or the agency or attorney arranging the adoption are to pay expenses involved in the adoption, including expenses the mother has paid and expects to receive or has received reimbursement for, and, if so, what expenses are to be or have been paid and an estimate of the expenses;

(vi) Any other information related to expenses the department determines appropriate to be included in the component.

(c) A component the parent may sign to authorize the agency or attorney arranging the adoption to provide to the child or adoptive parent materials, other than photographs of the parent, that the parent requests be given to the child or adoptive parent pursuant to section 3107.68 of the Revised Code.

(d) A component the parent may sign to authorize the agency or attorney arranging the adoption to provide to the child or adoptive parent photographs of the parent pursuant to section 3107.68 of the Revised Code.

(e) A component the parent may sign to authorize the agency or attorney arranging the adoption to provide to the child or adoptive parent the first name of the parent pursuant to section 3107.68 of the Revised Code.

(2) State at the bottom of the form that the parent is to receive a copy of the form the parent signed.

(3) Provide copies of the form prescribed under this division to probate and juvenile courts, public children services agencies, private child placing agencies, private noncustodial agencies, and attorneys.

(C) Prepare the written materials about adoption that are required to be given to parents under division (A) of section 3107.082 and division (A) of section 5103.152 of the Revised Code. The materials shall provide information about the adoption process, including ramifications of a parent consenting to a child's adoption or entering into a voluntary permanent custody surrender agreement. The materials also shall include referral information for professional counseling and adoption support organizations. The director shall provide the materials to assessors.

(D) Adopt rules in accordance with Chapter 119. of the Revised Code specifying the documents that must be filed with a probate court under divisions (B) and (D) of section 3107.081 of the Revised Code and a juvenile court under divisions (C) and (E) of section 5103.151 of the Revised Code.

Sec. 3111.04. (A) An action to determine the existence or nonexistence of the father and child relationship may be brought by the child or the child's personal representative, the child's mother or her personal representative, a man alleged or alleging himself to be the child's father, the child support enforcement agency of the county in which the child resides if the child's

mother, father, or alleged father is a recipient of public assistance or of services under Title IV-D of the "Social Security Act," 88 Stat. 2351 (1975), 42 U.S.C.A. 651, as amended, or the alleged father's personal representative.

(B) An agreement does not bar an action under this section.

(C) If an action under this section is brought before the birth of the child and if the action is contested, all proceedings, except service of process and the taking of depositions to perpetuate testimony, may be stayed until after the birth.

(D) A recipient of public assistance or of services under Title IV-D of the "Social Security Act," 88 Stat. 2351 (1975), 42 U.S.C.A. 651, as amended, shall cooperate with the child support enforcement agency of the county in which a child resides to obtain an administrative determination pursuant to sections 3111.38 to 3111.54 of the Revised Code, or, if necessary, a court determination pursuant to sections 3111.01 to 3111.18 of the Revised Code, of the existence or nonexistence of a parent and child relationship between the father and the child. If the recipient fails to cooperate, the agency may commence an action to determine the existence or nonexistence of a parent and child relationship between the father and the child pursuant to sections 3111.01 to 3111.18 of the Revised Code.

(E) As used in this section, "public assistance" means medical assistance under ~~Chapter 5111. of~~ the ~~Revised Code~~ medicaid program, assistance under Chapter 5107. of the Revised Code, disability financial assistance under Chapter 5115. of the Revised Code, or the disability medical assistance ~~under Chapter 5115. of the Revised Code~~ program.

Sec. 3111.72. The contract between the department of job and family services and a local hospital shall require all of the

following:

(A) That the hospital provide a staff person to meet with each unmarried mother who gave birth in or en route to the hospital within twenty-four hours of the birth or before the mother is released from the hospital;

(B) That the staff person attempt to meet with the father of the unmarried mother's child if possible;

(C) That the staff person explain to the unmarried mother and the father, if he is present, the benefit to the child of establishing a parent and child relationship between the father and the child and the various proper procedures for establishing a parent and child relationship;

(D) That the staff person present to the unmarried mother and, if possible, the father, the pamphlet or statement regarding the rights and responsibilities of a natural parent that is prepared and provided by the department of job and family services pursuant to section 3111.32 of the Revised Code;

(E) That the staff person provide the mother and, if possible, the father, all forms and statements necessary to voluntarily establish a parent and child relationship, including, but not limited to, the acknowledgment of paternity affidavit prepared by the department of job and family services pursuant to section 3111.31 of the Revised Code;

(F) That the staff person, at the request of both the mother and father, help the mother and father complete any form or statement necessary to establish a parent and child relationship;

(G) That the hospital provide a notary public to notarize an acknowledgment of paternity affidavit signed by the mother and father;

(H) That the staff person present to an unmarried mother who

is not participating in the Ohio works first program established under Chapter 5107. or receiving ~~medical assistance under Chapter 5111. of the Revised Code~~ medicaid an application for Title IV-D services;

(I) That the staff person forward any completed acknowledgment of paternity, no later than ten days after it is completed, to the office of child support in the department of job and family services;

(J) That the department of job and family services pay the hospital twenty dollars for every correctly signed and notarized acknowledgment of paternity affidavit from the hospital.

Sec. 3119.54. ~~If~~ (A) As used in this section:

(1) "Eligible party" means a party to a child support order issued in accordance with section 3119.30 of the Revised Code who is eligible for a medical assistance program.

(2) "Medical assistance program" means either of the following:

(a) The medicaid program.

(b) The disability medical assistance program established under Chapter 5115. of the Revised Code.

(B) If either party to a child support order issued in accordance with section 3119.30 of the Revised Code is an eligible ~~for medical assistance under Chapter 5111. or 5115. of the Revised Code~~ party and the other party has obtained health insurance coverage, the ~~party~~ eligible ~~for medical assistance~~ party shall notify any ~~physician, hospital, or other~~ provider of medical services ~~for which~~ covered by the eligible party's medical assistance ~~is available~~ program of the name and address of the other party's insurer and of the number of the other party's health insurance or health care policy, contract, or plan. Any

~~physician, hospital, or other~~ provider of medical services ~~for which medical assistance is available under Chapter 5111. or 5115. of the Revised Code~~ who is notified under this ~~division~~ section of the existence of a health insurance or health care policy, contract, or plan with coverage for children who are eligible for a medical assistance program shall first bill the insurer for any services provided for those children. If the insurer fails to pay all or any part of a claim filed under this section and the services for which the claim is filed are covered by ~~Chapter 5111. or 5115. of the Revised Code~~ the children's medical assistance program, the ~~physician, hospital, or other~~ medical services provider shall bill the remaining unpaid costs of the services in accordance with ~~Chapter 5111. or 5115. of the Revised Code~~ the law governing the children's medical assistance program.

Sec. 3121.441. (A) Notwithstanding the provisions of this chapter, Chapters 3119., 3123., and 3125., and sections 3770.071 and 5107.20 of the Revised Code providing for the office of child support in the department of job and family services to collect, withhold, or deduct spousal support, when a court pursuant to section 3105.18 or 3105.65 of the Revised Code issues or modifies an order requiring an obligor to pay spousal support or grants or modifies a decree of dissolution of marriage incorporating a separation agreement that provides for spousal support, or at any time after the issuance, granting, or modification of an order or decree of that type, the court may permit the obligor to make the spousal support payments directly to the obligee instead of to the office if the obligee and the obligor have no minor children born as a result of their marriage and the obligee has not assigned the spousal support amounts to the department pursuant to section ~~5101.59 or~~ 5107.20 or 5160.37 of the Revised Code.

(B) A court that permits an obligor to make spousal support payments directly to the obligee pursuant to division (A) of this

section shall order the obligor to make the spousal support payments as a check, as a money order, or in any other form that establishes a clear record of payment.

(C) If a court permits an obligor to make spousal support payments directly to an obligee pursuant to division (A) of this section and the obligor is in default in making any spousal support payment to the obligee, the court, upon motion of the obligee or on its own motion, may rescind the permission granted under that division. After the rescission, the court shall determine the amount of arrearages in the spousal support payments and order the obligor to make to the office of child support in the department of job and family services any spousal support payments that are in arrears and any future spousal support payments. Upon the issuance of the order of the court under this division, the provisions of this chapter, Chapters 3119., 3123., and 3125., and sections 3770.071 and 5107.20 of the Revised Code apply with respect to the collection, withholding, or deduction of the obligor's spousal support payments that are the subject of that order of the court.

Sec. 3121.898. ~~The~~ As used in this section, "state agency" means every department, bureau, board, commission, office, or other organized body established by the constitution or laws of this state for the exercise of state government; every entity of county government that is subject to the rules of a state agency; and every contractual agent of a state agency.

The department of job and family services shall use the new hire reports it receives for any of the following purposes set forth in 42 U.S.C. 653a, as amended, including:

(A) To locate individuals for the purposes of establishing paternity and for establishing, modifying, and enforcing child support orders.

(B) ~~As used in this division, "state agency" means every department, bureau, board, commission, office, or other organized body established by the constitution or laws of this state for the exercise of state government; every entity of county government that is subject to the rules of a state agency; and every contractual agent of a state agency.~~

To make available to any state agency responsible for administering any of the following programs for purposes of verifying program eligibility:

(1) Any Title IV-A program as defined in section 5101.80 of the Revised Code;

(2) The medicaid program ~~authorized by Chapter 5111. of the Revised Code~~;

(3) The unemployment compensation program authorized by Chapter 4141. of the Revised Code;

(4) The food stamp program authorized by section 5101.54 of the Revised Code;

(5) Any other program authorized in 42 U.S.C. 1320b-7(b), as amended.

(C) The administration of the employment security program under the director of job and family services.

Sec. 3125.36. (A) Subject to division (B) of this section, all support orders that are administered by a child support enforcement agency designated under section 307.981 of the Revised Code or former section 2301.35 of the Revised Code and are eligible for Title IV-D services shall be Title IV-D cases under Title IV-D of the "Social Security Act." Subject to division (B) of this section, all obligees of support orders administered by the agency shall be considered to have filed a signed application for Title IV-D services.

(B) Except as provided in division (D) of this section, a court that issues or modifies a support order shall require the obligee under the order to sign, at the time of the issuance or modification of the order, an application for Title IV-D services and to file, as soon as possible, the signed application with the child support enforcement agency that will administer the order. The application shall be on a form prescribed by the department of job and family services. Except as provided in division (D) of this section, a support order that is administered by a child support enforcement agency, and that is eligible for Title IV-D services shall be a Title IV-D case under Title IV-D of the "Social Security Act" only upon the filing of the signed application for Title IV-D services.

(C) A child support enforcement agency shall make available an application for Title IV-D services to all persons requesting a child support enforcement agency's assistance in an action under sections 3111.01 to 3111.18 of the Revised Code or in an administrative proceeding brought to establish a parent and child relationship, to establish or modify an administrative support order, or to establish or modify an order to provide health insurance coverage for the children subject to a support order.

(D) An obligee under a support order who has assigned the right to the support pursuant to section ~~5101.59 or~~ 5107.20 or 5160.37 of the Revised Code shall not be required to sign an application for Title IV-D services. The support order shall be considered a Title IV-D case.

Sec. 3307.20. (A) As used in this section:

(1) "Personal history record" means information maintained by the state teachers retirement board on an individual who is a member, former member, contributor, former contributor, retirant, or beneficiary that includes the address, telephone number, social

security number, record of contributions, correspondence with the state teachers retirement system, or other information the board determines to be confidential.

(2) "Retirant" has the same meaning as in section 3307.50 of the Revised Code.

(B) The records of the board shall be open to public inspection, except for the following, which shall be excluded, except with the written authorization of the individual concerned:

(1) The individual's personal records provided for in section 3307.23 of the Revised Code;

(2) The individual's personal history record;

(3) Any information identifying, by name and address, the amount of a monthly allowance or benefit paid to the individual.

(C) All medical reports and recommendations under sections 3307.62, 3307.64, and 3307.66 of the Revised Code are privileged, except that copies of such medical reports or recommendations shall be made available to the personal physician, attorney, or authorized agent of the individual concerned upon written release received from the individual or the individual's agent, or, when necessary for the proper administration of the fund, to the board assigned physician.

(D) Any person who is a member or contributor of the system shall be furnished, on written request, with a statement of the amount to the credit of the person's account. The board need not answer more than one request of a person in any one year.

(E) Notwithstanding the exceptions to public inspection in division (B) of this section, the board may furnish the following information:

(1) If a member, former member, retirant, contributor, or former contributor is subject to an order issued under section

2907.15 of the Revised Code or is convicted of or pleads guilty to a violation of section 2921.41 of the Revised Code, on written request of a prosecutor as defined in section 2935.01 of the Revised Code, the board shall furnish to the prosecutor the information requested from the individual's personal history record.

(2) Pursuant to a court or administrative order issued under section 3119.80, 3119.81, 3121.02, 3121.03, or 3123.06 of the Revised Code, the board shall furnish to a court or child support enforcement agency the information required under that section.

(3) At the written request of any person, the board shall provide to the person a list of the names and addresses of members, former members, retirants, contributors, former contributors, or beneficiaries. The costs of compiling, copying, and mailing the list shall be paid by such person.

(4) Within fourteen days after receiving ~~from the director of job and family services~~ a list of the names and social security numbers of recipients of public assistance pursuant to section 5101.181 of the Revised Code or a list of the names and social security numbers of public medical assistance program recipients pursuant to section 5160.43 of the Revised Code, the board shall inform the auditor of state of the name, current or most recent employer address, and social security number of each member whose name and social security number are the same as that of a person whose name or social security number ~~was submitted by the director~~ is included on the list. The board and its employees shall, except for purposes of furnishing the auditor of state with information required by this section, preserve the confidentiality of recipients of public assistance in compliance with ~~division (A) of~~ section 5101.181 of the Revised Code and preserve the confidentiality of public medical assistance program recipients in compliance with section 5160.43 of the Revised Code.

(5) The system shall comply with orders issued under section 3105.87 of the Revised Code.

On the written request of an alternate payee, as defined in section 3105.80 of the Revised Code, the system shall furnish to the alternate payee information on the amount and status of any amounts payable to the alternate payee under an order issued under section 3105.171 or 3105.65 of the Revised Code.

(6) At the request of any person, the board shall make available to the person copies of all documents, including resumes, in the board's possession regarding filling a vacancy of a contributing member or retired teacher member of the board. The person who made the request shall pay the cost of compiling, copying, and mailing the documents. The information described in this division is a public record.

(F) A statement that contains information obtained from the system's records that is signed by an officer of the retirement system and to which the system's official seal is affixed, or copies of the system's records to which the signature and seal are attached, shall be received as true copies of the system's records in any court or before any officer of this state.

Sec. 3309.22. (A)(1) As used in this division, "personal history record" means information maintained by the board on an individual who is a member, former member, contributor, former contributor, retirant, or beneficiary that includes the address, telephone number, social security number, record of contributions, correspondence with the system, and other information the board determines to be confidential.

(2) The records of the board shall be open to public inspection, except for the following, which shall be excluded, except with the written authorization of the individual concerned:

(a) The individual's statement of previous service and other information as provided for in section 3309.28 of the Revised Code;

(b) Any information identifying by name and address the amount of a monthly allowance or benefit paid to the individual;

(c) The individual's personal history record.

(B) All medical reports and recommendations required by the system are privileged except that copies of such medical reports or recommendations shall be made available to the personal physician, attorney, or authorized agent of the individual concerned upon written release received from the individual or the individual's agent, or when necessary for the proper administration of the fund, to the board assigned physician.

(C) Any person who is a contributor of the system shall be furnished, on written request, with a statement of the amount to the credit of the person's account. The board need not answer more than one such request of a person in any one year.

(D) Notwithstanding the exceptions to public inspection in division (A)(2) of this section, the board may furnish the following information:

(1) If a member, former member, contributor, former contributor, or retirant is subject to an order issued under section 2907.15 of the Revised Code or is convicted of or pleads guilty to a violation of section 2921.41 of the Revised Code, on written request of a prosecutor as defined in section 2935.01 of the Revised Code, the board shall furnish to the prosecutor the information requested from the individual's personal history record.

(2) Pursuant to a court or administrative order issued under section 3119.80, 3119.81, 3121.02, 3121.03, or 3123.06 of the Revised Code, the board shall furnish to a court or child support

enforcement agency the information required under that section.

(3) At the written request of any person, the board shall provide to the person a list of the names and addresses of members, former members, retirants, contributors, former contributors, or beneficiaries. The costs of compiling, copying, and mailing the list shall be paid by such person.

(4) Within fourteen days after receiving ~~from the director of job and family services~~ a list of the names and social security numbers of recipients of public assistance pursuant to section 5101.181 of the Revised Code or a list of the names and social security numbers of public medical assistance program recipients pursuant to section 5160.43 of the Revised Code, the board shall inform the auditor of state of the name, current or most recent employer address, and social security number of each contributor whose name and social security number are the same as that of a person whose name or social security number ~~was submitted by the director~~ is included on the list. The board and its employees shall, except for purposes of furnishing the auditor of state with information required by this section, preserve the confidentiality of recipients of public assistance in compliance with ~~division (A) of~~ section 5101.181 of the Revised Code and preserve the confidentiality of public medical assistance program recipients in compliance with section 5160.43 of the Revised Code.

(5) The system shall comply with orders issued under section 3105.87 of the Revised Code.

On the written request of an alternate payee, as defined in section 3105.80 of the Revised Code, the system shall furnish to the alternate payee information on the amount and status of any amounts payable to the alternate payee under an order issued under section 3105.171 or 3105.65 of the Revised Code.

(6) At the request of any person, the board shall make

available to the person copies of all documents, including resumes, in the board's possession regarding filling a vacancy of an employee member or retirant member of the board. The person who made the request shall pay the cost of compiling, copying, and mailing the documents. The information described in this division is a public record.

(E) A statement that contains information obtained from the system's records that is signed by an officer of the retirement system and to which the system's official seal is affixed, or copies of the system's records to which the signature and seal are attached, shall be received as true copies of the system's records in any court or before any officer of this state.

Sec. 3313.714. (A) As used in this section:

(1) "Board of education" means the board of education of a city, local, exempted village, or joint vocational school district.

(2) "Healthcheck" means the early and periodic screening, diagnosis, and treatment program, a component of the ~~medical assistance~~ medicaid program ~~established under Title XIX of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 302, as amended, and Chapter 5111. of the Revised Code~~.

(3) "Pupil" means a person under age twenty-two enrolled in the schools of a city, local, exempted village, or joint vocational school district.

(4) "Parent" means either parent with the following exceptions:

(a) If one parent has custody by court order, "parent" means the parent with custody.

(b) If neither parent has legal custody, "parent" means the person or government entity with legal custody.

(c) The child's legal guardian or a person who has accepted responsibility for the health, safety, and welfare of the child.

(B) At the request of the department of ~~job and family services~~ health care administration, a board of education shall establish and conduct a healthcheck program for pupils enrolled in the schools of the district who are medicaid recipients ~~of medical assistance under Chapter 5111. of the Revised Code~~. At the request of a board of education, the department may authorize the board to establish a healthcheck program. A board that establishes a healthcheck program shall enter into a ~~medical assistance~~ medicaid provider agreement with the department.

A healthcheck program established by a board of education shall be conducted in accordance with rules adopted by the director of ~~job and family services~~ health care administration under division (F) of this section. The healthcheck program shall include all of the following components:

(1) A comprehensive health and development history;

(2) A comprehensive physical examination;

(3) A developmental assessment;

(4) A nutritional assessment;

(5) A vision assessment;

(6) A hearing assessment;

(7) An immunization assessment;

(8) Lead screening and laboratory tests ordered by a doctor of medicine or osteopathic medicine as part of one of the other components;

(9) Such other assessment as may be required by the department of ~~job and family services~~ health care administration in accordance with the requirements of the healthcheck program.

All services included in a board of education's healthcheck program that the board provided under sections 3313.67, 3313.673, 3313.68, 3313.69, and 3313.71 of the Revised Code during the 1990-1991 school year shall continue to be provided to ~~medical assistance~~ medicaid recipients by the board pursuant to those sections. The services shall be considered part of the healthcheck program for medicaid recipients ~~of medical assistance~~, and the board shall be eligible for reimbursement from the ~~state~~ department in accordance with this division for providing the services.

The department shall reimburse boards of education for healthcheck program services provided under this division at the rates paid under the ~~medical assistance~~ medicaid program to physicians, dentists, nurses, and other providers of healthcheck services.

(C) Each board of education that conducts a healthcheck program shall determine for each pupil enrolled in the schools of the district whether the pupil is a ~~medical assistance~~ medicaid recipient. The department of ~~job and family services~~ health care administration and county departments of ~~human~~ job and family services shall assist the board in making these determinations. Except as necessary to carry out the purposes of this section, all information received by a board under this division shall be confidential.

Before the first day of October of each year, each board that conducts a healthcheck program shall send the parent of each pupil who is under age eighteen and a medicaid recipient ~~of medical assistance~~ notice that the pupil will be examined under the district's healthcheck program unless the parent notifies the board that the parent denies consent for the examination. The notice shall include a form to be used by the parent to indicate that the parent denies consent. The denial shall be effective only

if the form is signed by the parent and returned to the board or the school in which the pupil is enrolled. If the parent does not return a signed form indicating denial of consent within two weeks after the date the notice is sent, the school district and the department of ~~job and family services~~ health care administration shall deem the parent to have consented to examination of the parent's child under the healthcheck program. In the case of a pupil age eighteen or older, the notice shall be given to the pupil, and the school district and the department ~~of job and family services~~ shall deem the pupil to have consented to examination unless the pupil returns the signed form indicating the pupil's denial of consent.

(D)(1) As used in this division:

(a) "Nonfederal share" means the portion of expenditures for services that is required under the ~~medical assistance~~ medicaid program to be paid for with state or local government funds.

(b) "Federal financial participation" means the portion of expenditures for services that is reimbursed under the ~~medical assistance~~ medicaid program with federal funds.

(2) At the request of a board of education, the ~~state~~ department may enter into an agreement with board under which the board provides medical services to a medicaid recipient ~~of medical assistance~~ that are reimbursable under the ~~medical assistance~~ medicaid program but not under the healthcheck program. The agreement may be for a term specified in the agreement and renewable by mutual consent of the board and the department, or may continue in force as long as agreeable to the board and the department.

The board shall use state or local funds of the district to pay the nonfederal share of expenditures for services provided under this division. Prior to entering into or renewing an

agreement and at any other time requested by the department while the agreement is in force, the board shall certify to the department in accordance with the rules adopted under division (F) of this section that it will have sufficient state or local funds to pay the nonfederal share of expenditures under this division. If the board fails to make the certification, the department shall not enter into or renew the agreement. If an agreement has been entered into, it shall be void unless the board makes the certification not later than fifteen days after receiving notice from the department that the certification is due. The board shall report to the department, in accordance with the rules, the amount of state or local funds it spends to provide services under this division.

The department shall reimburse the board the federal financial participation allowed for the board's expenditures for services under this division. The total of the nonfederal share spent by the board and the federal financial participation reimbursed by the department for a service rendered under this division shall be an amount agreed to by the board and the department, but shall not exceed the maximum reimbursable for that service under rules adopted by the director of ~~job and family services~~ health care administration under ~~Chapter 5111.~~ section 5163.15 of the Revised Code. The rules adopted under division (F) of this section shall include procedures under which the department will recover from a board overpayments and subsequent federal audit disallowances of federal financial participation reimbursed by the department.

(E) A board of education shall provide services under division (D) of this section and under its healthcheck program as provided in division (E)(1), (2), or (3) of this section:

(1) By having the services performed by physicians, dentists, and nurses employed by the board;

(2) By contracting with physicians, dentists, nurses, and other providers of services who have ~~medical assistance~~ medicaid provider agreements with the department of ~~job and family services~~ health care administration;

(3) By having some of the services performed by persons described in division (E)(1) of this section and others performed by persons described in division (E)(2) of this section.

(F) The director of ~~job and family services~~ health care administration shall adopt rules in accordance with Chapter 119. of the Revised Code governing healthcheck programs conducted under this section and services provided under division (D) of this section.

Sec. 3313.715. The board of education of a school district may request from the director of mental retardation and developmental disabilities the appropriate identification numbers for all students residing in the district who are ~~medical assistance~~ medicaid recipients ~~under Chapter 5111. of the Revised Code~~. The director shall furnish such numbers upon receipt of lists of student names furnished by the district board, in such form as the director may require.

The director of ~~job and family services~~ health care administration shall provide the director of mental retardation and developmental disabilities with the data necessary for compliance with this section.

Section 3319.321 of the Revised Code does not apply to the release of student names or other data to the director of mental retardation and developmental disabilities for the purposes of this section. Chapter 1347. of the Revised Code does not apply to information required to be kept by a school board or the departments of ~~job and family services~~ health care administration or mental retardation and developmental disabilities to the extent

necessary to comply with this section and section 3313.714 of the Revised Code. However, any such information or data shall be used only for the specific legal purposes of such boards and departments and shall not be released to any unauthorized person.

Sec. 3317.023. (A) Notwithstanding section 3317.022 of the Revised Code, the amounts required to be paid to a district under this chapter shall be adjusted by the amount of the computations made under divisions (B) to (O) of this section.

As used in this section:

(1) "Classroom teacher" means a licensed employee who provides direct instruction to pupils, excluding teachers funded from money paid to the district from federal sources; educational service personnel; and vocational and special education teachers.

(2) "Educational service personnel" shall not include such specialists funded from money paid to the district from federal sources or assigned full-time to vocational or special education students and classes and may only include those persons employed in the eight specialist areas in a pattern approved by the department of education under guidelines established by the state board of education.

(3) "Annual salary" means the annual base salary stated in the state minimum salary schedule for the performance of the teacher's regular teaching duties that the teacher earns for services rendered for the first full week of October of the fiscal year for which the adjustment is made under division (C) of this section. It shall not include any salary payments for supplemental teachers contracts.

(4) "Regular student population" means the formula ADM plus the number of students reported as enrolled in the district pursuant to division (A)(1) of section 3313.981 of the Revised

Code; minus the number of students reported under division (A)(2) of section 3317.03 of the Revised Code; minus the FTE of students reported under division (B)(6), (7), (8), (9), (10), (11), or (12) of that section who are enrolled in a vocational education class or receiving special education; and minus twenty per cent of the students enrolled concurrently in a joint vocational school district.

(5) "State share percentage" has the same meaning as in section 3317.022 of the Revised Code.

(6) "VEPD" means a school district or group of school districts designated by the department of education as being responsible for the planning for and provision of vocational education services to students within the district or group.

(7) "Lead district" means a school district, including a joint vocational school district, designated by the department as a VEPD, or designated to provide primary vocational education leadership within a VEPD composed of a group of districts.

(B) If the district employs less than one full-time equivalent classroom teacher for each twenty-five pupils in the regular student population in any school district, deduct the sum of the amounts obtained from the following computations:

(1) Divide the number of the district's full-time equivalent classroom teachers employed by one twenty-fifth;

(2) Subtract the quotient in (1) from the district's regular student population;

(3) Multiply the difference in (2) by seven hundred fifty-two dollars.

(C) If a positive amount, add one-half of the amount obtained by multiplying the number of full-time equivalent classroom teachers by:

(1) The mean annual salary of all full-time equivalent classroom teachers employed by the district at their respective training and experience levels minus;

(2) The mean annual salary of all such teachers at their respective levels in all school districts receiving payments under this section.

The number of full-time equivalent classroom teachers used in this computation shall not exceed one twenty-fifth of the district's regular student population. In calculating the district's mean salary under this division, those full-time equivalent classroom teachers with the highest training level shall be counted first, those with the next highest training level second, and so on, in descending order. Within the respective training levels, teachers with the highest years of service shall be counted first, the next highest years of service second, and so on, in descending order.

(D) This division does not apply to a school district that has entered into an agreement under division (A) of section 3313.42 of the Revised Code. Deduct the amount obtained from the following computations if the district employs fewer than five full-time equivalent educational service personnel, including elementary school art, music, and physical education teachers, counselors, librarians, visiting teachers, school social workers, and school nurses for each one thousand pupils in the regular student population:

(1) Divide the number of full-time equivalent educational service personnel employed by the district by five one-thousandths;

(2) Subtract the quotient in (1) from the district's regular student population;

(3) Multiply the difference in (2) by ninety-four dollars.

(E) If a local school district, or a city or exempted village school district to which a governing board of an educational service center provides services pursuant to section 3313.843 of the Revised Code, deduct the amount of the payment required for the reimbursement of the governing board under section 3317.11 of the Revised Code.

(F)(1) If the district is required to pay to or entitled to receive tuition from another school district under division (C)(2) or (3) of section 3313.64 or section 3313.65 of the Revised Code, or if the superintendent of public instruction is required to determine the correct amount of tuition and make a deduction or credit under section 3317.08 of the Revised Code, deduct and credit such amounts as provided in division (J) of section 3313.64 or section 3317.08 of the Revised Code.

(2) For each child for whom the district is responsible for tuition or payment under division (A)(1) of section 3317.082 or section 3323.091 of the Revised Code, deduct the amount of tuition or payment for which the district is responsible.

(G) If the district has been certified by the superintendent of public instruction under section 3313.90 of the Revised Code as not in compliance with the requirements of that section, deduct an amount equal to ten per cent of the amount computed for the district under section 3317.022 of the Revised Code.

(H) If the district has received a loan from a commercial lending institution for which payments are made by the superintendent of public instruction pursuant to division (E)(3) of section 3313.483 of the Revised Code, deduct an amount equal to such payments.

(I)(1) If the district is a party to an agreement entered into under division (D), (E), or (F) of section 3311.06 or division (B) of section 3311.24 of the Revised Code and is

obligated to make payments to another district under such an agreement, deduct an amount equal to such payments if the district school board notifies the department in writing that it wishes to have such payments deducted.

(2) If the district is entitled to receive payments from another district that has notified the department to deduct such payments under division (I)(1) of this section, add the amount of such payments.

(J) If the district is required to pay an amount of funds to a cooperative education district pursuant to a provision described by division (B)(4) of section 3311.52 or division (B)(8) of section 3311.521 of the Revised Code, deduct such amounts as provided under that provision and credit those amounts to the cooperative education district for payment to the district under division (B)(1) of section 3317.19 of the Revised Code.

(K)(1) If a district is educating a student entitled to attend school in another district pursuant to a shared education contract, compact, or cooperative education agreement other than an agreement entered into pursuant to section 3313.842 of the Revised Code, credit to that educating district on an FTE basis both of the following:

(a) An amount equal to the greater of the following:

(i) The fiscal year 2005 formula amount times the fiscal year 2005 cost of doing business factor of the school district where the student is entitled to attend school pursuant to section 3313.64 or 3313.65 of the Revised Code;

(ii) The sum of (the current formula amount times the current cost-of-doing-business factor of the school district when the student is entitled to attend school pursuant to section 3313.64 or 3313.65 of the Revised Code) plus the per pupil amount of the base funding supplements specified in divisions (C)(1) to (4) of

section 3317.012 of the Revised Code.

(b) An amount equal to the current formula amount times the state share percentage times any multiple applicable to the student pursuant to section 3317.013 or 3317.014 of the Revised Code.

(2) Deduct any amount credited pursuant to division (K)(1) of this section from amounts paid to the school district in which the student is entitled to attend school pursuant to section 3313.64 or 3313.65 of the Revised Code.

(3) If the district is required by a shared education contract, compact, or cooperative education agreement to make payments to an educational service center, deduct the amounts from payments to the district and add them to the amounts paid to the service center pursuant to section 3317.11 of the Revised Code.

(L)(1) If a district, including a joint vocational school district, is a lead district of a VEPD, credit to that district the amounts calculated for all the school districts within that VEPD pursuant to division (E)(2) of section 3317.022 of the Revised Code.

(2) Deduct from each appropriate district that is not a lead district, the amount attributable to that district that is credited to a lead district under division (L)(1) of this section.

(M) If the department pays a joint vocational school district under division (G)(4) of section 3317.16 of the Revised Code for excess costs of providing special education and related services to a handicapped student, as calculated under division (G)(2) of that section, the department shall deduct the amount of that payment from the city, local, or exempted village school district that is responsible as specified in that section for the excess costs.

(N)(1) If the district reports an amount of excess cost for

special education services for a child under division (C) of section 3323.14 of the Revised Code, the department shall pay that amount to the district.

(2) If the district reports an amount of excess cost for special education services for a child under division (C) of section 3323.14 of the Revised Code, the department shall deduct that amount from the district of residence of that child.

(O) If the department of ~~job and family services~~ health care administration presents to the department of education a payment request through an intrastate transfer voucher for the nonfederal share of reimbursements made to a school district for medicaid services provided by the district, the department of education shall pay the amount of that request to the department of ~~job and family services~~ health care administration and shall deduct the amount of that payment from the district.

Sec. 3323.021. As used in this section, "participating county MR/DD board" means a county board of mental retardation and developmental disabilities electing to participate in the provision of or contracting for educational services for children under division (D) of section 5126.05 of the Revised Code.

(A) When a school district, educational service center, or participating county MR/DD board enters into an agreement or contract with another school district, educational service center, or participating county MR/DD board to provide educational services to a disabled child during a school year, both of the following shall apply:

(1) Beginning with fiscal year 1999, if the provider of the services intends to increase the amount it charges for some or all of those services during the next school year or if the provider intends to cease offering all or part of those services during the next school year, the provider shall notify the entity for which

the services are provided of these intended changes no later ~~that~~ than the first day of March of the current fiscal year.

(2) Beginning with fiscal year 1999, if the entity for which services are provided intends to cease obtaining those services from the provider for the next school year or intends to change the type or amount of services it obtains from the provider for the next school year, the entity shall notify the service provider of these intended changes no later than the first day of March of the current fiscal year.

(B) School districts, educational service centers, participating county MR/DD boards, and other applicable governmental entities shall collaborate where possible to maximize federal sources of revenue to provide additional funds for special education related services for disabled children. Annually, each school district shall report to the department of education any amounts of money the district received through ~~such medical assistance~~ the medicaid program.

(C) The state board of education, the department of mental retardation and developmental disabilities, and the department of ~~job and family services~~ health care administration shall develop working agreements for pursuing additional funds for services for disabled children.

Sec. 3599.45. (A) No candidate for the office of attorney general or county prosecutor or such a candidate's campaign committee shall knowingly accept any contribution from a provider of services or goods under contract with the department of ~~job and family services~~ health care administration pursuant to the medicaid program ~~of Title XIX of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C. 301, as amended,~~ or from any person having an ownership interest in the provider.

As used in this section "candidate," "campaign committee,"

and "contribution" have the same meaning as in section 3517.01 of the Revised Code.

(B) Whoever violates this section is guilty of a misdemeanor of the first degree.

Sec. 3701.023. (A) The department of health shall review applications for eligibility for the program for medically handicapped children that are submitted to the department by city and general health districts and physician providers approved in accordance with division (C) of this section. The department shall determine whether the applicants meet the medical and financial eligibility requirements established by the public health council pursuant to division (A)(1) of section 3701.021 of the Revised Code, and by the department in the manual of operational procedures and guidelines for the program for medically handicapped children developed pursuant to division (B) of that section. Referrals of potentially eligible children for the program may be submitted to the department on behalf of the child by parents, guardians, public health nurses, or any other interested person. The department of health may designate other agencies to refer applicants to the department of health.

(B) In accordance with the procedures established in rules adopted under division (A)(4) of section 3701.021 of the Revised Code, the department of health shall authorize a provider or providers to provide to any Ohio resident under twenty-one years of age, without charge to the resident or the resident's family and without restriction as to the economic status of the resident or the resident's family, diagnostic services necessary to determine whether the resident has a medically handicapping or potentially medically handicapping condition.

(C) The department of health shall review the applications of health professionals, hospitals, medical equipment suppliers, and

other individuals, groups, or agencies that apply to become providers. The department shall enter into a written agreement with each applicant who is determined, pursuant to the requirements set forth in rules adopted under division (A)(2) of section 3701.021 of the Revised Code, to be eligible to be a provider in accordance with the provider agreement required by the ~~medical assistance~~ medicaid program ~~established under section 5111.01 of the Revised Code~~. No provider shall charge a medically handicapped child or the child's parent or guardian for services authorized by the department under division (B) or (D) of this section.

The department, in accordance with rules adopted under division (A)(3) of section 3701.021 of the Revised Code, may disqualify any provider from further participation in the program for violating any requirement set forth in rules adopted under division (A)(2) of that section. The disqualification shall not take effect until a written notice, specifying the requirement violated and describing the nature of the violation, has been delivered to the provider and the department has afforded the provider an opportunity to appeal the disqualification under division (H) of this section.

(D) The department of health shall evaluate applications from city and general health districts and approved physician providers for authorization to provide treatment services, service coordination, and related goods to children determined to be eligible for the program for medically handicapped children pursuant to division (A) of this section. The department shall authorize necessary treatment services, service coordination, and related goods for each eligible child in accordance with an individual plan of treatment for the child. As an alternative, the department may authorize payment of health insurance premiums on behalf of eligible children when the department determines, in

accordance with criteria set forth in rules adopted under division (A)(9) of section 3701.021 of the Revised Code, that payment of the premiums is cost-effective.

(E) The department of health shall pay, from appropriations to the department, any necessary expenses, including but not limited to, expenses for diagnosis, treatment, service coordination, supportive services, transportation, and accessories and their upkeep, provided to medically handicapped children, provided that the provision of the goods or services is authorized by the department under division (B) or (D) of this section. Money appropriated to the department of health may also be expended for reasonable administrative costs incurred by the program. The department of health also may purchase liability insurance covering the provision of services under the program for medically handicapped children by physicians and other health care professionals.

Payments made to providers by the department of health pursuant to this division for inpatient hospital care, outpatient care, and all other medical assistance furnished to eligible recipients shall be made in accordance with rules adopted by the public health council pursuant to division (A) of section 3701.021 of the Revised Code.

The departments of health and ~~job and family services~~ health care administration shall jointly implement procedures to ensure that duplicate payments are not made under the program for medically handicapped children and the ~~medical assistance~~ medicaid program ~~established under section 5111.01 of the Revised Code~~ and to identify and recover duplicate payments.

(F) At the time of applying for participation in the program for medically handicapped children, a medically handicapped child or the child's parent or guardian shall disclose the identity of any third party against whom the child or the child's parent or

guardian has or may have a right of recovery for goods and services provided under division (B) or (D) of this section. The department of health shall require a medically handicapped child who receives services from the program or the child's parent or guardian to apply for all third-party benefits for which the child may be eligible and require the child, parent, or guardian to apply all third-party benefits received to the amount determined under division (E) of this section as the amount payable for goods and services authorized under division (B) or (D) of this section. The department is the payer of last resort and shall pay for authorized goods or services, up to the amount determined under division (E) of this section for the authorized goods or services, only to the extent that payment for the authorized goods or services is not made through third-party benefits. When a third party fails to act on an application or claim for benefits by a medically handicapped child or the child's parent or guardian, the department shall pay for the goods or services only after ninety days have elapsed since the date the child, parents, or guardians made an application or claim for all third-party benefits. Third-party benefits received shall be applied to the amount determined under division (E) of this section. Third-party payments for goods and services not authorized under division (B) or (D) of this section shall not be applied to payment amounts determined under division (E) of this section. Payment made by the department shall be considered payment in full of the amount determined under division (E) of this section. Medicaid payments for persons eligible for the ~~medical assistance~~ medicaid program ~~established under section 5111.01 of the Revised Code~~ shall be considered payment in full of the amount determined under division (E) of this section.

(G) The department of health shall administer a program to provide services to Ohio residents who are twenty-one or more years of age who have cystic fibrosis and who meet the eligibility

requirements established by the rules of the public health council pursuant to division (A)(7) of section 3701.021 of the Revised Code, subject to all provisions of this section, but not subject to section 3701.024 of the Revised Code.

(H) The department of health shall provide for appeals, in accordance with rules adopted under section 3701.021 of the Revised Code, of denials of applications for the program for medically handicapped children under division (A) or (D) of this section, disqualification of providers, or amounts paid under division (E) of this section. Appeals under this division are not subject to Chapter 119. of the Revised Code.

The department may designate ombudspersons to assist medically handicapped children or their parents or guardians, upon the request of the children, parents, or guardians, in filing appeals under this division and to serve as children's, parents', or guardians' advocates in matters pertaining to the administration of the program for medically handicapped children and eligibility for program services. The ombudspersons shall receive no compensation but shall be reimbursed by the department, in accordance with rules of the office of budget and management, for their actual and necessary travel expenses incurred in the performance of their duties.

(I) The department of health, and city and general health districts providing service coordination pursuant to division (A)(2) of section 3701.024 of the Revised Code, shall provide service coordination in accordance with the standards set forth in the rules adopted under section 3701.021 of the Revised Code, without charge, and without restriction as to economic status.

Sec. 3701.024. (A)(1) Under a procedure established in rules adopted under section 3701.021 of the Revised Code, the department of health shall determine the amount each county shall provide

annually for the program for medically handicapped children, based on a proportion of the county's total general property tax duplicate, not to exceed one-tenth of a mill, and charge the county for any part of expenses incurred under the program for treatment services on behalf of medically handicapped children having legal settlement in the county that is not paid from federal funds or through the ~~medical assistance~~ medicaid program ~~established under section 5111.01 of the Revised Code~~. The department shall not charge the county for expenses exceeding the difference between the amount determined under division (A)(1) of this section and any amounts retained under divisions (A)(2) and (3) of this section.

All amounts collected by the department under division (A)(1) of this section shall be deposited into the state treasury to the credit of the medically handicapped children-county assessment fund, which is hereby created. The fund shall be used by the department to comply with sections 3701.021 to 3701.028 of the Revised Code.

(2) The department, in accordance with rules adopted under section 3701.021 of the Revised Code, may allow each county to retain up to ten per cent of the amount determined under division (A)(1) of this section to provide funds to city or general health districts of the county with which the districts shall provide service coordination, public health nursing, or transportation services for medically handicapped children.

(3) In addition to any amount retained under division (A)(2) of this section, the department, in accordance with rules adopted under section 3701.021 of the Revised Code, may allow counties that it determines have significant numbers of potentially eligible medically handicapped children to retain an amount equal to the difference between:

(a) Twenty-five per cent of the amount determined under

division (A)(1) of this section;

(b) Any amount retained under division (A)(2) of this section.

Counties shall use amounts retained under division (A)(3) of this section to provide funds to city or general health districts of the county with which the districts shall conduct outreach activities to increase participation in the program for medically handicapped children.

(4) Prior to any increase in the millage charged to a county, the public health council shall hold a public hearing on the proposed increase and shall give notice of the hearing to each board of county commissioners that would be affected by the increase at least thirty days prior to the date set for the hearing. Any county commissioner may appear and give testimony at the hearing. Any increase in the millage any county is required to provide for the program for medically handicapped children shall be determined, and notice of the amount of the increase shall be provided to each affected board of county commissioners, no later than the first day of June of the fiscal year next preceding the fiscal year in which the increase will take effect.

(B) Each board of county commissioners shall establish a medically handicapped children's fund and shall appropriate thereto an amount, determined in accordance with division (A)(1) of this section, for the county's share in providing medical, surgical, and other aid to medically handicapped children residing in such county and for the purposes specified in divisions (A)(2) and (3) of this section. Each county shall use money retained under divisions (A)(2) and (3) of this section only for the purposes specified in those divisions.

Sec. 3701.027. The department of health shall administer funds received from the "Maternal and Child Health Block Grant,"

Title V of the "Social Security Act," 95 Stat. 818 (1981), 42 U.S.C.A. 701, as amended, for programs including the program for medically handicapped children, and to provide technical assistance and consultation to city and general health districts and local health planning organizations in implementing local, community-based, family-centered, coordinated systems of care for medically handicapped children. The department may make grants to persons and other entities for the provision of services with the funds. In addition, the department may use the funds to purchase liability insurance covering the provision of services under the programs by physicians and other health care professionals, and to pay health insurance premiums on behalf of medically handicapped children participating in the program for medically handicapped children when the department determines, in accordance with criteria set forth in rules adopted under division (A)(9) of section 3701.021 of the Revised Code, that payment of the premiums is cost effective.

In determining eligibility for services provided with funds received from the "Maternal and Child Health Block Grant," the department may use the application form established under section ~~5111.013~~ 5162.15 of the Revised Code. The department may require applicants to furnish their social security numbers.

Sec. 3701.043. If authorized by federal statute or regulation, the director of health may establish and collect fees for conducting the initial certification of any person or entity as a provider of health services for purposes 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~~. The fee established for conducting an initial medicare certification shall not exceed the actual and necessary costs incurred by the department of health in conducting the certification.

All fees collected under this section shall be deposited into the state treasury to the credit of the medicare initial certification fund, which is hereby created. Money credited to the fund shall be used solely to pay the costs of conducting initial medicare certifications.

Sec. 3701.132. The department of health is hereby designated as the state agency to administer the "special supplemental nutrition program for women, infants, and children" established under the "Child Nutrition Act of 1966," 80 Stat. 885, 42 U.S.C. 1786, as amended. The public health council may adopt rules pursuant to Chapter 119. of the Revised Code as necessary for administering the program. The rules may include civil money penalties for violations of the rules.

In determining eligibility for services provided under the program, the department may use the application form established under section ~~5111.013~~ 5162.15 of the Revised Code for the healthy start program. The department may require applicants to furnish their social security numbers.

If the department determines that a vendor has committed an act with respect to the program that federal statutes or regulations or state statutes or rules prohibit, the department shall take action against the vendor in the manner required by 7 C.F.R. part 246, including imposition of a civil money penalty in accordance with 7 C.F.R. 246.12, or rules adopted under this section.

Sec. 3701.243. (A) Except as provided in this section or section 3701.248 of the Revised Code, no person or agency of state or local government that acquires the information while providing any health care service or while in the employ of a health care facility or health care provider shall disclose or compel another

to disclose any of the following:

(1) The identity of any individual on whom an HIV test is performed;

(2) The results of an HIV test in a form that identifies the individual tested;

(3) The identity of any individual diagnosed as having AIDS or an AIDS-related condition.

(B)(1) Except as provided in divisions (B)(2), (C), (D), and (F) of this section, the results of an HIV test or the identity of an individual on whom an HIV test is performed or who is diagnosed as having AIDS or an AIDS-related condition may be disclosed only to the following:

(a) The individual who was tested or the individual's legal guardian, and the individual's spouse or any sexual partner;

(b) A person to whom disclosure is authorized by a written release, executed by the individual tested or by the individual's legal guardian and specifying to whom disclosure of the test results or diagnosis is authorized and the time period during which the release is to be effective;

(c) The individual's physician;

(d) The department of health or a health commissioner to which reports are made under section 3701.24 of the Revised Code;

(e) A health care facility or provider that procures, processes, distributes, or uses a human body part from a deceased individual, donated for a purpose specified in Chapter 2108. of the Revised Code, and that needs medical information about the deceased individual to ensure that the body part is medically acceptable for its intended purpose;

(f) Health care facility staff committees or accreditation or oversight review organizations conducting program monitoring,

program evaluation, or service reviews;

(g) A health care provider, emergency medical services worker, or peace officer who sustained a significant exposure to the body fluids of another individual, if that individual was tested pursuant to division (E)(6) of section 3701.242 of the Revised Code, except that the identity of the individual tested shall not be revealed;

(h) To law enforcement authorities pursuant to a search warrant or a subpoena issued by or at the request of a grand jury, a prosecuting attorney, a city director of law or similar chief legal officer of a municipal corporation, or a village solicitor, in connection with a criminal investigation or prosecution.

(2) The results of an HIV test or a diagnosis of AIDS or an AIDS-related condition may be disclosed to a health care provider, or an authorized agent or employee of a health care facility or a health care provider, if the provider, agent, or employee has a medical need to know the information and is participating in the diagnosis, care, or treatment of the individual on whom the test was performed or who has been diagnosed as having AIDS or an AIDS-related condition.

This division does not impose a standard of disclosure different from the standard for disclosure of all other specific information about a patient to health care providers and facilities. Disclosure may not be requested or made solely for the purpose of identifying an individual who has a positive HIV test result or has been diagnosed as having AIDS or an AIDS-related condition in order to refuse to treat the individual. Referral of an individual to another health care provider or facility based on reasonable professional judgment does not constitute refusal to treat the individual.

(3) Not later than ninety days after November 1, 1989, each

health care facility in this state shall establish a protocol to be followed by employees and individuals affiliated with the facility in making disclosures authorized by division (B)(2) of this section. A person employed by or affiliated with a health care facility who determines in accordance with the protocol established by the facility that a disclosure is authorized by division (B)(2) of this section is immune from liability to any person in a civil action for damages for injury, death, or loss to person or property resulting from the disclosure.

(C)(1) Any person or government agency may seek access to or authority to disclose the HIV test records of an individual in accordance with the following provisions:

(a) The person or government agency shall bring an action in a court of common pleas requesting disclosure of or authority to disclose the results of an HIV test of a specific individual, who shall be identified in the complaint by a pseudonym but whose name shall be communicated to the court confidentially, pursuant to a court order restricting the use of the name. The court shall provide the individual with notice and an opportunity to participate in the proceedings if the individual is not named as a party. Proceedings shall be conducted in chambers unless the individual agrees to a hearing in open court.

(b) The court may issue an order granting the plaintiff access to or authority to disclose the test results only if the court finds by clear and convincing evidence that the plaintiff has demonstrated a compelling need for disclosure of the information that cannot be accommodated by other means. In assessing compelling need, the court shall weigh the need for disclosure against the privacy right of the individual tested and against any disservice to the public interest that might result from the disclosure, such as discrimination against the individual or the deterrence of others from being tested.

(c) If the court issues an order, it shall guard against unauthorized disclosure by specifying the persons who may have access to the information, the purposes for which the information shall be used, and prohibitions against future disclosure.

(2) A person or government agency that considers it necessary to disclose the results of an HIV test of a specific individual in an action in which it is a party may seek authority for the disclosure by filing an in camera motion with the court in which the action is being heard. In hearing the motion, the court shall employ procedures for confidentiality similar to those specified in division (C)(1) of this section. The court shall grant the motion only if it finds by clear and convincing evidence that a compelling need for the disclosure has been demonstrated.

(3) Except for an order issued in a criminal prosecution or an order under division (C)(1) or (2) of this section granting disclosure of the result of an HIV test of a specific individual, a court shall not compel a blood bank, hospital blood center, or blood collection facility to disclose the result of HIV tests performed on the blood of voluntary donors in a way that reveals the identity of any donor.

(4) In a civil action in which the plaintiff seeks to recover damages from an individual defendant based on an allegation that the plaintiff contracted the HIV virus as a result of actions of the defendant, the prohibitions against disclosure in this section do not bar discovery of the results of any HIV test given to the defendant or any diagnosis that the defendant suffers from AIDS or an AIDS-related condition.

(D) The results of an HIV test or the identity of an individual on whom an HIV test is performed or who is diagnosed as having AIDS or an AIDS-related condition may be disclosed to a federal, state, or local government agency, or the official representative of such an agency, for purposes of the ~~medical~~

~~assistance~~ medicaid program ~~established under section 5111.01 of the Revised Code~~, 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 any other public assistance program.

(E) Any disclosure pursuant to this section shall be in writing and accompanied by a written statement that includes the following or substantially similar language: "This information has been disclosed to you from confidential records protected from disclosure by state law. You shall make no further disclosure of this information without the specific, written, and informed release of the individual to whom it pertains, or as otherwise permitted by state law. A general authorization for the release of medical or other information is not sufficient for the purpose of the release of HIV test results or diagnoses."

(F) An individual who knows that the individual has received a positive result on an HIV test or has been diagnosed as having AIDS or an AIDS-related condition shall disclose this information to any other person with whom the individual intends to make common use of a hypodermic needle or engage in sexual conduct as defined in section 2907.01 of the Revised Code. An individual's compliance with this division does not prohibit a prosecution of the individual for a violation of division (B) of section 2903.11 of the Revised Code.

(G) Nothing in this section prohibits the introduction of evidence concerning an HIV test of a specific individual in a criminal proceeding.

Sec. 3701.507. (A) To assist in implementing sections 3701.503 to 3701.509 of the Revised Code, the medically handicapped children's medical advisory council created in section 3701.025 of the Revised Code shall appoint a permanent infant hearing screening subcommittee. The subcommittee shall consist of

the following members:

(1) One otolaryngologist;

(2) One neonatologist;

(3) One pediatrician;

(4) One neurologist;

(5) One hospital administrator;

(6) Two or more audiologists who are experienced in infant hearing screening and evaluation;

(7) One speech-language pathologist licensed under section 4753.07 of the Revised Code;

(8) Two persons who are each a parent of a hearing-impaired child;

(9) One geneticist;

(10) One epidemiologist;

(11) One adult who is deaf or hearing impaired;

(12) One representative from an organization for the deaf or hearing impaired;

(13) One family advocate;

(14) One nurse from a well-baby neonatal nursery;

(15) One nurse from a special care neonatal nursery;

(16) One teacher of the deaf who works with infants and toddlers;

(17) One representative of the health insurance industry;

(18) One representative of the bureau for children with medical handicaps;

(19) One representative of the department of education;

(20) One representative of the ~~Ohio~~ department of ~~job and~~

~~family services who has responsibilities regarding medicaid~~ health care administration;

(21) Any other person the advisory council appoints.

(B) The infant hearing subcommittee shall:

(1) Consult with the director of health regarding the administration of sections 3701.503 to 3701.509 of the Revised Code;

(2) Advise and make recommendations regarding proposed rules prior to their adoption by the public health council under section 3701.508 of the Revised Code;

(3) Consult with the director of health and advise and make recommendations regarding program development and implementation under sections 3701.503 to 3701.509 of the Revised Code, including all of the following:

(a) Establishment under section 3701.504 of the Revised Code of the statewide hearing screening, tracking, and early intervention program to identify newborn and infant hearing impairment;

(b) Identification of locations where hearing evaluations may be conducted;

(c) Recommendations for methods and techniques of hearing screening and hearing evaluation;

(d) Referral, data recording and compilation, and procedures to encourage follow-up hearing care;

(e) Maintenance of a register of newborns and infants who do not pass the hearing screening;

(f) Preparation of the information required by section 3701.506 of the Revised Code and any other information the public health council requires the department of health to provide.

Sec. 3701.74. (A) As used in this section and section 3701.741 of the Revised Code:

(1) "Ambulatory care facility" means a facility that provides medical, diagnostic, or surgical treatment to patients who do not require hospitalization, including a dialysis center, ambulatory surgical facility, cardiac catheterization facility, diagnostic imaging center, extracorporeal shock wave lithotripsy center, home health agency, inpatient hospice, birthing center, radiation therapy center, emergency facility, and an urgent care center. "Ambulatory care facility" does not include the private office of a physician or dentist, whether the office is for an individual or group practice.

(2) "Chiropractor" means an individual licensed under Chapter 4734. of the Revised Code to practice chiropractic.

(3) "Emergency facility" means a hospital emergency department or any other facility that provides emergency medical services.

(4) "Health care practitioner" means all of the following:

(a) A dentist or dental hygienist licensed under Chapter 4715. of the Revised Code;

(b) A registered or licensed practical nurse licensed under Chapter 4723. of the Revised Code;

(c) An optometrist licensed under Chapter 4725. of the Revised Code;

(d) A dispensing optician, spectacle dispensing optician, contact lens dispensing optician, or spectacle-contact lens dispensing optician licensed under Chapter 4725. of the Revised Code;

(e) A pharmacist licensed under Chapter 4729. of the Revised Code;

(f) A physician;

(g) A physician assistant authorized under Chapter 4730. of the Revised Code to practice as a physician assistant;

(h) A practitioner of a limited branch of medicine issued a certificate under Chapter 4731. of the Revised Code;

(i) A psychologist licensed under Chapter 4732. of the Revised Code;

(j) A chiropractor;

(k) A hearing aid dealer or fitter licensed under Chapter 4747. of the Revised Code;

(l) A speech-language pathologist or audiologist licensed under Chapter 4753. of the Revised Code;

(m) An occupational therapist or occupational therapy assistant licensed under Chapter 4755. of the Revised Code;

(n) A physical therapist or physical therapy assistant licensed under Chapter 4755. of the Revised Code;

(o) A professional clinical counselor, professional counselor, social worker, or independent social worker licensed, or a social work assistant registered, under Chapter 4757. of the Revised Code;

(p) A dietitian licensed under Chapter 4759. of the Revised Code;

(q) A respiratory care professional licensed under Chapter 4761. of the Revised Code;

(r) An emergency medical technician-basic, emergency medical technician-intermediate, or emergency medical technician-paramedic certified under Chapter 4765. of the Revised Code.

(5) "Health care provider" means a hospital, ambulatory care facility, long-term care facility, pharmacy, emergency facility,

or health care practitioner.

(6) "Hospital" has the same meaning as in section 3727.01 of the Revised Code.

(7) "Long-term care facility" means a nursing home, residential care facility, or home for the aging, as those terms are defined in section 3721.01 of the Revised Code; an adult care facility, as defined in section 3722.01 of the Revised Code; a nursing facility or intermediate care facility for the mentally retarded, as those terms are defined in section ~~5111.20~~ 5164.01 of the Revised Code; a facility or portion of a facility certified as a skilled nursing facility under ~~Title XVIII of~~ the ~~"Social Security Act," 49 Stat. 286 (1965), 42 U.S.C.A. 1395, as amended~~ medicare program.

(8) "Medical record" means data in any form that pertains to a patient's medical history, diagnosis, prognosis, or medical condition and that is generated and maintained by a health care provider in the process of the patient's health care treatment.

(9) "Medical records company" means a person who stores, locates, or copies medical records for a health care provider, or is compensated for doing so by a health care provider, and charges a fee for providing medical records to a patient or patient's representative.

(10) "Patient" means either of the following:

(a) An individual who received health care treatment from a health care provider;

(b) A guardian, as defined in section 1337.11 of the Revised Code, of an individual described in division (A)(10)(a) of this section.

(11) "Patient's personal representative" means a minor patient's parent or other person acting in loco parentis, a

court-appointed guardian, or a person with durable power of attorney for health care for a patient, the executor or administrator of the patient's estate, or the person responsible for the patient's estate if it is not to be probated. "Patient's personal representative" does not include an insurer authorized under Title XXXIX of the Revised Code to do the business of sickness and accident insurance in this state, a health insuring corporation holding a certificate of authority under Chapter 1751. of the Revised Code, or any other person not named in this division.

(12) "Pharmacy" has the same meaning as in section 4729.01 of the Revised Code.

(13) "Physician" means a person authorized under Chapter 4731. of the Revised Code to practice medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery.

(14) "Authorized person" means a person to whom a patient has given written authorization to act on the patient's behalf regarding the patient's medical record.

(B) A patient, a patient's personal representative or an authorized person who wishes to examine or obtain a copy of part or all of a medical record shall submit to the health care provider a written request signed by the patient, personal representative, or authorized person dated not more than sixty days before the date on which it is submitted. The request shall indicate whether the copy is to be sent to the requestor, physician or chiropractor, ~~,~~ or held for the requestor at the office of the health care provider. Within a reasonable time after receiving a request that meets the requirements of this division and includes sufficient information to identify the record requested, a health care provider that has the patient's medical records shall permit the patient to examine the record during

regular business hours without charge or, on request, shall provide a copy of the record in accordance with section 3701.741 of the Revised Code, except that if a physician or chiropractor who has treated the patient determines for clearly stated treatment reasons that disclosure of the requested record is likely to have an adverse effect on the patient, the health care provider shall provide the record to a physician or chiropractor designated by the patient. The health care provider shall take reasonable steps to establish the identity of the person making the request to examine or obtain a copy of the patient's record.

(C) If a health care provider fails to furnish a medical record as required by division (B) of this section, the patient, personal representative, or authorized person who requested the record may bring a civil action to enforce the patient's right of access to the record.

(D)(1) This section does not apply to medical records whose release is covered by section 173.20 or 3721.13 of the Revised Code, by Chapter 1347. or 5122. of the Revised Code, by 42 C.F.R. part 2, "Confidentiality of Alcohol and Drug Abuse Patient Records," or by 42 C.F.R. 483.10.

(2) Nothing in this section is intended to supersede the confidentiality provisions of sections 2305.24, 2305.25, 2305.251, and 2305.252 of the Revised Code.

Sec. 3701.741. (A) Through December 31, 2008, each health care provider and medical records company shall provide copies of medical records in accordance with this section.

(B) Except as provided in divisions (C) and (E) of this section, a health care provider or medical records company that receives a request for a copy of a patient's medical record shall charge not more than the amounts set forth in this section.

(1) If the request is made by the patient or the patient's personal representative, total costs for copies and all services related to those copies shall not exceed the sum of the following:

(a) With respect to data recorded on paper, the following amounts:

(i) Two dollars and fifty cents per page for the first ten pages;

(ii) Fifty-one cents per page for pages eleven through fifty;

(iii) Twenty cents per page for pages fifty-one and higher;

(b) With respect to data recorded other than on paper, one dollar and seventy cents per page;

(c) The actual cost of any related postage incurred by the health care provider or medical records company.

(2) If the request is made other than by the patient or the patient's personal representative, total costs for copies and all services related to those copies shall not exceed the sum of the following:

(a) An initial fee of fifteen dollars and thirty-five cents, which shall compensate for the records search;

(b) With respect to data recorded on paper, the following amounts:

(i) One dollar and two cents per page for the first ten pages;

(ii) Fifty-one cents per page for pages eleven through fifty;

(iii) Twenty cents per page for pages fifty-one and higher.

(c) With respect to data recorded other than on paper, one dollar and seventy cents per page;

(d) The actual cost of any related postage incurred by the health care provider or medical records company.

(C)(1) A health care provider or medical records company shall provide one copy without charge to the following:

(a) The bureau of workers' compensation, in accordance with Chapters 4121. and 4123. of the Revised Code and the rules adopted under those chapters;

(b) The industrial commission, in accordance with Chapters 4121. and 4123. of the Revised Code and the rules adopted under those chapters;

(c) The department of job and family services, in accordance with Chapter 5101. of the Revised Code and the rules adopted under those chapters;

(d) The attorney general, in accordance with sections 2743.51 to 2743.72 of the Revised Code and any rules that may be adopted under those sections;

(e) A patient or patient's personal representative if the medical record is necessary to support a claim under Title II ~~or Title XVI~~ of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 401 ~~and 1381~~, as amended, or the supplemental security income program and the request is accompanied by documentation that a claim has been filed.

(2) Nothing in division (C)(1) of this section requires a health care provider or medical records company to provide a copy without charge to any person or entity not listed in division (C)(1) of this section.

(D) Division (C) of this section shall not be construed to supersede any rule of the bureau of workers' compensation, the industrial commission, or the department of job and family services.

(E) A health care provider or medical records company may enter into a contract with either of the following for the copying

of medical records at a fee other than as provided in division (B) of this section:

(1) A patient, a patient's personal representative, or an authorized person;

(2) An insurer authorized under Title XXXIX of the Revised Code to do the business of sickness and accident insurance in this state or health insuring corporations holding a certificate of authority under Chapter 1751. of the Revised Code.

(F) This section does not apply to medical records the copying of which is covered by section 173.20 of the Revised Code or by 42 C.F.R. 483.10.

Sec. 3701.881. (A) As used in this section:

(1) "Applicant" means both of the following:

(a) A person who is under final consideration for appointment to or employment with a home health agency in a position as a person responsible for the care, custody, or control of a child;

(b) A person who is under final consideration for employment with a home health agency in a full-time, part-time, or temporary position that involves providing direct care to an older adult. With regard to persons providing direct care to older adults, "applicant" does not include a person who provides direct care as a volunteer without receiving or expecting to receive any form of remuneration other than reimbursement for actual expenses.

(2) "Criminal records check" and "older adult" have the same meanings as in section 109.572 of the Revised Code.

(3) "Home health agency" means a person or government entity, other than a nursing home, residential care facility, or hospice care program, that has the primary function of providing any of the following services to a patient at a place of residence used as the patient's home:

(a) Skilled nursing care;

(b) Physical therapy;

(c) Speech-language pathology;

(d) Occupational therapy;

(e) Medical social services;

(f) Home health aide services.

(4) "Home health aide services" means any of the following services provided by an individual employed with or contracted for by a home health agency:

(a) Hands-on bathing or assistance with a tub bath or shower;

(b) Assistance with dressing, ambulation, and toileting;

(c) Catheter care but not insertion;

(d) Meal preparation and feeding.

(5) "Hospice care program" has the same meaning as in section 3712.01 of the Revised Code.

(6) "Medical social services" means services provided by a social worker under the direction of a patient's attending physician.

(7) "Minor drug possession offense" has the same meaning as in section 2925.01 of the Revised Code.

(8) "Nursing home," "residential care facility," and "skilled nursing care" have the same meanings as in section 3721.01 of the Revised Code.

(9) "Occupational therapy" has the same meaning as in section 4755.04 of the Revised Code.

(10) "Physical therapy" has the same meaning as in section 4755.40 of the Revised Code.

(11) "Social worker" means a person licensed under Chapter

4757. of the Revised Code to practice as a social worker or independent social worker.

(12) "Speech-language pathology" has the same meaning as in section 4753.01 of the Revised Code.

(B)(1) Except as provided in division (I) of this section, the chief administrator of a home health agency shall request the superintendent of the bureau of criminal identification and investigation to conduct a criminal records check with respect to each applicant. If the position may involve both responsibility for the care, custody, or control of a child and provision of direct care to an older adult, the chief administrator shall request that the superintendent conduct a single criminal records check for the applicant. If an applicant for whom a criminal records check request is required under this division does not present proof of having been a resident of this state for the five-year period immediately prior to the date upon which the criminal records check is requested or does not provide evidence that within that five-year period the superintendent has requested information about the applicant from the federal bureau of investigation in a criminal records check, the chief administrator shall request that the superintendent obtain information from the federal bureau of investigation as a part of the criminal records check for the applicant. Even if an applicant for whom a criminal records check request is required under this division presents proof that the applicant has been a resident of this state for that five-year period, the chief administrator may request that the superintendent include information from the federal bureau of investigation in the criminal records check.

(2) Any person required by division (B)(1) of this section to request a criminal records check shall provide to each applicant for whom a criminal records check request is required under that division a copy of the form prescribed pursuant to division (C)(1)

of section 109.572 of the Revised Code and a standard impression sheet prescribed pursuant to division (C)(2) of section 109.572 of the Revised Code, obtain the completed form and impression sheet from each applicant, and forward the completed form and impression sheet to the superintendent of the bureau of criminal identification and investigation at the time the chief administrator requests a criminal records check pursuant to division (B)(1) of this section.

(3) An applicant who receives pursuant to division (B)(2) of this section a copy of the form prescribed pursuant to division (C)(1) of section 109.572 of the Revised Code and a copy of an impression sheet prescribed pursuant to division (C)(2) of that section and who is requested to complete the form and provide a set of fingerprint impressions shall complete the form or provide all the information necessary to complete the form and shall provide the impression sheets with the impressions of the applicant's fingerprints. If an applicant, upon request, fails to provide the information necessary to complete the form or fails to provide fingerprint impressions, the home health agency shall not employ that applicant for any position for which a criminal records check is required by division (B)(1) of this section.

(C)(1) Except as provided in rules adopted by the department of health in accordance with division (F) of this section and subject to division (C)(3) of this section, no home health agency shall employ a person as a person responsible for the care, custody, or control of a child if the person previously has been convicted of or pleaded guilty to any of the following:

(a) A violation of section 2903.01, 2903.02, 2903.03, 2903.04, 2903.11, 2903.12, 2903.13, 2903.16, 2903.21, 2903.34, 2905.01, 2905.02, 2905.05, 2907.02, 2907.03, 2907.04, 2907.05, 2907.06, 2907.07, 2907.08, 2907.09, 2907.21, 2907.22, 2907.23, 2907.25, 2907.31, 2907.32, 2907.321, 2907.322, 2907.323, 2911.01,

2911.02, 2911.11, 2911.12, 2919.12, 2919.22, 2919.24, 2919.25, 2923.12, 2923.13, 2923.161, 2925.02, 2925.03, 2925.04, 2925.05, 2925.06, or 3716.11 of the Revised Code, a violation of section 2905.04 of the Revised Code as it existed prior to July 1, 1996, a violation of section 2919.23 of the Revised Code that would have been a violation of section 2905.04 of the Revised Code as it existed prior to July 1, 1996, had the violation been committed prior to that date, a violation of section 2925.11 of the Revised Code that is not a minor drug possession offense, or felonious sexual penetration in violation of former section 2907.12 of the Revised Code;

(b) A violation of an existing or former law of this state, any other state, or the United States that is substantially equivalent to any of the offenses listed in division (C)(1)(a) of this section.

(2) Except as provided in rules adopted by the department of health in accordance with division (F) of this section and subject to division (C)(3) of this section, no home health agency shall employ a person in a position that involves providing direct care to an older adult if the person previously has been convicted of or pleaded guilty to any of the following:

(a) A violation of section 2903.01, 2903.02, 2903.03, 2903.04, 2903.11, 2903.12, 2903.13, 2903.16, 2903.21, 2903.34, 2905.01, 2905.02, 2905.11, 2905.12, 2907.02, 2907.03, 2907.05, 2907.06, 2907.07, 2907.08, 2907.09, 2907.12, 2907.25, 2907.31, 2907.32, 2907.321, 2907.322, 2907.323, 2911.01, 2911.02, 2911.11, 2911.12, 2911.13, 2913.02, 2913.03, 2913.04, 2913.11, 2913.21, 2913.31, 2913.40, 2913.43, 2913.47, 2913.51, 2919.25, 2921.36, 2923.12, 2923.13, 2923.161, 2925.02, 2925.03, 2925.11, 2925.13, 2925.22, 2925.23, or 3716.11 of the Revised Code.

(b) A violation of an existing or former law of this state, any other state, or the United States that is substantially

equivalent to any of the offenses listed in division (C)(2)(a) of this section.

(3)(a) A home health agency may employ conditionally an applicant for whom a criminal records check request is required under division (B) of this section as a person responsible for the care, custody, or control of a child until the criminal records check regarding the applicant required by this section is completed and the agency receives the results of the criminal records check. If the results of the criminal records check indicate that, pursuant to division (C)(1) of this section, the applicant does not qualify for employment, the agency shall release the applicant from employment unless the agency chooses to employ the applicant pursuant to division (F) of this section.

(b)(i) A home health agency may employ conditionally an applicant for whom a criminal records check request is required under division (B) of this section in a position that involves providing direct care to an older adult or in a position that involves both responsibility for the care, custody, and control of a child and the provision of direct care to older adults prior to obtaining the results of a criminal records check regarding the individual, provided that the agency shall request a criminal records check regarding the individual in accordance with division (B)(1) of this section not later than five business days after the individual begins conditional employment. In the circumstances described in division (I)(2) of this section, a home health agency may employ conditionally in a position that involves providing direct care to an older adult an applicant who has been referred to the home health agency by an employment service that supplies full-time, part-time, or temporary staff for positions involving the direct care of older adults and for whom, pursuant to that division, a criminal records check is not required under division (B) of this section. In the circumstances described in division

(I)(4) of this section, a home health agency may employ conditionally in a position that involves both responsibility for the care, custody, and control of a child and the provision of direct care to older adults an applicant who has been referred to the home health agency by an employment service that supplies full-time, part-time, or temporary staff for positions involving both responsibility for the care, custody, and control of a child and the provision of direct care to older adults and for whom, pursuant to that division, a criminal records check is not required under division (B) of this section.

(ii) A home health agency that employs an individual conditionally under authority of division (C)(3)(b)(i) of this section shall terminate the individual's employment if the results of the criminal records check requested under division (B)(1) of this section or described in division (I)(2) or (4) of this section, other than the results of any request for information from the federal bureau of investigation, are not obtained within the period ending thirty days after the date the request is made. Regardless of when the results of the criminal records check are obtained, if the individual was employed conditionally in a position that involves the provision of direct care to older adults and the results indicate that the individual has been convicted of or pleaded guilty to any of the offenses listed or described in division (C)(2) of this section, or if the individual was employed conditionally in a position that involves both responsibility for the care, custody, and control of a child and the provision of direct care to older adults and the results indicate that the individual has been convicted of or pleaded guilty to any of the offenses listed or described in division (C)(1) or (2) of this section, the agency shall terminate the individual's employment unless the agency chooses to employ the individual pursuant to division (F) of this section. Termination of employment under this division shall be considered just cause

for discharge for purposes of division (D)(2) of section 4141.29 of the Revised Code if the individual makes any attempt to deceive the agency about the individual's criminal record.

(D)(1) Each home health agency shall pay to the bureau of criminal identification and investigation the fee prescribed pursuant to division (C)(3) of section 109.572 of the Revised Code for each criminal records check conducted in accordance with that section upon the request pursuant to division (B)(1) of this section of the chief administrator of the home health agency.

(2) A home health agency may charge an applicant a fee for the costs it incurs in obtaining a criminal records check under this section, unless the ~~medical assistance~~ medicaid program ~~established under Chapter 5111. of the Revised Code~~ reimburses the agency for the costs. A fee charged under division (D)(2) of this section shall not exceed the amount of fees the agency pays under division (D)(1) of this section. If a fee is charged under division (D)(2) of this section, the agency shall notify the applicant at the time of the applicant's initial application for employment of the amount of the fee and that, unless the fee is paid, the agency will not consider the applicant for employment.

(E) The report of any criminal records check conducted by the bureau of criminal identification and investigation in accordance with section 109.572 of the Revised Code and pursuant to a request made under division (B)(1) of this section is not a public record for the purposes of section 149.43 of the Revised Code and shall not be made available to any person other than the following:

(1) The individual who is the subject of the criminal records check or the individual's representative;

(2) The home health agency requesting the criminal records check or its representative;

(3) The administrator of any other facility, agency, or

program that provides direct care to older adults that is owned or operated by the same entity that owns or operates the home health agency;

(4) Any court, hearing officer, or other necessary individual involved in a case dealing with a denial of employment of the applicant or dealing with employment or unemployment benefits of the applicant;

(5) Any person to whom the report is provided pursuant to, and in accordance with, division (I)(1), (2), (3), or (4) of this section.

(F) The department of health shall adopt rules in accordance with Chapter 119. of the Revised Code to implement this section. The rules shall specify circumstances under which the home health agency may employ a person who has been convicted of or pleaded guilty to an offense listed or described in division (C)(1) of this section but who meets standards in regard to rehabilitation set by the department or employ a person who has been convicted of or pleaded guilty to an offense listed or described in division (C)(2) of this section but meets personal character standards set by the department.

(G) Any person required by division (B)(1) of this section to request a criminal records check shall inform each person, at the time of initial application for employment that the person is required to provide a set of fingerprint impressions and that a criminal records check is required to be conducted and satisfactorily completed in accordance with section 109.572 of the Revised Code if the person comes under final consideration for appointment or employment as a precondition to employment for that position.

(H) In a tort or other civil action for damages that is brought as the result of an injury, death, or loss to person or

property caused by an individual who a home health agency employs in a position that involves providing direct care to older adults, all of the following shall apply:

(1) If the agency employed the individual in good faith and reasonable reliance on the report of a criminal records check requested under this section, the agency shall not be found negligent solely because of its reliance on the report, even if the information in the report is determined later to have been incomplete or inaccurate;

(2) If the agency employed the individual in good faith on a conditional basis pursuant to division (C)(3)(b) of this section, the agency shall not be found negligent solely because it employed the individual prior to receiving the report of a criminal records check requested under this section;

(3) If the agency in good faith employed the individual according to the personal character standards established in rules adopted under division (F) of this section, the agency shall not be found negligent solely because the individual prior to being employed had been convicted of or pleaded guilty to an offense listed or described in division (C)(1) or (2) of this section.

(I)(1) The chief administrator of a home health agency is not required to request that the superintendent of the bureau of criminal identification and investigation conduct a criminal records check of an applicant for a position that involves the provision of direct care to older adults if the applicant has been referred to the agency by an employment service that supplies full-time, part-time, or temporary staff for positions involving the direct care of older adults and both of the following apply:

(a) The chief administrator receives from the employment service or the applicant a report of the results of a criminal records check regarding the applicant that has been conducted by

the superintendent within the one-year period immediately preceding the applicant's referral;

(b) The report of the criminal records check demonstrates that the person has not been convicted of or pleaded guilty to an offense listed or described in division (C)(2) of this section, or the report demonstrates that the person has been convicted of or pleaded guilty to one or more of those offenses, but the home health agency chooses to employ the individual pursuant to division (F) of this section.

(2) The chief administrator of a home health agency is not required to request that the superintendent of the bureau of criminal identification and investigation conduct a criminal records check of an applicant for a position that involves providing direct care to older adults and may employ the applicant conditionally in a position of that nature as described in this division, if the applicant has been referred to the agency by an employment service that supplies full-time, part-time, or temporary staff for positions involving the direct care of older adults and if the chief administrator receives from the employment service or the applicant a letter from the employment service that is on the letterhead of the employment service, dated, and signed by a supervisor or another designated official of the employment service and that states that the employment service has requested the superintendent to conduct a criminal records check regarding the applicant, that the requested criminal records check will include a determination of whether the applicant has been convicted of or pleaded guilty to any offense listed or described in division (C)(2) of this section, that, as of the date set forth on the letter, the employment service had not received the results of the criminal records check, and that, when the employment service receives the results of the criminal records check, it promptly will send a copy of the results to the home health

agency. If a home health agency employs an applicant conditionally in accordance with this division, the employment service, upon its receipt of the results of the criminal records check, promptly shall send a copy of the results to the home health agency, and division (C)(3)(b) of this section applies regarding the conditional employment.

(3) The chief administrator of a home health agency is not required to request that the superintendent of the bureau of criminal identification and investigation conduct a criminal records check of an applicant for a position that involves both responsibility for the care, custody, and control of a child and the provision of direct care to older adults if the applicant has been referred to the agency by an employment service that supplies full-time, part-time, or temporary staff for positions involving both responsibility for the care, custody, and control of a child and the provision of direct care to older adults and both of the following apply:

(a) The chief administrator receives from the employment service or applicant a report of a criminal records check of the type described in division (I)(1)(a) of this section;

(b) The report of the criminal records check demonstrates that the person has not been convicted of or pleaded guilty to an offense listed or described in division (C)(1) or (2) of this section, or the report demonstrates that the person has been convicted of or pleaded guilty to one or more of those offenses, but the home health agency chooses to employ the individual pursuant to division (F) of this section.

(4) The chief administrator of a home health agency is not required to request that the superintendent of the bureau of criminal identification and investigation conduct a criminal records check of an applicant for a position that involves both responsibility for the care, custody, and control of a child and

the provision of direct care to older adults and may employ the applicant conditionally in a position of that nature as described in this division, if the applicant has been referred to the agency by an employment service that supplies full-time, part-time, or temporary staff for positions involving both responsibility for the care, custody, and control of a child and the direct care of older adults and if the chief administrator receives from the employment service or the applicant a letter from the employment service that is on the letterhead of the employment service, dated, and signed by a supervisor or another designated official of the employment service and that states that the employment service has requested the superintendent to conduct a criminal records check regarding the applicant, that the requested criminal records check will include a determination of whether the applicant has been convicted of or pleaded guilty to any offense listed or described in division (C)(1) or (2) of this section, that, as of the date set forth on the letter, the employment service had not received the results of the criminal records check, and that, when the employment service receives the results of the criminal records check, it promptly will send a copy of the results to the home health agency. If a home health agency employs an applicant conditionally in accordance with this division, the employment service, upon its receipt of the results of the criminal records check, promptly shall send a copy of the results to the home health agency, and division (C)(3)(b) of this section applies regarding the conditional employment.

Sec. 3702.30. (A) As used in this section:

(1) "Ambulatory surgical facility" means a facility, whether or not part of the same organization as a hospital, that is located in a building distinct from another in which inpatient care is provided, and to which any of the following apply:

(a) Outpatient surgery is routinely performed in the facility, and the facility functions separately from a hospital's inpatient surgical service and from the offices of private physicians, podiatrists, and dentists.

(b) Anesthesia is administered in the facility by an anesthesiologist or certified registered nurse anesthetist, and the facility functions separately from a hospital's inpatient surgical service and from the offices of private physicians, podiatrists, and dentists.

(c) The facility applies to be certified by the United States centers for medicare and medicaid services as an ambulatory surgical center for purposes of reimbursement under Part B of the medicare program, Part B of ~~Title XVIII of~~ the ~~"Social Security Act," 79 Stat. 286 (1965), 42 U.S.C.A. 1395, as amended~~ medicare program.

(d) The facility applies to be certified by a national accrediting body approved by the centers for medicare and medicaid services for purposes of deemed compliance with the conditions for participating in the medicare program as an ambulatory surgical center.

(e) The facility bills or receives from any third-party payer, governmental health care program, or other person or government entity any ambulatory surgical facility fee that is billed or paid in addition to any fee for professional services.

(f) The facility is held out to any person or government entity as an ambulatory surgical facility or similar facility by means of signage, advertising, or other promotional efforts.

"Ambulatory surgical facility" does not include a hospital emergency department.

(2) "Ambulatory surgical facility fee" means a fee for certain overhead costs associated with providing surgical services

in an outpatient setting. A fee is an ambulatory surgical facility fee only if it directly or indirectly pays for costs associated with any of the following:

(a) Use of operating and recovery rooms, preparation areas, and waiting rooms and lounges for patients and relatives;

(b) Administrative functions, record keeping, housekeeping, utilities, and rent;

(c) Services provided by nurses, orderlies, technical personnel, and others involved in patient care related to providing surgery.

"Ambulatory surgical facility fee" does not include any additional payment in excess of a professional fee that is provided to encourage physicians, podiatrists, and dentists to perform certain surgical procedures in their office or their group practice's office rather than a health care facility, if the purpose of the additional fee is to compensate for additional cost incurred in performing office-based surgery.

(3) "Governmental health care program" has the same meaning as in section 4731.65 of the Revised Code.

(4) "Health care facility" means any of the following:

(a) An ambulatory surgical facility;

(b) A freestanding dialysis center;

(c) A freestanding inpatient rehabilitation facility;

(d) A freestanding birthing center;

(e) A freestanding radiation therapy center;

(f) A freestanding or mobile diagnostic imaging center.

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

(B) By rule adopted in accordance with sections 3702.12 and

3702.13 of the Revised Code, the director of health shall establish quality standards for health care facilities. The standards may incorporate accreditation standards or other quality standards established by any entity recognized by the director.

(C) Every ambulatory surgical facility shall require that each physician who practices at the facility comply with all relevant provisions in the Revised Code that relate to the obtaining of informed consent from a patient.

(D) The director shall issue a license to each health care facility that makes application for a license and demonstrates to the director that it meets the quality standards established by the rules adopted under division (B) of this section and satisfies the informed consent compliance requirements specified in division (C) of this section.

(E)(1) Except as provided in section 3702.301 of the Revised Code, no health care facility shall operate without a license issued under this section.

(2) If the department of health finds that a physician who practices at a health care facility is not complying with any provision of the Revised Code related to the obtaining of informed consent from a patient, the department shall report its finding to the state medical board, the physician, and the health care facility.

(3) This division does not create, and shall not be construed as creating, a new cause of action or substantive legal right against a health care facility and in favor of a patient who allegedly sustains harm as a result of the failure of the patient's physician to obtain informed consent from the patient prior to performing a procedure on or otherwise caring for the patient in the health care facility.

(F) The rules adopted under division (B) of this section

shall include all of the following:

(1) Provisions governing application for, renewal, suspension, and revocation of a license under this section;

(2) Provisions governing orders issued pursuant to section 3702.32 of the Revised Code for a health care facility to cease its operations or to prohibit certain types of services provided by a health care facility;

(3) Provisions governing the imposition under section 3702.32 of the Revised Code of civil penalties for violations of this section or the rules adopted under this section, including a scale for determining the amount of the penalties.

Sec. 3702.31. (A) The quality monitoring and inspection fund is hereby created in the state treasury. The director of health shall use the fund to administer and enforce this section and sections 3702.11 to 3702.20, 3702.30, 3702.301, and 3702.32 of the Revised Code and rules adopted pursuant to those sections. The director shall deposit in the fund any moneys collected pursuant to this section or section 3702.32 of the Revised Code. All investment earnings of the fund shall be credited to the fund.

(B) The director of health shall adopt rules pursuant to Chapter 119. of the Revised Code establishing fees for both of the following:

(1) Initial and renewal license applications submitted under section 3702.30 of the Revised Code. The fees established under division (B)(1) of this section shall not exceed the actual and necessary costs of performing the activities described in division (A) of this section.

(2) Inspections conducted under section 3702.15 or 3702.30 of the Revised Code. The fees established under division (B)(2) of this section shall not exceed the actual and necessary costs

incurred during an inspection, including any indirect costs incurred by the department for staff, salary, or other administrative costs. The director of health shall provide to each health care facility or provider inspected pursuant to section 3702.15 or 3702.30 of the Revised Code a written statement of the fee. The statement shall itemize and total the costs incurred. Within fifteen days after receiving a statement from the director, the facility or provider shall forward the total amount of the fee to the director.

(3) The fees described in divisions (B)(1) and (2) of this section shall meet both of the following requirements:

(a) For each service described in section 3702.11 of the Revised Code, the fee shall not exceed one thousand seven hundred fifty dollars annually, except that the total fees charged to a health care provider under this section shall not exceed five thousand dollars annually.

(b) The fee shall exclude any costs reimbursable by the United States centers for medicare and medicaid services as part of the certification process for the medicare program ~~established under Title XVIII of the "Social Security Act," 79 Stat. 286 (1935), 42 U.S.C.A. 1395, as amended~~, and the medicaid program ~~established under Title XIX of the "Social Security Act," 79 Stat. 286 (1965), 42 U.S.C. 1396~~.

(4) The director shall not establish a fee for any service for which a licensure or inspection fee is paid by the health care provider to a state agency for the same or similar licensure or inspection.

Sec. 3702.51. As used in sections 3702.51 to 3702.62 of the Revised Code:

(A) "Applicant" means any person that submits an application

for a certificate of need and who is designated in the application as the applicant.

(B) "Person" means any individual, corporation, business trust, estate, firm, partnership, association, joint stock company, insurance company, government unit, or other entity.

(C) "Certificate of need" means a written approval granted by the director of health to an applicant to authorize conducting a reviewable activity.

(D) "Health service area" means a geographic region designated by the director of health under section 3702.58 of the Revised Code.

(E) "Health service" means a clinically related service, such as a diagnostic, treatment, rehabilitative, or preventive service.

(F) "Health service agency" means an agency designated to serve a health service area in accordance with section 3702.58 of the Revised Code.

(G) "Health care facility" means:

(1) A hospital registered under section 3701.07 of the Revised Code;

(2) A nursing home licensed under section 3721.02 of the Revised Code, or by a political subdivision certified under section 3721.09 of the Revised Code;

(3) A county home or a county nursing home as defined in section 5155.31 of the Revised Code that is certified under ~~Title XVIII or XIX of~~ the ~~"Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended~~ medicare program, or under the medicaid program;

(4) A freestanding dialysis center;

(5) A freestanding inpatient rehabilitation facility;

(6) An ambulatory surgical facility;

(7) A freestanding cardiac catheterization facility;

(8) A freestanding birthing center;

(9) A freestanding or mobile diagnostic imaging center;

(10) A freestanding radiation therapy center.

A health care facility does not include the offices of private physicians and dentists whether for individual or group practice, residential facilities licensed under section 5123.19 of the Revised Code, or an institution for the sick that is operated exclusively for patients who use spiritual means for healing and for whom the acceptance of medical care is inconsistent with their religious beliefs, accredited by a national accrediting organization, exempt from federal income taxation under section 501 of the Internal Revenue Code of 1986, 100 Stat. 2085, 26 U.S.C.A. 1, as amended, and providing twenty-four hour nursing care pursuant to the exemption in division (E) of section 4723.32 of the Revised Code from the licensing requirements of Chapter 4723. of the Revised Code.

(H) "Medical equipment" means a single unit of medical equipment or a single system of components with related functions that is used to provide health services.

(I) "Third-party payer" means a health insuring corporation licensed under Chapter 1751. of the Revised Code, a health maintenance organization as defined in division (K) of this section, an insurance company that issues sickness and accident insurance in conformity with Chapter 3923. of the Revised Code, a state-financed health insurance program under Chapter 3701.~~,~~ or 4123.~~, or 5111.~~ of the Revised Code, the medicaid program, or any self-insurance plan.

(J) "Government unit" means the state and any county,

municipal corporation, township, or other political subdivision of the state, or any department, division, board, or other agency of the state or a political subdivision.

(K) "Health maintenance organization" means a public or private organization organized under the law of any state that is qualified under section 1310(d) of Title XIII of the "Public Health Service Act," 87 Stat. 931 (1973), 42 U.S.C. 300e-9.

(L) "Existing health care facility" means either of the following:

(1) A health care facility that is licensed or otherwise authorized to operate in this state in accordance with applicable law, is staffed and equipped to provide health care services, and is actively providing health services;

(2) A health care facility that is licensed or has beds registered under section 3701.07 of the Revised Code as skilled nursing beds or long-term care beds and has provided services for at least three hundred sixty-five consecutive days within the twenty-four months immediately preceding the date a certificate of need application is filed with the director of health.

(M) "State" means the state of Ohio, including, but not limited to, the general assembly, the supreme court, the offices of all elected state officers, and all departments, boards, offices, commissions, agencies, institutions, and other instrumentalities of the state of Ohio. "State" does not include political subdivisions.

(N) "Political subdivision" means a municipal corporation, township, county, school district, and all other bodies corporate and politic responsible for governmental activities only in geographic areas smaller than that of the state to which the sovereign immunity of the state attaches.

(O) "Affected person" means:

(1) An applicant for a certificate of need, including an applicant whose application was reviewed comparatively with the application in question;

(2) The person that requested the reviewability ruling in question;

(3) Any person that resides or regularly uses health care facilities within the geographic area served or to be served by the health care services that would be provided under the certificate of need or reviewability ruling in question;

(4) Any health care facility that is located in the health service area where the health care services would be provided under the certificate of need or reviewability ruling in question;

(5) Third-party payers that reimburse health care facilities for services in the health service area where the health care services would be provided under the certificate of need or reviewability ruling in question;

(6) Any other person who testified at a public hearing held under division (B) of section 3702.52 of the Revised Code or submitted written comments in the course of review of the certificate of need application in question.

(P) "Osteopathic hospital" means a hospital registered under section 3701.07 of the Revised Code that advocates osteopathic principles and the practice and perpetuation of osteopathic medicine by doing any of the following:

(1) Maintaining a department or service of osteopathic medicine or a committee on the utilization of osteopathic principles and methods, under the supervision of an osteopathic physician;

(2) Maintaining an active medical staff, the majority of which is comprised of osteopathic physicians;

(3) Maintaining a medical staff executive committee that has osteopathic physicians as a majority of its members.

(Q) "Ambulatory surgical facility" has the same meaning as in section 3702.30 of the Revised Code.

(R) Except as otherwise provided in division (T) of this section, and until the termination date specified in section 3702.511 of the Revised Code, "reviewable activity" means any of the following:

(1) The addition by any person of any of the following health services, regardless of the amount of operating costs or capital expenditures:

(a) A heart, heart-lung, lung, liver, kidney, bowel, pancreas, or bone marrow transplantation service, a stem cell harvesting and reinfusion service, or a service for transplantation of any other organ unless transplantation of the organ is designated by public health council rule not to be a reviewable activity;

(b) A cardiac catheterization service;

(c) An open-heart surgery service;

(d) Any new, experimental medical technology that is designated by rule of the public health council.

(2) The acceptance of high-risk patients, as defined in rules adopted under section 3702.57 of the Revised Code, by any cardiac catheterization service that was initiated without a certificate of need pursuant to division (R)(3)(b) of the version of this section in effect immediately prior to April 20, 1995;

(3)(a) The establishment, development, or construction of a new health care facility other than a new long-term care facility or a new hospital;

(b) The establishment, development, or construction of a new

hospital or the relocation of an existing hospital;

(c) The relocation of hospital beds, other than long-term care, perinatal, or pediatric intensive care beds, into or out of a rural area.

(4)(a) The replacement of an existing hospital;

(b) The replacement of an existing hospital obstetric or newborn care unit or freestanding birthing center.

(5)(a) The renovation of a hospital that involves a capital expenditure, obligated on or after June 30, 1995, of five million dollars or more, not including expenditures for equipment, staffing, or operational costs. For purposes of division (R)(5)(a) of this section, a capital expenditure is obligated:

(i) When a contract enforceable under Ohio law is entered into for the construction, acquisition, lease, or financing of a capital asset;

(ii) When the governing body of a hospital takes formal action to commit its own funds for a construction project undertaken by the hospital as its own contractor;

(iii) In the case of donated property, on the date the gift is completed under applicable Ohio law.

(b) The renovation of a hospital obstetric or newborn care unit or freestanding birthing center that involves a capital expenditure of five million dollars or more, not including expenditures for equipment, staffing, or operational costs.

(6) Any change in the health care services, bed capacity, or site, or any other failure to conduct the reviewable activity in substantial accordance with the approved application for which a certificate of need was granted, if the change is made prior to the date the activity for which the certificate was issued ceases to be a reviewable activity;

(7) Any of the following changes in perinatal bed capacity or pediatric intensive care bed capacity:

(a) An increase in bed capacity;

(b) A change in service or service-level designation of newborn care beds or obstetric beds in a hospital or freestanding birthing center, other than a change of service that is provided within the service-level designation of newborn care or obstetric beds as registered by the department of health;

(c) A relocation of perinatal or pediatric intensive care beds from one physical facility or site to another, excluding the relocation of beds within a hospital or freestanding birthing center or the relocation of beds among buildings of a hospital or freestanding birthing center at the same site.

(8) The expenditure of more than one hundred ten per cent of the maximum expenditure specified in a certificate of need;

(9) Any transfer of a certificate of need issued prior to April 20, 1995, from the person to whom it was issued to another person before the project that constitutes a reviewable activity is completed, any agreement that contemplates the transfer of a certificate of need issued prior to that date upon completion of the project, and any transfer of the controlling interest in an entity that holds a certificate of need issued prior to that date. However, the transfer of a certificate of need issued prior to that date or agreement to transfer such a certificate of need from the person to whom the certificate of need was issued to an affiliated or related person does not constitute a reviewable transfer of a certificate of need for the purposes of this division, unless the transfer results in a change in the person that holds the ultimate controlling interest in the certificate of need.

(10)(a) The acquisition by any person of any of the following

medical equipment, regardless of the amount of operating costs or capital expenditure:

(i) A cobalt radiation therapy unit;

(ii) A linear accelerator;

(iii) A gamma knife unit.

(b) The acquisition by any person of medical equipment with a cost of two million dollars or more. The cost of acquiring medical equipment includes the sum of the following:

(i) The greater of its fair market value or the cost of its lease or purchase;

(ii) The cost of installation and any other activities essential to the acquisition of the equipment and its placement into service.

(11) The addition of another cardiac catheterization laboratory to an existing cardiac catheterization service.

(S) Except as provided in division (T) of this section, "reviewable activity" also means any of the following activities, none of which are subject to a termination date:

(1) The establishment, development, or construction of a new long-term care facility;

(2) The replacement of an existing long-term care facility;

(3) The renovation of a long-term care facility that involves a capital expenditure of two million dollars or more, not including expenditures for equipment, staffing, or operational costs;

(4) Any of the following changes in long-term care bed capacity:

(a) An increase in bed capacity;

(b) A relocation of beds from one physical facility or site

to another, excluding the relocation of beds within a long-term care facility or among buildings of a long-term care facility at the same site;

(c) A recategorization of hospital beds registered under section 3701.07 of the Revised Code from another registration category to skilled nursing beds or long-term care beds.

(5) Any change in the health services, bed capacity, or site, or any other failure to conduct the reviewable activity in substantial accordance with the approved application for which a certificate of need concerning long-term care beds was granted, if the change is made within five years after the implementation of the reviewable activity for which the certificate was granted;

(6) The expenditure of more than one hundred ten per cent of the maximum expenditure specified in a certificate of need concerning long-term care beds;

(7) Any transfer of a certificate of need that concerns long-term care beds and was issued prior to April 20, 1995, from the person to whom it was issued to another person before the project that constitutes a reviewable activity is completed, any agreement that contemplates the transfer of such a certificate of need upon completion of the project, and any transfer of the controlling interest in an entity that holds such a certificate of need. However, the transfer of a certificate of need that concerns long-term care beds and was issued prior to April 20, 1995, or agreement to transfer such a certificate of need from the person to whom the certificate was issued to an affiliated or related person does not constitute a reviewable transfer of a certificate of need for purposes of this division, unless the transfer results in a change in the person that holds the ultimate controlling interest in the certificate of need.

(T) "Reviewable activity" does not include any of the

following activities:

(1) Acquisition of computer hardware or software;

(2) Acquisition of a telephone system;

(3) Construction or acquisition of parking facilities;

(4) Correction of cited deficiencies that are in violation of federal, state, or local fire, building, or safety laws and rules and that constitute an imminent threat to public health or safety;

(5) Acquisition of an existing health care facility that does not involve a change in the number of the beds, by service, or in the number or type of health services;

(6) Correction of cited deficiencies identified by accreditation surveys of the joint commission on accreditation of healthcare organizations or of the American osteopathic association;

(7) Acquisition of medical equipment to replace the same or similar equipment for which a certificate of need has been issued if the replaced equipment is removed from service;

(8) Mergers, consolidations, or other corporate reorganizations of health care facilities that do not involve a change in the number of beds, by service, or in the number or type of health services;

(9) Construction, repair, or renovation of bathroom facilities;

(10) Construction of laundry facilities, waste disposal facilities, dietary department projects, heating and air conditioning projects, administrative offices, and portions of medical office buildings used exclusively for physician services;

(11) Acquisition of medical equipment to conduct research required by the United States food and drug administration or clinical trials sponsored by the national institute of health. Use

of medical equipment that was acquired without a certificate of need under division (T)(11) of this section and for which premarket approval has been granted by the United States food and drug administration to provide services for which patients or reimbursement entities will be charged shall be a reviewable activity.

(12) Removal of asbestos from a health care facility.

Only that portion of a project that meets the requirements of division (T) of this section is not a reviewable activity.

(U) "Small rural hospital" means a hospital that is located within a rural area, has fewer than one hundred beds, and to which fewer than four thousand persons were admitted during the most recent calendar year.

(V) "Children's hospital" means any of the following:

(1) A hospital registered under section 3701.07 of the Revised Code that provides general pediatric medical and surgical care, and in which at least seventy-five per cent of annual inpatient discharges for the preceding two calendar years were individuals less than eighteen years of age;

(2) A distinct portion of a hospital registered under section 3701.07 of the Revised Code that provides general pediatric medical and surgical care, has a total of at least one hundred fifty registered pediatric special care and pediatric acute care beds, and in which at least seventy-five per cent of annual inpatient discharges for the preceding two calendar years were individuals less than eighteen years of age;

(3) A distinct portion of a hospital, if the hospital is registered under section 3701.07 of the Revised Code as a children's hospital and the children's hospital meets all the requirements of division (V)(1) of this section.

(W) "Long-term care facility" means any of the following:

(1) A nursing home licensed under section 3721.02 of the Revised Code or by a political subdivision certified under section 3721.09 of the Revised Code;

(2) The portion of any facility, including a county home or county nursing home, that is certified as a skilled nursing facility or a nursing facility under Title XVIII or XIX of the "Social Security Act";

(3) The portion of any hospital that contains beds registered under section 3701.07 of the Revised Code as skilled nursing beds or long-term care beds.

(X) "Long-term care bed" means a bed in a long-term care facility.

(Y) "Perinatal bed" means a bed in a hospital that is registered under section 3701.07 of the Revised Code as a newborn care bed or obstetric bed, or a bed in a freestanding birthing center.

(Z) "Freestanding birthing center" means any facility in which deliveries routinely occur, regardless of whether the facility is located on the campus of another health care facility, and which is not licensed under Chapter 3711. of the Revised Code as a level one, two, or three maternity unit or a limited maternity unit.

(AA)(1) "Reviewability ruling" means a ruling issued by the director of health under division (A) of section 3702.52 of the Revised Code as to whether a particular proposed project is or is not a reviewable activity.

(2) "Nonreviewability ruling" means a ruling issued under that division that a particular proposed project is not a reviewable activity.

(BB)(1) "Metropolitan statistical area" means an area of this state designated a metropolitan statistical area or primary metropolitan statistical area in United States office of management and budget bulletin ~~No.~~ no. 93-17, June 30, 1993, and its attachments.

(2) "Rural area" means any area of this state not located within a metropolitan statistical area.

Sec. 3702.522. (A) Reviews of applications for certificates of need to recategorize hospital beds to skilled nursing beds shall be conducted in accordance with this division and rules adopted by the public health council.

(1) No hospital recategorizing beds shall apply for a certificate of need for more than twenty skilled nursing beds.

(2) No beds for which a certificate of need is requested under this division shall be reviewed under or counted in any formula developed under public health council rules for the purpose of determining the number of long-term care beds that may be needed within the state.

(3) No beds shall be approved under this division unless the hospital certifies and demonstrates in the application that the beds will be dedicated to patients with a length of stay of no more than thirty days.

(4) No beds shall be approved under this division unless the hospital can satisfactorily demonstrate in the application that it is routinely unable to place the patients planned for the beds in accessible skilled nursing facilities.

(5) In developing rules to implement this division, the public health council shall give special attention to the required documentation of the need for such beds, including the efforts made by the hospital to place patients in suitable skilled nursing

facilities, and special attention to the appropriate size of units with such beds given the historical pattern of the applicant hospital's documented difficulty in placing skilled nursing patients.

(B) To assist the director of health in monitoring the use of hospital beds recategorized as skilled nursing beds after August 5, 1989, the public health council shall adopt rules specifying appropriate quarterly procedures for reporting to the department of health.

(C) A patient may stay in a hospital bed that, after August 5, 1989, has been recategorized as a skilled nursing bed for more than thirty days if the hospital is able to demonstrate that it made a good faith effort to place the patient in an accessible skilled nursing facility acceptable to the patient within the thirty-day period, but was unable to do so.

(D) No hospital bed recategorized after August 5, 1989, as a skilled nursing bed shall be covered by a provider agreement under the ~~medical assistance~~ medicaid program ~~established under Chapter 5111. of the Revised Code~~.

(E) Nothing in this section requires a hospital to place a patient in any nursing home if the patient does not wish to be placed in the nursing home. Nothing in this section limits the ability of a hospital to file a certificate of need application for the addition of long-term care beds that meet the definition of "home" in section 3721.01 of the Revised Code. Nothing in this section limits the ability of the director to grant certificates of need necessary for hospitals to engage in demonstration projects authorized by the federal government for the purpose of enhancing long-term quality of care and cost containment. Nothing in this section limits the ability of hospitals to develop swing bed programs in accordance with federal regulations.

No hospital that is granted a certificate of need after August 5, 1989, to recategorize hospital beds as skilled nursing beds is subject to sections 3721.01 to 3721.09 of the Revised Code. If the portion of the hospital in which the recategorized beds are located is certified as a skilled nursing facility under ~~Title XVIII of~~ the ~~"Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended~~ medicare program, that portion of the hospital is subject to sections 3721.10 to 3721.17 and sections 3721.21 to 3721.34 of the Revised Code. If the beds are registered pursuant to section 3701.07 of the Revised Code as long-term care beds, the beds are subject to sections ~~3721.50~~ 5166.20 to ~~3721.58~~ 5166.30 of the Revised Code.

(F) The public health council shall adopt rules authorizing the creation of one or more nursing home placement clearinghouses. Any public or private agency or facility may apply to the department of health to serve as a nursing home placement clearinghouse, and the rules shall provide the procedure for application and process for designation of clearinghouses.

The department may approve one or more clearinghouses, but in no event shall there be more than one nursing home placement clearinghouse in each county. Any nursing home may list with a nursing home placement clearinghouse the services it provides and the types of patients it is approved for and equipped to serve. The clearinghouse shall make reasonable efforts to update its information at least every six months.

If an appropriate clearinghouse has been designated, each hospital granted a certificate of need after August 5, 1989, to recategorize hospital beds as skilled nursing beds shall, and any other hospital may, utilize the nursing home placement clearinghouse prior to admitting a patient to a skilled nursing bed within the hospital and prior to keeping a patient in a skilled nursing bed within a hospital in excess of thirty days.

The department shall provide at least annually to all hospitals a list of the designated nursing home placement clearinghouses.

Sec. 3702.62. (A) Any action pursuant to section 140.03, 140.04, 140.05, 307.091, 313.21, 339.01, 339.021, 339.03, 339.06, 339.08, 339.09, 339.12, 339.14, 513.05, 513.07, 513.08, 513.081, 513.12, 513.15, 513.17, 513.171, 749.02, 749.03, 749.14, 749.16, 749.20, 749.25, 749.28, 749.35, 1751.06, or 3707.29 of the Revised Code shall be taken in accordance with sections 3702.51 to 3702.61 of the Revised Code.

(B) A nursing home certified as an intermediate care facility for the mentally retarded under ~~Title XIX of~~ the ~~"Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended~~ medicaid program, that is required to apply for licensure as a residential facility under section 5123.19 of the Revised Code is not, with respect to the portion of the home certified as an intermediate care facility for the mentally retarded, subject to sections 3702.51 to 3702.61 of the Revised Code.

Sec. 3702.63. As specified in former Section 11 of Am. Sub. S.B. 50 of the 121st general assembly, as amended by Am. Sub. H.B. 405 of the 124th general assembly, all of the following apply:

(A) The removal of former divisions (E) and (F) of section 3702.52 of the Revised Code by Sections 1 and 2 of Am. Sub. S.B. 50 of the 121st general assembly does not release the holders of certificates of need issued under those divisions from complying with any conditions on which the granting of the certificates of need was based, including the requirement of former division (E)(6) of that section that the holders not enter into medicaid provider agreements ~~under Chapter 5111. of the Revised Code and Title XIX of the "Social Security Act," 49 Stat. 620 (1935), 42~~

~~U.S.C. 301, as amended,~~ for at least ten years following initial licensure of the long-term care facilities for which the certificates were granted.

(B) The repeal of section 3702.55 of the Revised Code by Section 2 of Am. Sub. S.B. 50 of the 121st general assembly does not release the holders of certificates of need issued under that section from complying with any conditions on which the granting of the certificates of need was based, other than the requirement of division (A)(6) of that section that the holders not seek certification under ~~Title XVIII of~~ the ~~"Social Security Act"~~ medicare program for beds recategorized under the certificates. That repeal also does not eliminate the requirement that the director of health revoke the licensure of the beds under Chapter 3721. of the Revised Code if a person to which their ownership is transferred fails, as required by division (A)(6) of the repealed section, to file within ten days after the transfer a sworn statement not to seek certification under ~~Title XIX of the "Social Security Act"~~ the medicaid program for beds recategorized under the certificates of need.

(C) The repeal of section 3702.56 of the Revised Code by Section 2 of Am. Sub. S.B. 50 of the 121st general assembly does not release the holders of certificates of need issued under that section from complying with any conditions on which the granting of the certificates of need was based.

Sec. 3702.74. (A) A primary care physician who has signed a letter of intent under section 3702.73 of the Revised Code, the director of health, and the Ohio board of regents may enter into a contract for the physician's participation in the physician loan repayment program. A lending institution may also be a party to the contract.

(B) The contract shall include all of the following

obligations:

(1) The primary care physician agrees to provide primary care services in the health resource shortage area identified in the letter of intent for at least two years or one year per twenty thousand dollars of repayment agreed to under division (B)(3) of this section, whichever is greater;

(2) When providing primary care services in the health resource shortage area, the primary care physician agrees to do all of the following:

(a) Provide primary care services for a minimum of forty hours per week;

(b) Provide primary care services without regard to a patient's ability to pay;

(c) Meet the conditions ~~prescribed by the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended, and the department of job and family services~~ for participation in the ~~medical assistance~~ medicaid program ~~established under Chapter 5111. of the Revised Code~~ and enter into a contract with the department of health care administration to provide primary care services to medicaid recipients ~~of the medical assistance program~~;

(d) Meet the conditions established by the department of job and family services for participation in the disability medical assistance program ~~established under Chapter 5115. of the Revised Code~~ and enter into a contract with the department to provide primary care services to recipients of disability medical assistance.

(3) The Ohio board of regents agrees, as provided in section 3702.75 of the Revised Code, to repay, so long as the primary care physician performs the service obligation agreed to under division (B)(1) of this section, all or part of the principal and interest of a government or other educational loan taken by the primary

care physician for expenses described in section 3702.75 of the Revised Code;

(4) The primary care physician agrees to pay the board the following as damages if the physician fails to complete the service obligation agreed to under division (B)(1) of this section:

(a) If the failure occurs during the first two years of the service obligation, three times the total amount the board has agreed to repay under division (B)(3) of this section;

(b) If the failure occurs after the first two years of the service obligation, three times the amount the board is still obligated to repay under division (B)(3) of this section.

(C) The contract may include any other terms agreed upon by the parties, including an assignment to the Ohio board of regents of the physician's duty to pay the principal and interest of a government or other educational loan taken by the physician for expenses described in section 3702.75 of the Revised Code. If the board assumes the physician's duty to pay a loan, the contract shall set forth the total amount of principal and interest to be paid, an amortization schedule, and the amount of each payment to be made under the schedule.

Sec. 3702.91. (A) An individual who has signed a letter of intent under section 3702.90 of the Revised Code may enter into a contract with the director of health and the Ohio board of regents for participation in the dentist loan repayment program. A lending institution may also be a party to the contract.

(B) The contract shall include all of the following obligations:

(1) The individual agrees to provide dental services in the dental health resource shortage area identified in the letter of

intent for at least one year.

(2) When providing dental services in the dental health resource shortage area, the individual agrees to do all of the following:

(a) Provide dental services for a minimum of forty hours per week;

(b) Provide dental services without regard to a patient's ability to pay;

(c) Meet the conditions ~~prescribed by the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C. 301, as amended, and the department of job and family services~~ for participation in the medicaid program ~~established under Chapter 5111. of the Revised Code~~ and enter into a contract with the department of health care administration to provide dental services to medicaid recipients.

(3) The Ohio board of regents agrees, as provided in section 3702.85 of the Revised Code, to repay, so long as the individual performs the service obligation agreed to under division (B)(1) of this section, all or part of the principal and interest of a government or other educational loan taken by the individual for expenses described in section 3702.85 of the Revised Code up to but not exceeding twenty thousand dollars per year of service.

(4) The individual agrees to pay the board the following as damages if the individual fails to complete the service obligation agreed to under division (B)(1) of this section:

(a) If the failure occurs during the first two years of the service obligation, three times the total amount the board has agreed to repay under division (B)(3) of this section;

(b) If the failure occurs after the first two years of the service obligation, three times the amount the board is still obligated to repay under division (B)(3) of this section.

(C) The contract may include any other terms agreed upon by the parties, including an assignment to the Ohio board of regents of the individual's duty to pay the principal and interest of a government or other educational loan taken by the individual for expenses described in section 3702.85 of the Revised Code. If the board assumes the individual's duty to pay a loan, the contract shall set forth the total amount of principal and interest to be paid, an amortization schedule, and the amount of each payment to be made under the schedule.

(D) Not later than the thirty-first day of January of each year, the Ohio board of regents shall mail to each individual to whom or on whose behalf repayment is made under the dentist loan repayment program a statement showing the amount of principal and interest repaid by the board pursuant to the contract in the preceding year. The statement shall be sent by ordinary mail with address correction and forwarding requested in the manner prescribed by the United States postal service.

Sec. 3712.07. (A) As used in this section, "terminal care facility for the homeless" means a facility that provides accommodations to homeless individuals who are terminally ill.

(B) A person or public agency licensed under this chapter to provide a hospice care program may enter into an agreement with a terminal care facility for the homeless under which hospice care program services may be provided to individuals residing at the facility, if all of the following apply:

(1) Each resident of the facility has been diagnosed by a physician as having a terminal condition and an anticipated life expectancy of six months or less;

(2) No resident of the facility has a relative or other person willing or capable of providing the care necessary to cope with ~~his~~ the resident's terminal illness or is financially capable

of hiring a person to provide such care;

(3) Each resident of the facility is under the direct care of a physician;

(4) No resident of the facility requires the staff of the facility to administer medication by injection;

(5) The facility does not receive any remuneration, directly or indirectly, from the residents;

(6) The facility does not receive any remuneration, directly or indirectly, from the ~~medical assistance~~ medicaid program ~~established under section 5111.01 of the Revised Code~~ or the medicare program ~~established under Title XVIII of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended~~;

(7) The facility meets all applicable state and federal health and safety standards, including standards for fire prevention, maintenance of safe and sanitary conditions, and proper preparation and storage of foods.

(C) Hospice care program services may be provided at a terminal care facility for the homeless only by the personnel of the person or public agency that has entered into an agreement with the facility under this section.

(D) A terminal care facility for the homeless that has entered into an agreement under this section may assist its residents with the self-administration of medication if the medication has been prescribed by a physician and is not administered by injection. In the event that a resident has entered the final stages of dying and is no longer mentally alert, the facility may administer medication to that resident if the medication has been prescribed by a physician and is not administered by injection. Determinations of whether an individual has entered the final stages of dying and is no longer mentally alert shall be based on directions from the personnel who provide

hospice care program services at the facility.

Sec. 3712.09. (A) As used in this section:

(1) "Applicant" means a person who is under final consideration for employment with a hospice care program in a full-time, part-time, or temporary position that involves providing direct care to an older adult. "Applicant" does not include a person who provides direct care as a volunteer without receiving or expecting to receive any form of remuneration other than reimbursement for actual expenses.

(2) "Criminal records check" and "older adult" have the same meanings as in section 109.572 of the Revised Code.

(B)(1) Except as provided in division (I) of this section, the chief administrator of a hospice care program shall request that the superintendent of the bureau of criminal identification and investigation conduct a criminal records check with respect to each applicant. If an applicant for whom a criminal records check request is required under this division does not present proof of having been a resident of this state for the five-year period immediately prior to the date the criminal records check is requested or provide evidence that within that five-year period the superintendent has requested information about the applicant from the federal bureau of investigation in a criminal records check, the chief administrator shall request that the superintendent obtain information from the federal bureau of investigation as part of the criminal records check of the applicant. Even if an applicant for whom a criminal records check request is required under this division presents proof of having been a resident of this state for the five-year period, the chief administrator may request that the superintendent include information from the federal bureau of investigation in the criminal records check.

(2) A person required by division (B)(1) of this section to request a criminal records check shall do both of the following:

(a) Provide to each applicant for whom a criminal records check request is required under that division a copy of the form prescribed pursuant to division (C)(1) of section 109.572 of the Revised Code and a standard fingerprint impression sheet prescribed pursuant to division (C)(2) of that section, and obtain the completed form and impression sheet from the applicant;

(b) Forward the completed form and impression sheet to the superintendent of the bureau of criminal identification and investigation.

(3) An applicant provided the form and fingerprint impression sheet under division (B)(2)(a) of this section who fails to complete the form or provide fingerprint impressions shall not be employed in any position for which a criminal records check is required by this section.

(C)(1) Except as provided in rules adopted by the public health council in accordance with division (F) of this section and subject to division (C)(2) of this section, no hospice care program shall employ a person in a position that involves providing direct care to an older adult if the person has been convicted of or pleaded guilty to any of the following:

(a) A violation of section 2903.01, 2903.02, 2903.03, 2903.04, 2903.11, 2903.12, 2903.13, 2903.16, 2903.21, 2903.34, 2905.01, 2905.02, 2905.11, 2905.12, 2907.02, 2907.03, 2907.05, 2907.06, 2907.07, 2907.08, 2907.09, 2907.12, 2907.25, 2907.31, 2907.32, 2907.321, 2907.322, 2907.323, 2911.01, 2911.02, 2911.11, 2911.12, 2911.13, 2913.02, 2913.03, 2913.04, 2913.11, 2913.21, 2913.31, 2913.40, 2913.43, 2913.47, 2913.51, 2919.25, 2921.36, 2923.12, 2923.13, 2923.161, 2925.02, 2925.03, 2925.11, 2925.13, 2925.22, 2925.23, or 3716.11 of the Revised Code.

(b) A violation of an existing or former law of this state, any other state, or the United States that is substantially equivalent to any of the offenses listed in division (C)(1)(a) of this section.

(2)(a) A hospice care program may employ conditionally an applicant for whom a criminal records check request is required under division (B) of this section prior to obtaining the results of a criminal records check regarding the individual, provided that the program shall request a criminal records check regarding the individual in accordance with division (B)(1) of this section not later than five business days after the individual begins conditional employment. In the circumstances described in division (I)(2) of this section, a hospice care program may employ conditionally an applicant who has been referred to the hospice care program by an employment service that supplies full-time, part-time, or temporary staff for positions involving the direct care of older adults and for whom, pursuant to that division, a criminal records check is not required under division (B) of this section.

(b) A hospice care program that employs an individual conditionally under authority of division (C)(2)(a) of this section shall terminate the individual's employment if the results of the criminal records check requested under division (B) of this section or described in division (I)(2) of this section, other than the results of any request for information from the federal bureau of investigation, are not obtained within the period ending thirty days after the date the request is made. Regardless of when the results of the criminal records check are obtained, if the results indicate that the individual has been convicted of or pleaded guilty to any of the offenses listed or described in division (C)(1) of this section, the program shall terminate the individual's employment unless the program chooses to employ the

individual pursuant to division (F) of this section. Termination of employment under this division shall be considered just cause for discharge for purposes of division (D)(2) of section 4141.29 of the Revised Code if the individual makes any attempt to deceive the program about the individual's criminal record.

(D)(1) Each hospice care program shall pay to the bureau of criminal identification and investigation the fee prescribed pursuant to division (C)(3) of section 109.572 of the Revised Code for each criminal records check conducted pursuant to a request made under division (B) of this section.

(2) A hospice care program may charge an applicant a fee not exceeding the amount the program pays under division (D)(1) of this section. A program may collect a fee only if both of the following apply:

(a) The program notifies the person at the time of initial application for employment of the amount of the fee and that, unless the fee is paid, the person will not be considered for employment;

(b) The ~~medical assistance~~ medicaid program ~~established under Chapter 5111. of the Revised Code~~ does not reimburse the program the fee it pays under division (D)(1) of this section.

(E) The report of a criminal records check conducted pursuant to a request made under this section is not a public record for the purposes of section 149.43 of the Revised Code and shall not be made available to any person other than the following:

(1) The individual who is the subject of the criminal records check or the individual's representative;

(2) The chief administrator of the program requesting the criminal records check or the administrator's representative;

(3) The administrator of any other facility, agency, or

program that provides direct care to older adults that is owned or operated by the same entity that owns or operates the hospice care program;

(4) A court, hearing officer, or other necessary individual involved in a case dealing with a denial of employment of the applicant or dealing with employment or unemployment benefits of the applicant;

(5) Any person to whom the report is provided pursuant to, and in accordance with, division (I)(1) or (2) of this section.

(F) The public health council shall adopt rules in accordance with Chapter 119. of the Revised Code to implement this section. The rules shall specify circumstances under which a hospice care program may employ a person who has been convicted of or pleaded guilty to an offense listed or described in division (C)(1) of this section but meets personal character standards set by the council.

(G) The chief administrator of a hospice care program shall inform each individual, at the time of initial application for a position that involves providing direct care to an older adult, that the individual is required to provide a set of fingerprint impressions and that a criminal records check is required to be conducted if the individual comes under final consideration for employment.

(H) In a tort or other civil action for damages that is brought as the result of an injury, death, or loss to person or property caused by an individual who a hospice care program employs in a position that involves providing direct care to older adults, all of the following shall apply:

(1) If the program employed the individual in good faith and reasonable reliance on the report of a criminal records check requested under this section, the program shall not be found

negligent solely because of its reliance on the report, even if the information in the report is determined later to have been incomplete or inaccurate;

(2) If the program employed the individual in good faith on a conditional basis pursuant to division (C)(2) of this section, the program shall not be found negligent solely because it employed the individual prior to receiving the report of a criminal records check requested under this section;

(3) If the program in good faith employed the individual according to the personal character standards established in rules adopted under division (F) of this section, the program shall not be found negligent solely because the individual prior to being employed had been convicted of or pleaded guilty to an offense listed or described in division (C)(1) of this section.

(I)(1) The chief administrator of a hospice care program is not required to request that the superintendent of the bureau of criminal identification and investigation conduct a criminal records check of an applicant if the applicant has been referred to the program by an employment service that supplies full-time, part-time, or temporary staff for positions involving the direct care of older adults and both of the following apply:

(a) The chief administrator receives from the employment service or the applicant a report of the results of a criminal records check regarding the applicant that has been conducted by the superintendent within the one-year period immediately preceding the applicant's referral;

(b) The report of the criminal records check demonstrates that the person has not been convicted of or pleaded guilty to an offense listed or described in division (C)(1) of this section, or the report demonstrates that the person has been convicted of or pleaded guilty to one or more of those offenses, but the hospice

care program chooses to employ the individual pursuant to division (F) of this section.

(2) The chief administrator of a hospice care program is not required to request that the superintendent of the bureau of criminal identification and investigation conduct a criminal records check of an applicant and may employ the applicant conditionally as described in this division, if the applicant has been referred to the program by an employment service that supplies full-time, part-time, or temporary staff for positions involving the direct care of older adults and if the chief administrator receives from the employment service or the applicant a letter from the employment service that is on the letterhead of the employment service, dated, and signed by a supervisor or another designated official of the employment service and that states that the employment service has requested the superintendent to conduct a criminal records check regarding the applicant, that the requested criminal records check will include a determination of whether the applicant has been convicted of or pleaded guilty to any offense listed or described in division (C)(1) of this section, that, as of the date set forth on the letter, the employment service had not received the results of the criminal records check, and that, when the employment service receives the results of the criminal records check, it promptly will send a copy of the results to the hospice care program. If a hospice care program employs an applicant conditionally in accordance with this division, the employment service, upon its receipt of the results of the criminal records check, promptly shall send a copy of the results to the hospice care program, and division (C)(2)(b) of this section applies regarding the conditional employment.

Sec. 3721.01. (A) As used in sections 3721.01 to 3721.09 and 3721.99 of the Revised Code:

(1)(a) "Home" means an institution, residence, or facility that provides, for a period of more than twenty-four hours, whether for a consideration or not, accommodations to three or more unrelated individuals who are dependent upon the services of others, including a nursing home, residential care facility, home for the aging, and a veterans' home operated under Chapter 5907. of the Revised Code.

(b) "Home" also means both of the following:

(i) Any facility that a person, as defined in section 3702.51 of the Revised Code, proposes for certification as a skilled nursing facility ~~or nursing facility~~ under ~~Title XVIII or XIX of~~ the ~~"Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended~~ medicare program, or as a nursing facility under the medicaid program and for which a certificate of need, other than a certificate to recategorize hospital beds as described in section 3702.522 of the Revised Code or division (R)(7)(d) of the version of section 3702.51 of the Revised Code in effect immediately prior to April 20, 1995, has been granted to the person under sections 3702.51 to 3702.62 of the Revised Code after August 5, 1989;

(ii) A county home or district home that is or has been licensed as a residential care facility.

(c) "Home" does not mean any of the following:

(i) Except as provided in division (A)(1)(b) of this section, a public hospital or hospital as defined in section 3701.01 or 5122.01 of the Revised Code;

(ii) A residential facility for mentally ill persons as defined under section 5119.22 of the Revised Code;

(iii) A residential facility as defined in section 5123.19 of the Revised Code;

(iv) A community alternative home as defined in section

3724.01 of the Revised Code;

(v) An adult care facility as defined in section 3722.01 of the Revised Code;

(vi) An alcohol or drug addiction program as defined in section 3793.01 of the Revised Code;

(vii) A facility licensed to provide methadone treatment under section 3793.11 of the Revised Code;

(viii) A facility providing services under contract with the department of mental retardation and developmental disabilities under section 5123.18 of the Revised Code;

(ix) A facility operated by a hospice care program licensed under section 3712.04 of the Revised Code that is used exclusively for care of hospice patients;

(x) A facility, infirmary, or other entity that is operated by a religious order, provides care exclusively to members of religious orders who take vows of celibacy and live by virtue of their vows within the orders as if related, and does not participate in the medicare program ~~established under Title XVIII of the "Social Security Act"~~ or the ~~medical assistance~~ medicaid program ~~established under Chapter 5111. of the Revised Code and Title XIX of the "Social Security Act,"~~ if on January 1, 1994, the facility, infirmary, or entity was providing care exclusively to members of the religious order;

(xi) A county home or district home that has never been licensed as a residential care facility.

(2) "Unrelated individual" means one who is not related to the owner or operator of a home or to the spouse of the owner or operator as a parent, grandparent, child, grandchild, brother, sister, niece, nephew, aunt, uncle, or as the child of an aunt or uncle.

(3) "Mental impairment" does not mean mental illness as defined in section 5122.01 of the Revised Code or mental retardation as defined in section 5123.01 of the Revised Code.

(4) "Skilled nursing care" means procedures that require technical skills and knowledge beyond those the untrained person possesses and that are commonly employed in providing for the physical, mental, and emotional needs of the ill or otherwise incapacitated. "Skilled nursing care" includes, but is not limited to, the following:

(a) Irrigations, catheterizations, application of dressings, and supervision of special diets;

(b) Objective observation of changes in the patient's condition as a means of analyzing and determining the nursing care required and the need for further medical diagnosis and treatment;

(c) Special procedures contributing to rehabilitation;

(d) Administration of medication by any method ordered by a physician, such as hypodermically, rectally, or orally, including observation of the patient after receipt of the medication;

(e) Carrying out other treatments prescribed by the physician that involve a similar level of complexity and skill in administration.

(5)(a) "Personal care services" means services including, but not limited to, the following:

(i) Assisting residents with activities of daily living;

(ii) Assisting residents with self-administration of medication, in accordance with rules adopted under section 3721.04 of the Revised Code;

(iii) Preparing special diets, other than complex therapeutic diets, for residents pursuant to the instructions of a physician or a licensed dietitian, in accordance with rules adopted under

section 3721.04 of the Revised Code.

(b) "Personal care services" does not include "skilled nursing care" as defined in division (A)(4) of this section. A facility need not provide more than one of the services listed in division (A)(5)(a) of this section to be considered to be providing personal care services.

(6) "Nursing home" means a home used for the reception and care of individuals who by reason of illness or physical or mental impairment require skilled nursing care and of individuals who require personal care services but not skilled nursing care. A nursing home is licensed to provide personal care services and skilled nursing care.

(7) "Residential care facility" means a home that provides either of the following:

(a) Accommodations for seventeen or more unrelated individuals and supervision and personal care services for three or more of those individuals who are dependent on the services of others by reason of age or physical or mental impairment;

(b) Accommodations for three or more unrelated individuals, supervision and personal care services for at least three of those individuals who are dependent on the services of others by reason of age or physical or mental impairment, and, to at least one of those individuals, any of the skilled nursing care authorized by section 3721.011 of the Revised Code.

(8) "Home for the aging" means a home that provides services as a residential care facility and a nursing home, except that the home provides its services only to individuals who are dependent on the services of others by reason of both age and physical or mental impairment.

The part or unit of a home for the aging that provides services only as a residential care facility is licensed as a

residential care facility. The part or unit that may provide skilled nursing care beyond the extent authorized by section 3721.011 of the Revised Code is licensed as a nursing home.

(9) "County home" and "district home" mean a county home or district home operated under Chapter 5155. of the Revised Code.

(B) The public health council may further classify homes. For the purposes of this chapter, any residence, institution, hotel, congregate housing project, or similar facility that meets the definition of a home under this section is such a home regardless of how the facility holds itself out to the public.

(C) For purposes of this chapter, personal care services or skilled nursing care shall be considered to be provided by a facility if they are provided by a person employed by or associated with the facility or by another person pursuant to an agreement to which neither the resident who receives the services nor the resident's sponsor is a party.

(D) Nothing in division (A)(4) of this section shall be construed to permit skilled nursing care to be imposed on an individual who does not require skilled nursing care.

Nothing in division (A)(5) of this section shall be construed to permit personal care services to be imposed on an individual who is capable of performing the activity in question without assistance.

(E) Division (A)(1)(c)(x) of this section does not prohibit a facility, infirmary, or other entity described in that division from seeking licensure under sections 3721.01 to 3721.09 of the Revised Code or certification under Title XVIII or XIX of the "Social Security Act." However, such a facility, infirmary, or entity that applies for licensure or certification must meet the requirements of those sections or titles and the rules adopted under them and obtain a certificate of need from the director of

health under section 3702.52 of the Revised Code.

(F) Nothing in this chapter, or rules adopted pursuant to it, shall be construed as authorizing the supervision, regulation, or control of the spiritual care or treatment of residents or patients in any home who rely upon treatment by prayer or spiritual means in accordance with the creed or tenets of any recognized church or religious denomination.

Sec. 3721.011. (A) In addition to providing accommodations, supervision, and personal care services to its residents, a residential care facility may provide skilled nursing care to its residents as follows:

(1) Supervision of special diets;

(2) Application of dressings, in accordance with rules adopted under section 3721.04 of the Revised Code;

(3) Subject to division (B)(1) of this section, administration of medication;

(4) Subject to division (C) of this section, other skilled nursing care provided on a part-time, intermittent basis for not more than a total of one hundred twenty days in a twelve-month period;

(5) Subject to division (D) of this section, skilled nursing care provided for more than one hundred twenty days in a twelve-month period to a hospice patient, as defined in section 3712.01 of the Revised Code.

A residential care facility may not admit or retain an individual requiring skilled nursing care that is not authorized by this section. A residential care facility may not provide skilled nursing care beyond the limits established by this section.

(B)(1) A residential care facility may admit or retain an

individual requiring medication, including biologicals, only if the individual's personal physician has determined in writing that the individual is capable of self-administering the medication or the facility provides for the medication to be administered to the individual by a home health agency certified under ~~Title XVIII of~~ the ~~"Social Security Act," 79 Stat. 620 (1965), 42 U.S.C.A. 1395, as amended~~ medicare program; a hospice care program licensed under Chapter 3712. of the Revised Code; or a member of the staff of the residential care facility who is qualified to perform medication administration. Medication may be administered in a residential care facility only by the following persons authorized by law to administer medication:

(a) A registered nurse licensed under Chapter 4723. of the Revised Code;

(b) A licensed practical nurse licensed under Chapter 4723. of the Revised Code who holds proof of successful completion of a course in medication administration approved by the board of nursing and who administers the medication only at the direction of a registered nurse or a physician authorized under Chapter 4731. of the Revised Code to practice medicine and surgery or osteopathic medicine and surgery;

(c) A medication aide certified under Chapter 4723. of the Revised Code;

(d) A physician authorized under Chapter 4731. of the Revised Code to practice medicine and surgery or osteopathic medicine and surgery.

(2) In assisting a resident with self-administration of medication, any member of the staff of a residential care facility may do the following:

(a) Remind a resident when to take medication and watch to ensure that the resident follows the directions on the container;

(b) Assist a resident by taking the medication from the locked area where it is stored, in accordance with rules adopted pursuant to section 3721.04 of the Revised Code, and handing it to the resident. If the resident is physically unable to open the container, a staff member may open the container for the resident.

(c) Assist a physically impaired but mentally alert resident, such as a resident with arthritis, cerebral palsy, or Parkinson's disease, in removing oral or topical medication from containers and in consuming or applying the medication, upon request by or with the consent of the resident. If a resident is physically unable to place a dose of medicine to the resident's mouth without spilling it, a staff member may place the dose in a container and place the container to the mouth of the resident.

(C) A residential care facility may admit or retain individuals who require skilled nursing care beyond the supervision of special diets, application of dressings, or administration of medication, only if the care will be provided on a part-time, intermittent basis for not more than a total of one hundred twenty days in any twelve-month period. In accordance with Chapter 119. of the Revised Code, the public health council shall adopt rules specifying what constitutes the need for skilled nursing care on a part-time, intermittent basis. The council shall adopt rules that are consistent with rules pertaining to home health care adopted by the director of ~~job and family services~~ health care administration for the ~~medical assistance~~ medicaid program ~~established under Chapter 5111. of the Revised Code~~. Skilled nursing care provided pursuant to this division may be provided by a home health agency certified under ~~Title XVIII of~~ the ~~"Social Security Act,"~~ medicare program, a hospice care program licensed under Chapter 3712. of the Revised Code, or a member of the staff of a residential care facility who is qualified to perform skilled nursing care.

A residential care facility that provides skilled nursing care pursuant to this division shall do both of the following:

(1) Evaluate each resident receiving the skilled nursing care at least once every seven days to determine whether the resident should be transferred to a nursing home;

(2) Meet the skilled nursing care needs of each resident receiving the care.

(D) A residential care facility may admit or retain a hospice patient who requires skilled nursing care for more than one hundred twenty days in any twelve-month period only if the facility has entered into a written agreement with a hospice care program licensed under Chapter 3712. of the Revised Code. The agreement between the residential care facility and hospice program shall include all of the following provisions:

(1) That the hospice patient will be provided skilled nursing care in the facility only if a determination has been made that the patient's needs can be met at the facility;

(2) That the hospice patient will be retained in the facility only if periodic redeterminations are made that the patient's needs are being met at the facility;

(3) That the redeterminations will be made according to a schedule specified in the agreement;

(4) That the hospice patient has been given an opportunity to choose the hospice care program that best meets the patient's needs.

(E) Notwithstanding any other provision of this chapter, a residential care facility in which residents receive skilled nursing care pursuant to this section is not a nursing home.

Sec. 3721.021. Every person who operates a home, as defined in section 3721.01 of the Revised Code, and each county home and

district home licensed as a residential care facility shall have available in the home for review by prospective patients and residents, their guardians, or other persons assisting in their placement, each inspection report completed pursuant to section 3721.02 of the Revised Code and each statement of deficiencies and plan of correction completed and made available to the public under ~~Titles XVIII and XIX of~~ the ~~"Social Security Act," 49 Stat. 620 (1935), 42 U.S.C. 301, as amended~~ medicare program and medicaid program, and any rules promulgated under ~~Titles XVIII and XIX~~ those programs, including such reports that result from life safety code and health inspections during the preceding three years, and shall post prominently within the home a notice of this requirement.

Sec. 3721.022. (A) As used in this section:

(1) "Nursing facility" has the same meaning as in section ~~5111.20~~ 5164.01 of the Revised Code.

(2) "Deficiency" and "survey" have the same meanings as in section ~~5111.35~~ 5164.50 of the Revised Code.

(B) The department of health is hereby designated the state agency responsible for establishing and maintaining health standards and serving as the state survey agency for the purposes of ~~Titles XVIII and XIX of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended~~ the medicare and medicaid programs. The department shall carry out these functions in accordance with the regulations, guidelines, and procedures issued ~~under Titles XVIII and XIX~~ for the medicare and medicaid programs by the United States secretary of health and human services and with sections ~~5111.35~~ 5164.50 to ~~5111.62~~ 5164.78 of the Revised Code. The director of health shall enter into agreements with regard to these functions with the department of ~~job and family services~~ health care administration and the United States

department of health and human services. The director may also enter into agreements with the department of ~~job and family services~~ health care administration under which the department of health is designated to perform functions under sections ~~5111.35~~ 5164.50 to ~~5111.62~~ 5164.78 of the Revised Code.

The director, in accordance with Chapter 119. of the Revised Code, shall adopt rules necessary to implement the survey and certification requirements for skilled nursing facilities and nursing facilities established by the United States secretary of health and human services ~~under Titles XVIII and XIX of the "Social Security Act,"~~ for the medicare and medicaid programs and the survey requirements established under sections ~~5111.35~~ 5164.50 to ~~5111.62~~ 5164.78 of the Revised Code. The rules shall include an informal process by which a facility may obtain a review of deficiencies that have been cited on a statement of deficiencies made by the department of health under section ~~5111.42~~ 5164.58 of the Revised Code. The review shall be conducted by an employee of the department who did not participate in and was not otherwise involved in any way with the survey. If the employee conducting the review determines that any deficiency citation is unjustified, that determination shall be reflected clearly in all records relating to the survey.

The director need not adopt as rules any of the regulations, guidelines, or procedures issued ~~under Titles XVIII and XIX of the "Social Security Act"~~ for the medicare or medicaid programs by the United States secretary of health and human services.

Sec. 3721.024. As used in this section, "nursing facility" has the same meaning as in section ~~5111.20~~ 5164.01 of the Revised Code.

The department of health may establish a program of recognition of nursing facilities that provide the highest quality

care to residents who are medicaid recipients ~~of medical assistance under Chapter 5111. of the Revised Code~~. The program may be funded with public funds appropriated by the general assembly for the purpose of the program or any funds appropriated for nursing home licensure.

Sec. 3721.026. (A) As used in this section and section 3721.027 of the Revised Code, "nursing facility" and "survey" have the same meanings as in section ~~5111.35~~ 5164.50 of the Revised Code.

(B) The director of health shall establish a unit within the department of health to provide advice and technical assistance and to conduct on-site visits to nursing facilities for the purpose of improving resident outcomes. The director shall assign to the unit employees who have training or experience in conducting or supervising surveys, but employees assigned to the unit shall not conduct surveys. The director shall adopt rules in accordance with Chapter 119. of the Revised Code to implement this section and shall consult with interested parties in developing the rules. Technical assistance reports are not public records under section 149.43 of the Revised Code and shall not be distributed to any person outside the unit except:

(1) The nursing facility that is provided with the technical assistance;

(2) Persons charged with inspecting nursing facilities under section 3721.02 of the Revised Code or with conducting surveys or reviews of nursing facilities under section 3721.022 of the Revised Code whenever any such person finds that there is serious harm to resident health or safety that is more than isolated at the nursing facility.

The provisions of this section and rules adopted under this section do not affect the department's authority to administer and

enforce other sections of this chapter.

(C) On or before the last day of December each year, the director shall submit a report to the governor and the general assembly describing the unit's activities that year and its effectiveness in improving resident outcomes.

Sec. 3721.071. The buildings in which a home is housed shall be equipped with both an automatic fire extinguishing system and fire alarm system. Such systems shall conform to standards set forth in the regulations of the board of building standards and the state fire marshal.

The time for compliance with the requirements imposed by this section shall be January 1, 1975, except that the date for compliance with the automatic fire extinguishing requirements is extended to January 1, 1976, provided the buildings of the home are otherwise in compliance with fire safety laws and regulations and:

(A) The home within thirty days after August 4, 1975, files a written plan with the state fire marshal's office that:

(1) Outlines the interim safety procedures which shall be carried out to reduce the possibility of a fire;

(2) Provides evidence that the home has entered into an agreement for a fire safety inspection to be conducted not less than monthly by a qualified independent safety engineer consultant or a township, municipal, or other legally constituted fire department, or by a township or municipal fire prevention officer;

(3) Provides verification that the home has entered into a valid contract for the installation of an automatic fire extinguishing system or fire alarm system, or both, as required to comply with this section;

(4) Includes a statement regarding the expected date for the

completion of the fire extinguishing system or fire alarm system, or both.

(B) Inspections by a qualified independent safety engineer consultant or a township, municipal, or other legally constituted fire department, or by a township or municipal fire prevention officer are initiated no later than sixty days after August 4, 1975, and are conducted no less than monthly thereafter, and reports of the consultant, fire department, or fire prevention officer identifying existing hazards and recommended corrective actions are submitted to the state fire marshal, the division of industrial compliance in the department of commerce, and the department of health.

It is the express intent of the general assembly that the department of ~~job and family services~~ health care administration shall terminate medicaid payments ~~under Title XIX of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C. 301, as amended,~~ to those homes which do not comply with the requirements of this section for the submission of a written fire safety plan and the deadline for entering into contracts for the installation of systems.

Sec. 3721.08. (A) As used in this section, "real and present danger" means imminent danger of serious physical or life-threatening harm to one or more occupants of a home.

(B) The director of health may petition the court of common pleas of the county in which the home is located for an order enjoining any person from operating a home without a license or enjoining a county home or district home that has had its license revoked from continuing to operate. The court shall have jurisdiction to grant such injunctive relief upon a showing that the respondent named in the petition is operating a home without a license or that the county home or district home named in the

petition is operating despite the revocation of its license. The court shall have jurisdiction to grant such injunctive relief against the operation of a home without a valid license regardless of whether the home meets essential licensing requirements.

(C) Unless the department of ~~job and family services~~ health care administration or contracting agency has taken action under section ~~5111.51~~ 5164.67 of the Revised Code to appoint a temporary manager or seek injunctive relief, if, in the judgment of the director of health, real and present danger exists at any home, the director may petition the court of common pleas of the county in which the home is located for such injunctive relief as is necessary to close the home, transfer one or more occupants to other homes or other appropriate care settings, or otherwise eliminate the real and present danger. The court shall have the jurisdiction to grant such injunctive relief upon a showing that there is real and present danger.

(D)(1) If the director determines that real and present danger exists at a home and elects not to immediately seek injunctive relief under division (C) of this section, the director may give written notice of proposed action to the home. The notice shall specify all of the following:

(a) The nature of the conditions giving rise to the real and present danger;

(b) The measures that the director determines the home must take to respond to the conditions;

(c) The date on which the director intends to seek injunctive relief under division (C) of this section if the director determines that real and present danger exists at the home.

(2) If the home notifies the director, within the time specified pursuant to division (D)(1)(c) of this section, that it believes the conditions giving rise to the real and present danger

have been substantially corrected, the director shall conduct an inspection to determine whether real and present danger exists. If the director determines on the basis of the inspection that real and present danger exists, the director may petition under division (C) of this section for injunctive relief.

(E)(1) If in the judgment of the director of health conditions exist at a home that will give rise to real and present danger if not corrected, the director shall give written notice of proposed action to the home. The notice shall specify all of the following:

(a) The nature of the conditions giving rise to the director's judgment;

(b) The measures that the director determines the home must take to respond to the conditions;

(c) The date, which shall be no less than ten days after the notice is delivered, on which the director intends to seek injunctive relief under division (C) of this section if the conditions are not substantially corrected and the director determines that a real and present danger exists.

(2) If the home notifies the director, within the period of time specified pursuant to division (E)(1)(c) of this section, that the conditions giving rise to the director's determination have been substantially corrected, the director shall conduct an inspection. If the director determines on the basis of the inspection that the conditions have not been corrected and a real and present danger exists, the director may petition under division (C) of this section for injunctive relief.

(F)(1) A court that grants injunctive relief under division (C) of this section may also appoint a special master who, subject to division (F)(2) of this section, shall have such powers and authority over the home and length of appointment as the court

considers necessary. Subject to division (F)(2) of this section, the salary of a special master and any costs incurred by a special master shall be the obligation of the home.

(2) No special master shall enter into any employment contract on behalf of a home, or purchase with the home's funds any capital goods totaling more than ten thousand dollars, unless the special master has obtained approval for the contract or purchase from the home's operator or the court.

(G) If the director takes action under division (C), (D), or (E) of this section, the director may also appoint employees of the department of health to conduct on-site monitoring of the home. Appointment of monitors is not subject to appeal under Chapter 119. or any other section of the Revised Code. No employee of a home for which monitors are appointed, no person employed by the home within the previous two years, and no person who currently has a consulting contract with the department or a home, shall be appointed under this division. Every monitor shall have the professional qualifications necessary to monitor correction of the conditions that give rise to or, in the director's judgment, will give rise to real and present danger. The number of monitors present at a home at any given time shall not exceed one for every fifty residents, or fraction thereof.

(H) On finding that the real and present danger for which injunctive relief was granted under division (C) of this section has been eliminated and that the home's operator has demonstrated the capacity to prevent the real and present danger from recurring, the court shall terminate its jurisdiction over the home and return control and management of the home to the operator. If the real and present danger cannot be eliminated practicably within a reasonable time following appointment of a special master, the court may order the special master to close the home and transfer all residents to other homes or other

appropriate care settings.

(I) The director of health shall give notice of proposed action under divisions (D) and (E) of this section to both of the following:

(1) The home's administrator;

(2) If the home is operated by an organization described in subsection 501(c)(3) and tax exempt under subsection 501(a) of the "Internal Revenue Code of 1986," 100 Stat. 2085, 26 U.S.C.A. 1, as amended, the board of trustees of the organization; or, if the home is not operated by such an organization, the owner of the home.

Notices shall be delivered by certified mail or hand delivery. If notices are mailed, they shall be addressed to the persons specified in divisions (I)(1) and (2) of this section, as indicated in the department of health's records. If they are hand delivered, they shall be delivered to persons who would reasonably appear to the average prudent person to have authority to accept them.

(J) If ownership of a home is assigned or transferred to a different person, the new owner is responsible and liable for compliance with any notice of proposed action or order issued under this section prior to the effective date of the assignment or transfer.

Sec. 3721.10. As used in sections 3721.10 to 3721.18 of the Revised Code:

(A) "Home" means all of the following:

(1) A home as defined in section 3721.01 of the Revised Code;

(2) Any facility or part of a facility not defined as a home under section 3721.01 of the Revised Code that is certified as a skilled nursing facility ~~under Title XVIII of the "Social Security~~

~~Act," 79 Stat. 286 (1965), 42 U.S.C.A. 1395 and 1396, as amended,~~ for the medicare program or as a nursing facility ~~as defined in section 5111.20 of the Revised Code~~ for the medicaid program;

(3) A county home or district home operated pursuant to Chapter 5155. of the Revised Code.

(B) "Resident" means a resident or a patient of a home.

(C) "Administrator" means all of the following:

(1) With respect to a home as defined in section 3721.01 of the Revised Code, a nursing home administrator as defined in section 4751.01 of the Revised Code;

(2) With respect to a facility or part of a facility not defined as a home in section 3721.01 of the Revised Code that is authorized to provide skilled nursing facility or nursing facility services, the administrator of the facility or part of a facility;

(3) With respect to a county home or district home, the superintendent appointed under Chapter 5155. of the Revised Code.

(D) "Sponsor" means an adult relative, friend, or guardian of a resident who has an interest or responsibility in the resident's welfare.

(E) "Residents' rights advocate" means:

(1) An employee or representative of any state or local government entity that has a responsibility regarding residents and that has registered with the department of health under division (B) of section 3701.07 of the Revised Code;

(2) An employee or representative of any private nonprofit corporation or association that qualifies for tax-exempt status under section 501(a) of the "Internal Revenue Code of 1986," 100 Stat. 2085, 26 U.S.C.~~A.~~ 1, as amended, and that has registered with the department of health under division (B) of section 3701.07 of the Revised Code and whose purposes include educating

and counseling residents, assisting residents in resolving problems and complaints concerning their care and treatment, and assisting them in securing adequate services to meet their needs;

(3) A member of the general assembly.

(F) "Physical restraint" means, but is not limited to, any article, device, or garment that interferes with the free movement of the resident and that the resident is unable to remove easily, a geriatric chair, or a locked room door.

(G) "Chemical restraint" means any medication bearing the American hospital formulary service therapeutic class 4.00, 28:16:08, 28:24:08, or 28:24:92 that alters the functioning of the central nervous system in a manner that limits physical and cognitive functioning to the degree that the resident cannot attain the resident's highest practicable physical, mental, and psychosocial well-being.

(H) "Ancillary service" means, but is not limited to, podiatry, dental, hearing, vision, physical therapy, occupational therapy, speech therapy, and psychological and social services.

(I) "Facility" means a facility, or part of a facility, certified as a nursing facility or skilled nursing facility under ~~Title XVIII or Title XIX of~~ the ~~"Social Security Act."~~ the medicare or medicaid programs. "Facility" does not include an intermediate care facility for the mentally retarded, as defined in section ~~5111.20~~ 5164.01 of the Revised Code.

~~(J) "Medicare" means the program established by Title XVIII of the "Social Security Act."~~

~~(K) "Medicaid" means the program established by Title XIX of the "Social Security Act" and Chapter 5111. of the Revised Code.~~

Sec. 3721.12. (A) The administrator of a home shall:

(1) With the advice of residents, their sponsors, or both,

establish and review at least annually, written policies regarding the applicability and implementation of residents' rights under sections 3721.10 to 3721.17 of the Revised Code, the responsibilities of residents regarding the rights, and the home's grievance procedure established under division (A)(2) of this section. The administrator is responsible for the development of, and adherence to, procedures implementing the policies.

(2) Establish a grievance committee for review of complaints by residents. The grievance committee shall be comprised of the home's staff and residents, sponsors, or outside representatives in a ratio of not more than one staff member to every two residents, sponsors, or outside representatives.

(3) Furnish to each resident and sponsor prior to or at the time of admission, and to each member of the home's staff, at least one of each of the following:

(a) A copy of the rights established under sections 3721.10 to 3721.17 of the Revised Code;

(b) A written explanation of the provisions of sections 3721.16 to 3721.162 of the Revised Code;

(c) A copy of the home's policies and procedures established under this section;

(d) A copy of the home's rules;

(e) A copy of the addresses and telephone numbers of the board of health of the health district of the county in which the home is located, the county department of job and family services of the county in which the home is located, the state departments of health and job and family services, the state and local offices of the department of aging, and any Ohio nursing home ombudsperson program.

(B) Written acknowledgment of the receipt of copies of the

materials listed in this section shall be made part of the resident's record and the staff member's personnel record.

(C) The administrator shall post all of the following prominently within the home:

(1) A copy of the rights of residents as listed in division (A) of section 3721.13 of the Revised Code;

(2) A copy of the home's rules and its policies and procedures regarding the rights and responsibilities of residents;

(3) A notice that a copy of this chapter, rules of the department of health applicable to the home, and federal regulations adopted under the medicare and medicaid programs, and the materials required to be available in the home under section 3721.021 of the Revised Code, are available for inspection in the home at reasonable hours;

(4) A list of residents' rights advocates;

(5) A notice that the following are available in a place readily accessible to residents:

(a) If the home is licensed under section 3721.02 of the Revised Code, a copy of the most recent licensure inspection report prepared for the home under that section;

(b) If the home is a facility, a copy of the most recent statement of deficiencies issued to the home under section ~~5111.42~~ 5164.58 of the Revised Code.

(D) The administrator of a home may, with the advice of residents, their sponsors, or both, establish written policies regarding the applicability and administration of any additional residents' rights beyond those set forth in sections 3721.10 to 3721.17 of the Revised Code, and the responsibilities of residents regarding the rights. Policies established under this division shall be reviewed, and procedures developed and adhered to as in

division (A)(1) of this section.

Sec. 3721.121. (A) As used in this section:

(1) "Adult day-care program" means a program operated pursuant to rules adopted by the public health council under section 3721.04 of the Revised Code and provided by and on the same site as homes licensed under this chapter.

(2) "Applicant" means a person who is under final consideration for employment with a home or adult day-care program in a full-time, part-time, or temporary position that involves providing direct care to an older adult. "Applicant" does not include a person who provides direct care as a volunteer without receiving or expecting to receive any form of remuneration other than reimbursement for actual expenses.

(3) "Criminal records check" and "older adult" have the same meanings as in section 109.572 of the Revised Code.

(4) "Home" means a home as defined in section 3721.10 of the Revised Code.

(B)(1) Except as provided in division (I) of this section, the chief administrator of a home or adult day-care program shall request that the superintendent of the bureau of criminal identification and investigation conduct a criminal records check with respect to each applicant. If an applicant for whom a criminal records check request is required under this division does not present proof of having been a resident of this state for the five-year period immediately prior to the date the criminal records check is requested or provide evidence that within that five-year period the superintendent has requested information about the applicant from the federal bureau of investigation in a criminal records check, the chief administrator shall request that the superintendent obtain information from the federal bureau of

investigation as part of the criminal records check of the applicant. Even if an applicant for whom a criminal records check request is required under this division presents proof of having been a resident of this state for the five-year period, the chief administrator may request that the superintendent include information from the federal bureau of investigation in the criminal records check.

(2) A person required by division (B)(1) of this section to request a criminal records check shall do both of the following:

(a) Provide to each applicant for whom a criminal records check request is required under that division a copy of the form prescribed pursuant to division (C)(1) of section 109.572 of the Revised Code and a standard fingerprint impression sheet prescribed pursuant to division (C)(2) of that section, and obtain the completed form and impression sheet from the applicant;

(b) Forward the completed form and impression sheet to the superintendent of the bureau of criminal identification and investigation.

(3) An applicant provided the form and fingerprint impression sheet under division (B)(2)(a) of this section who fails to complete the form or provide fingerprint impressions shall not be employed in any position for which a criminal records check is required by this section.

(C)(1) Except as provided in rules adopted by the director of health in accordance with division (F) of this section and subject to division (C)(2) of this section, no home or adult day-care program shall employ a person in a position that involves providing direct care to an older adult if the person has been convicted of or pleaded guilty to any of the following:

(a) A violation of section 2903.01, 2903.02, 2903.03, 2903.04, 2903.11, 2903.12, 2903.13, 2903.16, 2903.21, 2903.34,

2905.01, 2905.02, 2905.11, 2905.12, 2907.02, 2907.03, 2907.05, 2907.06, 2907.07, 2907.08, 2907.09, 2907.12, 2907.25, 2907.31, 2907.32, 2907.321, 2907.322, 2907.323, 2911.01, 2911.02, 2911.11, 2911.12, 2911.13, 2913.02, 2913.03, 2913.04, 2913.11, 2913.21, 2913.31, 2913.40, 2913.43, 2913.47, 2913.51, 2919.25, 2921.36, 2923.12, 2923.13, 2923.161, 2925.02, 2925.03, 2925.11, 2925.13, 2925.22, 2925.23, or 3716.11 of the Revised Code.

(b) A violation of an existing or former law of this state, any other state, or the United States that is substantially equivalent to any of the offenses listed in division (C)(1)(a) of this section.

(2)(a) A home or an adult day-care program may employ conditionally an applicant for whom a criminal records check request is required under division (B) of this section prior to obtaining the results of a criminal records check regarding the individual, provided that the home or program shall request a criminal records check regarding the individual in accordance with division (B)(1) of this section not later than five business days after the individual begins conditional employment. In the circumstances described in division (I)(2) of this section, a home or adult day-care program may employ conditionally an applicant who has been referred to the home or adult day-care program by an employment service that supplies full-time, part-time, or temporary staff for positions involving the direct care of older adults and for whom, pursuant to that division, a criminal records check is not required under division (B) of this section.

(b) A home or adult day-care program that employs an individual conditionally under authority of division (C)(2)(a) of this section shall terminate the individual's employment if the results of the criminal records check requested under division (B) of this section or described in division (I)(2) of this section, other than the results of any request for information from the

federal bureau of investigation, are not obtained within the period ending thirty days after the date the request is made. Regardless of when the results of the criminal records check are obtained, if the results indicate that the individual has been convicted of or pleaded guilty to any of the offenses listed or described in division (C)(1) of this section, the home or program shall terminate the individual's employment unless the home or program chooses to employ the individual pursuant to division (F) of this section. Termination of employment under this division shall be considered just cause for discharge for purposes of division (D)(2) of section 4141.29 of the Revised Code if the individual makes any attempt to deceive the home or program about the individual's criminal record.

(D)(1) Each home or adult day-care program shall pay to the bureau of criminal identification and investigation the fee prescribed pursuant to division (C)(3) of section 109.572 of the Revised Code for each criminal records check conducted pursuant to a request made under division (B) of this section.

(2) A home or adult day-care program may charge an applicant a fee not exceeding the amount the home or program pays under division (D)(1) of this section. A home or program may collect a fee only if both of the following apply:

(a) The home or program notifies the person at the time of initial application for employment of the amount of the fee and that, unless the fee is paid, the person will not be considered for employment;

(b) The ~~medical assistance~~ medicaid program ~~established under Chapter 5111. of the Revised Code~~ does not reimburse the home or program the fee it pays under division (D)(1) of this section.

(E) The report of any criminal records check conducted pursuant to a request made under this section is not a public

record for the purposes of section 149.43 of the Revised Code and shall not be made available to any person other than the following:

(1) The individual who is the subject of the criminal records check or the individual's representative;

(2) The chief administrator of the home or program requesting the criminal records check or the administrator's representative;

(3) The administrator of any other facility, agency, or program that provides direct care to older adults that is owned or operated by the same entity that owns or operates the home or program;

(4) A court, hearing officer, or other necessary individual involved in a case dealing with a denial of employment of the applicant or dealing with employment or unemployment benefits of the applicant;

(5) Any person to whom the report is provided pursuant to, and in accordance with, division (I)(1) or (2) of this section;

(6) The board of nursing for purposes of accepting and processing an application for a medication aide certificate issued under Chapter 4723. of the Revised Code.

(F) In accordance with section 3721.11 of the Revised Code, the director of health shall adopt rules to implement this section. The rules shall specify circumstances under which a home or adult day-care program may employ a person who has been convicted of or pleaded guilty to an offense listed or described in division (C)(1) of this section but meets personal character standards set by the director.

(G) The chief administrator of a home or adult day-care program shall inform each individual, at the time of initial application for a position that involves providing direct care to

an older adult, that the individual is required to provide a set of fingerprint impressions and that a criminal records check is required to be conducted if the individual comes under final consideration for employment.

(H) In a tort or other civil action for damages that is brought as the result of an injury, death, or loss to person or property caused by an individual who a home or adult day-care program employs in a position that involves providing direct care to older adults, all of the following shall apply:

(1) If the home or program employed the individual in good faith and reasonable reliance on the report of a criminal records check requested under this section, the home or program shall not be found negligent solely because of its reliance on the report, even if the information in the report is determined later to have been incomplete or inaccurate;

(2) If the home or program employed the individual in good faith on a conditional basis pursuant to division (C)(2) of this section, the home or program shall not be found negligent solely because it employed the individual prior to receiving the report of a criminal records check requested under this section;

(3) If the home or program in good faith employed the individual according to the personal character standards established in rules adopted under division (F) of this section, the home or program shall not be found negligent solely because the individual prior to being employed had been convicted of or pleaded guilty to an offense listed or described in division (C)(1) of this section.

(I)(1) The chief administrator of a home or adult day-care program is not required to request that the superintendent of the bureau of criminal identification and investigation conduct a criminal records check of an applicant if the applicant has been

referred to the home or program by an employment service that supplies full-time, part-time, or temporary staff for positions involving the direct care of older adults and both of the following apply:

(a) The chief administrator receives from the employment service or the applicant a report of the results of a criminal records check regarding the applicant that has been conducted by the superintendent within the one-year period immediately preceding the applicant's referral;

(b) The report of the criminal records check demonstrates that the person has not been convicted of or pleaded guilty to an offense listed or described in division (C)(1) of this section, or the report demonstrates that the person has been convicted of or pleaded guilty to one or more of those offenses, but the home or adult day-care program chooses to employ the individual pursuant to division (F) of this section.

(2) The chief administrator of a home or adult day-care program is not required to request that the superintendent of the bureau of criminal identification and investigation conduct a criminal records check of an applicant and may employ the applicant conditionally as described in this division, if the applicant has been referred to the home or program by an employment service that supplies full-time, part-time, or temporary staff for positions involving the direct care of older adults and if the chief administrator receives from the employment service or the applicant a letter from the employment service that is on the letterhead of the employment service, dated, and signed by a supervisor or another designated official of the employment service and that states that the employment service has requested the superintendent to conduct a criminal records check regarding the applicant, that the requested criminal records check will include a determination of whether the applicant has been

convicted of or pleaded guilty to any offense listed or described in division (C)(1) of this section, that, as of the date set forth on the letter, the employment service had not received the results of the criminal records check, and that, when the employment service receives the results of the criminal records check, it promptly will send a copy of the results to the home or adult day-care program. If a home or adult day-care program employs an applicant conditionally in accordance with this division, the employment service, upon its receipt of the results of the criminal records check, promptly shall send a copy of the results to the home or adult day-care program, and division (C)(2)(b) of this section applies regarding the conditional employment.

Sec. 3721.13. (A) The rights of residents of a home shall include, but are not limited to, the following:

(1) The right to a safe and clean living environment pursuant to the medicare and medicaid programs and applicable state laws and regulations prescribed by the public health council;

(2) The right to be free from physical, verbal, mental, and emotional abuse and to be treated at all times with courtesy, respect, and full recognition of dignity and individuality;

(3) Upon admission and thereafter, the right to adequate and appropriate medical treatment and nursing care and to other ancillary services that comprise necessary and appropriate care consistent with the program for which the resident contracted. This care shall be provided without regard to considerations such as race, color, religion, national origin, age, or source of payment for care.

(4) The right to have all reasonable requests and inquiries responded to promptly;

(5) The right to have clothes and bed sheets changed as the

need arises, to ensure the resident's comfort or sanitation;

(6) The right to obtain from the home, upon request, the name and any specialty of any physician or other person responsible for the resident's care or for the coordination of care;

(7) The right, upon request, to be assigned, within the capacity of the home to make the assignment, to the staff physician of the resident's choice, and the right, in accordance with the rules and written policies and procedures of the home, to select as the attending physician a physician who is not on the staff of the home. If the cost of a physician's services is to be met under a federally supported program, the physician shall meet the federal laws and regulations governing such services.

(8) The right to participate in decisions that affect the resident's life, including the right to communicate with the physician and employees of the home in planning the resident's treatment or care and to obtain from the attending physician complete and current information concerning medical condition, prognosis, and treatment plan, in terms the resident can reasonably be expected to understand; the right of access to all information in the resident's medical record; and the right to give or withhold informed consent for treatment after the consequences of that choice have been carefully explained. When the attending physician finds that it is not medically advisable to give the information to the resident, the information shall be made available to the resident's sponsor on the resident's behalf, if the sponsor has a legal interest or is authorized by the resident to receive the information. The home is not liable for a violation of this division if the violation is found to be the result of an act or omission on the part of a physician selected by the resident who is not otherwise affiliated with the home.

(9) The right to withhold payment for physician visitation if the physician did not visit the resident;

(10) The right to confidential treatment of personal and medical records, and the right to approve or refuse the release of these records to any individual outside the home, except in case of transfer to another home, hospital, or health care system, as required by law or rule, or as required by a third-party payment contract;

(11) The right to privacy during medical examination or treatment and in the care of personal or bodily needs;

(12) The right to refuse, without jeopardizing access to appropriate medical care, to serve as a medical research subject;

(13) The right to be free from physical or chemical restraints or prolonged isolation except to the minimum extent necessary to protect the resident from injury to self, others, or to property and except as authorized in writing by the attending physician for a specified and limited period of time and documented in the resident's medical record. Prior to authorizing the use of a physical or chemical restraint on any resident, the attending physician shall make a personal examination of the resident and an individualized determination of the need to use the restraint on that resident.

Physical or chemical restraints or isolation may be used in an emergency situation without authorization of the attending physician only to protect the resident from injury to self or others. Use of the physical or chemical restraints or isolation shall not be continued for more than twelve hours after the onset of the emergency without personal examination and authorization by the attending physician. The attending physician or a staff physician may authorize continued use of physical or chemical restraints for a period not to exceed thirty days, and at the end of this period and any subsequent period may extend the authorization for an additional period of not more than thirty days. The use of physical or chemical restraints shall not be

continued without a personal examination of the resident and the written authorization of the attending physician stating the reasons for continuing the restraint.

If physical or chemical restraints are used under this division, the home shall ensure that the restrained resident receives a proper diet. In no event shall physical or chemical restraints or isolation be used for punishment, incentive, or convenience.

(14) The right to the pharmacist of the resident's choice and the right to receive pharmaceutical supplies and services at reasonable prices not exceeding applicable and normally accepted prices for comparably packaged pharmaceutical supplies and services within the community;

(15) The right to exercise all civil rights, unless the resident has been adjudicated incompetent pursuant to Chapter 2111. of the Revised Code and has not been restored to legal capacity, as well as the right to the cooperation of the home's administrator in making arrangements for the exercise of the right to vote;

(16) The right of access to opportunities that enable the resident, at the resident's own expense or at the expense of a third-party payer, to achieve the resident's fullest potential, including educational, vocational, social, recreational, and habilitation programs;

(17) The right to consume a reasonable amount of alcoholic beverages at the resident's own expense, unless not medically advisable as documented in the resident's medical record by the attending physician or unless contradictory to written admission policies;

(18) The right to use tobacco at the resident's own expense under the home's safety rules and under applicable laws and rules

of the state, unless not medically advisable as documented in the resident's medical record by the attending physician or unless contradictory to written admission policies;

(19) The right to retire and rise in accordance with the resident's reasonable requests, if the resident does not disturb others or the posted meal schedules and upon the home's request remains in a supervised area, unless not medically advisable as documented by the attending physician;

(20) The right to observe religious obligations and participate in religious activities; the right to maintain individual and cultural identity; and the right to meet with and participate in activities of social and community groups at the resident's or the group's initiative;

(21) The right upon reasonable request to private and unrestricted communications with the resident's family, social worker, and any other person, unless not medically advisable as documented in the resident's medical record by the attending physician, except that communications with public officials or with the resident's attorney or physician shall not be restricted. Private and unrestricted communications shall include, but are not limited to, the right to:

(a) Receive, send, and mail sealed, unopened correspondence;

(b) Reasonable access to a telephone for private communications;

(c) Private visits at any reasonable hour.

(22) The right to assured privacy for visits by the spouse, or if both are residents of the same home, the right to share a room within the capacity of the home, unless not medically advisable as documented in the resident's medical record by the attending physician;

(23) The right upon reasonable request to have room doors closed and to have them not opened without knocking, except in the case of an emergency or unless not medically advisable as documented in the resident's medical record by the attending physician;

(24) The right to retain and use personal clothing and a reasonable amount of possessions, in a reasonably secure manner, unless to do so would infringe on the rights of other residents or would not be medically advisable as documented in the resident's medical record by the attending physician;

(25) The right to be fully informed, prior to or at the time of admission and during the resident's stay, in writing, of the basic rate charged by the home, of services available in the home, and of any additional charges related to such services, including charges for services not covered under the medicare or medicaid program. The basic rate shall not be changed unless thirty days notice is given to the resident or, if the resident is unable to understand this information, to the resident's sponsor.

(26) The right of the resident and person paying for the care to examine and receive a bill at least monthly for the resident's care from the home that itemizes charges not included in the basic rates;

(27)(a) The right to be free from financial exploitation;

(b) The right to manage the resident's own personal financial affairs, or, if the resident has delegated this responsibility in writing to the home, to receive upon written request at least a quarterly accounting statement of financial transactions made on the resident's behalf. The statement shall include:

(i) A complete record of all funds, personal property, or possessions of a resident from any source whatsoever, that have been deposited for safekeeping with the home for use by the

resident or the resident's sponsor;

(ii) A listing of all deposits and withdrawals transacted, which shall be substantiated by receipts which shall be available for inspection and copying by the resident or sponsor.

(28) The right of the resident to be allowed unrestricted access to the resident's property on deposit at reasonable hours, unless requests for access to property on deposit are so persistent, continuous, and unreasonable that they constitute a nuisance;

(29) The right to receive reasonable notice before the resident's room or roommate is changed, including an explanation of the reason for either change.

(30) The right not to be transferred or discharged from the home unless the transfer is necessary because of one of the following:

(a) The welfare and needs of the resident cannot be met in the home.

(b) The resident's health has improved sufficiently so that the resident no longer needs the services provided by the home.

(c) The safety of individuals in the home is endangered.

(d) The health of individuals in the home would otherwise be endangered.

(e) The resident has failed, after reasonable and appropriate notice, to pay or to have the medicare or medicaid program pay on the resident's behalf, for the care provided by the home. A resident shall not be considered to have failed to have the resident's care paid for if the resident has applied for medicaid, unless both of the following are the case:

(i) The resident's application, or a substantially similar previous application, has been denied by the county department of

job and family services.

(ii) If the resident appealed the denial pursuant to division (C) of section ~~5101.35~~ 5160.34 of the Revised Code, the director of job and family services has upheld the denial.

(f) The home's license has been revoked, the home is being closed pursuant to section 3721.08, sections ~~5111.35~~ 5164.50 to ~~5111.62~~ 5164.78, or section 5155.31 of the Revised Code, or the home otherwise ceases to operate.

(g) The resident is a recipient of medicaid, and the home's participation in the medicaid program is involuntarily terminated or denied.

(h) The resident is a beneficiary under the medicare program, and the home's participation in the medicare program is involuntarily terminated or denied.

(31) The right to voice grievances and recommend changes in policies and services to the home's staff, to employees of the department of health, or to other persons not associated with the operation of the home, of the resident's choice, free from restraint, interference, coercion, discrimination, or reprisal. This right includes access to a residents' rights advocate, and the right to be a member of, to be active in, and to associate with persons who are active in organizations of relatives and friends of nursing home residents and other organizations engaged in assisting residents.

(32) The right to have any significant change in the resident's health status reported to the resident's sponsor. As soon as such a change is known to the home's staff, the home shall make a reasonable effort to notify the sponsor within twelve hours.

(B) A sponsor may act on a resident's behalf to assure that the home does not deny the residents' rights under sections

3721.10 to 3721.17 of the Revised Code.

(C) Any attempted waiver of the rights listed in division (A) of this section is void.

Sec. 3721.15. (A) Authorization from a resident or a sponsor with a power of attorney for a home to manage the resident's financial affairs shall be in writing and shall be attested to by a witness who is not connected in any manner whatsoever with the home or its administrator. The home shall maintain accounts pursuant to division (A)(27) of section 3721.13 of the Revised Code. Upon the resident's transfer, discharge, or death, the account shall be closed and a final accounting made. All remaining funds shall be returned to the resident or resident's sponsor, except in the case of death, when all remaining funds shall be transferred or used in accordance with section ~~5111.113~~ 5162.37 of the Revised Code.

(B) A home that manages a resident's financial affairs shall deposit the resident's funds in excess of one hundred dollars, and may deposit the resident's funds that are one hundred dollars or less, in an interest-bearing account separate from any of the home's operating accounts. Interest earned on the resident's funds shall be credited to the resident's account. A resident's funds that are one hundred dollars or less and have not been deposited in an interest-bearing account may be deposited in a noninterest-bearing account or petty cash fund.

(C) Each resident whose financial affairs are managed by a home shall be promptly notified by the home when the total of the amount of funds in the resident's accounts and the petty cash fund plus other nonexempt resources reaches two hundred dollars less than the maximum amount permitted a recipient of medicaid. The notice shall include an explanation of the potential effect on the resident's eligibility for medicaid if the amount in the

resident's accounts and the petty cash fund, plus the value of other nonexempt resources, exceeds the maximum assets a medicaid recipient may retain.

(D) Each home that manages the financial affairs of residents shall purchase a surety bond or otherwise provide assurance satisfactory to the director of health, or, in the case of a home that participates in the medicaid program, to the director of ~~job and family services~~ health care administration, to assure the security of all residents' funds managed by the home.

Sec. 3721.16. For each resident of a home, notice of a proposed transfer or discharge shall be in accordance with this section.

(A)(1) The administrator of a home shall notify a resident in writing, and the resident's sponsor in writing by certified mail, return receipt requested, in advance of any proposed transfer or discharge from the home. The administrator shall send a copy of the notice to the state department of health. The notice shall be provided at least thirty days in advance of the proposed transfer or discharge, unless any of the following applies:

(a) The resident's health has improved sufficiently to allow a more immediate discharge or transfer to a less skilled level of care;

(b) The resident has resided in the home less than thirty days;

(c) An emergency arises in which the safety of individuals in the home is endangered;

(d) An emergency arises in which the health of individuals in the home would otherwise be endangered;

(e) An emergency arises in which the resident's urgent medical needs necessitate a more immediate transfer or discharge.

In any of the circumstances described in divisions (A)(1)(a) to (e) of this section, the notice shall be provided as many days in advance of the proposed transfer or discharge as is practicable.

(2) The notice required under division (A)(1) of this section shall include all of the following:

(a) The reasons for the proposed transfer or discharge;

(b) The proposed date the resident is to be transferred or discharged;

(c) The proposed location to which the resident is to be transferred or discharged;

(d) Notice of the right of the resident and the resident's sponsor to an impartial hearing at the home on the proposed transfer or discharge, and of the manner in which and the time within which the resident or sponsor may request a hearing pursuant to section 3721.161 of the Revised Code;

(e) A statement that the resident will not be transferred or discharged before the date specified in the notice unless the home and the resident or, if the resident is not competent to make a decision, the home and the resident's sponsor, agree to an earlier date;

(f) The address of the legal services office of the department of health;

(g) The name, address, and telephone number of a representative of the state long-term care ombudsperson program and, if the resident or patient has a developmental disability or mental illness, the name, address, and telephone number of the Ohio legal rights service.

(B) No home shall transfer or discharge a resident before the date specified in the notice required by division (A) of this

section unless the home and the resident or, if the resident is not competent to make a decision, the home and the resident's sponsor, agree to an earlier date.

(C) Transfer or discharge actions shall be documented in the resident's medical record by the home if there is a medical basis for the action.

(D) A resident or resident's sponsor may challenge a transfer or discharge by requesting an impartial hearing pursuant to section 3721.161 of the Revised Code, unless the transfer or discharge is required because of one of the following reasons:

(1) The home's license has been revoked under this chapter;

(2) The home is being closed pursuant to section 3721.08~~, sections 5111.35 to 5111.62,~~ or ~~section~~ 5155.31, or sections 5164.50 to 5164.78 of the Revised Code;

(3) The resident is a recipient of medicaid and the home's participation in the medicaid program has been involuntarily terminated or denied by the federal government;

(4) The resident is a beneficiary under the medicare program and the home's certification under the medicare program has been involuntarily terminated or denied by the federal government.

(E) If a resident is transferred or discharged pursuant to this section, the home from which the resident is being transferred or discharged shall provide the resident with adequate preparation prior to the transfer or discharge to ensure a safe and orderly transfer or discharge from the home, and the home or alternative setting to which the resident is to be transferred or discharged shall have accepted the resident for transfer or discharge.

(F) At the time of a transfer or discharge of a resident who is a recipient of medicaid from a home to a hospital or for

therapeutic leave, the home shall provide notice in writing to the resident and in writing by certified mail, return receipt requested, to the resident's sponsor, specifying the number of days, if any, during which the resident will be permitted under the medicaid program to return and resume residence in the home and specifying the medicaid program's coverage of the days during which the resident is absent from the home. An individual who is absent from a home for more than the number of days specified in the notice and continues to require the services provided by the facility shall be given priority for the first available bed in a semi-private room.

Sec. 3721.17. (A) Any resident who believes that the resident's rights under sections 3721.10 to 3721.17 of the Revised Code have been violated may file a grievance under procedures adopted pursuant to division (A)(2) of section 3721.12 of the Revised Code.

When the grievance committee determines a violation of sections 3721.10 to 3721.17 of the Revised Code has occurred, it shall notify the administrator of the home. If the violation cannot be corrected within ten days, or if ten days have elapsed without correction of the violation, the grievance committee shall refer the matter to the department of health.

(B) Any person who believes that a resident's rights under sections 3721.10 to 3721.17 of the Revised Code have been violated may report or cause reports to be made of the information directly to the department of health. No person who files a report is liable for civil damages resulting from the report.

(C)(1) Within thirty days of receiving a complaint under this section, the department of health shall investigate any complaint referred to it by a home's grievance committee and any complaint from any source that alleges that the home provided substantially

less than adequate care or treatment, or substantially unsafe conditions, or, within seven days of receiving a complaint, refer it to the attorney general, if the attorney general agrees to investigate within thirty days.

(2) Within thirty days of receiving a complaint under this section, the department of health may investigate any alleged violation of sections 3721.10 to 3721.17 of the Revised Code, or of rules, policies, or procedures adopted pursuant to those sections, not covered by division (C)(1) of this section, or it may, within seven days of receiving a complaint, refer the complaint to the grievance committee at the home where the alleged violation occurred, or to the attorney general if the attorney general agrees to investigate within thirty days.

(D) If, after an investigation, the department of health finds probable cause to believe that a violation of sections 3721.10 to 3721.17 of the Revised Code, or of rules, policies, or procedures adopted pursuant to those sections, has occurred at a home that is certified under the medicare or medicaid program, it shall cite one or more findings or deficiencies under sections ~~5111.35~~ 5164.50 to ~~5111.62~~ 5164.78 of the Revised Code. If the home is not so certified, the department shall hold an adjudicative hearing within thirty days under Chapter 119. of the Revised Code.

(E) Upon a finding at an adjudicative hearing under division (D) of this section that a violation of sections 3721.10 to 3721.17 of the Revised Code, or of rules, policies, or procedures adopted pursuant thereto, has occurred, the department of health shall make an order for compliance, set a reasonable time for compliance, and assess a fine pursuant to division (F) of this section. The fine shall be paid to the general revenue fund only if compliance with the order is not shown to have been made within the reasonable time set in the order. The department of health may

issue an order prohibiting the continuation of any violation of sections 3721.10 to 3721.17 of the Revised Code.

Findings at the hearings conducted under this section may be appealed pursuant to Chapter 119. of the Revised Code, except that an appeal may be made to the court of common pleas of the county in which the home is located.

The department of health shall initiate proceedings in court to collect any fine assessed under this section that is unpaid thirty days after the violator's final appeal is exhausted.

(F) Any home found, pursuant to an adjudication hearing under division (D) of this section, to have violated sections 3721.10 to 3721.17 of the Revised Code, or rules, policies, or procedures adopted pursuant to those sections may be fined not less than one hundred nor more than five hundred dollars for a first offense. For each subsequent offense, the home may be fined not less than two hundred nor more than one thousand dollars.

A violation of sections 3721.10 to 3721.17 of the Revised Code is a separate offense for each day of the violation and for each resident who claims the violation.

(G) No home or employee of a home shall retaliate against any person who:

(1) Exercises any right set forth in sections 3721.10 to 3721.17 of the Revised Code, including, but not limited to, filing a complaint with the home's grievance committee or reporting an alleged violation to the department of health;

(2) Appears as a witness in any hearing conducted under this section or section 3721.162 of the Revised Code;

(3) Files a civil action alleging a violation of sections 3721.10 to 3721.17 of the Revised Code, or notifies a county prosecuting attorney or the attorney general of a possible

violation of sections 3721.10 to 3721.17 of the Revised Code.

If, under the procedures outlined in this section, a home or its employee is found to have retaliated, the violator may be fined up to one thousand dollars.

(H) When legal action is indicated, any evidence of criminal activity found in an investigation under division (C) of this section shall be given to the prosecuting attorney in the county in which the home is located for investigation.

(I)(1)(a) Any resident whose rights under sections 3721.10 to 3721.17 of the Revised Code are violated has a cause of action against any person or home committing the violation.

(b) An action under division (I)(1)(a) of this section may be commenced by the resident or by the resident's legal guardian or other legally authorized representative on behalf of the resident or the resident's estate. If the resident or the resident's legal guardian or other legally authorized representative is unable to commence an action under that division on behalf of the resident, the following persons in the following order of priority have the right to and may commence an action under that division on behalf of the resident or the resident's estate:

(i) The resident's spouse;

(ii) The resident's parent or adult child;

(iii) The resident's guardian if the resident is a minor child;

(iv) The resident's brother or sister;

(v) The resident's niece, nephew, aunt, or uncle.

(c) Notwithstanding any law as to priority of persons entitled to commence an action, if more than one eligible person within the same level of priority seeks to commence an action on behalf of a resident or the resident's estate, the court shall

determine, in the best interest of the resident or the resident's estate, the individual to commence the action. A court's determination under this division as to the person to commence an action on behalf of a resident or the resident's estate shall bar another person from commencing the action on behalf of the resident or the resident's estate.

(d) The result of an action commenced pursuant to division (I)(1)(a) of this section by a person authorized under division (I)(1)(b) of this section shall bind the resident or the resident's estate that is the subject of the action.

(e) A cause of action under division (I)(1)(a) of this section shall accrue, and the statute of limitations applicable to that cause of action shall begin to run, based upon the violation of a resident's rights under sections 3721.10 to 3721.17 of the Revised Code, regardless of the party commencing the action on behalf of the resident or the resident's estate as authorized under divisions (I)(1)(b) and (c) of this section.

(2)(a) The plaintiff in an action filed under division (I)(1) of this section may obtain injunctive relief against the violation of the resident's rights. The plaintiff also may recover compensatory damages based upon a showing, by a preponderance of the evidence, that the violation of the resident's rights resulted from a negligent act or omission of the person or home and that the violation was the proximate cause of the resident's injury, death, or loss to person or property.

(b) If compensatory damages are awarded for a violation of the resident's rights, section 2315.21 of the Revised Code shall apply to an award of punitive or exemplary damages for the violation.

(c) The court, in a case in which only injunctive relief is granted, may award to the prevailing party reasonable attorney's

fees limited to the work reasonably performed.

(3) Division (I)(2) (b) of this section shall be considered to be purely remedial in operation and shall be applied in a remedial manner in any civil action in which this section is relevant, whether the action is pending in court or commenced on or after July 9, 1998.

(4) Within thirty days after the filing of a complaint in an action for damages brought against a home under division (I)(1)(a) of this section by or on behalf of a resident or former resident of the home, the plaintiff or plaintiff's counsel shall send written notice of the filing of the complaint to the department of job and family services if the department has a right of recovery under section ~~5101.58~~ 5160.38 of the Revised Code against the liability of the home for the cost of medical services and care arising out of injury, disease, or disability of the resident or former resident.

Sec. 3721.19. (A) As used in this section:

(1) "Home" and "residential care facility" have the same meanings as in section 3721.01 of the Revised Code;

(2) "Sponsor" and "residents' rights advocate" have the same meanings as in section 3721.10 of the Revised Code.

A home licensed under this chapter that is not a party to a provider agreement, as defined in section ~~5111.20~~ 5164.01 of the Revised Code, shall provide each prospective resident, before admission, with the following information, orally and in a separate written notice on which is printed in a conspicuous manner: "This home is not a participant in the ~~medical assistance~~ medicaid program administered by the Ohio department of ~~job and family services~~ health care administration. Consequently, you may be discharged from this home if you are unable to pay for the

services provided by this home."

If the prospective resident has a sponsor whose identity is made known to the home, the home shall also inform the sponsor, before admission of the resident, of the home's status relative to the ~~medical assistance~~ medicaid program. Written ~~acknowledgement~~ acknowledgment of the receipt of the information shall be provided by the resident and, if the prospective resident has a sponsor who has been identified to the home, by the sponsor. The written ~~acknowledgement~~ acknowledgment shall be made part of the resident's record by the home.

No home shall terminate its status as a provider under the medicaid program unless it has complied with section ~~5111.66~~ 5164.83 of the Revised Code and, at least ninety days prior to such termination, provided written notice to the residents of the home and their sponsors of such action. This requirement shall not apply in cases where the department of ~~job and family services~~ health care administration terminates a home's provider agreement or provider status.

(B) A home licensed under this chapter as a residential care facility shall provide notice to each prospective resident or the individual's sponsor of the services offered by the facility and the types of skilled nursing care that the facility may provide. A residential care facility that, pursuant to section 3721.012 of the Revised Code, has a policy of entering into risk agreements with residents or their sponsors shall provide each prospective resident or the individual's sponsor a written explanation of the policy and the provisions that may be contained in a risk agreement. At the time the information is provided, the facility shall obtain a statement signed by the individual receiving the information acknowledging that the individual received the information. The facility shall maintain on file the individual's signed statement.

(C) A resident has a cause of action against a home for breach of any duty imposed by this section. The action may be commenced by the resident, or on the resident's behalf by the resident's sponsor or a residents' rights advocate, by the filing of a civil action in the court of common pleas of the county in which the home is located, or in the court of common pleas of Franklin county.

If the court finds that a breach of any duty imposed by this section has occurred, the court shall enjoin the home from discharging the resident from the home until arrangements satisfactory to the court are made for the orderly transfer of the resident to another mode of health care including, but not limited to, another home, and may award the resident and a person or public agency that brings an action on behalf of a resident reasonable attorney's fees. If a home discharges a resident to whom or to whose sponsor information concerning its status relative to the ~~medical assistance~~ medicaid program was not provided as required under this section, the court shall grant any appropriate relief including, but not limited to, actual damages, reasonable attorney's fees, and costs.

Sec. 3721.21. As used in sections 3721.21 to 3721.34 of the Revised Code:

(A) "Long-term care facility" means either of the following:

(1) A nursing home as defined in section 3721.01 of the Revised Code, other than a nursing home or part of a nursing home certified as an intermediate care facility for the mentally retarded under ~~Title XIX of~~ the ~~"Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended~~ medicaid program;

(2) A facility or part of a facility that is certified as a skilled nursing facility or a nursing facility under ~~Title XVIII or XIX of~~ the ~~"Social Security Act~~ medicare program and medicaid

program."

(B) "Residential care facility" has the same meaning as in section 3721.01 of the Revised Code.

(C) "Abuse" means knowingly causing physical harm or recklessly causing serious physical harm to a resident by physical contact with the resident or by use of physical or chemical restraint, medication, or isolation as punishment, for staff convenience, excessively, as a substitute for treatment, or in amounts that preclude habilitation and treatment.

(D) "Neglect" means recklessly failing to provide a resident with any treatment, care, goods, or service necessary to maintain the health or safety of the resident when the failure results in serious physical harm to the resident. "Neglect" does not include allowing a resident, at the resident's option, to receive only treatment by spiritual means through prayer in accordance with the tenets of a recognized religious denomination.

(E) "Misappropriation" means depriving, defrauding, or otherwise obtaining the real or personal property of a resident by any means prohibited by the Revised Code, including violations of Chapter 2911. or 2913. of the Revised Code.

(F) "Resident" includes a resident, patient, former resident or patient, or deceased resident or patient of a long-term care facility or a residential care facility.

(G) "Physical restraint" has the same meaning as in section 3721.10 of the Revised Code.

(H) "Chemical restraint" has the same meaning as in section 3721.10 of the Revised Code.

(I) "Nursing and nursing-related services" means the personal care services and other services not constituting skilled nursing care that are specified in rules the public health council shall

adopt in accordance with Chapter 119. of the Revised Code.

(J) "Personal care services" has the same meaning as in section 3721.01 of the Revised Code.

(K)(1) Except as provided in division (K)(2) of this section, "nurse aide" means an individual who provides nursing and nursing-related services to residents in a long-term care facility, either as a member of the staff of the facility for monetary compensation or as a volunteer without monetary compensation.

(2) "Nurse aide" does not include either of the following:

(a) A licensed health professional practicing within the scope of the professional's license;

(b) An individual providing nursing and nursing-related services in a religious nonmedical health care institution, if the individual has been trained in the principles of nonmedical care and is recognized by the institution as being competent in the administration of care within the religious tenets practiced by the residents of the institution.

(L) "Licensed health professional" means all of the following:

(1) An occupational therapist or occupational therapy assistant licensed under Chapter 4755. of the Revised Code;

(2) A physical therapist or physical therapy assistant licensed under Chapter 4755. of the Revised Code;

(3) A physician authorized under Chapter 4731. of the Revised Code to practice medicine and surgery, osteopathic medicine and surgery, or podiatry;

(4) A physician assistant authorized under Chapter 4730. of the Revised Code to practice as a physician assistant;

(5) A registered nurse or licensed practical nurse licensed

under Chapter 4723. of the Revised Code;

(6) A social worker or independent social worker licensed under Chapter 4757. of the Revised Code or a social work assistant registered under that chapter;

(7) A speech-language pathologist or audiologist licensed under Chapter 4753. of the Revised Code;

(8) A dentist or dental hygienist licensed under Chapter 4715. of the Revised Code;

(9) An optometrist licensed under Chapter 4725. of the Revised Code;

(10) A pharmacist licensed under Chapter 4729. of the Revised Code;

(11) A psychologist licensed under Chapter 4732. of the Revised Code;

(12) A chiropractor licensed under Chapter 4734. of the Revised Code;

(13) A nursing home administrator licensed or temporarily licensed under Chapter 4751. of the Revised Code;

(14) A professional counselor or professional clinical counselor licensed under Chapter 4757. of the Revised Code.

(M) "Religious nonmedical health care institution" means an institution that meets or exceeds the conditions to receive payment under the medicare program ~~established under Title XVIII of the "Social Security Act"~~ for inpatient hospital services or post-hospital extended care services furnished to an individual in a religious nonmedical health care institution, as defined in section 1861(ss)(1) of the "Social Security Act," 79 Stat. 286 (1965), 42 U.S.C. 1395x(ss)(1), as amended.

(N) "Competency evaluation program" means a program through which the competency of a nurse aide to provide nursing and

nursing-related services is evaluated.

(O) "Training and competency evaluation program" means a program of nurse aide training and evaluation of competency to provide nursing and nursing-related services.

Sec. 3721.28. (A)(1) Each nurse aide used by a long-term care facility on a full-time, temporary, per diem, or other basis on July 1, 1989, shall be provided by the facility a competency evaluation program approved by the director of health under division (A) of section 3721.31 of the Revised Code or conducted by ~~him~~ the director under division (C) of that section. Each long-term care facility using a nurse aide on July 1, 1989, shall provide the nurse aide the preparation necessary to complete the competency evaluation program by January 1, 1990.

(2) Each nurse aide used by a long-term care facility on a full-time, temporary, per diem, or other basis on January 1, 1990, who either was not used by the facility on July 1, 1989, or was used by the facility on July 1, 1989, but had not successfully completed a competency evaluation program by January 1, 1990, shall be provided by the facility a competency evaluation program approved by the director under division (A) of section 3721.31 of the Revised Code or conducted by ~~him~~ the director under division (C) of that section. Each long-term care facility using a nurse aide described in division (A)(2) of this section shall provide the nurse aide the preparation necessary to complete the competency evaluation program by October 1, 1990, and shall assist the nurse aide in registering for the program.

(B) Effective June 1, 1990, no long-term care facility shall use an individual as a nurse aide for more than four months unless the individual is competent to provide the services ~~he~~ the individual is to provide, the facility has received from the nurse aide registry established under section 3721.32 of the Revised

Code the information concerning the individual provided through the registry, and one of the following is the case:

(1) The individual was used by a facility as a nurse aide on a full-time, temporary, per diem, or other basis at any time during the period commencing July 1, 1989, and ending January 1, 1990, and successfully completed, not later than October 1, 1990, a competency evaluation program approved by the director under division (A) of section 3721.31 of the Revised Code or conducted by ~~him~~ the director under division (C) of that section.

(2) The individual has successfully completed a training and competency evaluation program approved by the director under division (A) of section 3721.31 of the Revised Code or conducted by ~~him~~ the director under division (C) of that section or has met the conditions specified in division (F) of this section and, in addition, if the training and competency evaluation program or the training, instruction, or education the individual completed in meeting the conditions specified in division (F) of this section was conducted by or in a long-term care facility, or if the director pursuant to division (E) of section 3721.31 of the Revised Code so requires, the individual has successfully completed a competency evaluation program conducted by the director.

(3) Prior to July 1, 1989, if the long-term care facility is certified as a skilled nursing facility or a nursing facility under ~~Title XVIII or XIX of~~ the ~~"Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended~~ medicare program or medicaid program, or prior to January 1, 1990, if the facility is not so certified, the individual completed a program that the director determines included a competency evaluation component no less stringent than the competency evaluation programs approved by ~~him~~ the director under division (A) of section 3721.31 of the Revised Code or conducted by ~~him~~ the director under division (C)

of that section, and was otherwise comparable to the training and competency evaluation programs being approved by the director under division (A) of that section.

(4) The individual is listed in a nurse aide registry maintained by another state and that state certifies that its program for training and evaluation of competency of nurse aides complies with ~~Titles XVIII and XIX of~~ the ~~"Social Security Act"~~ medicare program and medicaid program and regulations adopted thereunder.

(5) Prior to July 1, 1989, the individual was found competent to serve as a nurse aide after the completion of a course of nurse aide training of at least one hundred hours' duration.

(6) The individual is enrolled in a prelicensure program of nursing education approved by the board of nursing or by an agency of another state that regulates nursing education, has provided the long-term care facility with a certificate from the program indicating that the individual has successfully completed the courses that teach basic nursing skills including infection control, safety and emergency procedures, and personal care, and has successfully completed a competency evaluation program conducted by the director under division (C) of section 3721.31 of the Revised Code.

(7) The individual has the equivalent of twelve months or more of full-time employment in the preceding five years as a hospital aide or orderly and has successfully completed a competency evaluation program conducted by the director under division (C) of section 3721.31 of the Revised Code.

(C) Effective June 1, 1990, no long-term care facility shall continue for longer than four months to use as a nurse aide an individual who previously met the requirements of division (B) of this section but since most recently doing so has not performed

nursing and nursing-related services for monetary compensation for twenty-four consecutive months, unless the individual successfully completes additional training and competency evaluation by complying with divisions (C)(1) and (2) of this section:

(1) Doing one of the following:

(a) Successfully completing a training and competency evaluation program approved by the director under division (A) of section 3721.31 of the Revised Code or conducted by ~~him~~ the director under division (C) of that section;

(b) Successfully completing a training and competency evaluation program described in division (B)(4) of this section;

(c) Meeting the requirements specified in division (B)(6) or (7) of this section.

(2) If the training and competency evaluation program completed under division (C)(1)(a) of this section was conducted by or in a long-term care facility, or if the director pursuant to division (E) of section 3721.31 of the Revised Code so requires, successfully completing a competency evaluation program conducted by the director.

(D)(1) The four-month periods provided for in divisions (B) and (C) of this section include any time, on or after June 1, 1990, that an individual is used as a nurse aide on a full-time, temporary, per diem, or any other basis by the facility or any other long-term care facility.

(2) During the four-month period provided for in division (B) of this section, during which a long-term care facility may, subject to division (E) of this section, use as a nurse aide an individual who does not have the qualifications specified in divisions (B)(1) to (7) of this section, a facility shall require the individual to comply with divisions (D)(2)(a) and (b) of this section:

(a) Participate in one of the following:

(i) If the individual has successfully completed a training and competency evaluation program approved by the director under division (A) of section 3721.31 of the Revised Code, and the program was conducted by or in a long-term care facility, or the director pursuant to division (E) of section 3721.31 of the Revised Code so requires, a competency evaluation program conducted by the director;

(ii) If the individual is enrolled in a prelicensure program of nursing education described in division (B)(6) of this section and has completed or is working toward completion of the courses described in that division, or the individual has the experience described in division (B)(7) of this section, a competency evaluation program conducted by the director;

(iii) A training and competency evaluation program approved by the director under division (A) of section 3721.31 of the Revised Code or conducted by ~~him~~ the director under division (C) of that section.

(b) If the individual participates in or has successfully completed a training and competency evaluation program under division (D)(2)(a)(iii) of this section that is conducted by or in a long-term care facility, or the director pursuant to division (E) of section 3721.31 of the Revised Code so requires, ~~paticipate~~ participate in a competency evaluation program conducted by the director.

(3) During the four-month period provided for in division (C) of this section, during which a long-term care facility may, subject to division (E) of this section, use as a nurse aide an individual who does not have the qualifications specified in divisions (C)(1) and (2) of this section, a facility shall require the individual to comply with divisions (D)(3)(a) and (b) of this

section:

(a) Participate in one of the following:

(i) If the individual has successfully completed a training and competency evaluation program approved by the director, and the program was conducted by or in a long-term care facility, or the director pursuant to division (E) of section 3721.31 of the Revised Code so requires, a competency evaluation program conducted by the director;

(ii) If the individual is enrolled in a prelicensure program of nursing education described in division (B)(6) of this section and has completed or is working toward completion of the courses described in that division, or the individual has the experience described in division (B)(7) of this section, a competency evaluation program conducted by the director;

(iii) A training and competency evaluation program approved or conducted by the director.

(b) If the individual participates in or has successfully completed a training and competency evaluation program under division (D)(3)(a)(iii) of this section that is conducted by or in a long-term care facility, or the director pursuant to division (E) of section 3721.31 of the Revised Code so requires, participate in a competency evaluation program conducted by the director.

(E) A long-term care facility shall not permit an individual used by the facility as a nurse aide while participating in a training and competency evaluation program to provide nursing and nursing-related services unless both of the following are the case:

(1) The individual has completed the number of hours of training that ~~he~~ must ~~complete~~ be completed prior to providing services to residents as prescribed by rules that shall be adopted

by the director in accordance with Chapter 119. of the Revised Code;

(2) The individual is under the personal supervision of a registered or licensed practical nurse licensed under Chapter 4723. of the Revised Code.

(F) An individual shall be considered to have satisfied the requirement, under division (B)(2) of this section, of having successfully completed a training and competency evaluation program conducted or approved by the director, if the individual meets both of the following conditions:

(1) The individual, as of July 1, 1989, completed at least sixty hours divided between skills training and classroom instruction in the topic areas described in divisions (B)(1) to (8) of section 3721.30 of the Revised Code;

(2) The individual received, as of that date, at least the difference between seventy-five hours and the number of hours actually spent in training and competency evaluation in supervised practical nurse aide training or regular in-service nurse aide education.

(G) The public health council shall adopt rules in accordance with Chapter 119. of the Revised Code specifying persons, in addition to the director, who may establish competence of nurse aides under division (B)(5) of this section, and establishing criteria for determining whether an individual meets the conditions specified in division (F) of this section.

(H) The rules adopted pursuant to divisions (E)(1) and (G) of this section shall be no less stringent than the requirements, guidelines, and procedures established by the United States secretary of health and human services under sections 1819 and 1919 of the "Social Security Act."

Sec. 3721.32. (A) The director of health shall establish a state nurse aide registry listing all individuals who have done any of the following:

(1) Were used by a long-term care facility as nurse aides on a full-time, temporary, per diem, or other basis at any time during the period commencing July 1, 1989, and ending January 1, 1990, and successfully completed, not later than October 1, 1990, a competency evaluation program approved by the director under division (A) of section 3721.31 of the Revised Code or conducted by the director under division (C) of that section;

(2) Successfully completed a training and competency evaluation program approved by the director under division (A) of section 3721.31 of the Revised Code or met the conditions specified in division (F) of section 3721.28 of the Revised Code, and, if the training and competency evaluation program or the training, instruction, or education the individual completed in meeting the conditions specified in division (F) of section 3721.28 of the Revised Code was conducted in or by a long-term care facility, or if the director so required pursuant to division (E) of section 3721.31 of the Revised Code, has successfully completed a competency evaluation program conducted by the director;

(3) Successfully completed a training and competency evaluation program conducted by the director under division (C) of section 3721.31 of the Revised Code;

(4) Successfully completed, prior to July 1, 1989, a program that the director has determined under division (B)(3) of section 3721.28 of the Revised Code included a competency evaluation component no less stringent than the competency evaluation programs approved or conducted by the director under section 3721.31 of the Revised Code, and was otherwise comparable to the

training and competency evaluation program being approved by the director under section 3721.31 of the Revised Code;

(5) Are listed in a nurse aide registry maintained by another state that certifies that its program for training and evaluation of competency of nurse aides complies with ~~Titles XVIII and XIX of~~ the ~~"Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended~~ medicare program and medicaid program, or regulations adopted thereunder;

(6) Were found competent, as provided in division (B)(5) of section 3721.28 of the Revised Code, prior to July 1, 1989, after the completion of a course of nurse aide training of at least one hundred hours' duration;

(7) Are enrolled in a prelicensure program of nursing education approved by the board of nursing or by an agency of another state that regulates nursing education, have provided the long-term care facility with a certificate from the program indicating that the individual has successfully completed the courses that teach basic nursing skills including infection control, safety and emergency procedures, and personal care, and have successfully completed a competency evaluation program conducted by the director under division (A) of section 3721.31 of the Revised Code;

(8) Have the equivalent of twelve months or more of full-time employment in the five years preceding listing in the registry as a hospital aide or orderly and have successfully completed a competency evaluation program conducted by the director under division (C) of section 3721.31 of the Revised Code.

(B) The registry shall include both of the following:

(1) The statement required by section 3721.23 of the Revised Code detailing findings by the director under that section regarding alleged abuse or neglect of a resident or

misappropriation of resident property;

(2) Any statement provided by an individual under section 3721.23 of the Revised Code disputing the director's findings.

Whenever an inquiry is received as to the information contained in the registry concerning an individual about whom a statement required by section 3721.23 of the Revised Code is included in the registry, the director shall disclose the statement or a summary of the statement together with any statement provided by the individual under section 3721.23 or a clear and accurate summary of that statement.

(C) The director may by rule specify additional information that must be provided the registry by long-term care facilities and persons or government agencies conducting approved competency evaluation programs and training and competency evaluation programs.

(D) Information contained in the registry is a public record for the purposes of section 149.43 of the Revised Code, and is subject to inspection and copying under section 1347.08 of the Revised Code.

Sec. 3722.10. (A) The public health council shall have the exclusive authority to adopt and shall adopt rules in accordance with Chapter 119. of the Revised Code governing the licensing and operation of adult care facilities. The rules shall specify:

(1) Procedures for the issuance, renewal, and revocation of licenses and temporary licenses, for the granting and denial of waivers, and for the issuance and termination of orders of suspension of admission pursuant to section 3722.07 of the Revised Code;

(2) The qualifications required for owners, managers, and employees of adult care facilities, including character, training,

education, experience, and financial resources and the number of staff members required in a facility;

(3) Adequate space, equipment, safety, and sanitation standards for the premises of adult care facilities, and fire protection standards for adult family homes as required by section 3722.041 of the Revised Code;

(4) The personal, social, dietary, and recreational services to be provided to each resident of adult care facilities;

(5) Rights of residents of adult care facilities, in addition to the rights enumerated under section 3722.12 of the Revised Code, and procedures to protect and enforce the rights of these residents;

(6) Provisions for keeping records of residents and for maintaining the confidentiality of the records as required by division (B) of section 3722.12 of the Revised Code. The provisions for maintaining the confidentiality of records shall, at the minimum, meet the requirements for maintaining the confidentiality of records under ~~Title XIX of~~ the ~~Social Security Act, 49 Stat. 620, 42 U.S.C. 301, as amended~~ medicaid program, and regulations promulgated thereunder.

(7) Measures to be taken by adult care facilities relative to residents' medication, including policies and procedures concerning medication, storage of medication in a locked area, and disposal of medication and assistance with self-administration of medication, if the facility provides assistance;

(8) Requirements for initial and periodic health assessments of prospective and current adult care facility residents by physicians or other health professionals to ensure that they do not require a level of care beyond that which is provided by the adult care facility, including assessment of their capacity to self-administer the medications prescribed for them;

(9) Requirements relating to preparation of special diets;

(10) The amount of the fees for new and renewal license applications made pursuant to sections 3722.02 and 3722.04 of the Revised Code;

(11) Measures to be taken by any employee of the state or any political subdivision of the state authorized by this chapter to enter an adult care facility to inspect the facility or for any other purpose, to ensure that the employee respects the privacy and dignity of residents of the facility, cooperates with residents of the facility and behaves in a congenial manner toward them, and protects the rights of residents;

(12) How an owner or manager of an adult care facility is to comply with section 3722.18 of the Revised Code. The rules shall do at least both of the following:

(a) Establish the procedures an owner or manager is to follow under division (A)(2) of section 3722.18 of the Revised Code regarding referrals to the facility of prospective residents with mental illness or severe mental disability and effective arrangements for ongoing mental health services for such prospective residents. The procedures may provide for any of the following:

(i) That the owner or manager sign written agreements with the mental health agencies and boards of alcohol, drug addiction, and mental health services that refer such prospective residents to the facility. Each agreement shall cover all such prospective residents referred by the agency or board with which the owner or manager enters into the agreement.

(ii) That the owner or manager and the mental health agencies and boards of alcohol, drug addiction, and mental health services that refer such prospective residents to the facility develop and sign a plan for services for each such prospective resident;

(iii) Any other process regarding referrals and effective arrangements for ongoing mental health services.

(b) Specify the date an owner or manager must begin to follow the procedures established by division (A)(12)(a) of this section.

(13) Any other rules necessary for the administration and enforcement of this chapter.

(B) After consulting with relevant constituencies, the director of mental health shall prepare and submit to the director of health recommendations for the content of rules to be adopted under division (A)(12) of this section. The public health council shall adopt the rules required by division (A)(12) of this section no later than July 1, 2000.

(C) The director of health shall advise adult care facilities regarding compliance with the requirements of this chapter and with the rules adopted pursuant to this chapter.

(D) Any duty or responsibility imposed upon the director of health by this chapter may be carried out by an employee of the department of health.

(E) Employees of the department of health may enter, for the purposes of investigation, any institution, residence, facility, or other structure which has been reported to the department as, or that the department has reasonable cause to believe is, operating as an adult care facility without a valid license.

Sec. 3722.16. (A) No person shall:

(1) Operate an adult care facility unless the facility is validly licensed by the director of health under section 3722.04 of the Revised Code;

(2) Admit to an adult care facility more residents than the number authorized in the facility's license;

(3) Admit a resident to an adult care facility after the director has issued an order pursuant to section 3722.07 of the Revised Code suspending admissions to the facility. Violation of division (A)(3) of this section is cause for revocation of the facility's license.

(4) Interfere with any authorized inspection of an adult care facility conducted pursuant to section 3722.02 or 3722.04 of the Revised Code;

(5) Violate any of the provisions of this chapter or any of the rules adopted pursuant to it.

(B) No adult care facility shall provide, or admit or retain any resident in need of, skilled nursing care unless all of the following are the case:

(1) The care will be provided on a part-time, intermittent basis for not more than a total of one hundred twenty days in any twelve-month period by one or more of the following:

(a) A home health agency certified under ~~Title XVIII of~~ the ~~"Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended:~~ medicare program;

(b) A hospice care program licensed under Chapter 3712. of the Revised Code;

(c) A nursing home licensed under Chapter 3721. of the Revised Code and owned and operated by the same person and located on the same site as the adult care facility;

(d) A mental health agency or, pursuant to division (A)(8)(b) of section 340.03 of the Revised Code, a board of alcohol, drug addiction, and mental health services.

(2) The staff of the home health agency, hospice care program, nursing home, mental health agency, or board of alcohol, drug addiction, and mental health services does not train facility

staff to provide the skilled nursing care;

(3) The individual to whom the skilled nursing care is provided is suffering from a short-term illness;

(4) If the skilled nursing care is to be provided by the nursing staff of a nursing home, all of the following are the case:

(a) The adult care facility evaluates the individual receiving the skilled nursing care at least once every seven days to determine whether the individual should be transferred to a nursing home;

(b) The adult care facility meets at all times staffing requirements established by rules adopted under section 3722.10 of the Revised Code;

(c) The nursing home does not include the cost of providing skilled nursing care to the adult care facility residents in a cost report filed under section ~~5111.26~~ 5164.37 of the Revised Code;

(d) The nursing home meets at all times the nursing home licensure staffing ratios established by rules adopted under section 3721.04 of the Revised Code;

(e) The nursing home staff providing skilled nursing care to adult care facility residents are registered nurses or licensed practical nurses licensed under Chapter 4723. of the Revised Code and meet the personnel qualifications for nursing home staff established by rules adopted under section 3721.04 of the Revised Code;

(f) The skilled nursing care is provided in accordance with rules established for nursing homes under section 3721.04 of the Revised Code;

(g) The nursing home meets the skilled nursing care needs of

the adult care facility residents;

(h) Using the nursing home's nursing staff does not prevent the nursing home or adult care facility from meeting the needs of the nursing home and adult care facility residents in a quality and timely manner.

Notwithstanding section 3721.01 of the Revised Code, an adult care facility in which residents receive skilled nursing care as described in division (B) of this section is not a nursing home. No adult care facility shall provide skilled nursing care.

(C) A home health agency or hospice care program that provides skilled nursing care pursuant to division (B) of this section may not be associated with the adult care facility unless the facility is part of a home for the aged as defined in section 5701.13 of the Revised Code or the adult care facility is owned and operated by the same person and located on the same site as a nursing home licensed under Chapter 3721. of the Revised Code that is associated with the home health agency or hospice care program. In addition, the following requirements shall be met:

(1) The adult care facility shall evaluate the individual receiving the skilled nursing care not less than once every seven days to determine whether the individual should be transferred to a nursing home;

(2) If the costs of providing the skilled nursing care are included in a cost report filed pursuant to section ~~5111.26~~ 5164.37 of the Revised Code by the nursing home that is part of the same home for the aged, the home health agency or hospice care program shall not seek reimbursement for the care under the ~~medical assistance~~ medicaid program ~~established under Chapter 5111. of the Revised Code~~.

(D)(1) No person knowingly shall place or recommend placement of any person in an adult care facility that is operating without

a license.

(2) No employee of a unit of local or state government, board of alcohol, drug addiction, and mental health services, mental health agency, or PASSPORT administrative agency shall place or recommend placement of any person in an adult care facility if the employee knows that the facility cannot meet the needs of the potential resident.

(3) No person who has reason to believe that an adult care facility is operating without a license shall fail to report this information to the director of health.

(E) In accordance with Chapter 119. of the Revised Code, the public health council shall adopt rules that define a short-term illness for purposes of division (B)(3) of this section and specify, consistent with rules pertaining to home health care adopted by the director of ~~job and family services~~ health care administration under the ~~medical assistance~~ medicaid program ~~established under Chapter 5111. of the Revised Code and Title XIX of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C. 301, as amended~~, what constitutes a part-time, intermittent basis for purposes of division (B)(1) of this section.

Sec. 3727.02. (A) No person and no political subdivision, agency, or instrumentality of this state shall operate a hospital unless it is certified under ~~Title XVIII of~~ the ~~"Social Security Act," 49 Stat. 620 (1935), 42 U.S.C. 301, as amended~~ medicare program, or is accredited by the joint commission on accreditation of hospitals or the American osteopathic association.

(B) No person and no political subdivision, agency, or instrumentality of this state shall hold out as a hospital any health facility that is not certified or accredited as required in division (A) of this section.

Sec. 3742.30. Each child at risk of lead poisoning shall undergo a blood lead screening test to determine whether the child has lead poisoning. The at-risk children shall undergo the test at times determined by rules the public health council shall adopt in accordance with Chapter 119. of the Revised Code that are consistent with the guidelines established by the centers for disease control and prevention in the public health service of the United States department of health and human services. The rules shall specify which children are at risk of lead poisoning.

Neither this section nor the rules adopted under it affect the coverage of blood lead screening tests by any publicly funded health program, including the medicaid program ~~established by Chapter 5111. of the Revised Code~~. Neither this section nor the rules adopted under it apply to a child if a parent of the child objects to the test on the grounds that the test conflicts with the parent's religious tenets and practices.

Sec. 3742.51. (A) There is hereby created in the state treasury the lead poisoning prevention fund. The fund shall include all moneys appropriated to the department of health for the administration and enforcement of sections 3742.31 to 3742.50 of the Revised Code and the rules adopted under those sections. Any grants, contributions, or other moneys collected by the department for purposes of preventing lead poisoning shall be deposited in the state treasury to the credit of the fund.

(B) Moneys in the fund shall be used solely for the purposes of the child lead poisoning prevention program established under section 3742.31 of the Revised Code, including providing financial assistance to individuals who are unable to pay for the following:

(1) Costs associated with obtaining lead tests and lead poisoning treatment for children under six years of age who are

not covered by private medical insurance or are underinsured, are not eligible for the medicaid program ~~established under Chapter 5111. of the Revised Code~~ or any other government health program, and do not have access to another source of funds to cover the cost of lead tests and any indicated treatments;

(2) Costs associated with having lead abatement performed or having the preventive treatments specified in section 3742.41 of the Revised Code performed.

Sec. 3793.07. ~~(A) As used in this section:~~

~~(1) "Medicare program" means the program established under Title XVIII of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C. 301, as amended;~~

~~(2) "Medicaid program" means the program established under Title XIX of the "Social Security Act."~~

~~(B)~~(A) Except as provided in division ~~(D)~~(C) of this section, the department of alcohol and drug addiction services shall establish and administer a process for the certification or credentialing of chemical dependency counselors and alcohol and other drug prevention specialists for the purpose of qualifying their services for reimbursement under the medicare or medicaid program. The process shall be made available to any individual who is a member of the profession of drug abuse counseling or chemical dependency counseling or any individual who is an alcohol and other drug prevention specialist. Nothing in this section shall be construed as requiring such certification or credentials for services that are not reimbursed by medicare or medicaid.

The department shall cease to administer its process for the certification or credentialing of chemical dependency counselors and alcohol and other drug prevention specialists under this section at the earlier of the following:

(1) The date, which shall be specified in an agreement between the department and chemical dependency professionals board, on which the board is to assume, under Chapter 4758. of the Revised Code, the department's certification duties;

(2) Two years after ~~the effective date of this amendment~~ December 23, 2002.

~~(C)~~(B) The department shall adopt rules in accordance with Chapter 119. of the Revised Code establishing standards and procedures for the certification or credentialing process. The rules shall include the following:

(1) Eligibility requirements;

(2) Application procedures;

(3) Minimum educational and clinical training requirements that must be met for initial certification or credentialing;

(4) Continuing education and training requirements for certified or credentialed individuals;

(5) Application and renewal fees that do not exceed the cost incurred by the department in implementing and administering the process;

(6) Administration or approval of examinations;

(7) Investigation of complaints and alleged violations of this section;

(8) Maintenance of the confidentiality of the department's investigative records;

(9) Disciplinary actions, including application denial and suspension or revocation of certification or credentials;

(10) Any other rules the department considers necessary to establish or administer the certification or credentialing process.

~~(D)~~(C)(1) Except as provided in division ~~(D)~~(C)(2) of this section, the department shall not issue an initial certificate or credential to practice as a chemical dependency counselor I, but may renew such a certificate or credential issued prior to ~~the effective date of this amendment~~ December 23, 2002, or pursuant to division ~~(D)~~(C)(2) of this section until the department ceases to administer the certification and credentialing process under this section.

(2) The department may issue an initial certificate or credential to practice as a chemical dependency counselor I to an individual if the individual submitted the application for certification or credentials to the department prior to ~~the effective date of this amendment~~ December 23, 2002.

~~(E)~~(D) The department shall investigate alleged violations of this section or the rules adopted under it. As part of its investigation, the department may issue subpoenas, examine witnesses, and administer oaths. The department shall ensure that all records it holds pertaining to an investigation remain confidential.

~~(F)~~(E) With respect to hearings conducted by the department as part of the certification or credentialing process, both of the following apply:

(1) An individual whose application for certification or credentials issued under this section has been denied by the department may request a hearing in accordance with Chapter 119. of the Revised Code and the rules adopted under this section.

(2) The department may appoint a referee or hearing examiner to conduct the proceedings and make recommendations to the department as appropriate.

~~(G)~~(F) The department shall maintain a record of all fees collected under this section. All fees collected shall be paid

into the state treasury to the credit of the credentialing fund, which is hereby created. Money credited to the fund shall be used solely to pay the costs of establishing and administering the process for certification or credentialing of chemical dependency professionals under this section.

Money credited to the credentialing fund under this section shall be transferred to the occupational licensing and regulatory fund created under section 4743.05 of the Revised Code at the earlier of the following:

(1) The date, which shall be specified in an agreement between the department and chemical dependency professionals board, on which the board is to assume, under Chapter 4758. of the Revised Code, the department's certification duties;

(2) Two years after ~~the effective date of this amendment~~ December 23, 2002.

~~(H)~~(G) Certifications made and credentials issued by the Ohio credentialing board for chemical dependency professionals prior to the date the department establishes its certification or credentialing process under this section shall continue to be accepted by the department until, with respect to any particular individual, one of the following occurs:

(1) The individual's certification or credentials from the board have expired.

(2) The individual's certification or credentials from the board would be suspended or revoked by the department if the certification or credentials had been issued by the department under this section.

Sec. 3901.3814. Sections 3901.38 and 3901.381 to 3901.3813 of the Revised Code do not apply to the following:

(A) Policies offering coverage that is regulated under

Chapters 3935. and 3937. of the Revised Code;

(B) An employer's self-insurance plan and any of its administrators, as defined in section 3959.01 of the Revised Code, to the extent that federal law supersedes, preempts, prohibits, or otherwise precludes the application of any provisions of those sections to the plan and its administrators;

(C) A third-party payer for coverage provided under the medicare advantage program operated under ~~Title XVIII of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended~~ the medicare program;

(D) A third-party payer for coverage provided under the medicaid program ~~operated under Title XIX of the "Social Security Act,"~~ except that if a federal waiver applied for under section ~~5111.178~~ 5165.16 of the Revised Code is granted or the director of ~~job and family services~~ health care administration determines that this provision can be implemented without a waiver, sections 3901.38 and 3901.381 to 3901.3813 of the Revised Code apply to claims submitted electronically or non-electronically that are made with respect to coverage of medicaid recipients by health insuring corporations licensed under Chapter 1751. of the Revised Code, instead of the prompt payment requirements of 42 C.F.R. 447.46;

(E) A third-party payer for coverage provided under the tricare program offered by the United States department of defense.

Sec. 3903.14. (A) The superintendent of insurance as rehabilitator may appoint one or more special deputies, who shall have all the powers and responsibilities of the rehabilitator granted under this section, and the superintendent may employ such clerks and assistants as considered necessary. The compensation of the special deputies, clerks, and assistants and all expenses of

taking possession of the insurer and of conducting the proceedings shall be fixed by the superintendent, with the approval of the court and shall be paid out of the funds or assets of the insurer. The persons appointed under this section shall serve at the pleasure of the superintendent. In the event that the property of the insurer does not contain sufficient cash or liquid assets to defray the costs incurred, the superintendent may advance the costs so incurred out of any appropriation for the maintenance of the department of insurance. Any amounts so advanced for expenses of administration shall be repaid to the superintendent for the use of the department out of the first available money of the insurer.

(B) The rehabilitator may take such action as the rehabilitator considers necessary or appropriate to reform and revitalize the insurer. The rehabilitator shall have all the powers of the directors, officers, and managers, whose authority shall be suspended, except as they are redelegated by the rehabilitator. The rehabilitator shall have full power to direct and manage, to hire and discharge employees subject to any contract rights they may have, and to deal with the property and business of the insurer.

(C) If it appears to the rehabilitator that there has been criminal or tortious conduct, or breach of any contractual or fiduciary obligation detrimental to the insurer by any officer, manager, agent, director, trustee, broker, employee, or other person, the rehabilitator may pursue all appropriate legal remedies on behalf of the insurer.

(D) If the rehabilitator determines that reorganization, consolidation, conversion, reinsurance, merger, or other transformation of the insurer is appropriate, the rehabilitator shall prepare a plan to effect such changes. Upon application of the rehabilitator for approval of the plan, and after such notice

and hearings as the court may prescribe, the court may either approve or disapprove the plan proposed, or may modify it and approve it as modified. Any plan approved under this section shall be, in the judgment of the court, fair and equitable to all parties concerned. If the plan is approved, the rehabilitator shall carry out the plan. In the case of a life insurer, the plan proposed may include the imposition of liens upon the policies of the company, if all rights of shareholders are first relinquished. A plan for a life insurer may also propose imposition of a moratorium upon loan and cash surrender rights under policies, for such period and to such an extent as may be necessary.

(E) In the case of a medicaid health insuring corporation that has posted a bond or deposited securities in accordance with section 1751.271 of the Revised Code, the plan proposed under division (D) of this section may include the use of the proceeds of the bond or securities to first pay the claims of contracted providers for covered health care services provided to medicaid recipients, then next to pay other claimants with any remaining funds, consistent with the priorities set forth in sections 3903.421 and 3903.42 of the Revised Code.

(F) The rehabilitator shall have the power under sections 3903.26 and 3903.27 of the Revised Code to avoid fraudulent transfers.

(G) As used in this section:

(1) "Contracted provider" means a provider with a contract with a medicaid health insuring corporation to provide covered health care services to medicaid recipients.

(2) "Medicaid recipient" means a person eligible for ~~assistance under~~ the medicaid program ~~operated pursuant to Chapter 5111. of the Revised Code~~.

Sec. 3916.06. (A)(1) With each application for a viatical settlement, a viatical settlement provider or viatical settlement broker shall disclose at least the following to a viator no later than the time all parties sign the application for the viatical settlement contract:

(a) That there are possible alternatives to viatical settlement contracts, including any accelerated death benefits offered under the viator's life insurance policy or certificate;

(b) That some or all of the proceeds of the viatical settlement may be subject to federal income taxation and state franchise and income taxation, and that assistance should be sought from a professional tax advisor;

(c) That the proceeds of the viatical settlement could be subject to the claims of creditors;

(d) That receipt of the proceeds of the viatical settlement may adversely affect the viator's eligibility for ~~medical assistance under Chapter 5111. of the Revised Code~~ the medicaid program or other government benefits or entitlements, and that advice should be obtained from the appropriate government agencies;

(e) That the viator has a right to rescind the viatical settlement contract for at least fifteen calendar days after the viator receives the viatical settlement proceeds, as provided in section 3916.08 of the Revised Code~~,~~. If the insured dies during the rescission period, the settlement contract shall be deemed to have been rescinded, subject to repayment of all viatical settlement proceeds to the viatical settlement company.

(f) That funds will be sent to the viator within three business days after the viatical settlement provider has received acknowledgment from the insurer or group administrator that

ownership of the policy or interest in the certificate has been transferred and that the beneficiary has been designated pursuant to the viatical settlement contract;

(g) That entering into a viatical settlement contract may cause other rights or benefits, including conversion rights and waiver of premium benefits that may exist under the policy or certificate, to be forfeited by the viator and that assistance should be sought from a financial advisor.

(2) The viatical settlement provider or viatical settlement broker shall provide the disclosures under division (A)(1) of this section in a separate document that is signed by the viator and the viatical settlement provider or viatical settlement broker.

(3) Disclosure to a viator under division (A)(1) of this section shall include distribution of a brochure describing the process of viatical settlements. The viatical settlement provider or viatical settlement broker shall use the NAIC's form for the brochure unless one is developed by the superintendent.

(4) The disclosure document under division (A)(1) of this section shall contain the following language:

"All medical, financial, or personal information solicited or obtained by a viatical settlement provider or viatical settlement broker about an insured, including the insured's identity or the identity of family members, a spouse, or a significant other may be disclosed as necessary to effect the viatical settlement between the viator and the viatical settlement provider. If you are asked to provide this information, you will be asked to consent to the disclosure. The information may be provided to someone who buys the policy or provides funds for the purchase. You may be asked to renew your permission to share information every two years."

(B)(1) A viatical settlement provider shall disclose at least

the following to a viator prior to the date the viatical settlement contract is signed by all the necessary parties:

(a) The affiliation, if any, between the viatical settlement provider and the issuer of the insurance policy or certificate to be viaticated;

(b) The name, address, and telephone number of the viatical settlement provider;

(c) Regarding a viatical settlement broker, the amount and method of calculating the broker's compensation. As used in this division, "compensation" includes anything of value paid or given to a viatical settlement broker for the placement of a policy or certificate.

(d) If an insurance policy or certificate to be viaticated has been issued as a joint policy or certificate or involves family riders or any coverage of a life other than the insured under the policy or certificate to be viaticated, the possible loss of coverage on the other lives under the policy or certificate and that advice should be sought from the viator's insurance producer or the company issuing the policy or certificate;

(e) The dollar amount of the current death benefit payable to the viatical settlement provider under the policy or certificate, and, if known, the availability of any additional guaranteed insurance benefits, the dollar amount of any accidental death and dismemberment benefits under the policy or certificate, and the viatical settlement provider's interest in those benefits.

(f) The name, business address, and telephone number of the independent third-party escrow agent, and the fact that the viator or owner may inspect or receive copies of the relevant escrow or trust agreements or documents.

(2) The viatical settlement provider or viatical settlement

broker shall conspicuously display the disclosures under division (B)(1) of this section in a separate document signed by the viator and the viatical settlement provider or viatical settlement broker.

(C) If the provider transfers ownership or changes the beneficiary of the insurance policy or certificate, the provider shall communicate the change in ownership or beneficiary to the insured within twenty days after the change.

Sec. 3923.122. (A) Every policy of group sickness and accident insurance providing hospital, surgical, or medical expense coverage for other than specific diseases or accidents only, and delivered, issued for delivery, or renewed in this state on or after January 1, 1976, shall include a provision giving each insured the option to convert to the following:

(1) In the case of an individual who is not a federally eligible individual, any of the individual policies of hospital, surgical, or medical expense insurance then being issued by the insurer with benefit limits not to exceed those in effect under the group policy;

(2) In the case of a federally eligible individual, a basic or standard plan established by the board of directors of the Ohio health reinsurance program or plans substantially similar to the basic and standard plan in benefit design and scope of covered services. For purposes of division (A)(2) of this section, the superintendent of insurance shall determine whether a plan is substantially similar to the basic or standard plan in benefit design and scope of covered services.

(B) An option for conversion to an individual policy shall be available without evidence of insurability to every insured, including any person eligible under division (D) of this section, who terminates employment or membership in the group holding the

policy after having been continuously insured thereunder for at least one year.

Upon receipt of the insured's written application and upon payment of at least the first quarterly premium not later than thirty-one days after the termination of coverage under the group policy, the insurer shall issue a converted policy on a form then available for conversion. The premium shall be in accordance with the insurer's table of premium rates in effect on the later of the following dates:

(1) The effective date of the converted policy;

(2) The date of application therefor; and shall be applicable to the class of risk to which each person covered belongs and to the form and amount of the policy at the person's then attained age. However, premiums charged federally eligible individuals may not exceed an amount that is two times the midpoint of the standard rate charged any other individual of a group to which the insurer is currently accepting new business and for which similar copayments and deductibles are applied.

At the election of the insurer, a separate converted policy may be issued to cover any dependent of an employee or member of the group.

Except as provided in division (H) of this section, any converted policy shall become effective as of the day following the date of termination of insurance under the group policy.

Any probationary or waiting period set forth in the converted policy is deemed to commence on the effective date of the insured's coverage under the group policy.

(C) No insurer shall be required to issue a converted policy to any person who is, or is eligible to be, covered for benefits at least comparable to the group policy under:

(1) ~~Title XVIII of the Social Security Act, as amended or superseded~~ The medicare program;

(2) Any act of congress or law under this or any other state of the United States that duplicates coverage offered under division (C)(1) of this section;

(3) Any policy that duplicates coverage offered under division (C)(1) of this section;

(4) Any other group sickness and accident insurance providing hospital, surgical, or medical expense coverage for other than specific diseases or accidents only.

(D) The option for conversion shall be available:

(1) Upon the death of the employee or member, to the surviving spouse with respect to such of the spouse and dependents as are then covered by the group policy;

(2) To a child solely with respect to the child upon attaining the limiting age of coverage under the group policy while covered as a dependent thereunder;

(3) Upon the divorce, dissolution, or annulment of the marriage of the employee or member, to the divorced spouse, or former spouse in the event of annulment, of such employee or member, or upon the legal separation of the spouse from such employee or member, to the spouse.

Persons possessing the option for conversion pursuant to this division shall be considered members for the purposes of division (H) of this section.

(E) If coverage is continued under a group policy on an employee following retirement prior to the time the employee is, or is eligible to be, covered by ~~Title XVIII of~~ the ~~Social Security Act~~ medicare program, the employee may elect, in lieu of the continuance of group insurance, to have the same conversion

rights as would apply had the employee's insurance terminated at retirement by reason of termination of employment.

(F) If the insurer and the group policyholder agree upon one or more additional plans of benefits to be available for converted policies, the applicant for the converted policy may elect such a plan in lieu of a converted policy.

(G) The converted policy may contain provisions for avoiding duplication of benefits provided pursuant to divisions (C)(1), (2), (3), and (4) of this section or provided under any other insured or noninsured plan or program.

(H) If an employee or member becomes entitled to obtain a converted policy pursuant to this section, and if the employee or member has not received notice of the conversion privilege at least fifteen days prior to the expiration of the thirty-one-day conversion period provided in division (B) of this section, then the employee or member has an additional period within which to exercise the privilege. This additional period shall expire fifteen days after the employee or member receives notice, but in no event shall the period extend beyond sixty days after the expiration of the thirty-one-day conversion period.

Written notice presented to the employee or member, or mailed by the policyholder to the last known address of the employee or member as indicated on its records, constitutes notice for the purpose of this division. In the case of a person who is eligible for a converted policy under division (D)(2) or (D)(3) of this section, a policyholder shall not be responsible for presenting or mailing such notice, unless such policyholder has actual knowledge of the person's eligibility for a converted policy.

If an additional period is allowed by an employee or member for the exercise of a conversion privilege, and if written application for the converted policy, accompanied by at least the

first quarterly premium, is made after the expiration of the thirty-one-day conversion period, but within the additional period allowed an employee or member in accordance with this division, the effective date of the converted policy shall be the date of application.

(I) The converted policy may provide that any hospital, surgical, or medical expense benefits otherwise payable with respect to any person may be reduced by the amount of any such benefits payable under the group policy for the same loss after termination of coverage.

(J) The converted policy may contain:

(1) Any exclusion, reduction, or limitation contained in the group policy or customarily used in individual policies issued by the insurer;

(2) Any provision permitted in this section;

(3) Any other provision not prohibited by law.

Any provision required or permitted in this section may be made a part of any converted policy by means of an endorsement or rider.

(K) The time limit specified in a converted policy for certain defenses with respect to any person who was covered by a group policy shall commence on the effective date of such person's coverage under the group policy.

(L) No insurer shall use deterioration of health as the basis for refusing to renew a converted policy.

(M) No insurer shall use age as the basis for refusing to renew a converted policy.

(N) A converted policy made available pursuant to this section shall, if delivery of the policy is to be made in this state, comply with this section. If delivery of a converted policy

is to be made in another state, it may be on a form offered by the insurer in the jurisdiction where the delivery is to be made and which provides benefits substantially in compliance with those required in a policy delivered in this state.

(O) As used in this section, "federally eligible individual" means an eligible individual as defined in 45 C.F.R. 148.103.

Sec. 3923.27. No policy of sickness and accident insurance delivered, issued for delivery, or renewed in this state after August 26, 1976, including both individual and group policies, that provides hospitalization coverage for mental illness shall exclude such coverage for the reason that the insured is hospitalized in an institution or facility receiving tax support from the state, any municipal corporation, county, or joint county board, whether such institution or facility is deemed charitable or otherwise, provided the institution or facility or portion thereof is fully accredited by the joint commission on accreditation of hospitals or certified under ~~Titles XVIII and XIX of~~ the ~~"Social Security Act of 1935," 79 Stat. 291, 42 U.S.C.A. 1395, as amended~~ medicare program and medicaid program. The insurance coverage shall provide payment amounting to the lesser of either the full amount of the statutory charge for the cost of the services pursuant to section 5121.33 of the Revised Code or the benefits payable for the services under the applicable insurance policy. Insurance benefits for the coverage shall be paid so long as patients and their liable relatives retain their statutory liability pursuant to section 5121.33 of the Revised Code. Only that portion or per cent of the benefits shall be payable that has been assigned, or ordered to be paid, to the state or other appropriate provider for services rendered by the institution or facility.

Sec. 3923.281. (A) As used in this section:

(1) "Biologically based mental illness" means schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, and panic disorder, as these terms are defined in the most recent edition of the diagnostic and statistical manual of mental disorders published by the American psychiatric association.

(2) "Policy of sickness and accident insurance" has the same meaning as in section 3923.01 of the Revised Code, but excludes any hospital indemnity, medicare supplement, long-term care, disability income, one-time-limited-duration policy of not longer than six months, supplemental benefit, or other policy that provides coverage for specific diseases or accidents only; any policy that provides coverage for workers' compensation claims compensable pursuant to Chapters 4121. and 4123. of the Revised Code; and any policy that provides coverage to beneficiaries enrolled in ~~Title XIX of~~ the ~~"Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended, known as the medical assistance program or~~ medicaid~~, as provided by the Ohio department of job and family services under Chapter 5111. of the Revised Code~~ program.

(B) Notwithstanding section 3901.71 of the Revised Code, and subject to division (E) of this section, every group policy of sickness and accident insurance shall provide benefits for the diagnosis and treatment of biologically based mental illnesses on the same terms and conditions as, and shall provide benefits no less extensive than, those provided under the policy of sickness and accident insurance for the treatment and diagnosis of all other physical diseases and disorders, if both of the following apply:

(1) The biologically based mental illness is clinically diagnosed by a physician authorized under Chapter 4731. of the

Revised Code to practice medicine and surgery or osteopathic medicine and surgery; a psychologist licensed under Chapter 4732. of the Revised Code; a professional clinical counselor, professional counselor, or independent social worker licensed under Chapter 4757. of the Revised Code; or a clinical nurse specialist licensed under Chapter 4723. of the Revised Code whose nursing specialty is mental health.

(2) The prescribed treatment is not experimental or investigational, having proven its clinical effectiveness in accordance with generally accepted medical standards.

(C) Division (B) of this section applies to all coverages and terms and conditions of the policy of sickness and accident insurance, including, but not limited to, coverage of inpatient hospital services, outpatient services, and medication; maximum lifetime benefits; copayments; and individual and family deductibles.

(D) Nothing in this section shall be construed as prohibiting a sickness and accident insurance company from taking any of the following actions:

(1) Negotiating separately with mental health care providers with regard to reimbursement rates and the delivery of health care services;

(2) Offering policies that provide benefits solely for the diagnosis and treatment of biologically based mental illnesses;

(3) Managing the provision of benefits for the diagnosis or treatment of biologically based mental illnesses through the use of pre-admission screening, by requiring beneficiaries to obtain authorization prior to treatment, or through the use of any other mechanism designed to limit coverage to that treatment determined to be necessary;

(4) Enforcing the terms and conditions of a policy of

sickness and accident insurance.

(E) An insurer that offers a group policy of sickness and accident insurance is not required to provide benefits for the diagnosis and treatment of biologically based mental illnesses pursuant to division (B) of this section if all of the following apply:

(1) The insurer submits documentation certified by an independent member of the American academy of actuaries to the superintendent of insurance showing that incurred claims for diagnostic and treatment services for biologically based mental illnesses for a period of at least six months independently caused the insurer's costs for claims and administrative expenses for the coverage of all other physical diseases and disorders to increase by more than one per cent per year.

(2) The insurer submits a signed letter from an independent member of the American academy of actuaries to the superintendent of insurance opining that the increase described in division (E)(1) of this section could reasonably justify an increase of more than one per cent in the annual premiums or rates charged by the insurer for the coverage of all other physical diseases and disorders.

(3) The superintendent of insurance makes the following determinations from the documentation and opinion submitted pursuant to divisions (E)(1) and (2) of this section:

(a) Incurred claims for diagnostic and treatment services for biologically based mental illnesses for a period of at least six months independently caused the insurer's costs for claims and administrative expenses for the coverage of all other physical diseases and disorders to increase by more than one per cent per year.

(b) The increase in costs reasonably justifies an increase of

more than one per cent in the annual premiums or rates charged by the insurer for the coverage of all other physical diseases and disorders.

Any determination made by the superintendent under this division is subject to Chapter 119. of the Revised Code.

Sec. 3923.33. As used in section 3923.33 and sections 3923.331 to 3923.339 of the Revised Code:

(A) "Applicant" means:

(1) In the case of an individual medicare supplement policy, the person who seeks to contract for insurance benefits; and

(2) In the case of a group medicare supplement policy, the proposed certificate holder.

(B) "Certificate" means, for purposes of section 3923.33 and sections 3923.331 to 3923.339 of the Revised Code, any certificate delivered or issued for delivery in this state under a group medicare supplement policy.

(C) "Certificate form" means the form on which the certificate is delivered or issued for delivery by the issuer.

(D) "Direct response insurance policy" means a medicare supplement policy or certificate marketed without the direct involvement of an insurance agent.

(E) "Issuer" includes insurance companies, fraternal benefit societies, health insuring corporations, and any other entities delivering or issuing for delivery in this state medicare supplement policies or certificates.

(F) ~~"Medicare" means the "Health Insurance for the Aged Act," Title XVIII of the Social Security Amendments of 1965, 79 Stat. 291, 42 U.S.C.A. 1395, as then constituted or later amended.~~

~~(G)~~ "Medicare supplement policy" means a group or individual

policy of sickness and accident insurance or a subscriber contract of health insuring corporations or any other issuers, other than a policy issued pursuant to a contract under section 1876 of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A., 1395mm, as amended, or an issued policy under any demonstration project specified in 42 U.S.C.A. 1395ss(g)(1), which is advertised, marketed, or designed primarily as a supplement to reimbursements under medicare for the hospital, medical, or surgical expenses of persons eligible for medicare.

~~(H)~~(G) "Policy form" means the form on which the policy is delivered or issued for delivery by the issuer.

Sec. 3923.38. (A) As used in this section:

(1) "Group policy" includes any group sickness and accident policy or contract delivered, issued for delivery, or renewed in this state on or after June 28, 1984, and any private or public employer self-insurance plan or other plan that provides, or provides payment for, health care benefits for employees resident in this state other than through an insurer or health insuring corporation, to which both of the following apply:

(a) The policy insures employees for hospital, surgical, or major medical insurance on an expense incurred or service basis, other than for specified diseases or for accidental injuries only.

(b) The policy is in effect and covers an eligible employee at the time the employee's employment is terminated.

(2) "Eligible employee" includes only an employee to whom all of the following apply:

(a) The employee has been continuously insured under a group policy or under the policy and any prior similar group coverage replaced by the policy, during the entire three-month period preceding the termination of the employee's employment.

(b) The employee is entitled, at the time of the termination of the employee's employment, to unemployment compensation benefits under Chapter 4141. of the Revised Code.

(c) The employee is not, and does not become, covered by or eligible for coverage by medicare ~~under Title XVIII of the Social Security Act, as amended~~.

(d) The employee is not, and does not become, covered by or eligible for coverage by any other insured or uninsured arrangement that provides hospital, surgical, or medical coverage for individuals in a group and under which the person was not covered immediately prior to such termination. A person eligible for continuation of coverage under this section, who is also eligible for coverage under section 3923.123 of the Revised Code, may elect either coverage, but not both. A person who elects continuation of coverage may elect any coverage available under section 3923.123 of the Revised Code upon the termination of the continuation of coverage.

(3) "Group rate" means, in the case of an employer self-insurance or other health benefits plan, the average monthly cost per employee, over a period of at least twelve months, of the operation of the plan that would represent a group insurance rate if the same coverage had been provided under a group sickness and accident insurance policy.

(B) A group policy shall provide that any eligible employee may continue the employee's hospital, surgical, and medical insurance under the policy, for the employee and the employee's eligible dependents, for a period of six months after the date that the insurance coverage would otherwise terminate by reason of the termination of the employee's employment. Each certificate of coverage, or other notice of coverage, issued to employees under the policy shall include a notice of the employee's privilege of continuation.

(C) All of the following apply to the continuation of coverage required under division (B) of this section:

(1) Continuation need not include dental, vision care, prescription drug benefits, or any other benefits provided under the policy in addition to its hospital, surgical, or major medical benefits.

(2) The employer shall notify the employee of the right of continuation at the time the employer notifies the employee of the termination of employment. The notice shall inform the employee of the amount of contribution required by the employer under division (C)(4) of this section.

(3) The employee shall file a written election of continuation with the employer and pay the employer the first contribution required under division (C)(4) of this section. The request and payment must be received by the employer no later than the earlier of any of the following dates:

(a) Thirty-one days after the date on which the employee's coverage would otherwise terminate;

(b) Ten days after the date on which the employee's coverage would otherwise terminate, if the employer has notified the employee of the right of continuation prior to such date;

(c) Ten days after the employer notifies the employee of the right of continuation, if the notice is given after the date on which the employee's coverage would otherwise terminate.

(4) The employee must pay to the employer, on a monthly basis, in advance, the amount of contribution required by the employer. The amount required shall not exceed the group rate for the insurance being continued under the policy on the due date of each payment.

(5) The employee's privilege to continue coverage and the

coverage under any continuation ceases if any of the following occurs:

(a) The employee ceases to be an eligible employee under division (A)(2)(c) or (d) of this section;

(b) A period of six months expires after the date that the employee's insurance under the policy would otherwise have terminated because of the termination of employment;

(c) The employee fails to make a timely payment of a required contribution, in which event the coverage shall cease at the end of the coverage for which contributions were made;

(d) The policy is terminated, or the employer terminates participation under the policy, unless the employer replaces the coverage by similar coverage under another group policy or other group health arrangement.

If the employer replaces the policy with similar group health coverage, all of the following apply:

(i) The member shall be covered under the replacement coverage, for the balance of the period that the member would have remained covered under the terminated coverage if it had not been terminated.

(ii) The minimum level of benefits under the replacement coverage shall be the applicable level of benefits of the policy replaced reduced by any benefits payable under the policy replaced.

(iii) The policy replaced shall continue to provide benefits to the extent of its accrued liabilities and extensions of benefits as if the replacement had not occurred.

(D) This section does not apply to an employer's self-insurance plan if federal law supersedes, preempts, prohibits, or otherwise precludes its application to such plans.

Sec. 3923.49. The department of insurance shall establish an outreach program to educate consumers about the following:

(A) The need for long-term care insurance;

(B) Mechanisms for financing long-term care;

(C) The availability of long-term care insurance;

(D) The resource protection provided by the Ohio long-term care insurance program under section ~~5111.18~~ 5162.43 of the Revised Code;

(E) That a consumer who purchased a long-term care insurance policy that does not meet the requirements of section 3923.50 of the Revised Code may purchase a policy that meets those requirements.

The department shall develop and make available to consumers information to assist them in choosing long-term care insurance coverage.

Sec. 3923.50. For the purposes of the Ohio long-term care insurance program established under section ~~5111.18~~ 5162.43 of the Revised Code, the department of insurance shall notify the department of ~~job and family services~~ health care administration of all long-term care insurance policies that meet all of the following requirements:

(A) Comply with sections 3923.41 to 3923.48 of the Revised Code and the rules adopted under section 3923.47 of the Revised Code;

(B) Provide benefits for home and community-based services in addition to nursing home care;

(C) Include case management services in its coverage of home and community-based services;

(D) Provide five per cent inflation protection compounded annually;

(E) Provide for the keeping of records and explanation-of-benefit reports on insurance payments that count toward resource exclusion for the ~~medical assistance~~ medicaid program;

(F) Provide the information the director of ~~job and family services~~ health care administration determines is necessary to document the extent of resource exclusion and to evaluate the Ohio long-term care insurance program;

(G) Comply with other requirements established in rules adopted under this section.

The superintendent of insurance shall adopt rules in accordance with Chapter 119. of the Revised Code establishing requirements under division (G) of this section that policies must meet to qualify under the Ohio long-term care insurance program. The superintendent shall consult with the departments of aging and ~~job and family services~~ health care administration in adopting those rules.

Sec. 3923.58. (A) As used in sections 3923.58 and 3923.59 of the Revised Code:

(1) "Health benefit plan" and "MEWA" have the same meanings as in section 3924.01 of the Revised Code.

(2) "Insurer" means any sickness and accident insurance company authorized to do business in this state, or MEWA authorized to issue insured health benefit plans in this state. "Insurer" does not include any health insuring corporation that is owned or operated by an insurer.

(3) "Pre-existing conditions provision" means a policy provision that excludes or limits coverage for charges or expenses

incurred during a specified period following the insured's effective date of coverage as to a condition which, during a specified period immediately preceding the effective date of coverage, had manifested itself in such a manner as would cause an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment or for which medical advice, diagnosis, care, or treatment was recommended or received, or a pregnancy existing on the effective date of coverage.

(B) Beginning in January of each year, insurers in the business of issuing individual policies of sickness and accident insurance as contemplated by section 3923.021 of the Revised Code, except individual policies issued pursuant to section 3923.122 of the Revised Code, shall accept applicants for open enrollment coverage, as set forth in this division, in the order in which they apply for coverage and subject to the limitation set forth in division (G) of this section. Insurers shall accept for coverage pursuant to this section individuals to whom both of the following conditions apply:

(1) The individual is not applying for coverage as an employee of an employer, as a member of an association, or as a member of any other group.

(2) The individual is not covered, and is not eligible for coverage, under any other private or public health benefits arrangement, including 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 any other act of congress or law of this or any other state of the United States that provides benefits comparable to the benefits provided under this section, any medicare supplement policy, or any continuation of coverage policy under state or federal law.

(C) An insurer shall offer to any individual accepted under this section the Ohio health care basic and standard plans

established by the board of directors of the Ohio health reinsurance program under division (A) of section 3924.10 of the Revised Code or health benefit plans that are substantially similar to the Ohio health care basic and standard plans in benefit plan design and scope of covered services.

An insurer may offer other health benefit plans in addition to, but not in lieu of, the plans required to be offered under this division. A basic health benefit plan shall provide, at a minimum, the coverage provided by the Ohio health care basic plan or any health benefit plan that is substantially similar to the Ohio health care basic plan in benefit plan design and scope of covered services. A standard health benefit plan shall provide, at a minimum, the coverage provided by the Ohio health care standard plan or any health benefit plan that is substantially similar to the Ohio health care standard plan in benefit plan design and scope of covered services.

For purposes of this division, the superintendent of insurance shall determine whether a health benefit plan is substantially similar to the Ohio health care basic and standard plans in benefit plan design and scope of covered services.

(D) Health benefit plans issued under this section may establish pre-existing conditions provisions that exclude or limit coverage for a period of up to twelve months following the individual's effective date of coverage and that may relate only to conditions during the six months immediately preceding the effective date of coverage.

(E) Premiums charged to individuals under this section may not exceed an amount that is two and one-half times the highest rate charged any other individual to which the insurer is currently accepting new business, and for which similar copayments and deductibles are applied.

(F) In offering health benefit plans under this section, an insurer may require the purchase of health benefit plans that condition the reimbursement of health services upon the use of a specific network of providers.

(G)(1) In no event shall an insurer be required to accept annually under this section individuals who, in the aggregate, would cause the insurer to have a total number of new insureds that is more than one-half per cent of its total number of insured individuals in this state per year, as contemplated by section 3923.021 of the Revised Code, calculated as of the immediately preceding thirty-first day of December and excluding the insurer's medicare supplement policies and conversion or continuation of coverage policies under state or federal law and any policies described in division (L) of this section.

(2) An officer of the insurer shall certify to the department of insurance when it has met the enrollment limit set forth in division (G)(1) of this section. Upon providing such certification, the insurer shall be relieved of its open enrollment requirement under this section for the remainder of the calendar year.

(H) An insurer shall not be required to accept under this section applicants who, at the time of enrollment, are confined to a health care facility because of chronic illness, permanent injury, or other infirmity that would cause economic impairment to the insurer if the applicants were accepted, or to make the effective date of benefits for individuals accepted under this section earlier than ninety days after the date of acceptance.

(I) The requirements of this section do not apply to any insurer that is currently in a state of supervision, insolvency, or liquidation. If an insurer demonstrates to the satisfaction of the superintendent that the requirements of this section would place the insurer in a state of supervision, insolvency, or

liquidation, the superintendent may waive or modify the requirements of division (B) or (G) of this section. The actions of the superintendent under this division shall be effective for a period of not more than one year. At the expiration of such time, a new showing of need for a waiver or modification by the insurer shall be made before a new waiver or modification is issued or imposed.

(J) No hospital, health care facility, or health care practitioner, and no person who employs any health care practitioner, shall balance bill any individual or dependent of an individual for any health care supplies or services provided to the individual or dependent who is insured under a policy issued under this section. The hospital, health care facility, or health care practitioner, or any person that employs the health care practitioner, shall accept payments made to it by the insurer under the terms of the policy or contract insuring or covering such individual as payment in full for such health care supplies or services.

As used in this division, "hospital" has the same meaning as in section 3727.01 of the Revised Code; "health care practitioner" has the same meaning as in section 4769.01 of the Revised Code; and "balance bill" means charging or collecting an amount in excess of the amount reimbursable or payable under the policy or health care service contract issued to an individual under this section for such health care supply or service. "Balance bill" does not include charging for or collecting copayments or deductibles required by the policy or contract.

(K) An insurer shall pay an agent a commission in the amount of five per cent of the premium charged for initial placement or for otherwise securing the issuance of a policy or contract issued to an individual under this section, and four per cent of the premium charged for the renewal of such a policy or contract. The

superintendent may adopt, in accordance with Chapter 119. of the Revised Code, such rules as are necessary to enforce this division.

(L) This section does not apply to any policy that provides coverage for specific diseases or accidents only, or to any hospital indemnity, medicare supplement, long-term care, disability income, one-time-limited-duration policy of no longer than six months, or other policy that offers only supplemental benefits.

Sec. 3923.601. (A)(1) This section applies to both of the following:

(a) A sickness and accident insurer that issues or requires the use of a standardized identification card or an electronic technology for submission and routing of prescription drug claims pursuant to a policy, contract, or agreement for health care services;

(b) A person that a sickness and accident insurer contracts with to issue a standardized identification card or an electronic technology described in division (A)(1)(a) of this section.

(2) Notwithstanding division (A)(1) of this section, this section does not apply to the issuance or required use of a standardized identification card or an electronic technology for the submission and routing of prescription drug claims in connection with any of the following:

(a) Any individual or group policy of sickness and accident insurance covering only accident, credit, dental, disability income, long-term care, hospital indemnity, medicare supplement, medicare, tricare, specified disease, or vision care; coverage under a one-time-limited-duration policy of not longer than six months; coverage issued as a supplement to liability insurance;

insurance arising out of workers' compensation or similar law; automobile medical payment insurance; or insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(b) Coverage provided under the medicaid~~, as defined in section 5111.01 of the Revised Code~~ program.

(c) Coverage provided under an employer's self-insurance plan or by any of its administrators, as defined in section 3959.01 of the Revised Code, to the extent that federal law supersedes, preempts, prohibits, or otherwise precludes the application of this section to the plan and its administrators.

(B) A standardized identification card or an electronic technology issued or required to be used as provided in division (A)(1) of this section shall contain uniform prescription drug information in accordance with either division (B)(1) or (2) of this section.

(1) The standardized identification card or the electronic technology shall be in a format and contain information fields approved by the national council for prescription drug programs or a successor organization, as specified in the council's or successor organization's pharmacy identification card implementation guide in effect on the first day of October most immediately preceding the issuance or required use of the standardized identification card or the electronic technology.

(2) If the insurer or person under contract with the insurer to issue a standardized identification card or an electronic technology requires the information for the submission and routing of a claim, the standardized identification card or the electronic technology shall contain any of the following information:

(a) The insurer's name;

(b) The insured's name, group number, and identification number;

(c) A telephone number to inquire about pharmacy-related issues;

(d) The issuer's international identification number, labeled as "ANSI BIN" or "RxBIN";

(e) The processor's control number, labeled as "RxPCN";

(f) The insured's pharmacy benefits group number if different from the insured's medical group number, labeled as "RxGrp."

(C) If the standardized identification card or the electronic technology issued or required to be used as provided in division (A)(1) of this section is also used for submission and routing of nonpharmacy claims, the designation "Rx" is required to be included as part of the labels identified in divisions (B)(2)(d) and (e) of this section if the issuer's international identification number or the processor's control number is different for medical and pharmacy claims.

(D) Each sickness and accident insurer described in division (A) of this section shall annually file a certificate with the superintendent of insurance certifying that it or any person it contracts with to issue a standardized identification card or electronic technology for submission and routing of prescription drug claims complies with this section.

(E)(1) Except as provided in division (E)(2) of this section, if there is a change in the information contained in the standardized identification card or the electronic technology issued to an insured, the insurer or person under contract with the insurer to issue a standardized identification card or an electronic technology shall issue a new card or electronic technology to the insured.

(2) An insurer or person under contract with the insurer is not required under division (E)(1) of this section to issue a new card or electronic technology to an insured more than once during a twelve-month period.

(F) Nothing in this section shall be construed as requiring an insurer to produce more than one standardized identification card or one electronic technology for use by insureds accessing health care benefits provided under a policy of sickness and accident insurance.

Sec. 3923.70. Consistent with the Rules of Evidence, a written decision or opinion prepared by an independent review organization under section 3923.67 or 3923.68 of the Revised Code shall be admissible in any civil action related to the coverage decision that was the subject of the decision or opinion. The independent review organization's decision or opinion shall be presumed to be a scientifically valid and accurate description of the state of medical knowledge at the time it was written.

Consistent with the Rules of Evidence, any party to a civil action related to an insurer's decision involving an investigational or experimental drug, device, or treatment may introduce into evidence any applicable medicare reimbursement standards established under ~~Title XVIII of~~ the ~~"Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended~~ medicare program.

Sec. 3923.79. Consistent with the Rules of Evidence, a written decision or opinion prepared by an independent review organization under section 3923.76 or 3923.77 of the Revised Code shall be admissible in any civil action related to the coverage decision that was the subject of the decision or opinion. The independent review organization's decision or opinion shall be

presumed to be a scientifically valid and accurate description of the state of medical knowledge at the time it was written.

Consistent with the Rules of Evidence, any party to a civil action related to a plan's decision involving an investigational or experimental drug, device, or treatment may introduce into evidence any applicable medicare reimbursement standards established under ~~Title XVIII of~~ the ~~"Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended~~ medicare program.

Sec. 3923.83. (A)(1) This section applies to both of the following:

(a) A public employee benefit plan that issues or requires the use of a standardized identification card or an electronic technology for submission and routing of prescription drug claims pursuant to a policy, contract, or agreement for health care services;

(b) A person or entity that a public employee benefit plan contracts with to issue a standardized identification card or an electronic technology described in division (A)(1)(a) of this section.

(2) Notwithstanding division (A)(1) of this section, this section does not apply to the issuance or required use of a standardized identification card or an electronic technology for the submission and routing of prescription drug claims in connection with either of the following:

(a) Any individual or group policy of insurance covering only accident, credit, dental, disability income, long-term care, hospital indemnity, medicare supplement, medicare, tricare, specified disease, or vision care; coverage under a one-time-limited-duration policy of not longer than six months; coverage issued as a supplement to liability insurance; insurance

arising out of workers' compensation or similar law; automobile medical payment insurance; or insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(b) Coverage provided under the medicaid~~, as defined in section 5111.01 of the Revised Code~~ program.

(B) A standardized identification card or an electronic technology issued or required to be used as provided in division (A)(1) of this section shall contain uniform prescription drug information in accordance with either division (B)(1) or (2) of this section.

(1) The standardized identification card or the electronic technology shall be in a format and contain information fields approved by the national council for prescription drug programs or a successor organization, as specified in the council's or successor organization's pharmacy identification card implementation guide in effect on the first day of October most immediately preceding the issuance or required use of the standardized identification card or the electronic technology.

(2) If the public employee benefit plan or person under contract with the plan to issue a standardized identification card or an electronic technology requires the information for the submission and routing of a claim, the standardized identification card or the electronic technology shall contain any of the following information:

(a) The plan's name;

(b) The insured's name, group number, and identification number;

(c) A telephone number to inquire about pharmacy-related issues;

(d) The issuer's international identification number, labeled as "ANSI BIN" or "RxBIN";

(e) The processor's control number, labeled as "RxPCN";

(f) The insured's pharmacy benefits group number if different from the insured's medical group number, labeled as "RxGrp."

(C) If the standardized identification card or the electronic technology issued or required to be used as provided in division (A)(1) of this section is also used for submission and routing of nonpharmacy claims, the designation "Rx" is required to be included as part of the labels identified in divisions (B)(2)(d) and (e) of this section if the issuer's international identification number or the processor's control number is different for medical and pharmacy claims.

(D)(1) Except as provided in division (D)(2) of this section, if there is a change in the information contained in the standardized identification card or the electronic technology issued to an insured, the public employee benefit plan or person under contract with the plan to issue a standardized identification card or electronic technology shall issue a new card or electronic technology to the insured.

(2) A public employee benefit plan or person under contract with the plan is not required under division (D)(1) of this section to issue a new card or electronic technology to an insured more than once during a twelve-month period.

~~(F)~~(E) Nothing in this section shall be construed as requiring a public employee benefit plan to produce more than one standardized identification card or one electronic technology for use by insureds accessing health care benefits provided under a health benefit plan.

Sec. 3924.41. (A) As used in sections 3924.41 and 3924.42 of

the Revised Code, "health insurer" means any sickness and accident insurer or health insuring corporation. "Health insurer" also includes any group health plan as defined in section 607 of the federal "Employee Retirement Income Security Act of 1974," 88 Stat. 832, 29 U.S.C.A. 1167.

(B) Notwithstanding any other provision of the Revised Code, no health insurer shall take into consideration the availability of, or eligibility for, ~~medical assistance~~ the medicaid program in this state ~~under Chapter 5111. of the Revised Code~~ or in any other state ~~pursuant to Title XIX of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended,~~ when determining an individual's eligibility for coverage or when making payments to or on behalf of an enrollee, subscriber, policyholder, or certificate holder.

Sec. 3924.42. No health insurer shall impose requirements on the department of ~~job and family services~~ health care administration, when it has been assigned the rights of an individual who is eligible for ~~medical assistance under Chapter 5111. of the Revised Code~~ the medicaid program and who is covered under a health care policy, contract, or plan issued by the health insurer, that are different from the requirements applicable to an agent or assignee of any other individual so covered.

Sec. 4123.27. Information contained in the annual statement provided for in section 4123.26 of the Revised Code, and such other information as may be furnished to the bureau of workers' compensation by employers in pursuance of that section, is for the exclusive use and information of the bureau in the discharge of its official duties, and shall not be open to the public nor be used in any court in any action or proceeding pending therein unless the bureau is a party to the action or proceeding; but the information contained in the statement may be tabulated and

published by the bureau in statistical form for the use and information of other state departments and the public. No person in the employ of the bureau, except those who are authorized by the administrator of workers' compensation, shall divulge any information secured by the person while in the employ of the bureau in respect to the transactions, property, claim files, records, or papers of the bureau or in respect to the business or mechanical, chemical, or other industrial process of any company, firm, corporation, person, association, partnership, or public utility to any person other than the administrator or to the superior of such employee of the bureau.

Notwithstanding the restrictions imposed by this section, the governor, select or standing committees of the general assembly, the auditor of state, the attorney general, or their designees, pursuant to the authority granted in this chapter and Chapter 4121. of the Revised Code, may examine any records, claim files, or papers in possession of the industrial commission or the bureau. They also are bound by the privilege that attaches to these papers.

The administrator shall report to the director of job and family services or to the county director of job and family services the name, address, and social security number or other identification number of any person receiving workers' compensation whose name or social security number or other identification number is the same as that of a person required by a court or child support enforcement agency to provide support payments to a recipient or participant of public assistance, and whose name is submitted to the administrator by the director under section 5101.36 of the Revised Code. The administrator shall report to the director of health care administration or to the county director of job and family services the name, address, and social security number or other identification number of any

person receiving workers' compensation whose name or social security number or other identification number is the same as that of a person required by a court or child support enforcement agency to provide support payments to a public medical assistance program recipient, and whose name is submitted to the administrator by the director under section 5160.41 of the Revised Code. The administrator also shall inform the appropriate director of the amount of workers' compensation paid to the person during such period as the director specifies.

Within fourteen days after receiving ~~from the director of job and family services~~ a list of the names and social security numbers of recipients or participants of public assistance pursuant to section 5101.181 of the Revised Code or a list of the names and social security numbers of public medical assistance program recipients pursuant to section 5160.43 of the Revised Code, the administrator shall inform the auditor of state of the name, current or most recent address, and social security number of each person receiving workers' compensation pursuant to this chapter whose name and social security number are the same as that of a person whose name or social security number ~~was submitted by the director~~ is included in the list. The administrator also shall inform the auditor of state of the amount of workers' compensation paid to the person during such period as the director specifies.

The bureau and its employees, except for purposes of furnishing the auditor of state with information required by this section, shall preserve the confidentiality of recipients or participants of public assistance in compliance with ~~division (A) of~~ section 5101.181 of the Revised Code and preserve the confidentiality of public medical assistance program recipients in compliance with section 5160.43 of the Revised Code.

For the 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 the disability medical assistance ~~provided under Chapter 5115. of the Revised Code~~ program.

Sec. 4141.162. (A) The director of job and family services, in collaboration with the director of health care administration, shall establish an income and eligibility verification system that complies with section 1137 of the "Social Security Act." The programs included in the system are all of the following:

(1) Unemployment compensation pursuant to section 3304 of the "Internal Revenue Code of 1954";

(2) The state programs funded in part under part A of Title IV of the "Social Security Act" and administered under Chapters 5107. and 5108. of the Revised Code;

(3) Medicaid ~~pursuant to Title XIX of the "Social Security Act"~~;

(4) Food stamps pursuant to the "Food Stamp Act of 1977," 91 Stat. 958, 7 U.S.C.A. 2011, as amended;

(5) Any Ohio program under a plan approved under Title I, X, XIV, or XVI of the "Social Security Act."

Wage information provided by employers to the director shall be furnished to the income and eligibility verification system. Such information shall be used by the director to determine eligibility of individuals for unemployment compensation benefits and the amount of those benefits and used by the agencies that administer the programs identified in divisions (A)(2) to (5) of this section to determine or verify eligibility for or the amount

of benefits under those programs.

The director shall fully implement the use of wage information to determine eligibility for and the amount of unemployment compensation benefits by September 30, 1988.

Information furnished under the system shall also be made available to the appropriate state or local child support enforcement agency for the purposes of an approved plan under Title IV-D of the "Social Security Act" and to the appropriate federal agency for the purposes of Titles II and XVI of the "Social Security Act."

(B) The director shall adopt rules as necessary under which the department of job and family services and other state agencies that the director determines must participate in order to ensure compliance with section 1137 of the "Social Security Act" exchange information with each other or authorized federal agencies about individuals who are applicants for or recipients of benefits under any of the programs enumerated in division (A) of this section. The rules shall extend to all of the following:

(1) A requirement for standardized formats and procedures for a participating agency to request and receive information about an individual, which information shall include the individual's social security number;

(2) A requirement that all applicants for and recipients of benefits under any program enumerated in division (A) of this section be notified at the time of application, and periodically thereafter, that information available through the system may be shared with agencies that administer other benefit programs and utilized in establishing or verifying eligibility or benefit amounts under the other programs enumerated in division (A) of this section;

(3) A requirement that information is made available only to

the extent necessary to assist in the valid administrative needs of the program receiving the information and is targeted for use in ways which are most likely to be productive in identifying and preventing ineligibility and incorrect payments;

(4) A requirement that information is adequately protected against unauthorized disclosures for purposes other than to establish or verify eligibility or benefit amounts under the programs enumerated in division (A) of this section;

(5) A requirement that a program providing information is reimbursed by the program using the information for the actual costs of furnishing the information and that the director be reimbursed by the participating programs for any actual costs incurred in operating the system;

(6) Requirements for any other matters necessary to ensure the effective, efficient, and timely exchange of necessary information or that the director determines must be addressed in order to ensure compliance with the requirements of section 1137 of the "Social Security Act."

(C) Each participating agency shall furnish to the income and eligibility verification system established in division (A) of this section that information, which the director, by rule, determines is necessary in order to comply with section 1137 of the "Social Security Act."

(D) Notwithstanding the information disclosure requirements of this section and section 4141.21 and division (A) of section 4141.284 of the Revised Code, the director shall administer those provisions of law so as to comply with section 1137 of the "Social Security Act."

(E) Requirements in section 4141.21 of the Revised Code with respect to confidentiality of information obtained in the administration of Chapter 4141. of the Revised Code and any

sanctions imposed for improper disclosure of such information shall apply to the redisclosure of information disclosed under this section.

Sec. 4719.01. (A) As used in sections 4719.01 to 4719.18 of the Revised Code:

(1) "Affiliate" means a business entity that is owned by, operated by, controlled by, or under common control with another business entity.

(2) "Communication" means a written or oral notification or advertisement that meets both of the following criteria, as applicable:

(a) The notification or advertisement is transmitted by or on behalf of the seller of goods or services and by or through any printed, audio, video, cinematic, telephonic, or electronic means.

(b) In the case of a notification or advertisement other than by telephone, either of the following conditions is met:

(i) The notification or advertisement is followed by a telephone call from a telephone solicitor or salesperson.

(ii) The notification or advertisement invites a response by telephone, and, during the course of that response, a telephone solicitor or salesperson attempts to make or makes a sale of goods or services. As used in division (A)(2)(b)(ii) of this section, "invites a response by telephone" excludes the mere listing or inclusion of a telephone number in a notification or advertisement.

(3) "Gift, award, or prize" means anything of value that is offered or purportedly offered, or given or purportedly given by chance, at no cost to the receiver and with no obligation to purchase goods or services. As used in this division, "chance" includes a situation in which a person is guaranteed to receive an

item and, at the time of the offer or purported offer, the telephone solicitor does not identify the specific item that the person will receive.

(4) "Goods or services" means any real property or any tangible or intangible personal property, or services of any kind provided or offered to a person. "Goods or services" includes, but is not limited to, advertising; labor performed for the benefit of a person; personal property intended to be attached to or installed in any real property, regardless of whether it is so attached or installed; timeshare estates or licenses; and extended service contracts.

(5) "Purchaser" means a person that is solicited to become or does become financially obligated as a result of a telephone solicitation.

(6) "Salesperson" means an individual who is employed, appointed, or authorized by a telephone solicitor to make telephone solicitations but does not mean any of the following:

(a) An individual who comes within one of the exemptions in division (B) of this section;

(b) An individual employed, appointed, or authorized by a person who comes within one of the exemptions in division (B) of this section;

(c) An individual under a written contract with a person who comes within one of the exemptions in division (B) of this section, if liability for all transactions with purchasers is assumed by the person so exempted.

(7) "Telephone solicitation" means a communication to a person that meets both of the following criteria:

(a) The communication is initiated by or on behalf of a telephone solicitor or by a salesperson.

(b) The communication either represents a price or the quality or availability of goods or services or is used to induce the person to purchase goods or services, including, but not limited to, inducement through the offering of a gift, award, or prize.

(8) "Telephone solicitor" means a person that engages in telephone solicitation directly or through one or more salespersons either from a location in this state, or from a location outside this state to persons in this state. "Telephone solicitor" includes, but is not limited to, any such person that is an owner, operator, officer, or director of, partner in, or other individual engaged in the management activities of, a business.

(B) A telephone solicitor is exempt from the provisions of sections 4719.02 to 4719.18 and section 4719.99 of the Revised Code if the telephone solicitor is any one of the following:

(1) A person engaging in a telephone solicitation that is a one-time or infrequent transaction not done in the course of a pattern of repeated transactions of a like nature;

(2) A person engaged in telephone solicitation solely for religious or political purposes; a charitable organization, fund-raising counsel, or professional solicitor in compliance with the registration and reporting requirements of Chapter 1716. of the Revised Code; or any person or other entity exempt under section 1716.03 of the Revised Code from filing a registration statement under section 1716.02 of the Revised Code;

(3) A person, making a telephone solicitation involving a home solicitation sale as defined in section 1345.21 of the Revised Code, that makes the sales presentation and completes the sale at a later, face-to-face meeting between the seller and the purchaser rather than during the telephone solicitation. However,

if the person, following the telephone solicitation, causes another person to collect the payment of any money, this exemption does not apply.

(4) A licensed securities, commodities, or investment broker, dealer, investment advisor, or associated person when making a telephone solicitation within the scope of the person's license. As used in division (B)(4) of this section, "licensed securities, commodities, or investment broker, dealer, investment advisor, or associated person" means a person subject to licensure or registration as such by the securities and exchange commission; the National Association of Securities Dealers or other self-regulatory organization, as defined by 15 U.S.C.A. 78c; by the division of securities under Chapter 1707. of the Revised Code; or by an official or agency of any other state of the United States.

(5)(a) A person primarily engaged in soliciting the sale of a newspaper of general circulation;

(b) As used in division (B)(5)(a) of this section, "newspaper of general circulation" includes, but is not limited to, both of the following:

(i) A newspaper that is a daily law journal designated as an official publisher of court calendars pursuant to section 2701.09 of the Revised Code;

(ii) A newspaper or publication that has at least twenty-five per cent editorial, non-advertising content, exclusive of inserts, measured relative to total publication space, and an audited circulation to at least fifty per cent of the households in the newspaper's retail trade zone as defined by the audit.

(6)(a) An issuer, or its subsidiary, that has a class of securities to which all of the following apply:

(i) The class of securities is subject to section 12 of the

"Securities Exchange Act of 1934," 15 U.S.C.A. 78l, and is registered or is exempt from registration under 15 U.S.C.A. 78l(g)(2)(A), (B), (C), (E), (F), (G), or (H);

(ii) The class of securities is listed on the New York stock exchange, the American stock exchange, or the NASDAQ national market system;

(iii) The class of securities is a reported security as defined in 17 C.F.R. 240.11Aa3-1(a)(4).

(b) An issuer, or its subsidiary, that formerly had a class of securities that met the criteria set forth in division (B)(6)(a) of this section if the issuer, or its subsidiary, has a net worth in excess of one hundred million dollars, files or its parent files with the securities and exchange commission an S.E.C. form 10-K, and has continued in substantially the same business since it had a class of securities that met the criteria in division (B)(6)(a) of this section. As used in division (B)(6)(b) of this section, "issuer" and "subsidiary" include the successor to an issuer or subsidiary.

(7) A person soliciting a transaction regulated by the commodity futures trading commission, if the person is registered or temporarily registered for that activity with the commission under 7 U.S.C.A. 1 et. seq. and the registration or temporary registration has not expired or been suspended or revoked;

(8) A person soliciting the sale of any book, record, audio tape, compact disc, or video, if the person allows the purchaser to review the merchandise for at least seven days and provides a full refund within thirty days to a purchaser who returns the merchandise or if the person solicits the sale on behalf of a membership club operating in compliance with regulations adopted by the federal trade commission in 16 C.F.R. 425;

(9) A supervised financial institution or its subsidiary. As

used in division (B)(9) of this section, "supervised financial institution" means a bank, trust company, savings and loan association, savings bank, credit union, industrial loan company, consumer finance lender, commercial finance lender, or institution described in section 2(c)(2)(F) of the "Bank Holding Company Act of 1956," 12 U.S.C.A. 1841(c)(2)(F), as amended, supervised by an official or agency of the United States, this state, or any other state of the United States; or a licensee or registrant under sections 1321.01 to 1321.19, 1321.51 to 1321.60, or 1321.71 to 1321.83 of the Revised Code.

(10)(a) An insurance company, association, or other organization that is licensed or authorized to conduct business in this state by the superintendent of insurance pursuant to Title XXXIX of the Revised Code or Chapter 1751. of the Revised Code, when soliciting within the scope of its license or authorization.

(b) A licensed insurance broker, agent, or solicitor when soliciting within the scope of the person's license. As used in division (B)(10)(b) of this section, "licensed insurance broker, agent, or solicitor" means any person licensed as an insurance broker, agent, or solicitor by the superintendent of insurance pursuant to Title XXXIX of the Revised Code.

(11) A person soliciting the sale of services provided by a cable television system operating under authority of a governmental franchise or permit;

(12) A person soliciting a business-to-business sale under which any of the following conditions are met:

(a) The telephone solicitor has been operating continuously for at least three years under the same business name under which it solicits purchasers, and at least fifty-one per cent of its gross dollar volume of sales consists of repeat sales to existing customers to whom it has made sales under the same business name.

(b) The purchaser business intends to resell the goods purchased.

(c) The purchaser business intends to use the goods or services purchased in a recycling, reuse, manufacturing, or remanufacturing process.

(d) The telephone solicitor is a publisher of a periodical or of magazines distributed as controlled circulation publications as defined in division (CC) of section 5739.01 of the Revised Code and is soliciting sales of advertising, subscriptions, reprints, lists, information databases, conference participation or sponsorships, trade shows or media products related to the periodical or magazine, or other publishing services provided by the controlled circulation publication.

(13) A person that, not less often than once each year, publishes and delivers to potential purchasers a catalog that complies with both of the following:

(a) It includes all of the following:

(i) The business address of the seller;

(ii) A written description or illustration of each good or service offered for sale;

(iii) A clear and conspicuous disclosure of the sale price of each good or service; shipping, handling, and other charges; and return policy;

(b) One of the following applies:

(i) The catalog includes at least twenty-four pages of written material and illustrations, is distributed in more than one state, and has an annual postage-paid mail circulation of not less than two hundred fifty thousand households;

(ii) The catalog includes at least ten pages of written material or an equivalent amount of material in electronic form on

the internet or an on-line computer service, the person does not solicit customers by telephone but solely receives telephone calls made in response to the catalog, and during the calls the person takes orders but does not engage in further solicitation of the purchaser. As used in division (B)(13)(b)(ii) of this section, "further solicitation" does not include providing the purchaser with information about, or attempting to sell, any other item in the catalog that prompted the purchaser's call or in a substantially similar catalog issued by the seller.

(14) A political subdivision or instrumentality of the United States, this state, or any state of the United States;

(15) A college or university or any other public or private institution of higher education in this state;

(16) A public utility as defined in section 4905.02 of the Revised Code or a retail natural gas supplier as defined in section 4929.01 of the Revised Code, if the utility or supplier is subject to regulation by the public utilities commission, or the affiliate of the utility or supplier;

(17) A person that solicits sales through a television program or advertisement that is presented in the same market area no fewer than twenty days per month or offers for sale no fewer than ten distinct items of goods or services; and offers to the purchaser an unconditional right to return any good or service purchased within a period of at least seven days and to receive a full refund within thirty days after the purchaser returns the good or cancels the service;

(18)(a) A person that, for at least one year, has been operating a retail business under the same name as that used in connection with telephone solicitation and both of the following occur on a continuing basis:

(i) The person either displays goods and offers them for

retail sale at the person's business premises or offers services for sale and provides them at the person's business premises.

(ii) At least fifty-one per cent of the person's gross dollar volume of retail sales involves purchases of goods or services at the person's business premises.

(b) An affiliate of a person that meets the requirements in division (B)(18)(a) of this section if the affiliate meets all of the following requirements:

(i) The affiliate has operated a retail business for a period of less than one year;

(ii) The affiliate either displays goods and offers them for retail sale at the affiliate's business premises or offers services for sale and provides them at the affiliate's business premises;

(iii) At least fifty-one per cent of the affiliate's gross dollar volume of retail sales involves purchases of goods or services at the affiliate's business premises.

(c) A person that, for a period of less than one year, has been operating a retail business in this state under the same name as that used in connection with telephone solicitation, as long as all of the following requirements are met:

(i) The person either displays goods and offers them for retail sale at the person's business premises or offers services for sale and provides them at the person's business premises;

(ii) The goods or services that are the subject of telephone solicitation are sold at the person's business premises, and at least sixty-five per cent of the person's gross dollar volume of retail sales involves purchases of goods or services at the person's business premises;

(iii) The person conducts all telephone solicitation

activities according to sections 310.3, 310.4, and 310.5 of the telemarketing sales rule adopted by the federal trade commission in 16 C.F.R. part 310.

(19) A person who performs telephone solicitation sales services on behalf of other persons and to whom one of the following applies:

(a) The person has operated under the same ownership, control, and business name for at least five years, and the person receives at least seventy-five per cent of its gross revenues from written telephone solicitation contracts with persons who come within one of the exemptions in division (B) of this section.

(b) The person is an affiliate of one or more exempt persons and makes telephone solicitations on behalf of only the exempt persons of which it is an affiliate.

(c) The person makes telephone solicitations on behalf of only exempt persons, the person and each exempt person on whose behalf telephone solicitations are made have entered into a written contract that specifies the manner in which the telephone solicitations are to be conducted and that at a minimum requires compliance with the telemarketing sales rule adopted by the federal trade commission in 16 C.F.R. part 310, and the person conducts the telephone solicitations in the manner specified in the written contract.

(d) The person performs telephone solicitation for religious or political purposes, a charitable organization, a fund-raising council, or a professional solicitor in compliance with the registration and reporting requirements of Chapter 1716. of the Revised Code; and meets all of the following requirements:

(i) The person has operated under the same ownership, control, and business name for at least five years, and the person receives at least fifty-one per cent of its gross revenues from

written telephone solicitation contracts with persons who come within the exemption in division (B)(2) of this section;

(ii) The person does not conduct a prize promotion or offer the sale of an investment opportunity;

(iii) The person conducts all telephone solicitation activities according to sections 310.3, 310.4, and 310.5 of the telemarketing sales rules adopted by the federal trade commission in 16 C.F.R. part 310.

(20) A person that is a licensed real estate salesperson or broker under Chapter 4735. of the Revised Code when soliciting within the scope of the person's license;

(21)(a) Either of the following:

(i) A publisher that solicits the sale of the publisher's periodical or magazine of general, paid circulation, or a person that solicits a sale of that nature on behalf of a publisher under a written agreement directly between the publisher and the person.

(ii) A publisher that solicits the sale of the publisher's periodical or magazine of general, paid circulation, or a person that solicits a sale of that nature as authorized by a publisher under a written agreement directly with a publisher's clearinghouse provided the person is a resident of Ohio for more than three years and initiates all telephone solicitations from Ohio and the person conducts the solicitation and sale in compliance with 16 C.F.R. part 310, as adopted by the federal trade commission.

(b) As used in division (B)(21) of this section, "periodical or magazine of general, paid circulation" excludes a periodical or magazine circulated only as part of a membership package or given as a free gift or prize from the publisher or person.

(22) A person that solicits the sale of food, as defined in

section 3715.01 of the Revised Code, or the sale of products of horticulture, as defined in section 5739.01 of the Revised Code, if the person does not intend the solicitation to result in, or the solicitation actually does not result in, a sale that costs the purchaser an amount greater than five hundred dollars.

(23) A funeral director licensed pursuant to Chapter 4717. of the Revised Code when soliciting within the scope of that license, if both of the following apply:

(a) The solicitation and sale are conducted in compliance with 16 C.F.R. part 453, as adopted by the federal trade commission, and with sections 1107.33 and 1345.21 to 1345.28 of the Revised Code;

(b) The person provides to the purchaser of any preneed funeral contract a notice that clearly and conspicuously sets forth the cancellation rights specified in division (G) of section 1107.33 of the Revised Code, and retains a copy of the notice signed by the purchaser.

(24) A person, or affiliate thereof, licensed to sell or issue Ohio instruments designated as travelers checks pursuant to sections 1315.01 to 1315.18 of the Revised Code.

(25) A person that solicits sales from its previous purchasers and meets all of the following requirements:

(a) The solicitation is made under the same business name that was previously used to sell goods or services to the purchaser;

(b) The person has, for a period of not less than three years, operated a business under the same business name as that used in connection with telephone solicitation;

(c) The person does not conduct a prize promotion or offer the sale of an investment opportunity;

(d) The person conducts all telephone solicitation activities according to sections 310.3, 310.4, and 310.5 of the telemarketing sales rules adopted by the federal trade commission in 16 C.F.R. part 310;

(e) Neither the person nor any of its principals has been convicted of, pleaded guilty to, or has entered a plea of no contest for a felony or a theft offense as defined in sections 2901.02 and 2913.01 of the Revised Code or similar law of another state or of the United States;

(f) Neither the person nor any of its principals has had entered against them an injunction or a final judgment or order, including an agreed judgment or order, an assurance of voluntary compliance, or any similar instrument, in any civil or administrative action involving engaging in a pattern of corrupt practices, fraud, theft, embezzlement, fraudulent conversion, or misappropriation of property; the use of any untrue, deceptive, or misleading representation; or the use of any unfair, unlawful, deceptive, or unconscionable trade act or practice.

(26) An institution defined as a home health agency in section 3701.881 of the Revised Code, that conducts all telephone solicitation activities according to sections 310.3, 310.4, and 310.5 of the telemarketing sales rules adopted by the federal trade commission in 16 C.F.R. part 310, and engages in telephone solicitation only within the scope of the institution's certification, accreditation, contract with the department of aging, or status as a home health agency; and that meets one of the following requirements:

(a) The institution is certified as a provider of home health services under ~~Title XVIII of~~ the ~~Social Security Act, 49 Stat. 620, 42 U.S.C. 301, as amended~~ medicare program;

(b) The institution is accredited by either the joint

commission on accreditation of health care organizations or the community health accreditation program;

(c) The institution is providing passport services under the direction of the Ohio department of aging under section 173.40 of the Revised Code;

(d) An affiliate of an institution that meets the requirements of division (B)(26)(a), (b), or (c) of this section when offering for sale substantially the same goods and services as those that are offered by the institution that meets the requirements of division (B)(26)(a), (b), or (c) of this section.

(27) A person licensed to provide a hospice care program by the department of health pursuant to section 3712.04 of the Revised Code when conducting telephone solicitations within the scope of the person's license and according to sections 310.3, 310.4, and 310.5 of the telemarketing sales rules adopted by the federal trade commission in 16 C.F.R. part 310.

Sec. 4723.063. (A) As used in this section:

(1) "Health care facility" means:

(a) A hospital registered under section 3701.07 of the Revised Code;

(b) A nursing home licensed under section 3721.02 of the Revised Code, or by a political subdivision certified under section 3721.09 of the Revised Code;

(c) A county home or a county nursing home as defined in section 5155.31 of the Revised Code that is certified under ~~Title XVIII or XIX of~~ the ~~"Social Security Act," 49 Stat. 620 (1935), 42 U.S.C. 301, amended~~ medicare program or medicaid program;

(d) A freestanding dialysis center;

(e) A freestanding inpatient rehabilitation facility;

(f) An ambulatory surgical facility;

(g) A freestanding cardiac catheterization facility;

(h) A freestanding birthing center;

(i) A freestanding or mobile diagnostic imaging center;

(j) A freestanding radiation therapy center.

(2) "Nurse education program" means a prelicensure nurse education program approved by the board of nursing under section 4723.06 of the Revised Code or a postlicensure nurse education program approved by the board of regents under section 3333.04 of the Revised Code.

(B) The state board of nursing shall establish and administer the nurse education grant program. Under the program, the board shall award grants to nurse education programs that have partnerships with other education programs, community health agencies, or health care facilities. Grant recipients shall use the money to fund partnerships to increase the nurse education program's enrollment capacity. Methods of increasing a program's enrollment capacity may include hiring faculty and preceptors, purchasing educational equipment and materials, and other actions acceptable to the board. Grant money shall not be used to construct or renovate buildings. Partnerships may be developed between one or more nurse education programs and one or more health care facilities.

In awarding grants, the board shall give preference to partnerships between nurse education programs and hospitals, nursing homes, and county homes or county nursing homes, but may also award grants to fund partnerships between nurse education programs and other health care facilities.

(C) The board shall adopt rules in accordance with Chapter 119. of the Revised Code establishing the following:

(1) Eligibility requirements for receipt of a grant;

(2) Grant application forms and procedures;

(3) The amounts in which grants may be made and the total amount that may be awarded to a nurse education program that has a partnership with other education programs, a community health agency, or a health care facility;

(4) A method whereby the board may evaluate the effectiveness of a partnership between joint recipients in increasing the nurse education program's enrollment capacity;

(5) The percentage of the money in the fund that must remain in the fund at all times to maintain a fiscally responsible fund balance;

(6) The percentage of available grants to be awarded to licensed practical nurse education programs, registered nurse education programs, and graduate programs;

(7) Any other matters incidental to the operation of the program.

(D) From January 1, 2004, until December 31, 2013, the ten dollars of each biennial nursing license renewal fee collected under section 4723.08 of the Revised Code shall be dedicated to the nurse education grant program fund, which is hereby created in the state treasury. The board shall use money in the fund for grants awarded under division (A) of this section and for expenses of administering the grant program. The amount used for administrative expenses in any year shall not exceed ten per cent of the amount transferred to the fund in that year.

(E) Each quarter, for the purposes of transferring funds to the nurse education grant program, the board of nursing shall certify to the director of budget and management the number of biennial licenses renewed under this chapter during the preceding

quarter and the amount equal to that number times ten dollars.

(F) Notwithstanding the requirements of section 4743.05 of the Revised Code, from January 1, 2004, until December 31, 2013, at the end of each quarter, the director of budget and management shall transfer from the occupational licensing and regulatory fund to the nurse education grant program fund the amount certified under division (E) of this section.

Sec. 4723.17. (A) The board of nursing may authorize a licensed practical nurse to administer to an adult intravenous therapy authorized by an individual who is authorized to practice in this state and is acting within the course of the individual's professional practice, if the licensed practical nurse has a current, valid license issued under this chapter that includes authorization to administer medications and one of the following is the case:

(1) The nurse has successfully completed, within a practical nurse prelicensure education program approved by the board or by another jurisdiction's agency that regulates the practice of nursing, a course of study that prepares the nurse to safely perform the intravenous therapy procedures the board may authorize under this section. To meet this requirement, the course of study must include all of the following:

(a) Both didactic and clinical components;

(b) Curriculum requirements established in rules the board of nursing shall adopt in accordance with Chapter 119. of the Revised Code;

(c) Standards that require the nurse to perform a successful demonstration of the intravenous procedures, including all skills needed to perform them safely.

(2) The nurse has successfully completed a minimum of forty

hours of training that includes all of the following:

(a) The curriculum established by rules adopted by the board and in effect on January 1, 1999;

(b) Training in the anatomy and physiology of the cardiovascular system, signs and symptoms of local and systemic complications in the administration of fluids and antibiotic additives, and guidelines for management of these complications;

(c) Any other training or instruction the board considers appropriate.

(d) A testing component that requires the nurse to perform a successful demonstration of the intravenous procedures, including all skills needed to perform them safely.

(B) Except as provided in section 4723.171 of the Revised Code, a licensed practical nurse may perform intravenous therapy only if authorized by the board pursuant to division (A) of this section and only if it is performed in accordance with this section.

A licensed practical nurse authorized by the board to perform intravenous therapy may perform an intravenous therapy procedure only at the direction of one of the following:

(1) A licensed physician, dentist, optometrist, or podiatrist who, except as provided in division (C)(2) of this section, is present and readily available at the facility where the intravenous therapy procedure is performed;

(2) A registered nurse in accordance with division (C) of this section.

(C)(1) Except as provided in division (C)(2) of this section and section 4723.171 of the Revised Code, when a licensed practical nurse authorized by the board to perform intravenous therapy performs an intravenous therapy procedure at the direction

of a registered nurse, the registered nurse or another registered nurse shall be readily available at the site where the intravenous therapy is performed, and before the licensed practical nurse initiates the intravenous therapy, the registered nurse shall personally perform an on-site assessment of the individual who is to receive the intravenous therapy.

(2) When a licensed practical nurse authorized by the board to perform intravenous therapy performs an intravenous therapy procedure in a home as defined in section 3721.10 of the Revised Code, or in an intermediate care facility for the mentally retarded as defined in section ~~5111.20~~ 5164.01 of the Revised Code, at the direction of a registered nurse or licensed physician, dentist, optometrist, or podiatrist, a registered nurse shall be on the premises of the home or facility or accessible by some form of telecommunication.

(D) No licensed practical nurse shall perform any of the following intravenous therapy procedures:

(1) Initiating or maintaining any of the following:

(a) Blood or blood components;

(b) Solutions for total parenteral nutrition;

(c) Any cancer therapeutic medication including, but not limited to, cancer chemotherapy or an anti-neoplastic agent;

(d) Solutions administered through any central venous line or arterial line or any other line that does not terminate in a peripheral vein, except that a licensed practical nurse authorized by the board to perform intravenous therapy may maintain the solutions specified in division (D)(6)(a) of this section that are being administered through a central venous line or peripherally inserted central catheter;

(e) Any investigational or experimental medication.

(2) Initiating intravenous therapy in any vein, except that a licensed practical nurse authorized by the board to perform intravenous therapy may initiate intravenous therapy in accordance with this section in a vein of the hand, forearm, or antecubital fossa;

(3) Discontinuing a central venous, arterial, or any other line that does not terminate in a peripheral vein;

(4) Initiating or discontinuing a peripherally inserted central catheter;

(5) Mixing, preparing, or reconstituting any medication for intravenous therapy, except that a licensed practical nurse authorized by the board to perform intravenous therapy may prepare or reconstitute an antibiotic additive;

(6) Administering medication via the intravenous route, including all of the following activities:

(a) Adding medication to an intravenous solution or to an existing infusion, except that a licensed practical nurse authorized by the board to perform intravenous therapy may do either of the following:

(i) Initiate an intravenous infusion containing one or more of the following elements: dextrose 5%; normal saline; lactated ringers; sodium chloride .45%; sodium chloride 0.2%; sterile water.

(ii) Hang subsequent containers of the intravenous solutions specified in division (D)(6)(a) of this section that contain vitamins or electrolytes, if a registered nurse initiated the infusion of that same intravenous solution.

(b) Initiating or maintaining an intravenous piggyback infusion, except that a licensed practical nurse authorized by the board to perform intravenous therapy may initiate or maintain an

intravenous piggyback infusion containing an antibiotic additive;

(c) Injecting medication via a direct intravenous route, except that a licensed practical nurse authorized by the board to perform intravenous therapy may inject heparin or normal saline to flush an intermittent infusion device or heparin lock including, but not limited to, bolus or push.

(7) Aspirating any intravenous line to maintain patency;

(8) Changing tubing on any line including, but not limited to, an arterial line or a central venous line, except that a licensed practical nurse authorized by the board to perform intravenous therapy may change tubing on an intravenous line that terminates in a peripheral vein;

(9) Programming or setting any function of a patient controlled infusion pump.

(E) Notwithstanding division (D) of this section, at the direction of a physician or a registered nurse, a licensed practical nurse authorized by the board to perform intravenous therapy may perform the following activities for the purpose of performing dialysis:

(1) The routine administration and regulation of saline solution for the purpose of maintaining an established fluid plan;

(2) The administration of a heparin dose intravenously;

(3) The administration of a heparin dose peripherally via a fistula needle;

(4) The loading and activation of a constant infusion pump or the intermittent injection of a dose of medication prescribed by a licensed physician for dialysis.

(F) No person shall employ or direct a licensed practical nurse to perform an intravenous therapy procedure without first verifying that the licensed practical nurse is authorized by the

board to perform intravenous therapy.

(G) The board shall issue an intravenous therapy card to the licensed practical nurses authorized pursuant to division (A) of this section to perform intravenous therapy. A fee for issuing the card shall not be charged under section 4723.08 of the Revised Code if the licensed practical nurse receives the card by meeting the requirements of division (A)(1) of this section. The board shall maintain a registry of the names of licensed practical nurses who hold intravenous therapy cards.

Sec. 4723.63. (A) In consultation with the medication aide advisory council established under section 4723.62 of the Revised Code, the board of nursing shall conduct a pilot program for the use of medication aides in nursing homes and residential care facilities. The board shall conduct the pilot program in a manner consistent with human protection and other ethical concerns typically associated with research studies involving live subjects. The pilot program shall be commenced not later than May 1, 2006, and shall be conducted until July 1, 2007.

During the period the pilot program is conducted, a nursing home or residential care facility participating in the pilot program may use one or more medication aides to administer prescription medications to its residents, subject to both of the following conditions:

(1) Each individual used as a medication aide must hold a current, valid medication aide certificate issued by the board of nursing under this chapter.

(2) The nursing home or residential care facility shall ensure that the requirements of section 4723.67 of the Revised Code are met.

(B) The board, in consultation with the medication aide

advisory council, shall do all of the following not later than February 1, 2006:

(1) Design the pilot program;

(2) Establish standards to govern medication aides and the nursing homes and residential care facilities participating in the pilot program, including standards for the training of medication aides and the staff of participating nursing homes and residential care facilities;

(3) Establish standards to protect the health and safety of the residents of the nursing homes and residential care facilities participating in the program;

(4) Implement a process for selecting the nursing homes and residential care facilities to participate in the program.

(C)(1) A nursing home or residential care facility may volunteer to participate in the pilot program by submitting an application to the board on a form prescribed and provided by the board. From among the applicants, the board shall select eighty nursing homes and forty residential care facilities to participate in the pilot program.

(2) To be eligible to participate, a nursing home or residential care facility shall agree to observe the standards established by the board for the use of medication aides. A nursing home is eligible to participate only if the department of health has found in the two most recent surveys or inspections of the home that the home is free from deficiencies related to the administration of medication. A residential care facility is eligible to participate only if the department has found that the facility is free from deficiencies related to the provision of skilled nursing care or the administration of medication.

(D) As a condition of participation in the pilot program, a nursing home and residential care facility selected by the board

shall pay the participation fee established in rules adopted under section 4723.69 of the Revised Code. The participation fee is not reimbursable under the medicaid program ~~established under Chapter 5111. of the Revised Code~~.

(E) On receipt of evidence found credible by the board that continued participation by a nursing home or residential care facility poses an imminent danger, risk of serious harm, or jeopardy to a resident of the home or facility, the board may terminate the authority of the home or facility to participate in the pilot program.

(F)(1) With the assistance of the medication aide advisory council, the board shall conduct an evaluation of the pilot program. In conducting the evaluation, the board shall do all of the following:

(a) Assess whether medication aides are able to administer prescription medications safely to nursing home and residential care facility residents;

(b) Determine the financial implications of using medication aides in nursing homes and residential care facilities;

(c) Consider any other issue the board or council considers relevant to the evaluation.

(2) Not later than March 1, 2007, the board shall prepare a report of its findings and recommendations derived from the evaluation of the pilot program. The board shall submit the report to the governor, president and minority leader of the senate, speaker and minority leader of the house of representatives, and director of health.

Sec. 4731.151. (A) Naprapaths who received a certificate to practice from the board prior to March 2, 1992, may continue to practice naprapathy, as defined in rules adopted by the board.

Such naprapaths shall practice in accordance with rules adopted by the board.

(B)(1) As used in this division:

(a) "Mechanotherapy" means all of the following:

(i) Examining patients by verbal inquiry;

(ii) Examination of the musculoskeletal system by hand;

(iii) Visual inspection and observation;

(iv) Diagnosing a patient's condition only as to whether the patient has a disorder of the musculoskeletal system;

(v) In the treatment of patients, employing the techniques of advised or supervised exercise; electrical neuromuscular stimulation; massage or manipulation; or air, water, heat, cold, sound, or infrared ray therapy only to those disorders of the musculoskeletal system that are amenable to treatment by such techniques and that are identifiable by examination performed in accordance with division (B)(1)(a)(i) of this section and diagnosable in accordance with division (B)(1)(a)(ii) of this section.

(b) "Educational requirements" means the completion of a course of study appropriate for certification to practice mechanotherapy on or before November 3, 1985, as determined by rules adopted under this chapter.

(2) Mechanotherapists who received a certificate to practice from the board prior to March 2, 1992, may continue to practice mechanotherapy, as defined in rules adopted by the board. Such mechanotherapists shall practice in accordance with rules adopted by the board.

A person authorized by this division to practice as a mechanotherapist may examine, diagnose, and assume responsibility for the care of patients with due regard for first aid and the

hygienic and nutritional care of the patients. Roentgen rays shall be used by a mechanotherapist only for diagnostic purposes.

(3) A person who holds a certificate to practice mechanotherapy and completed educational requirements in mechanotherapy on or before November 3, 1985, is entitled to use the title "doctor of mechanotherapy" and is a "physician" who performs "medical services" for the purposes of Chapters 4121. and 4123. of the Revised Code and the medicaid program ~~established under section 5111.01 of the Revised Code~~, and shall receive payment or reimbursement as provided under those chapters and that ~~section~~ program.

Sec. 4731.65. As used in sections 4731.65 to 4731.71 of the Revised Code:

(A)(1) "Clinical laboratory services" means either of the following:

(a) Any examination of materials derived from the human body for the purpose of providing information for the diagnosis, prevention, or treatment of any disease or impairment or for the assessment of health;

(b) Procedures to determine, measure, or otherwise describe the presence or absence of various substances or organisms in the body.

(2) "Clinical laboratory services" does not include the mere collection or preparation of specimens.

(B) "Designated health services" means any of the following:

(1) Clinical laboratory services;

(2) Home health care services;

(3) Outpatient prescription drugs.

(C) "Fair market value" means the value in arms-length

transactions, consistent with general market value and:

(1) With respect to rentals or leases, the value of rental property for general commercial purposes, not taking into account its intended use;

(2) With respect to a lease of space, not adjusted to reflect the additional value the prospective lessee or lessor would attribute to the proximity or convenience to the lessor if the lessor is a potential source of referrals to the lessee.

(D) "Governmental health care program" means any program providing health care benefits that is administered by the federal government, this state, or a political subdivision of this state, including the medicare program ~~established under Title XVIII of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended~~, health care coverage for public employees, health care benefits administered by the bureau of workers' compensation, the ~~medical assistance~~ medicaid program ~~established under Chapter 5111. of the Revised Code~~, and the disability medical assistance program ~~established under Chapter 5115. of the Revised Code~~.

(E)(1) "Group practice" means a group of two or more holders of certificates under this chapter legally organized as a partnership, professional corporation or association, limited liability company, foundation, nonprofit corporation, faculty practice plan, or similar group practice entity, including an organization comprised of a nonprofit medical clinic that contracts with a professional corporation or association of physicians to provide medical services exclusively to patients of the clinic in order to comply with section 1701.03 of the Revised Code and including a corporation, limited liability company, partnership, or professional association described in division (B) of section 4731.226 of the Revised Code formed for the purpose of providing a combination of the professional services of optometrists who are licensed, certificated, or otherwise legally

authorized to practice optometry under Chapter 4725. of the Revised Code, chiropractors who are licensed, certificated, or otherwise legally authorized to practice chiropractic under Chapter 4734. of the Revised Code, psychologists who are licensed, certificated, or otherwise legally authorized to practice psychology under Chapter 4732. of the Revised Code, registered or licensed practical nurses who are licensed, certificated, or otherwise legally authorized to practice nursing under Chapter 4723. of the Revised Code, pharmacists who are licensed, certificated, or otherwise legally authorized to practice pharmacy under Chapter 4729. of the Revised Code, physical therapists who are licensed, certificated, or otherwise legally authorized to practice physical therapy under sections 4755.40 to 4755.56 of the Revised Code, occupational therapists who are licensed, certificated, or otherwise legally authorized to practice occupational therapy under sections 4755.04 to 4755.13 of the Revised Code, mechanotherapists who are licensed, certificated, or otherwise legally authorized to practice mechanotherapy under section 4731.151 of the Revised Code, and doctors of medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery who are licensed, certificated, or otherwise legally authorized for their respective practices under this chapter, to which all of the following apply:

(a) Each physician who is a member of the group practice provides substantially the full range of services that the physician routinely provides, including medical care, consultation, diagnosis, or treatment, through the joint use of shared office space, facilities, equipment, and personnel.

(b) Substantially all of the services of the members of the group are provided through the group and are billed in the name of the group and amounts so received are treated as receipts of the group.

(c) The overhead expenses of and the income from the practice are distributed in accordance with methods previously determined by members of the group.

(d) The group practice meets any other requirements that the state medical board applies in rules adopted under section 4731.70 of the Revised Code.

(2) In the case of a faculty practice plan associated with a hospital with a medical residency training program in which physician members may provide a variety of specialty services and provide professional services both within and outside the group, as well as perform other tasks such as research, the criteria in division (E)(1) of this section apply only with respect to services rendered within the faculty practice plan.

(F) "Home health care services" and "immediate family" have the same meanings as in the rules adopted under section 4731.70 of the Revised Code.

(G) "Hospital" has the same meaning as in section 3727.01 of the Revised Code.

(H) A "referral" includes both of the following:

(1) A request by a holder of a certificate under this chapter for an item or service, including a request for a consultation with another physician and any test or procedure ordered by or to be performed by or under the supervision of the other physician;

(2) A request for or establishment of a plan of care by a certificate holder that includes the provision of designated health services.

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

Sec. 4731.71. The auditor of state may implement procedures to detect violations of section 4731.66 or 4731.69 of the Revised

Code within governmental health care programs administered by the state. The auditor of state shall report any violation of either section to the state medical board and shall certify to the attorney general in accordance with section 131.02 of the Revised Code the amount of any refund owed to a state-administered governmental health care program under section 4731.69 of the Revised Code as a result of a violation. If a refund is owed to the ~~medical assistance~~ medicaid program ~~established under Chapter 5111. of the Revised Code~~ or the disability medical assistance program ~~established under Chapter 5115. of the Revised Code~~, the auditor of state also shall report the amount to the department of commerce.

The state medical board also may implement procedures to detect violations of section 4731.66 or 4731.69 of the Revised Code.

Sec. 4752.02. (A) Except as provided in division (B) of this section, no person shall provide home medical equipment services or claim to the public to be a home medical equipment services provider unless either of the following is the case:

(1) The person holds a valid license issued under this chapter;

(2) The person holds a valid certificate of registration issued under this chapter.

(B) Division (A) of this section does not apply to any of the following:

(1) A health care practitioner, as defined in section 4769.01 of the Revised Code, who does not sell or rent home medical equipment;

(2) A hospital that provides home medical equipment services only as an integral part of patient care and does not provide the

services through a separate entity that has its own medicare or medicaid provider number;

(3) A manufacturer or wholesale distributor of home medical equipment that does not sell directly to the public;

(4) A hospice care program, as defined by section 3712.01 of the Revised Code, that does not sell or rent home medical equipment;

(5) A home, as defined by section 3721.01 of the Revised Code;

(6) A home health agency that is certified under ~~Title XVIII of~~ the ~~"Social Security Act," 79 Stat. 286 (1965), 42 U.S.C. 1395,~~ medicare program as a provider of home health services and does not sell or rent home medical equipment;

(7) An individual who holds a current, valid license issued under Chapter 4741. of the Revised Code to practice veterinary medicine;

(8) An individual who holds a current, valid license issued under Chapter 4779. of the Revised Code to practice orthotics, prosthetics, or pedorthics;

(9) A pharmacy licensed under Chapter 4729. of the Revised Code that either does not sell or rent home medical equipment or receives total payments of less than ten thousand dollars per year from selling or renting home medical equipment;

(10) A home dialysis equipment provider regulated by federal law.

Sec. 4752.09. (A) The Ohio respiratory care board may, in accordance with Chapter 119. of the Revised Code, suspend or revoke a license issued under this chapter or discipline a license holder by imposing a fine of not more than five thousand dollars or taking other disciplinary action on any of the following

grounds:

(1) Violation of any provision of this chapter or an order or rule of the board, as those provisions, orders, or rules are applicable to persons licensed under this chapter;

(2) A plea of guilty to or a judicial finding of guilt of a felony or a misdemeanor that involves dishonesty or is directly related to the provision of home medical equipment services;

(3) Making a material misstatement in furnishing information to the board;

(4) Professional incompetence;

(5) Being guilty of negligence or gross misconduct in providing home medical equipment services;

(6) Aiding, assisting, or willfully permitting another person to violate any provision of this chapter or an order or rule of the board, as those provisions, orders, or rules are applicable to persons licensed under this chapter;

(7) Failing, within sixty days, to provide information in response to a written request by the board;

(8) Engaging in conduct likely to deceive, defraud, or harm the public;

(9) Denial, revocation, suspension, or restriction of a license to provide home medical equipment services, for any reason other than failure to renew, in another state or jurisdiction;

(10) Directly or indirectly giving to or receiving from any person a fee, commission, rebate, or other form of compensation for services not rendered;

(11) Knowingly making or filing false records, reports, or billings in the course of providing home medical equipment services, including false records, reports, or billings prepared for or submitted to state and federal agencies or departments;

(12) Failing to comply with federal rules issued pursuant to the medicare program ~~established under Title XVIII of the "Social Security Act," 49 Stat. 620(1935), 42 U.S.C. 1395, as amended~~, relating to operations, financial transactions, and general business practices of home medical services providers.

(B) The respiratory care board immediately may suspend a license without a hearing if it determines that there is evidence that the license holder is subject to actions under this section and that there is clear and convincing evidence that continued operation by the license holder presents an immediate and serious harm to the public. The president and executive director of the board shall make a preliminary determination and describe, by telephone conference or any other method of communication, the evidence on which they made their determination to the other members of the board. The board may by resolution designate another board member to act in place of the president of the board or another employee to act in the place of the executive director, in the event that the board president or executive director is unavailable or unable to act. On review of the evidence, the board may by a vote of not less than seven of its members, suspend a license without a prior hearing. The board may vote on the suspension by way of a telephone conference call.

Immediately following the decision to suspend a license under this division, the board shall issue a written order of suspension and cause it to be delivered in accordance with section 119.07 of the Revised Code. The order shall not be subject to suspension by the court during the pendency of any appeal filed under section 119.12 of the Revised Code. If the license holder requests an adjudication hearing, the date set for the hearing shall be within fifteen days but not earlier than seven days after the license holder requests the hearing, unless another date is agreed to by the license holder and the board. The suspension shall remain in

effect, unless reversed by the board, until a final adjudication order issued by the board pursuant to this section and Chapter 119. of the Revised Code becomes effective. The board shall issue its final adjudication order not later than ninety days after completion of the hearing. The board's failure to issue the order by that day shall cause the summary suspension to end, but shall not affect the validity of any subsequent final adjudication order.

Sec. 4753.071. A person who is required to meet the supervised professional experience requirement of division (F) of section 4753.06 of the Revised Code shall submit to the board of speech-language pathology and audiology an application for a conditional license. The application shall include a plan for the content of the supervised professional experience on a form the board shall prescribe. The board shall issue the conditional license to the applicant if the applicant meets the requirements of section 4753.06 of the Revised Code, other than the requirement to have obtained the supervised professional experience, and pays to the board the appropriate fee for a conditional license. An applicant may not begin employment until the conditional license has been issued.

A conditional license authorizes an individual to practice speech-language pathology or audiology while completing the supervised professional experience as required by division (F) of section 4753.06 of the Revised Code. A person holding a conditional license may practice speech-language pathology or audiology while working under the supervision of a person fully licensed in accordance with this chapter. A conditional license is valid for eighteen months unless suspended or revoked pursuant to section 3123.47 or 4753.10 of the Revised Code.

A person holding a conditional license may perform services

for which reimbursement will be sought under the medicare program ~~established under Title XVIII of the "Social Security Act," 79 Stat. 286 (1965), 42 U.S.C. 1395, as amended~~, or the medicaid program ~~established under Chapter 5111. of the Revised Code~~ but all requests for reimbursement for such services shall be made by the person who supervises the person performing the services.

Sec. 4755.481. (A) If a physical therapist evaluates and treats a patient without the prescription of, or the referral of the patient by, a person who is licensed to practice medicine and surgery, chiropractic, dentistry, osteopathic medicine and surgery, podiatric medicine and surgery, or nursing as a certified registered nurse anesthetist, clinical nurse specialist, certified nurse-midwife, or certified nurse practitioner, all of the following apply:

(1) The physical therapist shall, upon consent of the patient, inform the patient's physician, chiropractor, dentist, podiatrist, certified registered nurse anesthetist, clinical nurse specialist, certified nurse-midwife, or certified nurse practitioner of the evaluation not later than five business days after the evaluation is made.

(2) If the physical therapist determines, based on reasonable evidence, that no substantial progress has been made with respect to that patient during the thirty-day period immediately following the date of the patient's initial visit with the physical therapist, the physical therapist shall consult with or refer the patient to a licensed physician, chiropractor, dentist, podiatrist, certified registered nurse anesthetist, clinical nurse specialist, certified nurse-midwife, or certified nurse practitioner, unless either of the following applies:

(a) The evaluation, treatment, or services are being provided for fitness, wellness, or prevention purposes.

(b) The patient previously was diagnosed with chronic, neuromuscular, or developmental conditions and the evaluation, treatment, or services are being provided for problems or symptoms associated with one or more of those previously diagnosed conditions.

(3) If the physical therapist determines that orthotic devices are necessary to treat the patient, the physical therapist shall be limited to the application of the following orthotic devices:

(a) Upper extremity adaptive equipment used to facilitate the activities of daily living;

(b) Finger splints;

(c) Wrist splints;

(d) Prefabricated elastic or fabric abdominal supports with or without metal or plastic reinforcing stays and other prefabricated soft goods requiring minimal fitting;

(e) Nontherapeutic accommodative inlays;

(f) Shoes that are not manufactured or modified for a particular individual;

(g) Prefabricated foot care products;

(h) Custom foot orthotics;

(i) Durable medical equipment.

(4) If, at any time, the physical therapist has reason to believe that the patient has symptoms or conditions that require treatment or services beyond the scope of practice of a physical therapist, the physical therapist shall refer the patient to a licensed health care practitioner acting within the practitioner's scope of practice.

(B) Nothing in sections 4755.40 to 4755.56 of the Revised

Code shall be construed to require reimbursement under any health insuring corporation policy, contract, or agreement, any sickness and accident insurance policy, the ~~medical assistance~~ medicaid program ~~as defined in section 5111.01 of the Revised Code~~, or the health partnership program or qualified health plans established pursuant to sections 4121.44 to 4121.442 of the Revised Code, for any physical therapy service rendered without the prescription of, or the referral of the patient by, a licensed physician, chiropractor, dentist, podiatrist, certified registered nurse anesthetist, clinical nurse specialist, certified nurse-midwife, or certified nurse practitioner.

(C) For purposes of this section, "business day" means any calendar day that is not a Saturday, Sunday, or legal holiday. "Legal holiday" has the same meaning as in section 1.14 of the Revised Code.

Sec. 4758.02. (A) Effective two years after the date the department of alcohol and drug addiction services ceases to administer its certification and credentialing process under section 3793.07 of the Revised Code as specified in division ~~(B)~~(A) of that section and except as provided in sections 4758.03 and 4758.04 of the Revised Code, no person shall do any of the following:

(1) Engage in or represent to the public that the person engages in chemical dependency counseling for a fee, salary, or other consideration unless the person holds a valid independent chemical dependency counselor license, chemical dependency counselor III license, chemical dependency counselor II license, chemical dependency counselor I certificate, or chemical dependency counselor assistant certificate issued under this chapter;

(2) Use the title "licensed independent chemical dependency

counselor," "LICDC," "licensed chemical dependency counselor III," "LCDC III," "licensed chemical dependency counselor II," "LCDC II," "certified chemical dependency counselor I," "CCDC I," "chemical dependency counselor assistant," "CDCA," or any other title or description incorporating the word "chemical dependency counselor" or any other initials used to identify persons acting in those capacities unless currently authorized under this chapter to act in the capacity indicated by the title or initials;

(3) Represent to the public that the person is a registered applicant unless the person holds a valid registered applicant certificate issued under this chapter;

(4) Use the title "certified prevention specialist II," "CPS II," "certified prevention specialist I," "CPS I," "registered applicant," or any other title, description, or initials used to identify persons acting in those capacities unless currently authorized under this chapter to act in the capacity indicated by the title or initials.

(B) Effective six years after ~~the effective date of this section~~ December 23, 2002, no person shall engage in or represent to the public that the person engages in chemical dependency counseling as a chemical dependency counselor I.

Sec. 4758.04. After the date the department of alcohol and drug addiction services ceases to administer its certification and credentialing process under section 3793.07 of the Revised Code as specified in division ~~(B)~~(A) of that section, an individual who holds, on ~~the effective date of this section~~ December 23, 2002, a valid certificate or credentials that are accepted under section 3793.07 of the Revised Code as authority to practice as a chemical dependency counselor or alcohol and other drug prevention specialist may apply to the chemical dependency professionals board for the board to delay the expiration date of the

individual's certificate or credentials. If the board determines that there is good cause for delaying the expiration date, the board may delay the expiration date until a date the board specifies. The date the board specifies shall not be later than the date that is three years after the effective date of the board's initial rules adopted under section 4758.20 of the Revised Code.

An individual who has the expiration date of the individual's certificate or credentials delayed under this section may perform services within the scope, standards, and ethics of the certificate or credentials until the date of the delayed expiration date.

Sec. 4761.01. As used in this chapter:

(A) "Respiratory care" means rendering or offering to render to individuals, groups, organizations, or the public any service involving the evaluation of cardiopulmonary function, the treatment of cardiopulmonary impairment, the assessment of treatment effectiveness, and the care of patients with deficiencies and abnormalities associated with the cardiopulmonary system. The practice of respiratory care includes:

(1) Obtaining, analyzing, testing, measuring, and monitoring blood and gas samples in the determination of cardiopulmonary parameters and related physiologic data, including flows, pressures, and volumes, and the use of equipment employed for this purpose;

(2) Administering, monitoring, recording the results of, and instructing in the use of medical gases, aerosols, and bronchopulmonary hygiene techniques, including drainage, aspiration, and sampling, and applying, maintaining, and instructing in the use of artificial airways, ventilators, and other life support equipment employed in the treatment of

cardiopulmonary impairment and provided in collaboration with other licensed health care professionals responsible for providing care;

(3) Performing cardiopulmonary resuscitation and respiratory rehabilitation techniques;

(4) Administering medications for the testing or treatment of cardiopulmonary impairment.

(B) "Respiratory care professional" means a person who is licensed under this chapter to practice the full range of respiratory care services as defined in division (A) of this section.

(C) "Physician" means an individual authorized under Chapter 4731. of the Revised Code to practice medicine and surgery or osteopathic medicine and surgery.

(D) "Registered nurse" means an individual licensed under Chapter 4723. of the Revised Code to engage in the practice of nursing as a registered nurse.

(E) "Hospital" means a facility that meets the operating standards of section 3727.02 of the Revised Code.

(F) "Nursing facility" has the same meaning as in section ~~5111.20~~ 5164.01 of the Revised Code.

Sec. 4761.03. The Ohio respiratory care board shall regulate the practice of respiratory care in this state and the persons to whom the board issues licenses and limited permits under this chapter and shall license and register home medical equipment services providers under Chapter 4752. of the Revised Code ~~under this chapter~~. Rules adopted under this chapter that deal with the provision of respiratory care in a hospital, other than rules regulating the issuance of licenses or limited permits, shall be consistent with the conditions for participation under medicare~~,~~

~~Title XVIII of the "Social Security Act," 79 Stat. 286 (1965), 42 U.S.C.A. 1395, as amended,~~ and with the respiratory care accreditation standards of the joint commission on accreditation of healthcare organizations or the American osteopathic association.

The board shall:

(A) Adopt, and may rescind or amend, rules in accordance with Chapter 119. of the Revised Code to carry out the purposes of this chapter, including rules prescribing:

(1) The form and manner for filing applications for licensure and renewal, limited permits, and limited permit extensions under sections 4761.05 and 4761.06 of the Revised Code;

(2) The form, scoring, and scheduling of examinations and reexaminations for licensure and license renewal;

(3) Standards for the approval of educational programs required to qualify for licensure and continuing education programs required for license renewal;

(4) Continuing education courses and the number of hour requirements necessary for license renewal, in accordance with section 4761.06 of the Revised Code;

(5) Procedures for the issuance and renewal of licenses and limited permits, including the duties that may be fulfilled by the board's executive director and other board employees;

(6) Procedures for the denial, suspension, permanent revocation, refusal to renew, and reinstatement of licenses and limited permits, the conduct of hearings, and the imposition of fines for engaging in conduct that is grounds for such action and hearings under section 4761.09 of the Revised Code;

(7) Standards of ethical conduct for the practice of respiratory care;

(8) Conditions under which the license renewal fee and continuing education requirements may be waived at the request of a licensee who is not in active practice;

(9) The respiratory care tasks that may be performed by an individual practicing as a polysomnographic technologist pursuant to division (B)(3) of section 4761.10 of the Revised Code;

(10) Procedures for registering out-of-state respiratory care providers authorized to practice in this state under division (A)(4) of section 4761.11 of the Revised Code.

(B) Determine the sufficiency of an applicant's qualifications for admission to the licensing examination or a reexamination, and for the issuance or renewal of a license or limited permit;

(C) Determine the respiratory care educational programs that are acceptable for fulfilling the requirements of division (A) of section 4761.04 of the Revised Code;

(D) Schedule, administer, and score the licensing examination or any reexamination for license renewal or reinstatement. The board shall administer the licensing examinations at least twice a year and notify applicants of the time and place of the examinations.

(E) Investigate complaints concerning alleged violations of section 4761.10 of the Revised Code or grounds for the suspension, permanent revocation, or refusal to issue licenses or limited permits under section 3123.47 or 4761.09 of the Revised Code. The board shall employ investigators who shall, under the direction of the executive director of the board, investigate complaints and make inspections and other inquiries as, in the judgment of the board, are appropriate to enforce sections 3123.41 to 3123.50, 4761.09, and 4761.10 of the Revised Code. Pursuant to an investigation and inspection, the investigators may review and

audit records during normal business hours at the place of business of a licensee or person who is the subject of a complaint filed with the board or at any place where the records are kept.

Except when required by court order, the board and its employees shall not disclose confidential information obtained during an investigation or identifying information about any person who files a complaint with the board.

The board may hear testimony in matters relating to the duties imposed upon it and issue subpoenas pursuant to an investigation. The president and secretary of the board may administer oaths.

(F) Conduct hearings, keep records of its proceedings, and do all such other things as are necessary and proper to carry out and enforce the provisions of this chapter;

(G) Maintain, publish, and make available upon request, for a fee not to exceed the actual cost of printing and mailing:

(1) The requirements for the issuance of licenses and limited permits under this chapter and rules adopted by the board;

(2) A current register of every person licensed to practice respiratory care in this state, to include the addresses of the person's last known place of business and residence, the effective date and identification number of the license, the name and location of the institution that granted the person's degree or certificate of completion of respiratory care educational requirements, and the date the degree or certificate was issued;

(3) A list of the names and locations of the institutions that each year granted degrees or certificates of completion in respiratory care;

(4) After the administration of each examination, a list of persons who passed the examination.

(H) Submit to the governor and to the general assembly each year a report of all of its official actions during the preceding year, together with any findings and recommendations with regard to the improvement of the profession of respiratory care;

(I) Administer and enforce Chapter 4752. of the Revised Code.

Sec. 4769.01. As used in this chapter:

(A) ~~"Medicare" means the program established by Title XVIII of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended.~~

~~(B)~~ "Balance billing" means charging or collecting from a medicare beneficiary an amount in excess of the medicare reimbursement rate for medicare-covered services or supplies provided to a medicare beneficiary, except when medicare is the secondary insurer. When medicare is the secondary insurer, the health care practitioner may pursue full reimbursement under the terms and conditions of the primary coverage and, if applicable, the charge allowed under the terms and conditions of the appropriate provider contract, from the primary insurer, but the medicare beneficiary cannot be balance billed above the medicare reimbursement rate for a medicare-covered service or supply. "Balance billing" does not include charging or collecting deductibles or coinsurance required by the program.

~~(C)~~(B) "Health care practitioner" means all of the following:

(1) A dentist or dental hygienist licensed under Chapter 4715. of the Revised Code;

(2) A registered or licensed practical nurse licensed under Chapter 4723. of the Revised Code;

(3) An optometrist licensed under Chapter 4725. of the Revised Code;

(4) A dispensing optician, spectacle dispensing optician,

contact lens dispensing optician, or spectacle-contact lens dispensing optician licensed under Chapter 4725. of the Revised Code;

(5) A pharmacist licensed under Chapter 4729. of the Revised Code;

(6) A physician authorized under Chapter 4731. of the Revised Code to practice medicine and surgery, osteopathic medicine and surgery, or podiatry;

(7) A physician assistant authorized under Chapter 4730. of the Revised Code to practice as a physician assistant;

(8) A practitioner of a limited branch of medicine issued a certificate under Chapter 4731. of the Revised Code;

(9) A psychologist licensed under Chapter 4732. of the Revised Code;

(10) A chiropractor licensed under Chapter 4734. of the Revised Code;

(11) A hearing aid dealer or fitter licensed under Chapter 4747. of the Revised Code;

(12) A speech-language pathologist or audiologist licensed under Chapter 4753. of the Revised Code;

(13) An occupational therapist or occupational therapy assistant licensed under Chapter 4755. of the Revised Code;

(14) A physical therapist or physical therapy assistant licensed under Chapter 4755. of the Revised Code;

(15) A professional clinical counselor, professional counselor, social worker, or independent social worker licensed, or a social work assistant registered, under Chapter 4757. of the Revised Code;

(16) A dietitian licensed under Chapter 4759. of the Revised

Code;

(17) A respiratory care professional licensed under Chapter 4761. of the Revised Code;

(18) An emergency medical technician-basic, emergency medical technician-intermediate, or emergency medical technician-paramedic certified under Chapter 4765. of the Revised Code.

Sec. 5101.07. There is hereby created in the state treasury the ODJFS support services federal operating fund. The fund shall consist of federal funds the department of job and family services receives and that the director of job and family services determines are appropriate for deposit into the fund. Money in the fund shall be used to pay the federal share of both of the following:

(A) The department's costs for computer projects;

(B) The operating costs of the parts of the department that provide general support services for the department's work units established under section 5101.06 of the Revised Code.

Sec. 5101.071. There is hereby created in the state treasury the ODJFS support services state operating fund. The fund shall consist of payments made to the fund from other appropriation items by intrastate transfer voucher. Money in the fund shall be used to pay for both of the following:

(A) The department of job and family services' costs for computer projects;

(B) The operating costs of the parts of the department that provide general support services for the department's work units established under section 5101.06 of the Revised Code.

Sec. 5101.11. ~~This section does not apply to contracts~~

~~entered into under section 5111.90 or 5111.91 of the Revised Code.~~

(A) As used in this section:

(1) "Entity" includes an agency, board, commission, or department of the state or a political subdivision of the state; a private, nonprofit entity; a school district; a private school; or a public or private institution of higher education.

(2) "Federal financial participation" means the federal government's share of expenditures made by an entity in implementing a program administered by the department of job and family services.

(B) At the request of any public entity having authority to implement a program administered by the department of job and family services or any private entity under contract with a public entity to implement a program administered by the department, the department may seek to obtain federal financial participation for costs incurred by the entity. Federal financial participation may be sought from programs operated pursuant to Title IV-A~~,~~ and Title IV-E~~, and Title XIX~~ of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C. 301, as amended; the "Food Stamp Act of 1964," 78 Stat. 703, 7 U.S.C. 2011, as amended; and any other statute or regulation under which federal financial participation may be available, except that federal financial participation may be sought only for expenditures made with funds for which federal financial participation is available under federal law.

(C) All funds collected by the department of job and family services pursuant to division (B) of this section shall be distributed to the entities that incurred the costs, except for any amounts retained by the department pursuant to division (D)(3) of this section.

(D) In distributing federal financial participation pursuant to this section, the department may either enter into an agreement

with the entity that is to receive the funds or distribute the funds in accordance with rules adopted under division (F) of this section. If the department decides to enter into an agreement to distribute the funds, the agreement may include terms that do any of the following:

(1) Provide for the whole or partial reimbursement of any cost incurred by the entity in implementing the program;

(2) In the event that federal financial participation is disallowed or otherwise unavailable for any expenditure, require the department of job and family services or the entity, whichever party caused the disallowance or unavailability of federal financial participation, to assume responsibility for the expenditures;

(3) Permit the department to retain not more than five per cent of the amount of the federal financial participation to be distributed to the entity;

(4) Require the public entity to certify the availability of sufficient unencumbered funds to match the federal financial participation it receives under this section;

(5) Establish the length of the agreement, which may be for a fixed or a continuing period of time;

(6) Establish any other requirements determined by the department to be necessary for the efficient administration of the agreement.

(E) An entity that receives federal financial participation pursuant to this section for a program aiding children and their families shall establish a process for collaborative planning with the department of job and family services for the use of the funds to improve and expand the program.

(F) The director of job and family services shall adopt rules

as necessary to implement this section, including rules for the distribution of federal financial participation pursuant to this section. The rules shall be adopted in accordance with Chapter 119. of the Revised Code. The director may adopt or amend any statewide plan required by the federal government for a program administered by the department, as necessary to implement this section.

(G) Federal financial participation received pursuant to this section shall not be included in any calculation made under section 5101.16 or 5101.161 of the Revised Code.

Sec. 5101.16. (A) As used in this section and sections 5101.161 and 5101.162 of the Revised Code:

(1) "Disability financial assistance" means the financial assistance program established under Chapter 5115. of the Revised Code.

(2) ~~"Disability medical assistance" means the medical assistance program established under Chapter 5115. of the Revised Code.~~

~~(3)~~ "Food stamps" means the program administered by the department of job and family services pursuant to section 5101.54 of the Revised Code.

~~(4) "Medicaid" means the medical assistance program established by Chapter 5111. of the Revised Code, excluding transportation services provided under that chapter.~~

~~(5)~~(3) "Ohio works first" means the program established by Chapter 5107. of the Revised Code.

~~(6)~~(4) "Prevention, retention, and contingency" means the program established by Chapter 5108. of the Revised Code.

~~(7)~~(5) "Public assistance expenditures" means expenditures for all of the following:

(a) Ohio works first;

(b) County administration of Ohio works first;

(c) Prevention, retention, and contingency;

(d) County administration of prevention, retention, and contingency;

(e) Disability financial assistance;

(f) ~~Disability medical assistance;~~

~~(g)~~ County administration of disability financial assistance;

~~(h) County administration of disability medical assistance;~~

~~(i)~~(g) County administration of food stamps~~;~~

~~(j) County administration of medicaid~~.

~~(8)~~(6) "Public medical assistance expenditures" has the same meaning as in section 5160.26 of the Revised Code.

(7) "Title IV-A program" has the same meaning as in section 5101.80 of the Revised Code.

(B) Each board of county commissioners shall pay the county share of public assistance expenditures in accordance with section 5101.161 of the Revised Code. Except as provided in division (C) of this section, a county's share of public assistance expenditures is the sum of all of the following for state fiscal year 1998 and each state fiscal year thereafter:

(1) The amount that is twenty-five per cent of the county's total expenditures for disability financial assistance ~~and disability medical assistance~~ and county administration of ~~those programs~~ disability financial assistance during the state fiscal year ending in the previous calendar year that the department of job and family services determines are allowable.

(2) The amount that is ten per cent, or other percentage determined under division (D) of this section, of the county's

total expenditures for county administration of food stamps ~~and medicaid~~ during the state fiscal year ending in the previous calendar year that the department determines are allowable, less the amount of federal reimbursement credited to the county under division (E) of this section for the state fiscal year ending in the previous calendar year;

(3) A percentage of the actual amount of the county share of program and administrative expenditures during federal fiscal year 1994 for assistance and services, other than child care, provided under ~~Titles~~ former Title IV-A ~~and IV-F~~ of the "Social Security Act," 49 Stat. ~~620~~ 627 (1935), 42 U.S.C. ~~301~~ 601, and former Title IV-F of the "Social Security Act," 102 Stat. 2360 (1988), 42 U.S.C. 681, as those titles existed prior to the enactment of the "Personal Responsibility and Work Opportunity Reconciliation Act of 1996," 110 Stat. 2105. The department of job and family services shall determine the actual amount of the county share from expenditure reports submitted to the United States department of health and human services. The percentage shall be the percentage established in rules adopted under division (F) of this section.

(C)(1) If a county's share of public assistance expenditures determined under division (B) of this section and the county's share of public medical assistance expenditures determined under division (B) of section 5160.26 of the Revised Code for a state fiscal year exceeds one hundred ten per cent of the county's share for those expenditures for the immediately preceding state fiscal year, the department of job and family services shall reduce the county's share for expenditures under divisions (B)(1) and (2) of this section so that the total of the county's share for public assistance expenditures ~~under division (B) of this section~~ and public medical assistance expenditures equals one hundred ten per cent of the county's share of those expenditures for the

immediately preceding state fiscal year. The department of job and family services shall cooperate with the department of health care administration for the purpose of making reductions under division (C)(1) of this section.

(2) A county's share of public assistance expenditures determined under division (B) of this section may be increased pursuant to section 5101.163 of the Revised Code and a sanction under section 5101.24 of the Revised Code. An increase made pursuant to section 5101.163 of the Revised Code may cause the county's share to exceed the limit established by division (C)(1) of this section.

(D)(1) If the per capita tax duplicate of a county is less than the per capita tax duplicate of the state as a whole and division (D)(2) of this section does not apply to the county, the percentage to be used for the purpose of division (B)(2) of this section is the product of ten multiplied by a fraction of which the numerator is the per capita tax duplicate of the county and the denominator is the per capita tax duplicate of the state as a whole. The department of job and family services shall compute the per capita tax duplicate for the state and for each county by dividing the tax duplicate for the most recent available year by the current estimate of population prepared by the department of development.

(2) If the percentage of families in a county with an annual income of less than three thousand dollars is greater than the percentage of such families in the state and division (D)(1) of this section does not apply to the county, the percentage to be used for the purpose of division (B)(2) of this section is the product of ten multiplied by a fraction of which the numerator is the percentage of families in the state with an annual income of less than three thousand dollars a year and the denominator is the percentage of such families in the county. The department of job

and family services shall compute the percentage of families with an annual income of less than three thousand dollars for the state and for each county by multiplying the most recent estimate of such families published by the department of development, by a fraction, the numerator of which is the estimate of average annual personal income published by the bureau of economic analysis of the United States department of commerce for the year on which the census estimate is based and the denominator of which is the most recent such estimate published by the bureau.

(3) If the per capita tax duplicate of a county is less than the per capita tax duplicate of the state as a whole and the percentage of families in the county with an annual income of less than three thousand dollars is greater than the percentage of such families in the state, the percentage to be used for the purpose of division (B)(2) of this section shall be determined as follows:

(a) Multiply ten by the fraction determined under division (D)(1) of this section;

(b) Multiply the product determined under division (D)(3)(a) of this section by the fraction determined under division (D)(2) of this section.

(4) The department of job and family services shall determine, for each county, the percentage to be used for the purpose of division (B)(2) of this section not later than the first day of July of the year preceding the state fiscal year for which the percentage is used.

(E) The department of job and family services shall credit to a county the amount of federal reimbursement the department receives from the United States ~~departments~~ department of agriculture ~~and health and human services~~ for the county's expenditures for administration of food stamps ~~and medicaid~~ that the department determines are allowable administrative

expenditures.

(F)(1) The director of job and family services shall adopt rules in accordance with section 111.15 of the Revised Code to establish all of the following:

(a) The method the department is to use to change a county's share of public assistance expenditures determined under division (B) of this section as provided in division (C) of this section;

(b) The allocation methodology and formula the department will use to determine the amount of funds to credit to a county under this section;

(c) The method the department will use to change the payment of the county share of public assistance expenditures from a calendar-year basis to a state fiscal year basis;

(d) The percentage to be used for the purpose of division (B)(3) of this section, which shall, except as provided in section 5101.163 of the Revised Code, meet both of the following requirements:

(i) The percentage shall not be less than seventy-five per cent nor more than eighty-two per cent;

(ii) The percentage shall not exceed the percentage that the state's qualified state expenditures is of the state's historic state expenditures as those terms are defined in 42 U.S.C. 609(a)(7).

(e) Other procedures and requirements necessary to implement this section.

(2) The director of job and family services may amend the rule adopted under division (F)(1)(d) of this section to modify the percentage on determination that the amount the general assembly appropriates for Title IV-A programs makes the modification necessary. The rule shall be adopted and amended as

if an internal management rule and in consultation with the director of budget and management.

Sec. 5101.162. Subject to available federal funds and appropriations made by the general assembly, the department of job and family services may, at its sole discretion, use available federal funds to reimburse county expenditures for county administration of food stamps ~~or medicaid~~ even though the county expenditures meet or exceed the maximum allowable reimbursement amount established by rules adopted under section 5101.161 of the Revised Code if the board of county commissioners has entered into a fiscal agreement with the director of job and family services under section 5101.21 of the Revised Code. The director may adopt internal management rules in accordance with section 111.15 of the Revised Code to implement this section.

Sec. 5101.18. ~~(A)~~ When the director of job and family services adopts rules under section 5107.05 regarding income requirements for the Ohio works first program and under section 5115.03 of the Revised Code regarding income and resource requirements for the disability financial assistance program, the director shall determine what payments shall be regarded or disregarded. In making this determination, the director shall consider:

~~(1)~~(A) The source of the payment;

~~(2)~~(B) The amount of the payment;

~~(3)~~(C) The purpose for which the payment was made;

~~(4)~~(D) Whether regarding the payment as income would be in the public interest;

~~(5)~~(E) Whether treating the payment as income would be detrimental to any of the programs administered in whole or in part by the department of job and family services or department of

health care administration and whether such determination would jeopardize the receipt of any federal grant or payment by the state or any receipt of aid under Chapter 5107. of the Revised Code.

~~(B) Any recipient of aid under Title XVI of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C. 301, as amended, whose money payment is discontinued as the result of a general increase in old-age, survivors, and disability insurance benefits under such act, shall remain a recipient for the purpose of receiving medical assistance through the medical assistance program established under section 5111.01 of the Revised Code.~~

Sec. 5101.181. ~~(A) As used in this section and section 5101.182 of the Revised Code, "public assistance" includes, in addition to Ohio works first, all of the following:~~

~~(1) Prevention, retention, and contingency;~~

~~(2) Medicaid;~~

~~(3) Disability financial assistance;~~

~~(4) Disability medical assistance;~~

~~(5) General assistance provided prior to July 17, 1995, under former Chapter 5113. of the Revised Code.~~

~~(B)~~ As part of the procedure for the determination of overpayment to a recipient of public assistance under Chapter 5107., 5108., ~~5111.,~~ or 5115. of the Revised Code, the director of job and family services shall furnish quarterly the name and social security number of each individual who receives public assistance to the director of administrative services, the administrator of the bureau of workers' compensation, and each of the state's retirement boards. Within fourteen days after receiving the name and social security number of an individual who receives public assistance, the director of administrative

services, administrator, or board shall inform the auditor of state as to whether such individual is receiving wages or benefits, the amount of any wages or benefits being received, the social security number, and the address of the individual. The director of administrative services, administrator, boards, and any agent or employee of those officials and boards shall comply with the rules ~~of the director of job and family services~~ adopted under section 5101.30 of the Revised Code restricting the disclosure of information regarding recipients of public assistance. Any person who violates this provision shall thereafter be disqualified from acting as an agent or employee or in any other capacity under appointment or employment of any state board, commission, or agency.

~~(C) The auditor of state may enter into a reciprocal agreement with the director of job and family services or comparable officer of any other state for the exchange of names, current or most recent addresses, or social security numbers of persons receiving public assistance under Title IV-A or under Title XIX of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C. 301, as amended.~~

~~(D)(1) The auditor of state shall retain, for not less than two years, at least one copy of all information received under this section and sections 145.27, 742.41, 3307.20, 3309.22, 4123.27, 5101.182, and 5505.04 of the Revised Code. The auditor shall review the information to determine whether overpayments were made to recipients of public assistance under Chapters 5107., 5108., 5111., and 5115. of the Revised Code. The auditor of state shall initiate action leading to prosecution, where warranted, of recipients who received overpayments by forwarding the name of each recipient who received overpayment, together with other pertinent information, to the director of job and family services and the attorney general, to the district director of job and~~

~~family services of the district through which public assistance was received, and to the county director of job and family services and county prosecutor of the county through which public assistance was received.~~

~~(2) The auditor of state and the attorney general or their designees may examine any records, whether in computer or printed format, in the possession of the director of job and family services or any county director of job and family services. They shall provide safeguards which restrict access to such records to purposes directly connected with an audit or investigation, prosecution, or criminal or civil proceeding conducted in connection with the administration of the programs and shall comply with the rules of the director of job and family services restricting the disclosure of information regarding recipients of public assistance. Any person who violates this provision shall thereafter be disqualified from acting as an agent or employee or in any other capacity under appointment or employment of any state board, commission, or agency.~~

~~(3) Costs incurred by the auditor of state in carrying out the auditor of state's duties under this division shall be borne by the auditor of state.~~

Sec. 5101.182. As part of the procedure for the determination of overpayment to a recipient of public assistance under Chapter 5107.~~, 5111.,~~ or 5115. of the Revised Code, the director of job and family services shall semiannually, at times determined jointly by the auditor of state and the tax commissioner, furnish to the tax commissioner in computer format the name and social security number of each individual who receives public assistance. Within sixty days after receiving the name and social security number of a recipient of public assistance, the commissioner shall inform the auditor of state whether the individual filed an Ohio

individual income tax return, separate or joint, as provided by section 5747.08 of the Revised Code, for either or both of the two taxable years preceding the year in which the director furnished the names and social security numbers to the commissioner. If the individual did so file, at the same time the commissioner shall also inform the auditor of state of the amount of the federal adjusted gross income as reported on such returns and of the addresses on such returns. The commissioner shall also advise the auditor of state whether such returns were filed on a joint basis, as provided in section 5747.08 of the Revised Code, in which case the federal adjusted gross income as reported may be that of the individual or the individual's spouse.

If the auditor of state determines that further investigation is needed, the auditor of state may request the commissioner to determine whether the individual filed income tax returns for any previous taxable years in which the individual received public assistance and for which the tax department retains income tax returns. Within fourteen days of receipt of the request, the commissioner shall inform the auditor of state whether the individual filed an individual income tax return for the taxable years in question, of the amount of the federal adjusted gross income as reported on such returns, of the addresses on such returns, and whether the returns were filed on a joint or separate basis.

If the auditor of state determines that further investigation is needed of a recipient of public assistance who filed an Ohio individual income tax return, the auditor of state may request a certified copy of the Ohio individual income tax return or returns of that person for the taxable years described above, together with any other documents the commissioner has concerning the return or returns. Within fourteen days of receipt of such a

request in writing, the commissioner shall forward the returns and documents to the auditor of state.

The director of job and family services, district director of job and family services, county director of job and family services, county prosecutor, attorney general, auditor of state, or any agent or employee of those officials having access to any information or documents furnished by the commissioner pursuant to this section shall not divulge or use any such information except for the purpose of determining overpayment of public assistance, or for an audit, investigation, or prosecution, or in accordance with a proper judicial order. Any person who violates this provision shall thereafter be disqualified from acting as an agent or employee or in any other capacity under appointment or employment of any state or county board, commission, or agency.

Sec. 5101.184. (A) The director of job and family services shall work with the tax commissioner to collect overpayments of assistance under Chapter 5107.~~, 5111.,~~ or 5115., former Chapter 5113., or section 5101.54 of the Revised Code from refunds of state income taxes for taxable year 1992 and thereafter that are payable to the recipients of such overpayments.

Any overpayment of assistance, whether obtained by fraud or misrepresentation, as the result of an error by the recipient or by the agency making the payment, or in any other manner, may be collected under this section. Any reduction under section 5747.12 or 5747.121 of the Revised Code to an income tax refund shall be made before a reduction under this section. No reduction shall be made under this section if the amount of the refund is less than twenty-five dollars after any reduction under section 5747.12 of the Revised Code. A reduction under this section shall be made before any part of the refund is contributed under section 5747.113 of the Revised Code, or is credited under section 5747.12

of the Revised Code against tax due in any subsequent year.

The director and the tax commissioner, by rules adopted in accordance with Chapter 119. of the Revised Code, shall establish procedures to implement this division. The procedures shall provide for notice to a recipient of assistance and an opportunity for the recipient to be heard before the recipient's income tax refund is reduced.

(B) The director of job and family services may enter into agreements with the federal government to collect overpayments of assistance from refunds of federal income taxes that are payable to recipients of the overpayments.

Sec. 5101.21. (A) As used in ~~this section, "county~~ sections 5101.21 to 5101.25 of the Revised Code:

(1) "County signer" means all of the following:

~~(1)~~(a) A board of county commissioners;

~~(2)~~(b) A county children services board appointed under section 5153.03 of the Revised Code if required by division (B) of this section to enter into a fiscal agreement;

~~(3)~~(c) A county elected official that is a child support enforcement agency if required by division (B) of this section to enter into a fiscal agreement.

"ODJFS family services duty" means a family services duty associated with a program that the department of job and family services supervises the administration of on the state level.

(B) The director of job and family services may enter into one or more written fiscal agreements with boards of county commissioners under which financial assistance is awarded for ODJFS family services duties included in the agreements. Boards of county commissioners shall select which ODJFS family services duties to include in a fiscal agreement. If a board of county

commissioners elects to include ODJFS family services duties of a public children services agency and a county children services board appointed under section 5153.03 of the Revised Code serves as the county's public children services agency, the board of county commissioners and county children services board shall jointly enter into the fiscal agreement with the director. If a board of county commissioners elects to include ODJFS family services duties of a child support enforcement agency and the entity designated under former section 2301.35 of the Revised Code prior to October 1, 1997, or designated under section 307.981 of the Revised Code as the county's child support enforcement agency is an elected official of the county, the board of county commissioners and county elected official shall jointly enter into the fiscal agreement with the director. A fiscal agreement shall do all of the following:

(1) Specify the ODJFS family services duties included in the agreement and the private and government entities designated under section 307.981 of the Revised Code to serve as the county family services agencies performing the ODJFS family services duties;

(2) Provide for the department of job and family services to award financial assistance for the ODJFS family services duties included in the agreement in accordance with a methodology for determining the amount of the award established by rules adopted under division (D) of this section;

(3) Specify the form of the award of financial assistance which may be an allocation, cash draw, reimbursement, property, or, to the extent authorized by an appropriation made by the general assembly and to the extent practicable and not in conflict with a federal or state law, a consolidated funding allocation for two or more ODJFS family services duties included in the agreement;

(4) Provide that the award of financial assistance is subject

to the availability of federal funds and appropriations made by the general assembly;

(5) Specify annual financial, administrative, or other incentive awards, if any, to be provided in accordance with section 5101.23 of the Revised Code;

(6) Include the assurance of each county signer that the county signer will do all of the following:

(a) Ensure that the financial assistance awarded under the agreement is used, and the ODJFS family services duties included in the agreement are performed, in accordance with requirements for the duties established by the department, a federal or state law, or any of the following that concern the ODJFS family services duties included in the fiscal agreement and are published under section 5101.212 of the Revised Code: state plans for receipt of federal financial participation, grant agreements between the department and a federal agency, and executive orders issued by the governor;

(b) Ensure that the board and county family services agencies utilize a financial management system and other accountability mechanisms for the financial assistance awarded under the agreement that meet requirements the department establishes;

(c) Require the county family services agencies to do both of the following:

(i) Monitor all private and government entities that receive a payment from financial assistance awarded under the agreement to ensure that each entity uses the payment in accordance with requirements for the ODJFS family services duties included in the agreement;

(ii) Take action to recover payments that are not used in accordance with the requirements for the ODJFS family services duties included in the agreement.

(d) Require county family services agencies to promptly reimburse the department the amount that represents the amount an agency is responsible for, pursuant to action the department takes under division (C) of section 5101.24 of the Revised Code, of funds the department pays to any entity because of an adverse audit finding, adverse quality control finding, final disallowance of federal financial participation, or other sanction or penalty;

(e) Require county family services agencies to take prompt corrective action, including paying amounts resulting from an adverse finding, sanction, or penalty, if the department, auditor of state, federal agency, or other entity authorized by federal or state law to determine compliance with requirements for ~~a~~ an ODJFS family services duty included in the agreement determines compliance has not been achieved.

(7) Provide for the department taking action pursuant to division (C) of section 5101.24 of the Revised Code if authorized by division (B)(1), (2), (3), or (4) of that section;

(8) Provide for timely audits required by federal and state law and require prompt release of audit findings and prompt action to correct problems identified in an audit;

(9) Comply with all of the requirements for the ODJFS family services duties that are included in the agreement and have been established by the department, federal or state law, or any of the following that concern the ODJFS family services duties included in the fiscal agreement and are published under section 5101.212 of the Revised Code: state plans for receipt of federal financial participation, grant agreements between the department and a federal agency, and executive orders issued by the governor;

(10) Provide for dispute resolution procedures in accordance with section 5101.24 of the Revised Code;

(11) Establish the method of amending or terminating the

agreement and an expedited process for correcting terms or conditions of the agreement that the director and each county signer agree are erroneous;

(12) Except as provided in rules adopted under division (D) of this section, begin on the first day of July of an odd-numbered year and end on the last day of June of the next odd-numbered year.

(C) The department shall make payments authorized by a fiscal agreement on vouchers it prepares and may include any funds appropriated or allocated to it for carrying out ODJFS family services duties included in the agreement, including funds for personal services and maintenance.

(D)(1) The director shall adopt rules in accordance with section 111.15 of the Revised Code governing fiscal agreements. The director shall adopt the rules as if they were internal management rules. Before adopting the rules, the director shall give the public an opportunity to review and comment on the proposed rules. The rules shall establish methodologies to be used to determine the amount of financial assistance to be awarded under the agreements. The rules also shall establish terms and conditions under which an agreement may be entered into after the first day of July of an odd-numbered year. The rules may do any or all of the following:

(a) Govern the establishment of allocations;

(b) Specify allowable uses of financial assistance awarded under the agreements;

(c) Establish reporting, cash management, audit, and other requirements the director determines are necessary to provide accountability for the use of financial assistance awarded under the agreements and determine compliance with requirements established by the department, a federal or state law, or any of

the following that concern the ODJFS family services duties included in the agreements and are published under section 5101.212 of the Revised Code: state plans for receipt of federal financial participation, grant agreements between the department and a federal entity, and executive orders issued by the governor.

(2) A requirement of a fiscal agreement established by a rule adopted under this division is applicable to a fiscal agreement without having to be restated in the fiscal agreement.

Sec. 5101.212. The department of job and family services shall publish in a manner accessible to the public all of the following that concern ODJFS family services duties included in fiscal agreements entered into under section 5101.21 of the Revised Code: state plans for receipt of federal financial participation, grant agreements between the department and a federal agency, and executive orders issued by the governor. The department may publish the materials electronically or otherwise.

Sec. 5101.213. (A) Except as provided in section 5101.211 of the Revised Code, if a fiscal agreement under section 5101.21 of the Revised Code between the director of job and family services and a board of county commissioners is not in effect, all of the following apply:

(1) The department of job and family services shall award to the county the board serves financial assistance for ODJFS family services duties in accordance with a methodology for determining the amount of the award established by rules adopted under division (B) of this section.

(2) The financial assistance may be provided in the form of allocations, cash draws, reimbursements, and property but may not be made in the form of a consolidated funding allocation.

(3) The award of the financial assistance is subject to the

availability of federal funds and appropriations made by the general assembly.

(4) The county family services agencies performing the ODJFS family services duties for which the financial assistance is awarded shall do all of the following:

(a) Use the financial assistance, and perform the ODJFS family services duties, in accordance with requirements for the duties established by the department, a federal or state law, or any of the following that concern the duties: state plans for receipt of federal financial participation, grant agreements between the department and a federal agency, and executive orders issued by the governor;

(b) Utilize a financial management system and other accountability mechanisms for the financial assistance that meet requirements the department establishes;

(c) Monitor all private and government entities that receive a payment from the financial assistance to ensure that each entity uses the payment in accordance with requirements for the ODJFS family services duties and take action to recover payments that are not used in accordance with the requirements for the ODJFS family services duties;

(d) Promptly reimburse the department the amount that represents the amount an agency is responsible for, pursuant to action the department takes under division (C) of section 5101.24 of the Revised Code, of funds the department pays to any entity because of an adverse audit finding, adverse quality control finding, final disallowance of federal financial participation, or other sanction or penalty;

(e) Take prompt corrective action, including paying amounts resulting from an adverse finding, sanction, or penalty, if the department, auditor of state, federal agency, or other entity

authorized by federal or state law to determine compliance with requirements for ~~a~~ an ODJFS family services duty determines compliance has not been achieved.

(B) The director shall adopt rules in accordance with 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. Before adopting the rules, the director shall give the public an opportunity to review and comment on the proposed rules. The rules shall establish methodologies to be used to determine the amount of financial assistance to be awarded and may do any or all of the following:

(1) Govern the establishment of funding allocations;

(2) Specify allowable uses of financial assistance the department awards under this section;

(3) Establish reporting, cash management, audit, and other requirements the director determines are necessary to provide accountability for the use of the financial assistance and determine compliance with requirements established by the department, a federal or state law, or any of the following that concern the ODJFS family services duties for which the financial assistance is awarded: state plans for receipt of federal financial participation, grant agreements between the department and a federal entity, and executive orders issued by the governor.

Sec. 5101.214. The director of job and family services may enter into a written agreement with one or more state agencies, as defined in section 117.01 of the Revised Code, and state universities and colleges to assist in the coordination, provision, or enhancement of the ODJFS family services duties of a county family services agency or the workforce development activities of a workforce development agency. The director also may enter into written agreements or contracts with, or issue

grants to, private and government entities under which funds are provided for the enhancement or innovation of ODJFS family services duties or workforce development activities on the state or local level.

The director may adopt internal management rules in accordance with section 111.15 of the Revised Code to implement this section.

Sec. 5101.216. The director of job and family services may enter into one or more written operational agreements with boards of county commissioners to do one or more of the following regarding ODJFS family services duties:

(A) Provide for the director to amend or rescind a rule the director previously adopted;

(B) Provide for the director to modify procedures or establish alternative procedures to accommodate special circumstances in a county;

(C) Provide for the director and board to jointly identify operational problems of mutual concern and develop a joint plan to address the problems;

(D) Establish a framework for the director and board to modify the use of existing resources in a manner that is beneficial to the department of job and family services and the county that the board serves and improves ODJFS family services duties for the recipients of the services.

Sec. 5101.22. The department of job and family services may establish performance and other administrative standards for the administration and outcomes of ODJFS family services duties and determine at intervals the department decides the degree to which a county family services agency complies with a performance or other administrative standard. The department may use statistical

sampling, performance audits, case reviews, or other methods it determines necessary and appropriate to determine compliance with performance and administrative standards.

Sec. 5101.221. (A) Except as provided by division (C) of this section, if the department of job and family services determines that a county family services agency has failed to comply with a performance or other administrative standard established under section 5101.22 of the Revised Code or by federal law for the administration or outcome of ~~a~~ an ODJFS family services duty, the department shall require the agency to develop, submit to the department for approval, and comply with a corrective action plan.

(B) If a county family services agency fails to develop, submit to the department, or comply with a corrective action plan under division (A) of this section, or the department disapproves the agency's corrective action plan, the department may require the agency to develop, submit to the department for approval, and comply with a corrective action plan that requires the agency to commit existing resources to the plan.

(C) The department may not require a county family services agency to take action under this section for failure to comply with a performance or other administrative standard established for an incentive awarded by the department. Instead, the department may require a county family services agency that fails to comply with that kind of performance or other administrative standard to take action in accordance with rules adopted by the department governing the standard.

(D) At the request of a county family services agency, the department shall assist the agency with the development of a corrective action plan under this section and provide the agency technical assistance in the implementation of the plan.

Sec. 5101.23. Subject to the availability of funds, the department of job and family services may provide annual financial, administrative, or other incentive awards to county family services agencies and workforce development agencies. A county family services agency or workforce development agency may spend funds provided as a financial incentive award only for the purpose for which the funds are appropriated. The department may adopt internal management rules in accordance with section 111.15 of the Revised Code to establish the amounts of awards, methodology for distributing the awards, types of awards, and standards for administration by the department.

There is hereby created in the state treasury the social services incentive fund. The director of job and family services may request that the director of budget and management transfer funds in the Title IV-A reserve fund created under section 5101.82 of the Revised Code and other funds appropriated for ODJFS family services duties or workforce investment activities into the fund. If the director of budget and management determines that the funds identified by the director of job and family services are available and appropriate for transfer, the director of budget and management shall make the transfer. Money in the fund shall be used to provide incentive awards under this section.

Sec. 5101.24. (A) As used in this section, "responsible entity" means a board of county commissioners or a county family services agency, whichever the director of job and family services determines is appropriate to take action against under division (C) of this section.

(B) Regardless of whether ~~a~~ an ODJFS family services duty is performed by a county family services agency, private or government entity pursuant to a contract entered into under section 307.982 of the Revised Code or division (C)(2) of section

5153.16 of the Revised Code, or private or government provider of ~~a~~ an ODJFS family service duty, the department of job and family services may take action under division (C) of this section against the responsible entity if the department determines any of the following are the case:

(1) A requirement of a fiscal agreement entered into under section 5101.21 of the Revised Code that includes the ODJFS family services duty, including a requirement for fiscal agreements established by rules adopted under that section, is not complied with;

(2) A county family services agency fails to develop, submit to the department, or comply with a corrective action plan under division (B) of section 5101.221 of the Revised Code, or the department disapproves the agency's corrective action plan developed under division (B) of section 5101.221 of the Revised Code;

(3) A requirement for the ODJFS family services duty established by the department or any of the following is not complied with: a federal or state law, state plan for receipt of federal financial participation, grant agreement between the department and a federal agency, or executive order issued by the governor;

(4) The responsible entity is solely or partially responsible, as determined by the director of job and family services, for an adverse audit finding, adverse quality control finding, final disallowance of federal financial participation, or other sanction or penalty regarding the ODJFS family services duty.

(C) The department may take one or more of the following actions against the responsible entity when authorized by division (B)(1), (2), (3), or (4) of this section:

(1) Require the responsible entity to comply with a corrective action plan pursuant to a time schedule specified by the department. The corrective action plan shall be established or approved by the department and shall not require a county family services agency to commit resources to the plan.

(2) Require the responsible entity to comply with a corrective action plan pursuant to a time schedule specified by the department. The corrective action plan shall be established or approved by the department and require a county family services agency to commit to the plan existing resources identified by the agency.

(3) Require the responsible entity to do one of the following:

(a) Share with the department a final disallowance of federal financial participation or other sanction or penalty;

(b) Reimburse the department the final amount the department pays to the federal government or another entity that represents the amount the responsible entity is responsible for of an adverse audit finding, adverse quality control finding, final disallowance of federal financial participation, or other sanction or penalty issued by the federal government, auditor of state, or other entity;

(c) Pay the federal government or another entity the final amount that represents the amount the responsible entity is responsible for of an adverse audit finding, adverse quality control finding, final disallowance of federal financial participation, or other sanction or penalty issued by the federal government, auditor of state, or other entity;

(d) Pay the department the final amount that represents the amount the responsible entity is responsible for of an adverse audit finding or adverse quality control finding.

(4) Impose an administrative sanction issued by the department against the responsible entity. A sanction may be increased if the department has previously taken action against the responsible entity under this division.

(5) Perform, or contract with a government or private entity for the entity to perform, the ODJFS family services duty until the department is satisfied that the responsible entity ensures that the duty will be performed satisfactorily. If the department performs or contracts with an entity to perform ~~a~~ an ODJFS family services duty under division (C)(5) of this section, the department may do either or both of the following:

(a) Spend funds in the county treasury appropriated by the board of county commissioners for the duty;

(b) Withhold funds allocated or reimbursements due to the responsible entity for the duty and spend the funds for the duty.

(6) Request that the attorney general bring mandamus proceedings to compel the responsible entity to take or cease the action that causes division (B)(1), (2), (3), or (4) of this section to apply. The attorney general shall bring mandamus proceedings in the Franklin county court of appeals at the department's request.

(7) If the department takes action under this division because of division (B)(3) of this section, temporarily withhold funds allocated or reimbursement due to the responsible entity until the department determines that the responsible entity is in compliance with the requirement. The department shall release the funds when the department determines that compliance has been achieved.

(D) If the department proposes to take action against the responsible entity under division (C) of this section, the department shall notify the responsible entity and county auditor.

The notice shall be in writing and specify the action the department proposes to take. The department shall send the notice by regular United States mail.

Except as provided by division (E) of this section, the responsible entity may request an administrative review of a proposed action in accordance with administrative review procedures the department shall establish. The administrative review procedures shall comply with all of the following:

(1) A request for an administrative review shall state specifically all of the following:

(a) The proposed action specified in the notice from the department for which the review is requested;

(b) The reason why the responsible entity believes the proposed action is inappropriate;

(c) All facts and legal arguments that the responsible entity wants the department to consider;

(d) The name of the person who will serve as the responsible entity's representative in the review.

(2) If the department's notice specifies more than one proposed action and the responsible entity does not specify all of the proposed actions in its request pursuant to division (D)(1)(a) of this section, the proposed actions not specified in the request shall not be subject to administrative review and the parts of the notice regarding those proposed actions shall be final and binding on the responsible entity.

(3) In the case of a proposed action under division (C)(1) of this section, the responsible entity shall have fifteen calendar days after the department mails the notice to the responsible entity to send a written request to the department for an administrative review. If it receives such a request within the

required time, the department shall postpone taking action under division (C)(1) of this section for fifteen calendar days following the day it receives the request or extended period of time provided for in division (D)(5) of this section to allow a representative of the department and a representative of the responsible entity an informal opportunity to resolve any dispute during that fifteen-day or extended period.

(4) In the case of a proposed action under division (C)(2), (3), (4), (5), or (7) of this section, the responsible entity shall have thirty calendar days after the department mails the notice to the responsible entity to send a written request to the department for an administrative review. If it receives such a request within the required time, the department shall postpone taking action under division (C)(2), (3), (4), (5), or (7) of this section for thirty calendar days following the day it receives the request or extended period of time provided for in division (D)(5) of this section to allow a representative of the department and a representative of the responsible entity an informal opportunity to resolve any dispute during that thirty-day or extended period.

(5) If the informal opportunity provided in division (D)(3) or (4) of this section does not result in a written resolution to the dispute within the fifteen- or thirty-day period, the director of job and family services and representative of the responsible entity may enter into a written agreement extending the time period for attempting an informal resolution of the dispute under division (D)(3) or (4) of this section.

(6) In the case of a proposed action under division (C)(3) of this section, the responsible entity may not include in its request disputes over a finding, final disallowance of federal financial participation, or other sanction or penalty issued by the federal government, auditor of state, or entity other than the department.

(7) If the responsible entity fails to request an administrative review within the required time, the responsible entity loses the right to request an administrative review of the proposed actions specified in the notice and the notice becomes final and binding on the responsible entity.

(8) If the informal opportunity provided in division (D)(3) or (4) of this section does not result in a written resolution to the dispute within the time provided by division (D)(3), (4), or (5) of this section, the director shall appoint an administrative review panel to conduct the administrative review. The review panel shall consist of department employees and one director or other representative of the type of county family services agency that is responsible for the kind of ODJFS family services duty that is the subject of the dispute and serves a different county than the county served by the responsible entity. No individual involved in the department's proposal to take action against the responsible entity may serve on the review panel. The review panel shall review the responsible entity's request. The review panel may require that the department or responsible entity submit additional information and schedule and conduct an informal hearing to obtain testimony or additional evidence. A review of a proposal to take action under division (C)(3) of this section shall be limited solely to the issue of the amount the responsible entity shall share with the department, reimburse the department, or pay to the federal government, department, or other entity under division (C)(3) of this section. The review panel is not required to make a stenographic record of its hearing or other proceedings.

(9) After finishing an administrative review, an administrative review panel appointed under division (D)(8) of this section shall submit a written report to the director setting forth its findings of fact, conclusions of law, and

recommendations for action. The director may approve, modify, or disapprove the recommendations. If the director modifies or disapproves the recommendations, the director shall state the reasons for the modification or disapproval and the actions to be taken against the responsible entity.

(10) The director's approval, modification, or disapproval under division (D)(9) of this section shall be final and binding on the responsible entity and shall not be subject to further departmental review.

(E) The responsible entity is not entitled to an administrative review under division (D) of this section for any of the following:

(1) An action taken under division (C)(6) of this section;

(2) An action taken under section 5101.242 of the Revised Code;

(3) An action taken under division (C)(3) of this section if the federal government, auditor of state, or entity other than the department has identified the county family services agency as being solely or partially responsible for an adverse audit finding, adverse quality control finding, final disallowance of federal financial participation, or other sanction or penalty;

(4) An adjustment to an allocation, cash draw, advance, or reimbursement to a county family services agency that the department determines necessary for budgetary reasons;

(5) Withholding of a cash draw or reimbursement due to noncompliance with a reporting requirement established in rules adopted under section 5101.243 of the Revised Code.

(F) This section does not apply to other actions the department takes against the responsible entity pursuant to authority granted by another state law unless the other state law

requires the department to take the action in accordance with this section.

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

Sec. 5101.243. The director of job and family services may adopt rules in accordance with section 111.15 of the Revised Code establishing reporting requirements for ODJFS family services duties and workforce development activities. If the director adopts the rules, the director shall adopt the rules as if they were internal management rules and, before adopting the rules, give the public an opportunity to review and comment on the proposed rules.

Sec. 5101.25. The department of ~~human~~ job and family services, in consultation with county representatives, shall develop annual training goals and model training curriculum regarding ODJFS family services duties for employees of county family services agencies and identify a variety of state funded training opportunities to meet the proposed goals.

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~~ government-funded program" means medical assistance provided under the ~~programs~~ medicaid program, the children's health insurance program, the disability medical assistance program, the refugee assistance program established under ~~sections~~ section 5101.49~~, 5101.50 to 5101.503, and 5101.51 to 5101.5110, Chapters 5111. and 5115.~~ of the Revised Code, or any other ~~provision of~~ program established under 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. 5101.27. (A) Except as permitted by this section, section 5101.28 or 5101.29 of the Revised Code, or the rules adopted under division (A) of section 5101.30 of the Revised Code, or required by federal law, no person or government entity shall solicit, disclose, receive, use, or knowingly permit, or participate in the use of any information regarding a public assistance recipient for any purpose not directly connected with the administration of a public assistance program.

(B) To the extent permitted by federal law, the department of job and family services and county agencies shall do all of the following:

(1) Release information regarding a public assistance recipient for purposes directly connected to the administration of the program to a government entity responsible for administering that public assistance program;

(2) Provide information regarding a public assistance recipient to a law enforcement agency for the purpose of any investigation, prosecution, or criminal or civil proceeding relating to the administration of that public assistance program;

(3) Provide, for purposes directly connected to the administration of a program that assists needy individuals with the costs of public utility services, information regarding a recipient of financial assistance provided under a program administered by the department or a county agency pursuant to Chapter 5107. or 5108. of the Revised Code or sections 5115.01 to 5115.07 of the Revised Code to an entity administering the public utility services program.

(C) To the extent permitted by federal law and section 1347.08 of the Revised Code, the department and county agencies

shall provide access to information regarding a public assistance recipient to all of the following:

(1) The recipient;

(2) The authorized representative;

(3) The legal guardian of the recipient;

(4) The attorney of the recipient, if the attorney has written authorization that complies with section 5101.271 of the Revised Code from the recipient.

(D) To the extent permitted by federal law and subject to division (E) of this section, the department and county agencies may do both of the following:

(1) Release information about a public assistance recipient if the recipient gives voluntary, written authorization that complies with section 5101.271 of the Revised Code;

(2) Release information regarding a public assistance recipient to a state, federal, or federally assisted program that provides cash or in-kind assistance or services directly to individuals based on need or for the purpose of protecting children to a government entity responsible for administering a children's protective services program.

(E) Except when the release is required by division (B), (C), or (D)(2) of this section, the department or county agency shall release the information only in accordance with the authorization. The department or county agency shall provide, at no cost, a copy of each written authorization to the individual who signed it.

(F) The department or county agency may release information under division (D) of this section concerning the receipt of medical assistance provided under a ~~public assistance~~ government-funded program only if all of the following conditions are met:

(1) The release of information is for purposes directly connected to the administration of or provision of medical assistance provided under a ~~public assistance~~ government-funded program;

(2) The information is released to persons or government entities that are subject to standards of confidentiality and safeguarding information substantially comparable to those established for medical assistance provided under a ~~public assistance~~ government-funded program;

(3) The department or county agency has obtained an authorization consistent with section 5101.271 of the Revised Code.

(G) Information concerning the receipt of medical assistance provided under a ~~public assistance~~ government-funded program may be released only if the release complies with this section and rules adopted by the department pursuant to section 5101.30 of the Revised Code or, if more restrictive, the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 1955, 42 U.S.C. 1320d, et seq., as amended, and regulations adopted by the United States department of health and human services to implement the act.

(H) The department of job and family services may adopt rules defining "authorized representative" for purposes of division (C)(2) of this section.

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~~ 5160.80, 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 ~~divisions~~ division (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 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)(4)(c), (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; or disability financial assistance provided under Chapter 5115. of the Revised Code~~; or disability medical assistance provided under Chapter 5115. of the Revised Code~~.

Sec. 5101.47. (A) 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)~~(2) The food stamp program administered by the department of job and family services pursuant to section 5101.54 of the Revised Code;

~~(5)~~(3) Other programs the director determines are supportive of children, adults, or families;

~~(6)~~(4) 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 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.

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

Sec. 5101.97. (A)(1) Not later than the last day of each July and January, the department of job and family services shall complete a report on the characteristics of the individuals who participate in or receive services through the programs operated by the department and the outcomes of the individuals' participation in or receipt of services through the programs. The reports shall be for the six-month periods ending on the last days of June and December and shall include information on the following:

(a) Work activities, developmental activities, and alternative work activities established under sections 5107.40 to 5107.69 of the Revised Code;

(b) Programs of publicly funded child care, as defined in section 5104.01 of the Revised Code;

(c) Child support enforcement programs~~;~~

~~(d) Births to recipients of the medical assistance program established under Chapter 5111. of the Revised Code~~.

(2) The department shall submit the reports required under division (A)(1) of this section to the speaker and minority leader of the house of representatives, the president and minority leader of the senate, the legislative budget officer, the director of budget and management, and each board of county commissioners. The department shall provide copies of the reports to any person or government entity on request.

In designing the format for the reports, the department shall consult with individuals, organizations, and government entities interested in the programs operated by the department, so that the reports are designed to enable the general assembly and the public to evaluate the effectiveness of the programs and identify any needs that the programs are not meeting.

(B) Whenever the federal government requires that the department submit a report on a program that is operated by the department or is otherwise under the department's jurisdiction, the department shall prepare and submit the report in accordance with the federal requirements applicable to that report. To the extent possible, the department may coordinate the preparation and submission of a particular report with any other report, plan, or other document required to be submitted to the federal government, as well as with any report required to be submitted to the general assembly. The reports required by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104-193) may be submitted as an annual summary.

Sec. 5103.02. As used in sections 5103.03 to 5103.17 of the Revised Code:

(A) "Association" or "institution" includes any incorporated or unincorporated organization, society, association, or agency, public or private, that receives or cares for children for two or more consecutive weeks; any individual, including the operator of a foster home, who, for hire, gain, or reward, receives or cares for children for two or more consecutive weeks, unless the individual is related to them by blood or marriage; and any individual not in the regular employ of a court, or of an institution or association certified in accordance with section 5103.03 of the Revised Code, who in any manner becomes a party to the placing of children in foster homes, unless the individual is

related to such children by blood or marriage, or is the appointed guardian of such children; provided, that any organization, society, association, school, agency, child guidance center, detention or rehabilitation facility, or children's clinic licensed, regulated, approved, operated under the direction of, or otherwise certified by the department of education, a local board of education, the department of youth services, the department of mental health, or the department of mental retardation and developmental disabilities, or any individual who provides care for only a single-family group, placed there by their parents or other relative having custody, shall not be considered as being within the purview of these sections.

(B) "Family foster home" means a foster home that is not a specialized foster home.

(C) "Foster caregiver" means a person holding a valid foster home certificate issued under section 5103.03 of the Revised Code.

(D) "Foster home" means a private residence in which children are received apart from their parents, guardian, or legal custodian, by an individual reimbursed for providing the children nonsecure care, supervision, or training twenty-four hours a day. "Foster home" does not include care provided for a child in the home of a person other than the child's parent, guardian, or legal custodian while the parent, guardian, or legal custodian is temporarily away. Family foster homes and specialized foster homes are types of foster homes.

(E) "Medically fragile foster home" means a foster home that provides specialized medical services designed to meet the needs of children with intensive health care needs who meet all of the following criteria:

(1) Under rules adopted by the ~~department~~ director of ~~job and family services~~ health care administration governing payment under

~~Chapter 5111. of the Revised Code~~ the medicaid program for long-term care services, the children require a skilled level of care.

(2) The children require the services of a doctor of medicine or osteopathic medicine at least once a week due to the instability of their medical conditions.

(3) The children require the services of a registered nurse on a daily basis.

(4) The children are at risk of institutionalization in a hospital, skilled nursing facility, or intermediate care facility for the mentally retarded.

(F) "Recommending agency" means a public children services agency, private child placing agency, or private noncustodial agency that recommends that the department of job and family services take any of the following actions under section 5103.03 of the Revised Code regarding a foster home:

(1) Issue a certificate;

(2) Deny a certificate;

(3) Renew a certificate;

(4) Deny renewal of a certificate;

(5) Revoke a certificate.

(G) "Specialized foster home" means a medically fragile foster home or a treatment foster home.

(H) "Treatment foster home" means a foster home that incorporates special rehabilitative services designed to treat the specific needs of the children received in the foster home and that receives and cares for children who are emotionally or behaviorally disturbed, chemically dependent, mentally retarded, developmentally disabled, or who otherwise have exceptional needs.

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.

(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~~ September 29, 2005.

(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 benefits under the supplemental security income ~~under Title XVI of the "Social Security Act," 86 Stat. 1475 (1972), 42 U.S.C.A. 1383, as amended,~~ program 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~~ 5160.37, ~~5101.59~~ 5160.38, 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)(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 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 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 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.

(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)(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. 5107.14. An assistance group is ineligible to participate in Ohio works first unless the minor head of household or each adult member of the assistance group, not later than thirty days after applying for or undergoing a redetermination of eligibility for the program, enters into a written self-sufficiency contract with the county department of job and family services. The contract shall set forth the rights and responsibilities of the assistance group as applicants for and participants of the program, including work responsibilities established under sections 5107.40 to 5107.69 of the Revised Code and other requirements designed to assist the assistance group in achieving self sufficiency and personal responsibility. The county department shall provide without charge a copy of the contract to each assistance group member who signs it.

Each self-sufficiency contract shall include, based on appraisals conducted under section 5107.41 of the Revised Code and assessments conducted under section 5107.70 of the Revised Code, the following:

(A) The assistance group's plan, developed under section 5107.41 of the Revised Code, to achieve the goal of self sufficiency and personal responsibility through unsubsidized employment within the time limit for participating in Ohio works first established by section 5107.18 of the Revised Code;

(B) Work activities, developmental activities, and alternative work activities to which members of the assistance group are assigned under sections 5107.40 to 5107.69 of the Revised Code;

(C) The responsibility of a caretaker member of the assistance group to cooperate in establishing a minor child's paternity and establishing, modifying, and enforcing a support order for the child in accordance with section 5107.22 of the Revised Code;

(D) Other responsibilities that members of the assistance group must satisfy to participate in Ohio works first and the consequences for failure or refusal to satisfy the responsibilities;

(E) An agreement that the assistance group will comply with the conditions of participating in Ohio works first established by this chapter and sections ~~5101.58, 5101.59~~ 5160.37, 5160.38, and 5101.83 of the Revised Code;

(F) Assistance and services the county department will provide to the assistance group;

(G) Assistance and services the child support enforcement agency and public children services agency will provide to the assistance group pursuant to a plan of cooperation entered into under section 307.983 of the Revised Code;

(H) Other provisions designed to assist the assistance group in achieving self sufficiency and personal responsibility;

(I) Procedures for assessing whether responsibilities are being satisfied and whether the contract should be amended;

(J) Procedures for amending the contract.

Sec. 5107.16. (A) If a member of an assistance group fails or refuses, without good cause, to comply in full with a provision of a self-sufficiency contract entered into under section 5107.14 of the Revised Code, a county department of job and family services shall sanction the assistance group as follows:

(1) For a first failure or refusal, the county department

shall deny or terminate the assistance group's eligibility to participate in Ohio works first for one payment month or until the failure or refusal ceases, whichever is longer;

(2) For a second failure or refusal, the county department shall deny or terminate the assistance group's eligibility to participate in Ohio works first for three payment months or until the failure or refusal ceases, whichever is longer;

(3) For a third or subsequent failure or refusal, the county department shall deny or terminate the assistance group's eligibility to participate in Ohio works first for six payment months or until the failure or refusal ceases, whichever is longer.

(B) Each county department of job and family services shall establish standards for the determination of good cause for failure or refusal to comply in full with a provision of a self-sufficiency contract.

(1) In the case of a failure or refusal to participate in a work activity, developmental activity, or alternative work activity under sections 5107.40 to 5107.69 of the Revised Code, good cause shall include, except as provided in division (B)(2) of this section, the following:

(a) Failure of the county department to place the member in an activity;

(b) Failure of the county department to provide for the assistance group to receive support services the county department determines under section 5107.66 of the Revised Code to be necessary. In determining whether good cause exists, a county department shall determine that day care is a necessary support service if a single custodial parent caring for a minor child under age six proves a demonstrated inability, as determined by the county department, to obtain needed child care for one or more

of the following reasons:

(i) Unavailability of appropriate child care within a reasonable distance from the parent's home or work site;

(ii) Unavailability or unsuitability of informal child care by a relative or under other arrangements;

(iii) Unavailability of appropriate and affordable formal child care arrangements.

(2) Good cause does not exist if the member of the assistance group is placed in a work activity established under section 5107.58 of the Revised Code and exhausts the support services available for that activity.

(C) When a state hearing under division (B) of section 5101.35 of the Revised Code or an administrative appeal under division (C) of that section is held regarding a sanction under this section, the hearing officer, director of job and family services, or director's designee shall base the decision in the hearing or appeal on the county department's standards of good cause for failure or refusal to comply in full with a provision of a self-sufficiency contract, if the county department provides the hearing officer, director, or director's designee a copy of the county department's good cause standards.

(D) After sanctioning an assistance group under division (A) of this section, a county department of job and family services shall continue to work with the assistance group to provide the member of the assistance group who caused the sanction an opportunity to demonstrate to the county department a willingness to cease the failure or refusal to comply with the self-sufficiency contract.

(E) An adult eligible for ~~medical assistance~~ the medicaid program pursuant to division (A)~~(1)(a)~~ of section ~~5111.01~~ 5162.01 of the Revised Code who is sanctioned under division (A)(3) of

this section for a failure or refusal, without good cause, to comply in full with a provision of a self-sufficiency contract related to work responsibilities under sections 5107.40 to 5107.69 of the Revised Code loses eligibility for ~~medical assistance~~ the medicaid program unless the adult is otherwise eligible for ~~medical assistance~~ the medicaid program pursuant to another division of section ~~5111.01~~ 5162.01 of the Revised Code.

(F) An assistance group that would be participating in Ohio works first if not for a sanction under this section shall continue to be eligible for all of the following:

(1) Publicly funded child care in accordance with division (A)(3) of section 5104.30 of the Revised Code;

(2) Support services in accordance with section 5107.66 of the Revised Code;

(3) To the extent permitted by the "Fair Labor Standards Act of 1938," 52 Stat. 1060, 29 U.S.C.A. 201, as amended, to participate in work activities, developmental activities, and alternative work activities in accordance with sections 5107.40 to 5107.69 of the Revised Code.

Sec. 5107.20. As used in this section, "support" means child support, spousal support, and support for a spouse or a former spouse.

Participation in Ohio works first constitutes an assignment to the department of job and family services of any rights members of an assistance group have to support from any other person, excluding medical support assigned pursuant to section ~~5101.59~~ 5160.37 of the Revised Code. The rights to support assigned to the department pursuant to this section constitute an obligation of the person who is responsible for providing the support to the state for the amount of cash assistance provided to the assistance

group.

The office of child support in the department of job and family services shall collect and distribute support payments owed to Ohio works first participants, whether assigned to the department or unassigned, in accordance with 42 U.S.C. 654 B and 657 and regulations adopted under those statutes, state statutes, and rules adopted under section 5107.05 of the Revised Code.

Upon implementation of centralized collection and disbursement under Chapter 3121. of the Revised Code, in accordance with 42 U.S.C. 654 B and 657 and regulations adopted under those statutes, the department shall deposit support payments it receives pursuant to this section into the state treasury to the credit of the child support collections fund or the child support administrative fund, both of which are hereby created. Money credited to the funds shall be used to make cash assistance payments under Ohio works first.

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 the medicaid program pursuant to section ~~5111.0115~~ 5162.09 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. 5115.02. (A) An individual is not eligible for disability financial assistance under this chapter if any of the following apply:

(1) The individual is eligible to participate in the Ohio works first program established under Chapter 5107. of the Revised Code; eligible ~~to receive~~ for the supplemental security income ~~provided pursuant to Title XVI of the "Social Security Act," 86 Stat. 1475 (1972), 42 U.S.C. 1383, as amended~~ program; or eligible to participate in or receive assistance through another state or federal program that provides financial assistance similar to disability financial assistance, as determined by the director of job and family services;

(2) The individual is ineligible to participate in the Ohio works first program because of any of the following:

(a) The time limit established by section 5107.18 of the Revised Code;

(b) Failure to comply with an application or verification procedure;

(c) The fraud control provisions of section 5101.83 of the Revised Code or the fraud control program established pursuant to 45 C.F.R. 235.112, as in effect July 1, 1996;

(d) The self-sufficiency contract provisions of sections 5107.14 and 5107.16 of the Revised Code;

(e) The minor parent provisions of section 5107.24 of the Revised Code;

(f) The provisions of section 5107.26 of the Revised Code regarding termination of employment without just cause.

(3) The individual, or any of the other individuals included in determining the individual's eligibility, is involved in a strike, as defined in section 5107.10 of the Revised Code;

(4) For the purpose of avoiding consideration of property in determinations of the individual's eligibility for disability financial assistance or a greater amount of assistance, the individual has transferred property during the two years preceding application for or most recent redetermination of eligibility for disability assistance;

(5) The individual is a child and does not live with the child's parents, guardians, or other persons standing in place of parents, unless the child is emancipated by being married, by serving in the armed forces, or by court order;

(6) The individual ~~reside~~ resides in a county home, city infirmary, jail, or public institution;

(7) The individual is a fugitive felon as defined in section 5101.26 of the Revised Code;

(8) The individual is violating a condition of probation, a community control sanction, parole, or a post-release control sanction imposed under federal or state law.

(B)(1) As used in division (B)(2) of this section, "assistance group" has the same meaning as in section 5107.02 of the Revised Code.

(2) Ineligibility under division (A)(2)(c) or (d) of this

section applies as follows:

(a) In the case of an individual who is under eighteen years of age, the individual is ineligible only if the individual caused the assistance group to be ineligible to participate in the Ohio works first program or resides with an individual eighteen years of age or older who was a member of the same ineligible assistance group.

(b) In the case of an individual who is eighteen years of age or older, the individual is ineligible regardless of whether the individual caused the assistance group to be ineligible to participate in the Ohio works first program.

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 benefits under the supplemental security income ~~benefits under Title XVI of the "Social Security Act," 86 Stat. 1475 (1972), 42 U.S.C.A. 1383, as amended~~ program, in applying for those benefits. The department of health care administration shall assist the department of job and family services and county departments with the program.

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 of job and family services or a county department of job and family services 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 and section 329.043 of the Revised Code;

(3) Requirements for the written authorization required by division ~~(C)(5)~~(E) of ~~this~~ section 329.043 of the Revised Code.

~~(E)~~(D) The department of job and family services shall provide basic and continuing training to employees of the county department of job and family services who perform duties under this section and section 329.043 of the Revised Code. 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)~~(E) The department of job and family services 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)~~(E) of ~~this~~ section 329.043 of the Revised Code 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)~~(F) The director of job and family services 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. 5117.10. (A) On or before the fifteenth day of January, the director of development shall pay each applicant determined eligible for a payment under divisions (A) and (B) of section 5117.07 of the Revised Code one hundred twenty-five dollars.

(B) The director may withhold from any payment to which a person would otherwise be entitled under division (A) of this section any amount that the director determines was erroneously received by such person in a preceding year under this or the program established under Am. Sub. H.B. 230, as amended by Am. H.B. 937, Am. Sub. H.B. 1073, Am. Sub. S.B. 493, and Am. Sub. S.B. 523 of the 112th general assembly, provided the director has employed all other legal methods reasonably available to obtain reimbursement for the erroneous payment or credit prior to the commencement of the current program year.

(C) Payments made under this section and credits granted under section 5117.09 of the Revised Code shall not be considered income for the purpose of determining eligibility or the level of benefits or assistance under section 329.042 or Chapters 5107.~~,~~ ~~5111.,~~ and 5115. of the Revised Code; the medicaid program; the disability medical assistance program; supplemental security income payments ~~under Title XVI of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C. 301, as amended~~; or any other program under which eligibility or the level of benefits or assistance is based upon need measured by income.

Sec. 5119.04. The department of mental health and any institutions under its supervision or jurisdiction shall, where applicable, be in substantial compliance with standards set forth for psychiatric facilities by the joint commission on accreditation of healthcare organizations or ~~medical assistance~~ medicaid standards ~~under Title XIX of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C. 301, as amended~~, or other applicable standards, except that the department and any institution under its supervision or jurisdiction shall be in substantial compliance with standards for physical facilities and equipment by July 1, 1989. The requirements of this section do not apply to any facility designated by the director of mental health for use as a psychiatric rehabilitation center.

The requirements of this section are in addition to any other requirements established by the Revised Code and nothing in this section shall be construed to limit any rights, privileges, protections, or immunities which may exist under the constitution and laws of the United States or this state.

Sec. 5119.061. (A) As used in this section, "mentally ill individual" and "specialized services" have the same meanings as in section ~~5111.202~~ 5119.061 of the Revised Code.

(B)(1) Except as provided in division (B)(2) of this section and rules adopted under division (E)(3) of this section, for purposes of section ~~5111.202~~ 5119.061 of the Revised Code, the department of mental health shall determine in accordance with ~~section 1919(e)(7) of the "Social Security Act," 49 Stat. 620 (1935),~~ 42 U.S.C.~~A. 301, as amended,~~ 1396r(e)(7) and regulations adopted under ~~section 1919(f)(8)(A) of that act~~ 42 U.S.C. 1396r(f)(8)(A) whether, because of the individual's physical and mental condition, a mentally ill individual seeking admission to a nursing facility requires the level of services provided by a

nursing facility and, if the individual requires that level of services, whether the individual requires specialized services for mental illness. The determination required by this division shall be based on an independent physical and mental evaluation performed by a person or entity other than the department.

(2) A determination under this division is not required for any of the following:

(a) An individual seeking readmission to a nursing facility after having been transferred from a nursing facility to a hospital for care;

(b) An individual who meets all of the following conditions:

(i) The individual is admitted to the nursing facility directly from a hospital after receiving inpatient care at the hospital;

(ii) The individual requires nursing facility services for the condition for which care in the hospital was received;

(iii) The individual's attending physician has certified, before admission to the nursing facility, that the individual is likely to require less than thirty days of nursing facility services.

(c) An individual transferred from one nursing facility to another nursing facility, with or without an intervening hospital stay.

(C) Except as provided in rules adopted under division (F)(3) of this section, the department of mental health shall review and determine for each resident of a nursing facility who is mentally ill, whether the resident, because of the resident's physical and mental condition, requires the level of services provided by a nursing facility and whether the resident requires specialized services for mental illness. The review and determination shall be

conducted in accordance with section 1919(e)(7) of the "Social Security Act" and the regulations adopted under section 1919(f)(8)(A) of the act and based on an independent physical and mental evaluation performed by a person or entity other than the department. The review and determination shall be completed promptly after a nursing facility has notified the department that there has been a significant change in the resident's mental or physical condition.

(D)(1) In the case of a nursing facility resident who has continuously resided in a nursing facility for at least thirty months before the date of a review and determination under division (C) of this section, if the resident is determined not to require the level of services provided by a nursing facility, but is determined to require specialized services for mental illness, the department, in consultation with the resident's family or legal representative and care givers, shall do all of the following:

(a) Inform the resident of the institutional and noninstitutional alternatives covered under the state medicaid plan ~~for medical assistance~~;

(b) Offer the resident the choice of remaining in the nursing facility or receiving covered services in an alternative institutional or noninstitutional setting;

(c) Clarify the effect on eligibility for services under the state medicaid plan ~~for medical assistance~~ if the resident chooses to leave the facility, including its effect on readmission to the facility;

(d) Provide for or arrange for the provision of specialized services for the resident's mental illness in the setting chosen by the resident.

(2) In the case of a nursing facility resident who has

continuously resided in a nursing facility for less than thirty months before the date of the review and determination under division (C) of this section, if the resident is determined not to require the level of services provided by a nursing facility, but is determined to require specialized services for mental illness, or if the resident is determined to require neither the level of services provided by a nursing facility nor specialized services for mental illness, the department shall act in accordance with its alternative disposition plan approved by the United States department of health and human services under section 1919(e)(7)(E) of the "Social Security Act."

(3) In the case of an individual who is determined under division (B) or (C) of this section to require both the level of services provided by a nursing facility and specialized services for mental illness, the department of mental health shall provide or arrange for the provision of the specialized services needed by the individual or resident while residing in a nursing facility.

(E) The department of mental health shall adopt rules in accordance with Chapter 119. of the Revised Code that do all of the following:

(1) Establish criteria to be used in making the determinations required by divisions (B) and (C) of this section. The criteria shall not exceed the criteria established by regulations adopted by the United States department of health and human services under section 1919(f)(8)(A) of the "Social Security Act."

(2) Specify information to be provided by the individual or nursing facility resident being assessed;

(3) Specify any circumstances, in addition to circumstances listed in division (B) of this section, under which determinations under divisions (B) and (C) of this section are not required to be

made.

Sec. 5119.16. As used in this section, "free clinic" has the same meaning as in section 2305.2341 of the Revised Code.

(A) The department of mental health is hereby designated to provide certain goods and services for the department of mental health, the department of mental retardation and developmental disabilities, the department of rehabilitation and correction, the department of youth services, and other state, county, or municipal agencies requesting ~~such~~ those goods and services when the department of mental health determines that it is in the public interest, and considers it advisable, to provide ~~these~~ those goods and services. The department of mental health also may provide goods and services to agencies operated by the United States government and to public or private nonprofit agencies, other than free clinics, that are funded in whole or in part by the state if the public or private nonprofit agencies are designated for participation in this program by the director of mental health for community mental health agencies, the director of mental retardation and developmental disabilities for community mental retardation and developmental disabilities agencies, the director of rehabilitation and correction for community rehabilitation and correction agencies, or the director of youth services for community youth services agencies.

Designated community agencies shall receive goods and services through the department of mental health only in those cases where the designating state agency certifies that providing ~~such~~ the goods and services to the agency will conserve public resources to the benefit of the public and where the provision of ~~such~~ the goods and services is considered feasible by the department of mental health.

(B) The department of mental health may permit free clinics

to purchase certain goods and services to the extent the purchases fall within the exemption to the Robinson-Patman Act, 15 U.S.C. 13 et seq., applicable to ~~non-profit~~ nonprofit institutions, in 15 U.S.C. 13c, as amended.

(C) The goods and services to be provided by the department of mental health under divisions (A) and (B) of this section may include all of the following:

(1) Procurement, storage, processing, and distribution of food and professional consultation on food operations;

(2) Procurement, storage, and distribution of medical and laboratory supplies, dental supplies, medical records, forms, optical supplies, and sundries, subject to section 5120.135 of the Revised Code;

(3) Procurement, storage, repackaging, distribution, and dispensing of drugs, the provision of professional pharmacy consultation, and drug information services;

(4) Other goods and services as may be agreed to.

(D) ~~The~~ Subject to section 5160.75 of the Revised Code, the department of mental health shall provide the goods and services designated in division (C) of this section to its institutions and to state-operated community-based mental health services.

(E) After consultation with and advice from the director of mental retardation and developmental disabilities, the director of rehabilitation and correction, and the director of youth services and subject to section 5160.75 of the Revised Code, the department of mental health shall provide the goods and services designated in division (C) of this section to the department of mental retardation and developmental disabilities, the department of rehabilitation and correction, and the department of youth services.

(F) The cost of administration of this section shall be determined by the department of mental health and paid by the agencies or free clinics receiving the goods and services to the department for deposit in the state treasury to the credit of the mental health fund, which is hereby created. The fund shall be used to pay the cost of administration of this section to the department.

(G) If the goods or services designated in division (C) of this section are not provided in a satisfactory manner by the department of mental health to the agencies described in division (A) of this section, the director of mental retardation and developmental disabilities, the director of rehabilitation and correction, the director of youth services, or the managing officer of a department of mental health institution shall attempt to resolve unsatisfactory service with the director of mental health. If, after ~~such~~ the attempt, the provision of goods or services continues to be unsatisfactory, the director or officer shall notify the director of mental health. If~~,~~ within thirty days of ~~such~~ that notice the department of mental health does not provide the specified goods and services in a satisfactory manner, the director of mental retardation and developmental disabilities, the director of rehabilitation and correction, the director of youth services, or the managing officer of the department of mental health institution shall notify the director of mental health of the director's or managing officer's intent to cease purchasing goods and services from the department. Following a sixty-day cancellation period from the date of ~~such~~ that notice and subject to section 5160.75 of the Revised Code, the department of mental retardation, department of rehabilitation and correction, department of youth services, or the department of mental health institution may obtain the goods and services from a source other than the department of mental health, if the department certifies to the department of administrative services

that the requirements of this division have been met.

(H) Whenever a state agency fails to make a payment for goods and services provided under this section within thirty-one days after the date the payment was due, the office of budget and management may transfer moneys from the state agency to the department of mental health. The amount transferred shall not exceed the amount of overdue payments. Prior to making a transfer under this division, the office of budget and management shall apply any credits the state agency has accumulated in payments for goods and services provided under this section.

(I) Purchases of goods and services under this section are not subject to section 307.86 of the Revised Code.

(J) The department shall not perform any acts described in division (A)(3) of this section for state departments or other state agencies covered by the operation of section 5160.75 of the Revised Code.

Sec. 5119.351. The department of mental health may pay an amount for personal use to each individual residing in a state institution as described in section 5119.02 of the Revised Code who would be eligible for supplemental security income benefits at the reduced rate established by ~~Title XVI of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 1382, as amended~~ the supplemental security income program, if the state medicaid plan ~~for providing medical assistance under section 5111.01 of the Revised Code~~ included reimbursement of services provided in such institutions. The amount paid by the department shall not exceed the reduced supplemental security income benefit rate established by ~~Title XVI of the "Social Security Act~~ the program.~~"~~

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~~ 5160.80 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 ~~5111.023~~ 5163.20 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~~ health care administration and mental health under section ~~5111.91~~ 5161.05 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. 5120.65. (A) The department of rehabilitation and correction may establish in one or more of the institutions for women operated by the department a prison nursery program under which eligible inmates and children born to them while in the custody of the department may reside together in the institution. If the department establishes a prison nursery program in one or more institutions under this section, sections 5120.651 to 5120.657 of the Revised Code apply regarding the program. If the department establishes a prison nursery program and an inmate participates in the program, neither the inmate's participation in the program nor any provision of sections 5120.65 to 5120.657 of the Revised Code affects, modifies, or interferes with the inmate's custodial rights of the child or establishes legal custody of the child with the department.

(B) As used in sections 5120.651 to 5120.657 of the Revised Code:

(1) "Prison nursery program" means the prison nursery program established by the department of rehabilitation and correction under this section, if one is so established.

(2) "Public assistance" ~~has the same meaning as in section 5101.58 of the Revised Code~~ means all of the following:

(a) Medicaid;

(b) Disability medical assistance;

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

(d) Disability financial assistance established under Chapter 5115. of the Revised Code.

(3) "Support" means amounts to be paid under a support order.

(4) "Support order" has the same meaning as in section 3119.01 of the Revised Code.

Sec. 5120.652. To participate in the prison nursery program, each eligible inmate selected by the department shall do all the following:

(A) Agree in writing to do all the following:

(1) Comply with any program, educational, counseling, and other requirements established for the program by the department of rehabilitation and correction;

(2) If eligible, have the child participate in the medicaid program or a health insurance program;

(3) Accept the normal risks of childrearing;

(4) Abide by any court decisions regarding the allocation of parental rights and responsibilities with respect to the child.

(B) Assign to the department any rights to support from any other person, excluding support assigned pursuant to section 5107.20 of the Revised Code and medical support assigned pursuant to section ~~5101.59~~ 5160.37 of the Revised Code;

(C) Specify with whom the child is to be placed in the event the inmate's participation in the program is terminated for a reason other than release from imprisonment.

Sec. 5121.04. (A) The department of mental retardation and developmental disabilities shall investigate the financial

condition of the residents in institutions, residents whose care or treatment is being paid for in a private facility or home under the control of the department, and of the relatives named in section 5121.06 of the Revised Code as liable for the support of such residents, in order to determine the ability of any resident or liable relatives to pay for the support of the resident and to provide suitable clothing as required by the superintendent of the institution.

(B) The department shall follow the provisions of this division in determining the ability to pay of a resident or the resident's liable relatives and the amount to be charged such resident or liable relatives.

(1) Subject to divisions (B)(10) and (11) of this section, a resident without dependents shall be liable for the full applicable cost. A resident without dependents who has a gross annual income equal to or exceeding the sum of the full applicable cost, plus fifty dollars per month, regardless of the source of such income, shall pay currently the full amount of the applicable cost; if the resident's gross annual income is less than such sum, not more than fifty dollars per month shall be kept for personal use by or on behalf of the resident, except as permitted in the state medicaid plan ~~for providing medical assistance under Title XIX of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C. 301, as amended~~, and the balance shall be paid currently on the resident's support. Subject to divisions (B)(10) and (11) of this section, the estate of a resident without dependents shall pay currently any remaining difference between the applicable cost and the amounts prescribed in this section, or shall execute an agreement with the department for payment to be made at some future date under terms suitable to the department. However, no security interest, mortgage, or lien shall be taken, granted, or charged against any principal residence of a resident without

dependents under an agreement or otherwise to secure support payments, and no foreclosure actions shall be taken on security interests, mortgages, or liens taken, granted, or charged against principal residences of residents prior to October 7, 1977.

(2) The ability to pay of a resident with dependents, or of a liable relative of a resident either with or without dependents, shall be determined in accordance with the resident's or liable relative's income or other assets, the needs of others who are dependent on such income and other assets for support, and, if applicable, divisions (B)(10) and (11) of this section.

For the first thirty days of care and treatment of each admission, but in no event for more than thirty days in any calendar year, the resident with dependents or the liable relative of a resident either with or without dependents shall be charged an amount equal to the percentage of the average applicable cost determined in accordance with the schedule of adjusted gross annual income contained after this paragraph. After such first thirty days of care and treatment, such resident or such liable relative shall be charged an amount equal to the percentage of a base support rate of four dollars per day for residents, as determined in accordance with the schedule of gross annual income contained after this paragraph, or in accordance with division (B)(5) of this section. Beginning January 1, 1978, the department shall increase the base rate when the consumer price index average is more than 4.0 for the preceding calendar year by not more than the average for such calendar year.

Adjusted Gross Annual Income of Resident or Liable Relative (FN a)	Number of Dependents (FN b)							
	1	2	3	4	5	6	7	8 or more
	Rate of Support (In Percentages)							

$15,000 or less	--	--	--	--	--	--	--	--	19164
15,001 to 17,500	20	--	--	--	--	--	--	--	19165
17,501 to 20,000	25	20	--	--	--	--	--	--	19166
20,001 to 21,000	30	25	20	--	--	--	--	--	19167
21,001 to 22,000	35	30	25	20	--	--	--	--	19168
22,001 to 23,000	40	35	30	25	20	--	--	--	19169
23,001 to 24,000	45	40	35	30	25	20	--	--	19170
24,001 to 25,000	50	45	40	35	30	25	20	--	19171
25,001 to 26,000	55	50	45	40	35	30	25	20	19172
26,001 to 27,000	60	55	50	45	40	35	30	25	19173
27,001 to 28,000	70	60	55	50	45	40	35	30	19174
28,001 to 30,000	80	70	60	55	50	45	40	35	19175
30,001 to 40,000	90	80	70	60	55	50	45	40	19176
40,001 and over	100	90	80	70	60	55	50	45	19177

Footnote a. The resident or relative shall furnish a copy of the resident's or relative's federal income tax return as evidence of gross annual income. 19178 19179 19180

Footnote b. The number of dependents includes the liable relative but excludes a resident in an institution. "Dependent" includes any person who receives more than half the person's support from the resident or the resident's liable relative. 19181 19182 19183 19184

(3) A resident or liable relative having medical, funeral, or related expenses in excess of four per cent of the adjusted gross annual income, which expenses were not covered by insurance, may adjust such gross annual income by reducing the adjusted gross annual income by the full amount of such expenses. Proof of such expenses satisfactory to the department must be furnished. 19185 19186 19187 19188 19189 19190

(4) Additional dependencies may be claimed if: 19191

(a) The liable relative is blind; 19192

(b) The liable relative is over sixty-five; 19193

(c) A child is a college student with expenses in excess of 19194

fifty dollars per month;

(d) The services of a housekeeper, costing in excess of fifty dollars per month, are required if the person who normally keeps house for minor children is the resident.

(5) If with respect to any resident with dependents there is chargeable under division (B)(2) of this section less than fifty per cent of the applicable cost or, if the base support rate was used, less than fifty per cent of the amount determined by use of the base support rate, and if with respect to such resident there is a liable relative who has an estate having a value in excess of fifteen thousand dollars or if such resident has a dependent and an estate having a value in excess of fifteen thousand dollars, there shall be paid with respect to such resident a total of fifty per cent of the applicable cost or the base support rate amount, as the case may be, on a current basis or there shall be executed with respect to such resident an agreement with the department for payment to be made at some future date under terms suitable to the department.

(6) When a person has been a resident for fifteen years and the support charges for which a relative is liable have been paid for the fifteen-year period, the liable relative shall be relieved of any further support charges.

(7) The department shall accept voluntary payments from residents or liable relatives whose incomes are below the minimum shown in the schedule set forth in this division. The department also shall accept voluntary payments in excess of required amounts from both liable and nonliable relatives.

(8) If a resident is covered by an insurance policy, or other contract that provides for payment of expenses for care and treatment for mental retardation or other developmental disability at or from an institution or facility (including a community

service unit under the jurisdiction of the department), the other provisions of this section, except divisions (B)(8), (10), and (11) of this section, and of section 5121.01 of the Revised Code shall be suspended to the extent that such insurance policy or other contract is in force, and such resident shall be charged the full amount of the applicable cost. Any insurance carrier or other third party payor providing coverage for such care and treatment shall pay for this support obligation in an amount equal to the lesser of either the applicable cost or the benefits provided under the policy or other contract. Whether or not an insured, owner of, or other person having an interest in such policy or other contract is liable for support payments under other provisions of this chapter, the insured, policy owner, or other person shall assign payment directly to the department of all assignable benefits under the policy or other contract and shall pay over to the department, within ten days of receipt, all insurance or other benefits received as reimbursement or payment for expenses incurred by the resident or for any other reason. If the insured, policy owner, or other person refuses to assign such payment to the department or refuses to pay such received reimbursements or payments over to the department within ten days of receipt, the insured's, policy owners', or other person's total liability for the services equals the applicable statutory liability for payment for the services as determined under other provisions of this chapter, plus the amounts payable under the terms of the policy or other contract. In no event shall this total liability exceed the full amount of the applicable cost. Upon its request, the department is entitled to a court order that compels the insured, owner of, or other person having an interest in the policy or other contract to comply with the assignment requirements of this division or that itself serves as a legally sufficient assignment in compliance with such requirements. Notwithstanding section 5123.89 of the Revised Code and any other

law relating to confidentiality of records, the managing officer of the institution or facility where a person is or has been a resident shall disclose pertinent medical information concerning the resident to the insurance carrier or other third party payor in question, in order to effect collection from the carrier or payor of the state's claim for care and treatment under this division. For such disclosure, the managing officer is not subject to any civil or criminal liability.

(9) The rate to be charged for pre-admission care, after-care, day-care, or routine consultation and treatment services shall be based upon the ability of the resident or the resident's liable relatives to pay. When it is determined by the department that a charge shall be made, such charge shall be computed as provided in divisions (B)(1) and (2) of this section.

(10) If a resident with or without dependents is the beneficiary of a trust created pursuant to section 1339.51 of the Revised Code, then, notwithstanding any contrary provision of this chapter or of a rule adopted pursuant to this chapter, divisions (C) and (D) of that section shall apply in determining the assets or resources of the resident, the resident's estate, the settlor, or the settlor's estate and to claims arising under this chapter against the resident, the resident's estate, the settlor, or the settlor's estate.

(11) If the department waives the liability of an individual and the individual's liable relatives pursuant to section 5123.194 of the Revised Code, the liability of the individual and relative ceases in accordance with the waiver's terms.

(C) The department may enter into agreements with a resident or a liable relative for support payments to be made in the future. However, no security interest, mortgage, or lien shall be taken, granted, or charged against any principal family residence of a resident with dependents or a liable relative under an

agreement or otherwise to secure support payments, and no foreclosure actions shall be taken on security interests, mortgages or liens taken, granted, or charged against principal residences of residents or liable relatives prior to October 7, 1977.

(D) The department shall make all investigations and determinations required by this section within ninety days after a resident is admitted to an institution under the department's control and immediately shall notify by mail the persons liable of the amount to be charged.

(E) All actions to enforce the collection of payments agreed upon or charged by the department shall be commenced within six years after the date of default of an agreement to pay support charges or the date such payment becomes delinquent. If a payment is made pursuant to an agreement which is in default, a new six-year period for actions to enforce the collection of payments under such agreement shall be computed from the date of such payment. For purposes of this division an agreement is in default or a payment is delinquent if a payment is not made within thirty days after it is incurred or a payment, pursuant to an agreement, is not made within thirty days after the date specified for such payment. In all actions to enforce the collection of payment for the liability for support, every court of record shall receive into evidence the proof of claim made by the state together with all debts and credits, and it shall be prima-facie evidence of the facts contained in it.

Sec. 5123.01. As used in this chapter:

(A) "Chief medical officer" means the licensed physician appointed by the managing officer of an institution for the mentally retarded with the approval of the director of mental retardation and developmental disabilities to provide medical

treatment for residents of the institution.

(B) "Chief program director" means a person with special training and experience in the diagnosis and management of the mentally retarded, certified according to division (C) of this section in at least one of the designated fields, and appointed by the managing officer of an institution for the mentally retarded with the approval of the director to provide habilitation and care for residents of the institution.

(C) "Comprehensive evaluation" means a study, including a sequence of observations and examinations, of a person leading to conclusions and recommendations formulated jointly, with dissenting opinions if any, by a group of persons with special training and experience in the diagnosis and management of persons with mental retardation or a developmental disability, which group shall include individuals who are professionally qualified in the fields of medicine, psychology, and social work, together with such other specialists as the individual case may require.

(D) "Education" means the process of formal training and instruction to facilitate the intellectual and emotional development of residents.

(E) "Habilitation" means the process by which the staff of the institution assists the resident in acquiring and maintaining those life skills that enable the resident to cope more effectively with the demands of the resident's own person and of the resident's environment and in raising the level of the resident's physical, mental, social, and vocational efficiency. Habilitation includes but is not limited to programs of formal, structured education and training.

(F) "Health officer" means any public health physician, public health nurse, or other person authorized or designated by a city or general health district.

(G) "Home and community-based services" means medicaid-funded home and community-based services specified in division (B)(1) of section ~~5111.87~~ 5163.65 of the Revised Code provided under the medicaid waiver components the department of mental retardation and developmental disabilities administers pursuant to section ~~5111.871~~ 5163.651 of the Revised Code.

(H) "Indigent person" means a person who is unable, without substantial financial hardship, to provide for the payment of an attorney and for other necessary expenses of legal representation, including expert testimony.

(I) "Institution" means a public or private facility, or a part of a public or private facility, that is licensed by the appropriate state department and is equipped to provide residential habilitation, care, and treatment for the mentally retarded.

(J) "Licensed physician" means a person who holds a valid certificate issued under Chapter 4731. of the Revised Code authorizing the person to practice medicine and surgery or osteopathic medicine and surgery, or a medical officer of the government of the United States while in the performance of the officer's official duties.

(K) "Managing officer" means a person who is appointed by the director of mental retardation and developmental disabilities to be in executive control of an institution for the mentally retarded under the jurisdiction of the department.

(L) ~~"Medicaid" has the same meaning as in section 5111.01 of the Revised Code.~~

~~(M)~~ "Medicaid case management services" means case management services provided to an individual with mental retardation or other developmental disability that the state medicaid plan requires.

~~(N)~~(M) "Mentally retarded person" means a person having significantly subaverage general intellectual functioning existing concurrently with deficiencies in adaptive behavior, manifested during the developmental period.

~~(O)~~(N) "Mentally retarded person subject to institutionalization by court order" means a person eighteen years of age or older who is at least moderately mentally retarded and in relation to whom, because of the person's retardation, either of the following conditions exist:

(1) The person represents a very substantial risk of physical impairment or injury to self as manifested by evidence that the person is unable to provide for and is not providing for the person's most basic physical needs and that provision for those needs is not available in the community;

(2) The person needs and is susceptible to significant habilitation in an institution.

~~(P)~~(O) "A person who is at least moderately mentally retarded" means a person who is found, following a comprehensive evaluation, to be impaired in adaptive behavior to a moderate degree and to be functioning at the moderate level of intellectual functioning in accordance with standard measurements as recorded in the most current revision of the manual of terminology and classification in mental retardation published by the American association on mental retardation.

~~(Q)~~(P) As used in this division, "substantial functional limitation," "developmental delay," and "established risk" have the meanings established pursuant to section 5123.011 of the Revised Code.

"Developmental disability" means a severe, chronic disability that is characterized by all of the following:

(1) It is attributable to a mental or physical impairment or

a combination of mental and physical impairments, other than a mental or physical impairment solely caused by mental illness as defined in division (A) of section 5122.01 of the Revised Code.

(2) It is manifested before age twenty-two.

(3) It is likely to continue indefinitely.

(4) It results in one of the following:

(a) In the case of a person under three years of age, at least one developmental delay or an established risk;

(b) In the case of a person at least three years of age but under six years of age, at least two developmental delays or an established risk;

(c) In the case of a person six years of age or older, a substantial functional limitation in at least three of the following areas of major life activity, as appropriate for the person's age: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and, if the person is at least sixteen years of age, capacity for economic self-sufficiency.

(5) It causes the person to need a combination and sequence of special, interdisciplinary, or other type of care, treatment, or provision of services for an extended period of time that is individually planned and coordinated for the person.

~~(R)~~(Q) "Developmentally disabled person" means a person with a developmental disability.

~~(S)~~(R) "State institution" means an institution that is tax-supported and under the jurisdiction of the department.

~~(T)~~(S) "Residence" and "legal residence" have the same meaning as "legal settlement," which is acquired by residing in Ohio for a period of one year without receiving general assistance prior to July 17, 1995, under former Chapter 5113. of the Revised

Code, financial assistance under Chapter 5115. of the Revised Code, or assistance from a private agency that maintains records of assistance given. A person having a legal settlement in the state shall be considered as having legal settlement in the assistance area in which the person resides. No adult person coming into this state and having a spouse or minor children residing in another state shall obtain a legal settlement in this state as long as the spouse or minor children are receiving public assistance, care, or support at the expense of the other state or its subdivisions. For the purpose of determining the legal settlement of a person who is living in a public or private institution or in a home subject to licensing by the department of job and family services, the department of mental health, or the department of mental retardation and developmental disabilities, the residence of the person shall be considered as though the person were residing in the county in which the person was living prior to the person's entrance into the institution or home. Settlement once acquired shall continue until a person has been continuously absent from Ohio for a period of one year or has acquired a legal residence in another state. A woman who marries a man with legal settlement in any county immediately acquires the settlement of her husband. The legal settlement of a minor is that of the parents, surviving parent, sole parent, parent who is designated the residential parent and legal custodian by a court, other adult having permanent custody awarded by a court, or guardian of the person of the minor, provided that:

(1) A minor female who marries shall be considered to have the legal settlement of her husband and, in the case of death of her husband or divorce, she shall not thereby lose her legal settlement obtained by the marriage.

(2) A minor male who marries, establishes a home, and who has resided in this state for one year without receiving general

assistance prior to July 17, 1995, under former Chapter 5113. of the Revised Code, financial assistance under Chapter 5115. of the Revised Code, or assistance from a private agency that maintains records of assistance given shall be considered to have obtained a legal settlement in this state.

(3) The legal settlement of a child under eighteen years of age who is in the care or custody of a public or private child caring agency shall not change if the legal settlement of the parent changes until after the child has been in the home of the parent for a period of one year.

No person, adult or minor, may establish a legal settlement in this state for the purpose of gaining admission to any state institution.

~~(U)~~(T)(1) "Resident" means, subject to division (R)(2) of this section, a person who is admitted either voluntarily or involuntarily to an institution or other facility pursuant to section 2945.39, 2945.40, 2945.401, or 2945.402 of the Revised Code subsequent to a finding of not guilty by reason of insanity or incompetence to stand trial or under this chapter who is under observation or receiving habilitation and care in an institution.

(2) "Resident" does not include a person admitted to an institution or other facility under section 2945.39, 2945.40, 2945.401, or 2945.402 of the Revised Code to the extent that the reference in this chapter to resident, or the context in which the reference occurs, is in conflict with any provision of sections 2945.37 to 2945.402 of the Revised Code.

~~(V)~~(U) "Respondent" means the person whose detention, commitment, or continued commitment is being sought in any proceeding under this chapter.

~~(W)~~(V) "Working day" and "court day" mean Monday, Tuesday, Wednesday, Thursday, and Friday, except when such day is a legal

holiday.

~~(X)~~(W) "Prosecutor" means the prosecuting attorney, village solicitor, city director of law, or similar chief legal officer who prosecuted a criminal case in which a person was found not guilty by reason of insanity, who would have had the authority to prosecute a criminal case against a person if the person had not been found incompetent to stand trial, or who prosecuted a case in which a person was found guilty.

~~(Y)~~(X) "Court" means the probate division of the court of common pleas.

Sec. 5123.021. (A) As used in this section, "mentally retarded individual" and "specialized services" have the same meanings as in section ~~5111.202~~ 5164.45 of the Revised Code.

(B)(1) Except as provided in division (B)(2) of this section and rules adopted under division (E)(3) of this section, for purposes of section ~~5111.202~~ 5164.41 of the Revised Code, the department of mental retardation and developmental disabilities shall determine in accordance with ~~section 1919(e)(7) of the "Social Security Act," 49 Stat. 620 (1935),~~ 42 U.S.C.~~A. 301, as amended,~~ 1396r(e)(7) and regulations adopted under ~~section 1919(f)(8)(A) of that act~~ 42 U.S.C. 1396r(f)(8)(A) whether, because of the individual's physical and mental condition, a mentally retarded individual seeking admission to a nursing facility requires the level of services provided by a nursing facility and, if the individual requires that level of services, whether the individual requires specialized services for mental retardation.

(2) A determination under this division is not required for any of the following:

(a) An individual seeking readmission to a nursing facility

after having been transferred from a nursing facility to a hospital for care;

(b) An individual who meets all of the following conditions:

(i) The individual is admitted to the nursing facility directly from a hospital after receiving inpatient care at the hospital;

(ii) The individual requires nursing facility services for the condition for which the individual received care in the hospital;

(iii) The individual's attending physician has certified, before admission to the nursing facility, that the individual is likely to require less than thirty days of nursing facility services.

(c) An individual transferred from one nursing facility to another nursing facility, with or without an intervening hospital stay.

(C) Except as provided in rules adopted under division (F)(3) of this section, the department of mental retardation and developmental disabilities shall review and determine, for each resident of a nursing facility who is mentally retarded, whether the resident, because of the resident's physical and mental condition, requires the level of services provided by a nursing facility and whether the resident requires specialized services for mental retardation. The review and determination shall be conducted in accordance with section 1919(e)(7) of the "Social Security Act" and the regulations adopted under section 1919(f)(8)(A) of the act. The review and determination shall be completed promptly after a nursing facility has notified the department that there has been a significant change in the resident's mental or physical condition.

(D)(1) In the case of a nursing facility resident who has

continuously resided in a nursing facility for at least thirty months before the date of a review and determination under division (C) of this section, if the resident is determined not to require the level of services provided by a nursing facility, but is determined to require specialized services for mental retardation, the department, in consultation with the resident's family or legal representative and care givers, shall do all of the following:

(a) Inform the resident of the institutional and noninstitutional alternatives covered under the state medicaid plan ~~for medical assistance~~;

(b) Offer the resident the choice of remaining in the nursing facility or receiving covered services in an alternative institutional or noninstitutional setting;

(c) Clarify the effect on eligibility for services under the state medicaid plan ~~for medical assistance~~ if the resident chooses to leave the facility, including its effect on readmission to the facility;

(d) Provide for or arrange for the provision of specialized services for the resident's mental retardation in the setting chosen by the resident.

(2) In the case of a nursing facility resident who has continuously resided in a nursing facility for less than thirty months before the date of the review and determination under division (C) of this section, if the resident is determined not to require the level of services provided by a nursing facility, but is determined to require specialized services for mental retardation, or if the resident is determined to require neither the level of services provided by a nursing facility nor specialized services for mental retardation, the department shall act in accordance with its alternative disposition plan approved

by the United States department of health and human services under section 1919(e)(7)(E) of the "Social Security Act."

(3) In the case of an individual who is determined under division (B) or (C) of this section to require both the level of services provided by a nursing facility and specialized services for mental retardation, the department of mental retardation and developmental disabilities shall provide or arrange for the provision of the specialized services needed by the individual or resident while residing in a nursing facility.

(E) The department of mental retardation and developmental disabilities shall adopt rules in accordance with Chapter 119. of the Revised Code that do all of the following:

(1) Establish criteria to be used in making the determinations required by divisions (B) and (C) of this section. The criteria shall not exceed the criteria established by regulations adopted by the United States department of health and human services under section 1919(f)(8)(A) of the "Social Security Act."

(2) Specify information to be provided by the individual or nursing facility resident being assessed;

(3) Specify any circumstances, in addition to circumstances listed in division (B) of this section, under which determinations under divisions (B) and (C) of this section are not required to be made.

Sec. 5123.0412. (A) The department of mental retardation and developmental disabilities shall charge each county board of mental retardation and developmental disabilities an annual fee equal to one and one-half per cent of the total value of all medicaid paid claims for medicaid case management services and home and community-based services provided during the year to an

individual eligible for services from the county board. No county board shall pass the cost of a fee charged to the county board under this section on to another provider of these services.

(B) The fees collected under this section shall be deposited into the ODMR/DD administration and oversight fund and the ~~ODJFS~~ ODHCA administration and oversight fund, both of which are hereby created in the state treasury. The portion of the fees to be deposited into the ODMR/DD administration and oversight fund and the portion of the fees to be deposited into the ~~ODJFS~~ ODHCA administration and oversight fund shall be the portion specified in an interagency agreement entered into under division (C) of this section. The department of mental retardation and developmental disabilities shall use the money in the ODMR/DD administration and oversight fund and the department of ~~job and family services~~ health care administration shall use the money in the ~~ODJFS~~ ODHCA administration and oversight fund for both of the following purposes:

(1) The administrative and oversight costs of medicaid case management services and home and community-based services. The administrative and oversight costs shall include costs for staff, systems, and other resources the departments need and dedicate solely to the following duties associated with the services:

(a) Eligibility determinations;

(b) Training;

(c) Fiscal management;

(d) Claims processing;

(e) Quality assurance oversight;

(f) Other duties the departments identify.

(2) Providing technical support to county boards' local administrative authority under section 5126.055 of the Revised

Code for the services.

(C) The departments of mental retardation and developmental disabilities and ~~job and family services~~ health care administration shall enter into an interagency agreement to do both of the following:

(1) Specify which portion of the fees collected under this section is to be deposited into the ODMR/DD administration and oversight fund and which portion is to be deposited into the ~~ODJFS~~ ODHCA administration and oversight fund;

(2) Provide for the departments to coordinate the staff whose costs are paid for with money in the ODMR/DD administration and oversight fund and the ~~ODJFS~~ ODHCA administration and oversight fund.

(D) The departments shall submit an annual report to the director of budget and management certifying how the departments spent the money in the ODMR/DD administration and oversight fund and the ~~ODJFS~~ ODHCA administration and oversight fund for the purposes specified in division (B) of this section.

Sec. 5123.171. As used in this section, "respite care" means appropriate, short-term, temporary care provided to a mentally retarded or developmentally disabled person to sustain the family structure or to meet planned or emergency needs of the family.

The department of mental retardation and developmental disabilities shall provide respite care services to persons with mental retardation or a developmental disability for the purpose of promoting self-sufficiency and normalization, preventing or reducing inappropriate institutional care, and furthering the unity of the family by enabling the family to meet the special needs of a mentally retarded or developmentally disabled person.

In order to be eligible for respite care services under this

section, the mentally retarded or developmentally disabled person must be in need of habilitation services as defined in section 5126.01 of the Revised Code.

Respite care may be provided in a facility licensed under section 5123.19 of the Revised Code or certified as an intermediate care facility for the mentally retarded under ~~Title XIX of~~ the ~~"Social Security Act," 49 Stat. 620 (1935), 42 U.S.C. 301, as amended,~~ medicaid program or certified as a respite care home under section 5126.05 of the Revised Code.

The department shall develop a system for locating vacant beds that are available for respite care and for making information on vacant beds available to users of respite care services. Facilities certified as intermediate care facilities for the mentally retarded and facilities holding contracts with the department for the provision of residential services under section 5123.18 of the Revised Code shall report vacant beds to the department but shall not be required to accept respite care clients.

The director of mental retardation and developmental disabilities shall adopt, and may amend or rescind, rules in accordance with Chapter 119. of the Revised Code for both of the following:

(A) Certification by county boards of mental retardation and developmental disabilities of respite care homes;

(B) Provision of respite care services authorized by this section. Rules adopted under this division shall establish all of the following:

(1) A formula for distributing funds appropriated for respite care services;

(2) Standards for supervision, training and quality control in the provision of respite care services;

(3) Eligibility criteria for emergency respite care services.

Sec. 5123.181. The director of mental retardation and developmental disabilities and the director of ~~job and family services~~ health care administration shall, in concert with each other, eliminate all double billings and double payments for services on behalf of persons with mental retardation or another developmental disability in intermediate care facilities. The department of mental retardation and developmental disabilities may enter into contracts with providers of services for the purpose of making payments to the providers for services rendered to eligible clients who are persons with mental retardation or a developmental disability over and above the services authorized and paid under ~~Chapter 5111. of~~ the ~~Revised Code~~ medicaid program. Payments authorized under this section and section 5123.18 of the Revised Code shall not be subject to audit findings ~~pursuant to Chapter 5111. of~~ under the ~~Revised Code~~ medicaid program, unless an audit determines that payment was made to the provider for services that were not rendered in accordance with the provisions of the provider agreement entered into with the department of ~~job and family services~~ health care administration or the department of mental retardation and developmental disabilities pursuant to this section.

Sec. 5123.19. (A) As used in this section and in sections 5123.191, 5123.194, 5123.196, 5123.198, and 5123.20 of the Revised Code:

(1)(a) "Residential facility" means a home or facility in which a mentally retarded or developmentally disabled person resides, except the home of a relative or legal guardian in which a mentally retarded or developmentally disabled person resides, a respite care home certified under section 5126.05 of the Revised Code, a county home or district home operated pursuant to Chapter

5155. of the Revised Code, or a dwelling in which the only mentally retarded or developmentally disabled residents are in an independent living arrangement or are being provided supported living.

(b) "Intermediate care facility for the mentally retarded" means a residential facility that is considered an intermediate care facility for the mentally retarded for the purposes of ~~Chapter 5111. of~~ the ~~Revised Code~~ medicaid program.

(2) "Political subdivision" means a municipal corporation, county, or township.

(3) "Independent living arrangement" means an arrangement in which a mentally retarded or developmentally disabled person resides in an individualized setting chosen by the person or the person's guardian, which is not dedicated principally to the provision of residential services for mentally retarded or developmentally disabled persons, and for which no financial support is received for rendering such service from any governmental agency by a provider of residential services.

(4) "Supported living" has the same meaning as in section 5126.01 of the Revised Code.

(5) "Licensee" means the person or government agency that has applied for a license to operate a residential facility and to which the license was issued under this section.

(B) Every person or government agency desiring to operate a residential facility shall apply for licensure of the facility to the director of mental retardation and developmental disabilities unless the residential facility is subject to section 3721.02, 3722.04, 5103.03, or 5119.20 of the Revised Code. Notwithstanding Chapter 3721. of the Revised Code, a nursing home that is certified as an intermediate care facility for the mentally retarded under ~~Title XIX of~~ the ~~"Social Security Act," 79 Stat.~~

~~286 (1965), 42 U.S.C.A. 1396, as amended,~~ medicaid program shall apply for licensure of the portion of the home that is certified as an intermediate care facility for the mentally retarded.

(C) Subject to section 5123.196 of the Revised Code, the director of mental retardation and developmental disabilities shall license the operation of residential facilities. An initial license shall be issued for a period that does not exceed one year, unless the director denies the license under division (D) of this section. A license shall be renewed for a period that does not exceed three years, unless the director refuses to renew the license under division (D) of this section. The director, when issuing or renewing a license, shall specify the period for which the license is being issued or renewed. A license remains valid for the length of the licensing period specified by the director, unless the license is terminated, revoked, or voluntarily surrendered.

(D) If it is determined that an applicant or licensee is not in compliance with a provision of this chapter that applies to residential facilities or the rules adopted under such a provision, the director may deny issuance of a license, refuse to renew a license, terminate a license, revoke a license, issue an order for the suspension of admissions to a facility, issue an order for the placement of a monitor at a facility, issue an order for the immediate removal of residents, or take any other action the director considers necessary consistent with the director's authority under this chapter regarding residential facilities. In the director's selection and administration of the sanction to be imposed, all of the following apply:

(1) The director may deny, refuse to renew, or revoke a license, if the director determines that the applicant or licensee has demonstrated a pattern of serious noncompliance or that a violation creates a substantial risk to the health and safety of

residents of a residential facility.

(2) The director may terminate a license if more than twelve consecutive months have elapsed since the residential facility was last occupied by a resident or a notice required by division (J) of this section is not given.

(3) The director may issue an order for the suspension of admissions to a facility for any violation that may result in sanctions under division (D)(1) of this section and for any other violation specified in rules adopted under division (G)(2) of this section. If the suspension of admissions is imposed for a violation that may result in sanctions under division (D)(1) of this section, the director may impose the suspension before providing an opportunity for an adjudication under Chapter 119. of the Revised Code. The director shall lift an order for the suspension of admissions when the director determines that the violation that formed the basis for the order has been corrected.

(4) The director may order the placement of a monitor at a residential facility for any violation specified in rules adopted under division (G)(2) of this section. The director shall lift the order when the director determines that the violation that formed the basis for the order has been corrected.

(5) If the director determines that two or more residential facilities owned or operated by the same person or government entity are not being operated in compliance with a provision of this chapter that applies to residential facilities or the rules adopted under such a provision, and the director's findings are based on the same or a substantially similar action, practice, circumstance, or incident that creates a substantial risk to the health and safety of the residents, the director shall conduct a survey as soon as practicable at each residential facility owned or operated by that person or government entity. The director may take any action authorized by this section with respect to any

facility found to be operating in violation of a provision of this chapter that applies to residential facilities or the rules adopted under such a provision.

(6) When the director initiates license revocation proceedings, no opportunity for submitting a plan of correction shall be given. The director shall notify the licensee by letter of the initiation of the proceedings. The letter shall list the deficiencies of the residential facility and inform the licensee that no plan of correction will be accepted. The director shall also notify each affected resident, the resident's guardian if the resident is an adult for whom a guardian has been appointed, the resident's parent or guardian if the resident is a minor, and the county board of mental retardation and developmental disabilities.

(7) Pursuant to rules which shall be adopted in accordance with Chapter 119. of the Revised Code, the director may order the immediate removal of residents from a residential facility whenever conditions at the facility present an immediate danger of physical or psychological harm to the residents.

(8) In determining whether a residential facility is being operated in compliance with a provision of this chapter that applies to residential facilities or the rules adopted under such a provision, or whether conditions at a residential facility present an immediate danger of physical or psychological harm to the residents, the director may rely on information obtained by a county board of mental retardation and developmental disabilities or other governmental agencies.

(9) In proceedings initiated to deny, refuse to renew, or revoke licenses, the director may deny, refuse to renew, or revoke a license regardless of whether some or all of the deficiencies that prompted the proceedings have been corrected at the time of the hearing.

(E) The director shall establish a program under which public notification may be made when the director has initiated license revocation proceedings or has issued an order for the suspension of admissions, placement of a monitor, or removal of residents. The director shall adopt rules in accordance with Chapter 119. of the Revised Code to implement this division. The rules shall establish the procedures by which the public notification will be made and specify the circumstances for which the notification must be made. The rules shall require that public notification be made if the director has taken action against the facility in the eighteen-month period immediately preceding the director's latest action against the facility and the latest action is being taken for the same or a substantially similar violation of a provision of this chapter that applies to residential facilities or the rules adopted under such a provision. The rules shall specify a method for removing or amending the public notification if the director's action is found to have been unjustified or the violation at the residential facility has been corrected.

(F)(1) Except as provided in division (F)(2) of this section, appeals from proceedings initiated to impose a sanction under division (D) of this section shall be conducted in accordance with Chapter 119. of the Revised Code.

(2) Appeals from proceedings initiated to order the suspension of admissions to a facility shall be conducted in accordance with Chapter 119. of the Revised Code, unless the order was issued before providing an opportunity for an adjudication, in which case all of the following apply:

(a) The licensee may request a hearing not later than ten days after receiving the notice specified in section 119.07 of the Revised Code.

(b) If a timely request for a hearing is made, the hearing shall commence not later than thirty days after the department

receives the request.

(c) After commencing, the hearing shall continue uninterrupted, except for Saturdays, Sundays, and legal holidays, unless other interruptions are agreed to by the licensee and the director.

(d) If the hearing is conducted by a hearing examiner, the hearing examiner shall file a report and recommendations not later than ten days after the close of the hearing.

(e) Not later than five days after the hearing examiner files the report and recommendations, the licensee may file objections to the report and recommendations.

(f) Not later than fifteen days after the hearing examiner files the report and recommendations, the director shall issue an order approving, modifying, or disapproving the report and recommendations.

(g) Notwithstanding the pendency of the hearing, the director shall lift the order for the suspension of admissions when the director determines that the violation that formed the basis for the order has been corrected.

(G) In accordance with Chapter 119. of the Revised Code, the director shall adopt and may amend and rescind rules for licensing and regulating the operation of residential facilities, including intermediate care facilities for the mentally retarded. The rules for intermediate care facilities for the mentally retarded may differ from those for other residential facilities. The rules shall establish and specify the following:

(1) Procedures and criteria for issuing and renewing licenses, including procedures and criteria for determining the length of the licensing period that the director must specify for each license when it is issued or renewed;

(2) Procedures and criteria for denying, refusing to renew, terminating, and revoking licenses and for ordering the suspension of admissions to a facility, placement of a monitor at a facility, and the immediate removal of residents from a facility;

(3) Fees for issuing and renewing licenses;

(4) Procedures for surveying residential facilities;

(5) Requirements for the training of residential facility personnel;

(6) Classifications for the various types of residential facilities;

(7) Certification procedures for licensees and management contractors that the director determines are necessary to ensure that they have the skills and qualifications to properly operate or manage residential facilities;

(8) The maximum number of persons who may be served in a particular type of residential facility;

(9) Uniform procedures for admission of persons to and transfers and discharges of persons from residential facilities;

(10) Other standards for the operation of residential facilities and the services provided at residential facilities;

(11) Procedures for waiving any provision of any rule adopted under this section.

(H) Before issuing a license, the director of the department or the director's designee shall conduct a survey of the residential facility for which application is made. The director or the director's designee shall conduct a survey of each licensed residential facility at least once during the period the license is valid and may conduct additional inspections as needed. A survey includes but is not limited to an on-site examination and evaluation of the residential facility, its personnel, and the

services provided there.

In conducting surveys, the director or the director's designee shall be given access to the residential facility; all records, accounts, and any other documents related to the operation of the facility; the licensee; the residents of the facility; and all persons acting on behalf of, under the control of, or in connection with the licensee. The licensee and all persons on behalf of, under the control of, or in connection with the licensee shall cooperate with the director or the director's designee in conducting the survey.

Following each survey, unless the director initiates a license revocation proceeding, the director or the director's designee shall provide the licensee with a report listing any deficiencies, specifying a timetable within which the licensee shall submit a plan of correction describing how the deficiencies will be corrected, and, when appropriate, specifying a timetable within which the licensee must correct the deficiencies. After a plan of correction is submitted, the director or the director's designee shall approve or disapprove the plan. A copy of the report and any approved plan of correction shall be provided to any person who requests it.

The director shall initiate disciplinary action against any department employee who notifies or causes the notification to any unauthorized person of an unannounced survey of a residential facility by an authorized representative of the department.

(I) In addition to any other information which may be required of applicants for a license pursuant to this section, the director shall require each applicant to provide a copy of an approved plan for a proposed residential facility pursuant to section 5123.042 of the Revised Code. This division does not apply to renewal of a license.

(J) A licensee shall notify the owner of the building in which the licensee's residential facility is located of any significant change in the identity of the licensee or management contractor before the effective date of the change if the licensee is not the owner of the building.

Pursuant to rules which shall be adopted in accordance with Chapter 119. of the Revised Code, the director may require notification to the department of any significant change in the ownership of a residential facility or in the identity of the licensee or management contractor. If the director determines that a significant change of ownership is proposed, the director shall consider the proposed change to be an application for development by a new operator pursuant to section 5123.042 of the Revised Code and shall advise the applicant within sixty days of the notification that the current license shall continue in effect or a new license will be required pursuant to this section. If the director requires a new license, the director shall permit the facility to continue to operate under the current license until the new license is issued, unless the current license is revoked, refused to be renewed, or terminated in accordance with Chapter 119. of the Revised Code.

(K) A county board of mental retardation and developmental disabilities, the legal rights service, and any interested person may file complaints alleging violations of statute or department rule relating to residential facilities with the department. All complaints shall be in writing and shall state the facts constituting the basis of the allegation. The department shall not reveal the source of any complaint unless the complainant agrees in writing to waive the right to confidentiality or until so ordered by a court of competent jurisdiction.

The department shall adopt rules in accordance with Chapter 119. of the Revised Code establishing procedures for the receipt,

referral, investigation, and disposition of complaints filed with the department under this division.

(L) The department shall establish procedures for the notification of interested parties of the transfer or interim care of residents from residential facilities that are closing or are losing their license.

(M) Before issuing a license under this section to a residential facility that will accommodate at any time more than one mentally retarded or developmentally disabled individual, the director shall, by first class mail, notify the following:

(1) If the facility will be located in a municipal corporation, the clerk of the legislative authority of the municipal corporation;

(2) If the facility will be located in unincorporated territory, the clerk of the appropriate board of county commissioners and the fiscal officer of the appropriate board of township trustees.

The director shall not issue the license for ten days after mailing the notice, excluding Saturdays, Sundays, and legal holidays, in order to give the notified local officials time in which to comment on the proposed issuance.

Any legislative authority of a municipal corporation, board of county commissioners, or board of township trustees that receives notice under this division of the proposed issuance of a license for a residential facility may comment on it in writing to the director within ten days after the director mailed the notice, excluding Saturdays, Sundays, and legal holidays. If the director receives written comments from any notified officials within the specified time, the director shall make written findings concerning the comments and the director's decision on the issuance of the license. If the director does not receive written

comments from any notified local officials within the specified time, the director shall continue the process for issuance of the license.

(N) Any person may operate a licensed residential facility that provides room and board, personal care, habilitation services, and supervision in a family setting for at least six but not more than eight persons with mental retardation or a developmental disability as a permitted use in any residential district or zone, including any single-family residential district or zone, of any political subdivision. These residential facilities may be required to comply with area, height, yard, and architectural compatibility requirements that are uniformly imposed upon all single-family residences within the district or zone.

(O) Any person may operate a licensed residential facility that provides room and board, personal care, habilitation services, and supervision in a family setting for at least nine but not more than sixteen persons with mental retardation or a developmental disability as a permitted use in any multiple-family residential district or zone of any political subdivision, except that a political subdivision that has enacted a zoning ordinance or resolution establishing planned unit development districts may exclude these residential facilities from those districts, and a political subdivision that has enacted a zoning ordinance or resolution may regulate these residential facilities in multiple-family residential districts or zones as a conditionally permitted use or special exception, in either case, under reasonable and specific standards and conditions set out in the zoning ordinance or resolution to:

(1) Require the architectural design and site layout of the residential facility and the location, nature, and height of any walls, screens, and fences to be compatible with adjoining land

uses and the residential character of the neighborhood;

(2) Require compliance with yard, parking, and sign regulation;

(3) Limit excessive concentration of these residential facilities.

(P) This section does not prohibit a political subdivision from applying to residential facilities nondiscriminatory regulations requiring compliance with health, fire, and safety regulations and building standards and regulations.

(Q) Divisions (N) and (O) of this section are not applicable to municipal corporations that had in effect on June 15, 1977, an ordinance specifically permitting in residential zones licensed residential facilities by means of permitted uses, conditional uses, or special exception, so long as such ordinance remains in effect without any substantive modification.

(R)(1) The director may issue an interim license to operate a residential facility to an applicant for a license under this section if either of the following is the case:

(a) The director determines that an emergency exists requiring immediate placement of persons in a residential facility, that insufficient licensed beds are available, and that the residential facility is likely to receive a permanent license under this section within thirty days after issuance of the interim license.

(b) The director determines that the issuance of an interim license is necessary to meet a temporary need for a residential facility.

(2) To be eligible to receive an interim license, an applicant must meet the same criteria that must be met to receive a permanent license under this section, except for any differing

procedures and time frames that may apply to issuance of a permanent license.

(3) An interim license shall be valid for thirty days and may be renewed by the director for a period not to exceed one hundred fifty days.

(4) The director shall adopt rules in accordance with Chapter 119. of the Revised Code as the director considers necessary to administer the issuance of interim licenses.

(S) Notwithstanding rules adopted pursuant to this section establishing the maximum number of persons who may be served in a particular type of residential facility, a residential facility shall be permitted to serve the same number of persons being served by the facility on the effective date of the rules or the number of persons for which the facility is authorized pursuant to a current application for a certificate of need with a letter of support from the department of mental retardation and developmental disabilities and which is in the review process prior to April 4, 1986.

(T) The director or the director's designee may enter at any time, for purposes of investigation, any home, facility, or other structure that has been reported to the director or that the director has reasonable cause to believe is being operated as a residential facility without a license issued under this section.

The director may petition the court of common pleas of the county in which an unlicensed residential facility is located for an order enjoining the person or governmental agency operating the facility from continuing to operate without a license. The court may grant the injunction on a showing that the person or governmental agency named in the petition is operating a residential facility without a license. The court may grant the injunction, regardless of whether the residential facility meets

the requirements for receiving a license under this section.

Sec. 5123.192. Notwithstanding section 5123.19 of the Revised Code, any nursing home that on June 30, 1987, contained beds that the department of health had certified prior to June 30, 1987, as intermediate care facility for the mentally retarded beds under ~~Title XIX of~~ the ~~"Social Security Act," 49 Stat. 620 (1935), 42 U.S.C. 301, as amended,~~ medicaid program or any nursing home that on June 30, 1987, had an application pending before the department to convert intermediate care facility beds to intermediate care facility for the mentally retarded beds, shall not be required to apply for licensure under section 5123.19 of the Revised Code, shall be subject to the requirements for licensure as a nursing home and all other requirements of Chapter 3721. of the Revised Code and any rules adopted under that chapter, and shall be subject to sections 3702.51 to 3702.62 of the Revised Code and any rules adopted under those sections, unless either of the following applies:

(A) The nursing home's certification or provider agreement as an intermediate care facility for the mentally retarded is subject to a final order of nonrenewal or termination with respect to which all appeal rights have been exhausted and the facility intends to apply for recertification;

(B) The nursing home intends to increase its number of beds certified as intermediate care facility for the mentally retarded beds. In such a case, the nursing home shall be required to apply for licensure of the additional beds under section 5123.19 of the Revised Code.

Sec. 5123.196. (A) Except as provided in division (F) of this section, the director of mental retardation and developmental disabilities shall not issue a license under section 5123.19 of

the Revised Code on or after July 1, 2003, if issuance will result in there being more beds in all residential facilities licensed under that section than is permitted under division (B) of this section.

(B) Except as provided in division (D) of this section, the maximum number of beds for the purpose of division (A) of this section shall not exceed ten thousand eight hundred thirty-eight minus, except as provided in division (C) of this section, both of the following:

(1) The number of such beds that cease to be residential facility beds on or after July 1, 2003, because a residential facility license is revoked, terminated, or not renewed for any reason or is surrendered in accordance with section 5123.19 of the Revised Code and after the issuance of an adjudication order pursuant to Chapter 119. of the Revised Code;

(2) The number of such beds for which a licensee voluntarily converts to use for supported living on or after July 1, 2003.

(C) The director is not required to reduce the maximum number of beds pursuant to division (B) of this section by a bed that ceases to be a residential facility bed if the director determines that the bed is needed to provide services to an individual with mental retardation or a developmental disability who resided in the residential facility in which the bed was located unless the reason the bed ceases to be a residential facility bed is because it is converted to providing home and community-based services under the ICF/MR conversion pilot program that is authorized by a waiver sought under division (B)(1) of section ~~5111.88~~ 5163.66 of the Revised Code.

(D) The director shall increase the number of beds determined under division (B) of this section if necessary to enable the operator of a residential facility to do either of the following:

(1) Obtain a residential facility license as required by section ~~5111.8814~~ 5163.6614 of the Revised Code;

(2) Reconvert beds to providing ICF/MR services under section ~~5111.8811~~ 5163.6611 of the Revised Code.

(E) The director shall maintain an up-to-date written record of the maximum number of residential facility beds provided for by division (B) of this section.

(F) The director may issue an interim license under division (R) of section 5123.19 of the Revised Code and issue, pursuant to rules adopted under division (G)(11) of that section, a waiver allowing a residential facility to admit more residents than the facility is licensed to admit regardless of whether the interim license or waiver will result in there being more beds in all residential facilities licensed under that section than is permitted under division (B) of this section.

Sec. 5123.198. (A) As used in this section, "date of the commitment" means the date that an individual specified in division (B) of this section begins to reside in a state-operated intermediate care facility for the mentally retarded after being committed to the facility pursuant to sections 5123.71 to 5123.76 of the Revised Code.

(B) Except as provided in division (C) of this section, whenever a resident of a residential facility is committed to a state-operated intermediate care facility for the mentally retarded pursuant to sections 5123.71 to 5123.76 of the Revised Code, the department of mental retardation and developmental disabilities, pursuant to an adjudication order issued in accordance with Chapter 119. of the Revised Code, shall reduce by one the number of residents for which the facility in which the resident resided is licensed.

(C) The department shall not reduce under division (B) of this section the number of residents for which a residential facility is licensed if any of the following are the case:

(1) The resident of the residential facility who is committed to a state-operated intermediate care facility for the mentally retarded resided in the residential facility because of the closure, on or after ~~the effective date of this section~~ June 26, 2003, of another state-operated intermediate care facility for the mentally retarded;

(2) The residential facility admits within ninety days of the date of the commitment an individual who resides on the date of the commitment in a state-operated intermediate care facility for the mentally retarded or another residential facility;

(3) The department fails to do either of the following within ninety days of the date of the commitment:

(a) Identify an individual to whom all of the following applies:

(i) Resides on the date of the commitment in a state-operated intermediate care facility for the mentally retarded or another residential facility;

(ii) Has indicated to the department an interest in relocating to the residential facility or has a parent or guardian who has indicated to the department an interest for the individual to relocate to the residential facility;

(iii) The department determines the individual has needs that the residential facility can meet.

(b) Provide the residential facility with information about the individual identified under division (C)(2)(a) of this section that the residential facility needs in order to determine whether the facility can meet the individual's needs.

(4) If the department completes the actions specified in divisions (C)(3)(a) and (b) of this section not later than ninety days after the date of the commitment and except as provided in division (D) of this section, the residential facility does all of the following not later than ninety days after the date of the commitment:

(a) Evaluates the information provided by the department;

(b) Assesses the identified individual's needs;

(c) Determines that the residential facility cannot meet the identified individual's needs.

(5) If the department completes the actions specified in divisions (C)(3)(a) and (b) of this section not later than ninety days after the date of the commitment and the residential facility determines that the residential facility can meet the identified individual's needs, the individual, or a parent or guardian of the individual, refuses placement in the residential facility.

(D) The department may reduce under division (B) of this section the number of residents for which a residential facility is licensed even though the residential facility completes the actions specified in division (C)(4) of this section not later than ninety days after the date of the commitment if all of the following are the case:

(1) The department disagrees with the residential facility's determination that the residential facility cannot meet the identified individual's needs.

(2) The department issues a written decision pursuant to the uniform procedures for admissions, transfers, and discharges established by rules adopted under division (G)(9) of section 5123.19 of the Revised Code that the residential facility should admit the identified individual.

(3) After the department issues the written decision specified in division (D)(2) of this section, the residential facility refuses to admit the identified individual.

(E) A residential facility that admits, refuses to admit, transfers, or discharges a resident under this section shall comply with the uniform procedures for admissions, transfers, and discharges established by rules adopted under division (G)(9) of section 5123.19 of the Revised Code.

(F) The department of mental retardation and developmental disabilities may notify the department of ~~job and family services~~ health care administration of any reduction under this section in the number of residents for which a residential facility that is an intermediate care facility for the mentally retarded is licensed. On receiving the notice, the department of ~~job and family services~~ health care administration may transfer to the department of mental retardation and developmental disabilities the savings in the nonfederal share of medicaid expenditures for each fiscal year after the year of the commitment to be used for costs of the resident's care in the state-operated intermediate care facility for the mentally retarded. In determining the amount saved, the department of ~~job and family services~~ health care administration shall consider medicaid payments for the remaining residents of the facility in which the resident resided.

Sec. 5123.199. (A) As used in this section:

(1) "Contractor" means a person or government agency that has entered into a contract with the department of mental retardation and developmental disabilities under this section.

(2) "Government agency" and "residential services" have the same meanings as in section 5123.18 of the Revised Code.

(3) "Intermediate care facility for the mentally retarded"

has the same meaning as in section ~~5111.20~~ 5164.01 of the Revised Code.

(4) "Respite care services" has the same meaning as in section 5123.171 of the Revised Code.

(B) The department of mental retardation and developmental disabilities may enter into a contract with a person or government agency to do any of the following:

(1) Provide residential services in an intermediate care facility for the mentally retarded to an individual who meets the criteria for admission to such a facility but is not eligible for ~~assistance under Chapter 5111. of the Revised Code~~ medicaid due to unliquidated assets subject to final probate action;

(2) Provide respite care services in an intermediate care facility for the mentally retarded;

(3) Provide residential services in a facility for which the person or government agency has applied for, but has not received, certification and payment as an intermediate care facility for the mentally retarded if the person or government agency is making a good faith effort to bring the facility into compliance with requirements for certification and payment as an intermediate care facility for the mentally retarded. In assigning payment amounts to such contracts, the department shall take into account costs incurred in attempting to meet certification requirements.

(4) Reimburse an intermediate care facility for the mentally retarded for costs not otherwise reimbursed under ~~Chapter 5111. of the Revised Code~~ the medicaid program for clothing for individuals who are mentally retarded or developmentally disabled. Reimbursement under such contracts shall not exceed a maximum amount per individual per year specified in rules that the department shall adopt in accordance with Chapter 119. of the Revised Code.

(C) The amount paid to a contractor under divisions (B)(1) to (3) of this section shall not exceed the reimbursement that would be made under ~~Chapter 5111. of the Revised Code~~ the medicaid program by the department of ~~job and family services~~ health care administration for the same goods and services.

(D) The department of mental retardation and developmental disabilities shall adopt rules as necessary to implement this section, including rules establishing standards and procedures for the submission of cost reports by contractors and the department's conduct of audits and reconciliations regarding the contracts. The rules shall be adopted in accordance with Chapter 119. of the Revised Code.

Sec. 5123.211. (A) As used in this section, "residential services" and "supported living" have the same meanings as in section 5126.01 of the Revised Code.

(B) The department of mental retardation and developmental disabilities shall provide or arrange provision of residential services for each person who, on or after July 1, 1989, ceases to be a resident of a state institution because of closure of the institution or a reduction in the institution's population by forty per cent or more within a period of one year. The services shall be provided in the county in which the person chooses to reside and shall consist of one of the following as determined appropriate by the department in consultation with the county board of mental retardation and developmental disabilities of the county in which the services are to be provided:

(1) Residential services provided pursuant to section 5123.18 of the Revised Code;

(2) Supported living provided pursuant to section 5123.182 of the Revised Code;

(3) Residential services for which reimbursement is made under the ~~medical assistance~~ medicaid program ~~established under section 5111.01 of the Revised Code~~;

(4) Residential services provided in a manner or setting approved by the director of mental retardation and developmental disabilities.

(C) Not less than six months prior to closing a state institution or reducing a state institution's population by forty per cent or more within a period of one year, the department shall identify those counties in which individuals leaving the institution have chosen to reside and notify the county boards of mental retardation and developmental disabilities in those counties of the need to develop the services specified in division (B) of this section. The notice shall specify the number of individuals requiring services who plan to reside in the county and indicate the amount of funds the department will use to provide or arrange services for those individuals.

(D) In each county in which one or more persons receive residential services pursuant to division (B) of this section, the department shall provide or arrange provision of residential services, or shall distribute moneys to the county board of mental retardation and developmental disabilities to provide or arrange provision of residential services, for an equal number of persons with mental retardation or developmental disabilities in that county who the county board has determined need residential services but are not receiving them.

Sec. 5123.41. As used in this section and sections 5123.42 to 5123.47 of the Revised Code:

(A) "Adult services" has the same meaning as in section 5126.01 of the Revised Code.

(B) "Certified home and community-based services provider" means a person or government entity certified under section 5123.16 of the Revised Code.

(C) "Certified supported living provider" means a person or government entity certified under section 5126.431 of the Revised Code.

(D) "Drug" has the same meaning as in section 4729.01 of the Revised Code.

(E) "Family support services" has the same meaning as in section 5126.01 of the Revised Code.

(F) "Health-related activities" means the following:

(1) Taking vital signs;

(2) Application of clean dressings that do not require health assessment;

(3) Basic measurement of bodily intake and output;

(4) Oral suctioning;

(5) Use of glucometers;

(6) External urinary catheter care;

(7) Emptying and replacing colostomy bags;

(8) Collection of specimens by noninvasive means.

(G) "Licensed health professional authorized to prescribe drugs" has the same meaning as in section 4729.01 of the Revised Code.

(H) ~~"Medicaid" has the same meaning as in section 5111.01 of the Revised Code.~~

~~(I)~~ "MR/DD personnel" means the employees and the workers under contract who provide specialized services to individuals with mental retardation and developmental disabilities. "MR/DD

personnel" includes those who provide the services as follows:

(1) Through direct employment with the department of mental retardation and developmental disabilities or a county board of mental retardation and developmental disabilities;

(2) Through an entity under contract with the department of mental retardation and developmental disabilities or a county board of mental retardation and developmental disabilities;

(3) Through direct employment or by being under contract with private entities, including private entities that operate residential facilities.

~~(J)~~(I) "Nursing delegation" means the process established in rules adopted by the board of nursing pursuant to Chapter 4723. of the Revised Code under which a registered nurse or licensed practical nurse acting at the direction of a registered nurse transfers the performance of a particular nursing activity or task to another person who is not otherwise authorized to perform the activity or task.

~~(K)~~(J) "Prescribed medication" means a drug that is to be administered according to the instructions of a licensed health professional authorized to prescribe drugs.

~~(L)~~(K) "Residential facility" means a facility licensed under section 5123.19 of the Revised Code or subject to section 5123.192 of the Revised Code.

~~(M)~~(L) "Specialized services" has the same meaning as in section 5123.50 of the Revised Code.

~~(N)~~(M) "Tube feeding" means the provision of nutrition to an individual through a gastrostomy tube or a jejunostomy tube.

Sec. 5123.71. (A)(1) Proceedings for the involuntary institutionalization of a person pursuant to sections 5123.71 to 5123.76 of the Revised Code shall be commenced by the filing of an

affidavit with the probate division of the court of common pleas of the county where the person resides or where the person is institutionalized, in the manner and form prescribed by the department of mental retardation and developmental disabilities either on information or actual knowledge, whichever is determined to be proper by the court. The affidavit may be filed only by a person who has custody of the individual as a parent, guardian, or service provider or by a person acting on behalf of the department or a county board of mental retardation and developmental disabilities. This section does not apply regarding the institutionalization of a person pursuant to section 2945.39, 2945.40, 2945.401, or 2945.402 of the Revised Code.

The affidavit shall contain an allegation setting forth the specific category or categories under division ~~(O)~~(N) of section 5123.01 of the Revised Code upon which the commencement of proceedings is based and a statement of the factual ground for the belief that the person is a mentally retarded person subject to institutionalization by court order. Except as provided in division (A)(2) of this section, the affidavit shall be accompanied by both of the following:

(a) A comprehensive evaluation report prepared by the person's evaluation team that includes a statement by the members of the team certifying that they have performed a comprehensive evaluation of the person and that they are of the opinion that the person is a mentally retarded person subject to institutionalization by court order;

(b) An assessment report prepared by the county board of mental retardation and developmental disabilities under section 5123.711 of the Revised Code specifying that the individual is in need of services on an emergency or priority basis.

(2) In lieu of the comprehensive evaluation report, the affidavit may be accompanied by a written and sworn statement that

the person or the guardian of a person adjudicated incompetent has refused to allow a comprehensive evaluation and county board assessment and assessment reports. Immediately after accepting an affidavit that is not accompanied by the reports of a comprehensive evaluation and county board assessment, the court shall cause a comprehensive evaluation and county board assessment of the person named in the affidavit to be performed. The evaluation shall be conducted in the least restrictive environment possible and the assessment shall be conducted in the same manner as assessments conducted under section 5123.711 of the Revised Code. The evaluation and assessment must be completed before a probable cause hearing or full hearing may be held under section 5123.75 or 5123.76 of the Revised Code.

A written report of the evaluation team's findings and the county board's assessment shall be filed with the court. The reports shall, consistent with the rules of evidence, be accepted as probative evidence in any proceeding under section 5123.75 or 5123.76 of the Revised Code. If the counsel for the person who is evaluated or assessed is known, the court shall send to the counsel a copy of the reports as soon as possible after they are filed and prior to any proceedings under section 5123.75 or 5123.76 of the Revised Code.

(B) Any person who is involuntarily detained in an institution or otherwise is in custody under this chapter shall be informed of the right to do the following:

(1) Immediately make a reasonable number of telephone calls or use other reasonable means to contact an attorney, a physician, or both, to contact any other person or persons to secure representation by counsel, or to obtain medical assistance, and be provided assistance in making calls if the assistance is needed and requested;

(2) Retain counsel and have independent expert evaluation

and, if the person is an indigent person, be represented by court-appointed counsel and have independent expert evaluation at court expense;

(3) Upon request, have a hearing to determine whether there is probable cause to believe that the person is a mentally retarded person subject to institutionalization by court order.

(C) No person who is being treated by spiritual means through prayer alone in accordance with a recognized religious method of healing may be ordered detained or involuntarily committed unless the court has determined that the person represents a very substantial risk of self-impairment, self-injury, or impairment or injury to others.

Sec. 5123.76. (A) The full hearing shall be conducted in a manner consistent with the procedures outlined in this chapter and with due process of law. The hearing shall be held by a judge of the probate division or, upon transfer by the judge of the probate division, by another judge of the court of common pleas, or a referee designated by the judge of the probate division. Any referee designated by the judge of the probate division must be an attorney.

(1) The following shall be made available to counsel for the respondent:

(a) All relevant documents, information, and evidence in the custody or control of the state or prosecutor;

(b) All relevant documents, information, and evidence in the custody or control of the institution, facility, or program in which the respondent currently is held or in which the respondent has been held pursuant to these proceedings;

(c) With the consent of the respondent, all relevant documents, information, and evidence in the custody or control of

any institution or person other than the state.

(2) The respondent has the right to be represented by counsel of the respondent's choice and has the right to attend the hearing except if unusual circumstances of compelling medical necessity exist that render the respondent unable to attend and the respondent has not expressed a desire to attend.

(3) If the respondent is not represented by counsel and the court determines that the conditions specified in division (A)(2) of this section justify the respondent's absence and the right to counsel has not been validly waived, the court shall appoint counsel forthwith to represent the respondent at the hearing, reserving the right to tax costs of appointed counsel to the respondent unless it is shown that the respondent is indigent. If the court appoints counsel, or if the court determines that the evidence relevant to the respondent's absence does not justify the absence, the court shall continue the case.

(4) The respondent shall be informed of the right to retain counsel, to have independent expert evaluation, and, if an indigent person, to be represented by court appointed counsel and have expert independent evaluation at court expense.

(5) The hearing may be closed to the public unless counsel for the respondent requests that the hearing be open to the public.

(6) Unless objected to by the respondent, the respondent's counsel, or the designee of the director of mental retardation and developmental disabilities, the court, for good cause shown, may admit persons having a legitimate interest in the proceedings.

(7) The affiant under section 5123.71 of the Revised Code shall be subject to subpoena by either party.

(8) The court shall examine the sufficiency of all documents filed and shall inform the respondent, if present, and the

respondent's counsel of the nature of the content of the documents and the reason for which the respondent is being held or for which the respondent's placement is being sought.

(9) The court shall receive only relevant, competent, and material evidence.

(10) The designee of the director shall present the evidence for the state. In proceedings under this chapter, the attorney general shall present the comprehensive evaluation, assessment, diagnosis, prognosis, record of habilitation and care, if any, and less restrictive habilitation plans, if any. The attorney general does not have a similar presentation responsibility in connection with a person who has been found not guilty by reason of insanity and who is the subject of a hearing under section 2945.40 of the Revised Code to determine whether the person is a mentally retarded person subject to institutionalization by court order.

(11) The respondent has the right to testify and the respondent or the respondent's counsel has the right to subpoena witnesses and documents and to present and cross-examine witnesses.

(12) The respondent shall not be compelled to testify and shall be so advised by the court.

(13) On motion of the respondent or the respondent's counsel for good cause shown, or upon the court's own motion, the court may order a continuance of the hearing.

(14) To an extent not inconsistent with this chapter, the Rules of Civil Procedure shall be applicable.

(B) Unless, upon completion of the hearing, the court finds by clear and convincing evidence that the respondent named in the affidavit is a mentally retarded person subject to institutionalization by court order, it shall order the respondent's discharge forthwith.

(C) If, upon completion of the hearing, the court finds by clear and convincing evidence that the respondent is a mentally retarded person subject to institutionalization by court order, the court may order the respondent's discharge or order the respondent, for a period not to exceed ninety days, to any of the following:

(1) A public institution, provided that commitment of the respondent to the institution will not cause the institution to exceed its licensed capacity determined in accordance with section 5123.19 of the Revised Code and provided that such a placement is indicated by the comprehensive evaluation report filed pursuant to section 5123.71 of the Revised Code;

(2) A private institution;

(3) A county mental retardation program;

(4) Receive private habilitation and care;

(5) Any other suitable facility, program, or the care of any person consistent with the comprehensive evaluation, assessment, diagnosis, prognosis, and habilitation needs of the respondent.

(D) Any order made pursuant to division (C)(2), (4), or (5) of this section shall be conditional upon the receipt by the court of consent by the facility, program, or person to accept the respondent.

(E) In determining the place to which, or the person with whom, the respondent is to be committed, the court shall consider the comprehensive evaluation, assessment, diagnosis, and projected habilitation plan for the respondent, and shall order the implementation of the least restrictive alternative available and consistent with habilitation goals.

(F) If, at any time it is determined by the director of the facility or program to which, or the person to whom, the

respondent is committed that the respondent could be equally well habilitated in a less restrictive environment that is available, the following shall occur:

(1) The respondent shall be released by the director of the facility or program or by the person forthwith and referred to the court together with a report of the findings and recommendations of the facility, program, or person.

(2) The director of the facility or program or the person shall notify the respondent's counsel and the designee of the director of mental retardation and developmental disabilities.

(3) The court shall dismiss the case or order placement in the less restrictive environment.

(G)(1) Except as provided in divisions (G)(2) and (3) of this section, any person who has been committed under this section may apply at any time during the ninety-day period for voluntary admission to an institution under section 5123.69 of the Revised Code. Upon admission of a voluntary resident, the managing officer immediately shall notify the court, the respondent's counsel, and the designee of the director in writing of that fact by mail or otherwise, and, upon receipt of the notice, the court shall dismiss the case.

(2) A person who is found incompetent to stand trial or not guilty by reason of insanity and who is committed pursuant to section 2945.39, 2945.40, 2945.401, or 2945.402 of the Revised Code shall not be voluntarily admitted to an institution pursuant to division (G)(1) of this section until after the termination of the commitment, as described in division (J) of section 2945.401 of the Revised Code.

(H) If, at the end of any commitment period, the respondent has not already been discharged or has not requested voluntary admission status, the director of the facility or program, or the

person to whose care the respondent has been committed, shall discharge the respondent forthwith, unless at least ten days before the expiration of that period the designee of the director of mental retardation and developmental disabilities or the prosecutor files an application with the court requesting continued commitment.

(1) An application for continued commitment shall include a written report containing a current comprehensive evaluation and assessment, a diagnosis, a prognosis, an account of progress and past habilitation, and a description of alternative habilitation settings and plans, including a habilitation setting that is the least restrictive setting consistent with the need for habilitation. A copy of the application shall be provided to respondent's counsel. The requirements for notice under section 5123.73 of the Revised Code and the provisions of divisions (A) to (E) of this section apply to all hearings on such applications.

(2) A hearing on the first application for continued commitment shall be held at the expiration of the first ninety-day period. The hearing shall be mandatory and may not be waived.

(3) Subsequent periods of commitment not to exceed one hundred eighty days each may be ordered by the court if the designee of the director of mental retardation and developmental disabilities files an application for continued commitment, after a hearing is held on the application or without a hearing if no hearing is requested and no hearing required under division (H)(4) of this section is waived. Upon the application of a person involuntarily committed under this section, supported by an affidavit of a licensed physician alleging that the person is no longer a mentally retarded person subject to institutionalization by court order, the court for good cause shown may hold a full hearing on the person's continued commitment prior to the expiration of any subsequent period of commitment set by the

court.

(4) A mandatory hearing shall be held at least every two years after the initial commitment.

(5) If the court, after a hearing upon a request to continue commitment, finds that the respondent is a mentally retarded person subject to institutionalization by court order, the court may make an order pursuant to divisions (C), (D), and (E) of this section.

(I) Notwithstanding the provisions of division (H) of this section, no person who is found to be a mentally retarded person subject to institutionalization by court order pursuant to division ~~(O)~~(N)(2) of section 5123.01 of the Revised Code shall be held under involuntary commitment for more than five years.

(J) The managing officer admitting a person pursuant to a judicial proceeding, within ten working days of the admission, shall make a report of the admission to the department.

Sec. 5126.01. As used in this chapter:

(A) As used in this division, "adult" means an individual who is eighteen years of age or over and not enrolled in a program or service under Chapter 3323. of the Revised Code and an individual sixteen or seventeen years of age who is eligible for adult services under rules adopted by the director of mental retardation and developmental disabilities pursuant to Chapter 119. of the Revised Code.

(1) "Adult services" means services provided to an adult outside the home, except when they are provided within the home according to an individual's assessed needs and identified in an individual service plan, that support learning and assistance in the area of self-care, sensory and motor development, socialization, daily living skills, communication, community

living, social skills, or vocational skills.

(2) "Adult services" includes all of the following:

(a) Adult day habilitation services;

(b) Adult day care;

(c) Prevocational services;

(d) Sheltered employment;

(e) Educational experiences and training obtained through entities and activities that are not expressly intended for individuals with mental retardation and developmental disabilities, including trade schools, vocational or technical schools, adult education, job exploration and sampling, unpaid work experience in the community, volunteer activities, and spectator sports;

(f) Community employment services and supported employment services.

(B)(1) "Adult day habilitation services" means adult services that do the following:

(a) Provide access to and participation in typical activities and functions of community life that are desired and chosen by the general population, including such activities and functions as opportunities to experience and participate in community exploration, companionship with friends and peers, leisure activities, hobbies, maintaining family contacts, community events, and activities where individuals without disabilities are involved;

(b) Provide supports or a combination of training and supports that afford an individual a wide variety of opportunities to facilitate and build relationships and social supports in the community.

(2) "Adult day habilitation services" includes all of the

following:

(a) Personal care services needed to ensure an individual's ability to experience and participate in vocational services, educational services, community activities, and any other adult day habilitation services;

(b) Skilled services provided while receiving adult day habilitation services, including such skilled services as behavior management intervention, occupational therapy, speech and language therapy, physical therapy, and nursing services;

(c) Training and education in self-determination designed to help the individual do one or more of the following: develop self-advocacy skills, exercise the individual's civil rights, acquire skills that enable the individual to exercise control and responsibility over the services received, and acquire skills that enable the individual to become more independent, integrated, or productive in the community;

(d) Recreational and leisure activities identified in the individual's service plan as therapeutic in nature or assistive in developing or maintaining social supports;

(e) Counseling and assistance provided to obtain housing, including such counseling as identifying options for either rental or purchase, identifying financial resources, assessing needs for environmental modifications, locating housing, and planning for ongoing management and maintenance of the housing selected;

(f) Transportation necessary to access adult day habilitation services;

(g) Habilitation management, as described in section 5126.14 of the Revised Code.

(3) "Adult day habilitation services" does not include activities that are components of the provision of residential

services, family support services, or supported living services.

(C) "Appointing authority" means the following:

(1) In the case of a member of a county board of mental retardation and developmental disabilities appointed by, or to be appointed by, a board of county commissioners, the board of county commissioners;

(2) In the case of a member of a county board appointed by, or to be appointed by, a senior probate judge, the senior probate judge.

(D) "Community employment services" or "supported employment services" means job training and other services related to employment outside a sheltered workshop. "Community employment services" or "supported employment services" include all of the following:

(1) Job training resulting in the attainment of competitive work, supported work in a typical work environment, or self-employment;

(2) Supervised work experience through an employer paid to provide the supervised work experience;

(3) Ongoing work in a competitive work environment at a wage commensurate with workers without disabilities;

(4) Ongoing supervision by an employer paid to provide the supervision.

(E) As used in this division, "substantial functional limitation," "developmental delay," and "established risk" have the meanings established pursuant to section 5123.011 of the Revised Code.

"Developmental disability" means a severe, chronic disability that is characterized by all of the following:

(1) It is attributable to a mental or physical impairment or

a combination of mental and physical impairments, other than a mental or physical impairment solely caused by mental illness as defined in division (A) of section 5122.01 of the Revised Code;

(2) It is manifested before age twenty-two;

(3) It is likely to continue indefinitely;

(4) It results in one of the following:

(a) In the case of a person under age three, at least one developmental delay or an established risk;

(b) In the case of a person at least age three but under age six, at least two developmental delays or an established risk;

(c) In the case of a person age six or older, a substantial functional limitation in at least three of the following areas of major life activity, as appropriate for the person's age: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and, if the person is at least age sixteen, capacity for economic self-sufficiency.

(5) It causes the person to need a combination and sequence of special, interdisciplinary, or other type of care, treatment, or provision of services for an extended period of time that is individually planned and coordinated for the person.

(F) "Early childhood services" means a planned program of habilitation designed to meet the needs of individuals with mental retardation or other developmental disabilities who have not attained compulsory school age.

(G)(1) "Environmental modifications" means the physical adaptations to an individual's home, specified in the individual's service plan, that are necessary to ensure the individual's health, safety, and welfare or that enable the individual to function with greater independence in the home, and without which

the individual would require institutionalization.

(2) "Environmental modifications" includes such adaptations as installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, and installation of specialized electric and plumbing systems necessary to accommodate the individual's medical equipment and supplies.

(3) "Environmental modifications" does not include physical adaptations or improvements to the home that are of general utility or not of direct medical or remedial benefit to the individual, including such adaptations or improvements as carpeting, roof repair, and central air conditioning.

(H) "Family support services" means the services provided under a family support services program operated under section 5126.11 of the Revised Code.

(I) "Habilitation" means the process by which the staff of the facility or agency assists an individual with mental retardation or other developmental disability in acquiring and maintaining those life skills that enable the individual to cope more effectively with the demands of the individual's own person and environment, and in raising the level of the individual's personal, physical, mental, social, and vocational efficiency. Habilitation includes, but is not limited to, programs of formal, structured education and training.

(J) "Home and community-based services" means medicaid-funded home and community-based services specified in division (B)(1) of section ~~5111.87~~ 5163.65 of the Revised Code and provided under the medicaid waiver components the department of mental retardation and developmental disabilities administers pursuant to section ~~5111.871~~ 5163.651 of the Revised Code.

(K) "Immediate family" means parents, grandparents, brothers, sisters, spouses, sons, daughters, aunts, uncles, mothers-in-law,

fathers-in-law, brothers-in-law, sisters-in-law, sons-in-law, and daughters-in-law.

(L) ~~"Medicaid" has the same meaning as in section 5111.01 of the Revised Code.~~

~~(M)~~ "Medicaid case management services" means case management services provided to an individual with mental retardation or other developmental disability that the state medicaid plan requires.

~~(N)~~(M) "Mental retardation" means a mental impairment manifested during the developmental period characterized by significantly subaverage general intellectual functioning existing concurrently with deficiencies in the effectiveness or degree with which an individual meets the standards of personal independence and social responsibility expected of the individual's age and cultural group.

~~(O)~~(N) "Residential services" means services to individuals with mental retardation or other developmental disabilities to provide housing, food, clothing, habilitation, staff support, and related support services necessary for the health, safety, and welfare of the individuals and the advancement of their quality of life. "Residential services" includes program management, as described in section 5126.14 of the Revised Code.

~~(P)~~(O) "Resources" means available capital and other assets, including moneys received from the federal, state, and local governments, private grants, and donations; appropriately qualified personnel; and appropriate capital facilities and equipment.

~~(Q)~~(P) "Senior probate judge" means the current probate judge of a county who has served as probate judge of that county longer than any of the other current probate judges of that county. If a county has only one probate judge, "senior probate judge" means

that probate judge.

~~(R)~~(Q) "Service and support administration" means the duties performed by a service and support administrator pursuant to section 5126.15 of the Revised Code.

~~(S)~~(R)(1) "Specialized medical, adaptive, and assistive equipment, supplies, and supports" means equipment, supplies, and supports that enable an individual to increase the ability to perform activities of daily living or to perceive, control, or communicate within the environment.

(2) "Specialized medical, adaptive, and assistive equipment, supplies, and supports" includes the following:

(a) Eating utensils, adaptive feeding dishes, plate guards, mylatex straps, hand splints, reaches, feeder seats, adjustable pointer sticks, interpreter services, telecommunication devices for the deaf, computerized communications boards, other communication devices, support animals, veterinary care for support animals, adaptive beds, supine boards, prone boards, wedges, sand bags, sidelayers, bolsters, adaptive electrical switches, hand-held shower heads, air conditioners, humidifiers, emergency response systems, folding shopping carts, vehicle lifts, vehicle hand controls, other adaptations of vehicles for accessibility, and repair of the equipment received.

(b) Nondisposable items not covered by medicaid that are intended to assist an individual in activities of daily living or instrumental activities of daily living.

~~(T)~~(S) "Supportive home services" means a range of services to families of individuals with mental retardation or other developmental disabilities to develop and maintain increased acceptance and understanding of such persons, increased ability of family members to teach the person, better coordination between school and home, skills in performing specific therapeutic and

management techniques, and ability to cope with specific situations.

~~(U)~~(T)(1) "Supported living" means services provided for as long as twenty-four hours a day to an individual with mental retardation or other developmental disability through any public or private resources, including moneys from the individual, that enhance the individual's reputation in community life and advance the individual's quality of life by doing the following:

(a) Providing the support necessary to enable an individual to live in a residence of the individual's choice, with any number of individuals who are not disabled, or with not more than three individuals with mental retardation and developmental disabilities unless the individuals are related by blood or marriage;

(b) Encouraging the individual's participation in the community;

(c) Promoting the individual's rights and autonomy;

(d) Assisting the individual in acquiring, retaining, and improving the skills and competence necessary to live successfully in the individual's residence.

(2) "Supported living" includes the provision of all of the following:

(a) Housing, food, clothing, habilitation, staff support, professional services, and any related support services necessary to ensure the health, safety, and welfare of the individual receiving the services;

(b) A combination of lifelong or extended-duration supervision, training, and other services essential to daily living, including assessment and evaluation and assistance with the cost of training materials, transportation, fees, and supplies;

(c) Personal care services and homemaker services;

(d) Household maintenance that does not include modifications to the physical structure of the residence;

(e) Respite care services;

(f) Program management, as described in section 5126.14 of the Revised Code.

Sec. 5126.035. (A) As used in this section:

(1) "Provider" means a person or government entity that provides services to an individual with mental retardation or other developmental disability pursuant to a service contract.

(2) "Service contract" means a contract between a county board of mental retardation and developmental disabilities and a provider under which the provider is to provide services to an individual with mental retardation or other developmental disability.

(B) Each service contract that a county board of mental retardation and developmental disabilities enters into with a provider shall do both of the following:

(1) If the provider is to provide home and community-based services or medicaid case management services, comply with all applicable statewide medicaid requirements;

(2) Include a general operating agreement component and an individual service needs addendum.

(C) The general operating agreement component shall include all of the following:

(1) The roles and responsibilities of the county board regarding services for individuals with mental retardation or other developmental disability who reside in the county the county board serves;

(2) The roles and responsibilities of the provider as specified in the individual service needs addendum;

(3) Procedures for the county board to monitor the provider's services;

(4) Procedures for the county board to evaluate the quality of care and cost effectiveness of the provider's services;

(5) Procedures for payment of eligible claims;

(6) If the provider is to provide home and community-based services or medicaid case management services, both of the following:

(a) Procedures for reimbursement that conform to the statewide reimbursement process and the county board's plan submitted under section 5126.054 of the Revised Code;

(b) Procedures that ensure that the county board pays the nonfederal share of the medicaid expenditures that the county board is required by division (A) of section 5126.057 of the Revised Code to pay.

(7) Procedures for the county board to perform service utilization reviews and the implementation of required corrective actions;

(8) Procedures for the provider to submit claims for payment for a service no later than three hundred thirty days after the date the service is provided;

(9) Procedures for rejecting claims for payment that are submitted after the time required by division (C)(8) of this section;

(10) Procedures for developing, modifying, and executing initial and subsequent service plans. The procedures shall provide for the provider's participation.

(11) Procedures for affording individuals due process

protections;

(12) General staffing, training, and certification requirements that are consistent with state requirements and compensation arrangements that are necessary to attract, train, and retain competent personnel to deliver the services pursuant to the individual service needs addendum;

(13) Methods to be used to document services provided and procedures for submitting reports the county board requires;

(14) Methods for authorizing and documenting within seventy-two hours changes to the individual service needs addendum. The methods shall allow for changes to be initially authorized verbally and subsequently in writing.

(15) Procedures for modifying the individual service needs addendum in accordance with changes to the recipient's individualized service plan;

(16) Procedures for terminating the individual service needs addendum within thirty days of a request made by the recipient;

(17) A requirement that all parties to the contract accept the contract's terms and conditions;

(18) A designated contact person and the method of contacting the designated person to respond to medical or behavioral problems and allegations of major unusual incidents or unusual incidents;

(19) Procedures for ensuring the health and welfare of the recipient;

(20) Procedures for ensuring fiscal accountability and the collection and reporting of programmatic data;

(21) Procedures for implementing the mediation and arbitration process under section 5126.036 of the Revised Code;

(22) Procedures for amending or terminating the contract, including as necessary to make the general operating agreement

component consistent with any changes made to the individual service needs addendum;

(23) Anything else allowable under federal and state law that the county board and provider agree to.

(D) The individual service needs addendum shall be consistent with the general operating agreement component and include all of the following:

(1) The name of the individual with mental retardation or other developmental disability who is to receive the services from the provider and any information about the recipient that the provider needs to be able to provide the services;

(2) A clear and complete description of the services that the recipient is to receive as determined using statewide assessment tools;

(3) A copy of the recipient's assessment and individualized service plan;

(4) A clear and complete description of the provider's responsibilities to the recipient and county board in providing appropriate services in a coordinated manner with other providers and in a manner that contributes to and ensures the recipient's health, safety, and welfare.

(E) A service contract does not negate the requirement that a provider of home and community-based services or medicaid case management services have a medicaid provider agreement with the department of ~~job and family services~~ health care administration.

Sec. 5126.036. (A) As used in this section:

(1) "Aggrieved party" means any of the following:

(a) The party to a service contract that is aggrieved by an action the other party has taken or not taken under the service

contract;

(b) A person or government entity aggrieved by the refusal of a county board of mental retardation and developmental disabilities to enter into a service contract with the person or government entity;

(c) A person or government entity aggrieved by termination by a county board of mental retardation and development disabilities of a service contract between the person or government entity and the county board.

(2) "Mediator/arbitrator" means either of the following:

(a) An attorney at law licensed to practice law in this state who is mutually selected by the parties under division (B)(4) of this section to conduct mediation and arbitration;

(b) A retired judge who is selected under division (B)(4) of this section to conduct mediation and arbitration.

(3) "Other party" means any of the following:

(a) The party to a service contract that has taken or not taken an action under the service contract that causes the aggrieved party to be aggrieved;

(b) A county board of mental retardation and developmental disabilities that refuses to enter into a service contract with a person or government entity;

(c) A county board of mental retardation and developmental disabilities that terminates a service contract.

(4) "Parties" mean either of the following:

(a) A county board of mental retardation and developmental disabilities and a provider that have or had a service contract with each other;

(b) A person or government entity that seeks a service

contract with a county board of mental retardation and developmental disabilities and the county board that refuses to enter into the service contract with the person or government entity.

(5) "Provider" means a person or government entity that provides services to an individual with mental retardation or other developmental disability pursuant to a service contract.

(6) "Service contract" means a contract between a county board of mental retardation and developmental disabilities and a provider under which the provider is to provide services to an individual with mental retardation or other developmental disability.

(B) An aggrieved party that seeks to require the other party to take or cease an action under a service contract that causes the aggrieved party to be aggrieved, a person or government entity aggrieved by the refusal of a county board of mental retardation and developmental disabilities to enter into a service contract with the person or government entity, or a person or government entity aggrieved by a county board's termination of a service contract between the person or government entity and the county board and the other party shall follow the following mediation and arbitration procedures:

(1) No later than thirty days after first notifying the other party that the aggrieved party is aggrieved, the aggrieved party shall file a written notice of mediation and arbitration with the department of mental retardation and developmental disabilities and provide a copy of the written notice to the other party. The written notice shall include an explanation of why the aggrieved party is aggrieved. The department of mental retardation and developmental disabilities shall provide the department of ~~job and family services~~ health care administration a copy of the notice.

(2) In the case of parties that have a current service contract with each other and unless otherwise agreed to by both parties, the parties shall continue to operate under the contract in the manner they have been operating until the mediation and arbitration process, including an appeal under division (B)(9) of this section, if any, is completed.

(3) During the thirty days following the date the aggrieved party files the written notice of mediation and arbitration under division (B)(1) of this section, the parties may attempt to resolve the conflict informally. If the parties are able to resolve the conflict informally within this time, the aggrieved party shall rescind the written notice of mediation and arbitration filed under division (B)(1) of this section.

(4) No later than thirty days after the date the aggrieved party files the written notice of mediation and arbitration under division (B)(1) of this section, the parties shall mutually select an attorney at law licensed to practice law in this state to conduct the mediation and arbitration and schedule the first meeting of the mediation unless the parties informally resolve the conflict under division (B)(3) of this section. If the parties fail to select an attorney to conduct the mediation and arbitration within the required time, the parties shall request that the chief justice of the supreme court of Ohio provide the parties a list of five retired judges who are willing to perform the mediation and arbitration duties. The chief justice shall create such a list and provide it to the parties. To select the retired judge to conduct the mediation and arbitration, the parties shall take turns, beginning with the aggrieved party, striking retired judges from the list. The retired judge remaining on the list after both parties have each stricken two retired judges from the list shall perform the mediation and arbitration duties, including scheduling the first meeting of mediation if the

parties are unable to agree on a date for the first meeting.

(5) A stenographic record or tape recording and transcript of each mediation and arbitration meeting shall be maintained as part of the mediation and arbitration's official records. The parties shall share the cost of the mediation and arbitration, including the cost of the mediator/arbitrator's services but excluding the cost of representation.

(6) The first mediation meeting shall be held no later than sixty days after the date the aggrieved party files the written notice of mediation and arbitration under division (B)(1) of this section unless the parties informally resolve the conflict under division (B)(3) of this section or the parties mutually agree to hold the first meeting at a later time. The mediation shall be conducted in the manner the parties mutually agree. If the parties are unable to agree on how the mediation is to be conducted, the mediator/arbitrator selected under division (B)(4) of this section shall determine how it is to be conducted. The rules of evidence may be used. The mediator/arbitrator shall attempt to resolve the conflict through the mediation process. The mediator/arbitrator's resolution of the conflict may be applied retroactively.

(7) If the conflict is not resolved through the mediation process, the mediator/arbitrator shall arbitrate the conflict. The parties shall present evidence to the mediator/arbitrator in the manner the mediator/arbitrator requires. The mediator/arbitrator shall render a written recommendation within thirty days of the conclusion of the last arbitration meeting based on the service contract, applicable law, and the preponderance of the evidence presented during the arbitration. The mediator/arbitrator's recommendation may be applied retroactively. If the parties agree, the mediator/arbitrator may continue to attempt to resolve the conflict through mediation while the mediator/arbitrator arbitrates the conflict.

(8) No later than thirty days after the mediator/arbitrator renders a recommendation in an arbitration, the mediator/arbitrator shall provide the parties with a written recommendation and forward a copy of the written recommendation, transcripts from each arbitration meeting, and a copy of all evidence presented to the mediator/arbitrator during the arbitration to the departments of mental retardation and developmental disabilities and ~~job and family services~~ health care administration.

(9) No later than thirty days after the department of mental retardation and developmental disabilities receives the mediator/arbitrator's recommendation and the materials required by division (B)(8) of this section, the department shall adopt, reject, or modify the mediator/arbitrator's recommendation consistent with the mediator/arbitrator's findings of fact and conclusions of law or remand any portion of the recommendation to the mediator/arbitrator for further findings on a specific factual or legal issue. The mediator/arbitrator shall complete the further findings and provide the parties and the department with a written response to the remand within sixty days of the date the mediator/arbitrator receives the remand. On receipt of the mediator/arbitrator's response to the remand, the department, within thirty days, unless the parties agree otherwise, shall adopt, reject, or modify the mediator/arbitrator's response. The department's actions regarding the mediator/arbitrator's recommendation and response are a final adjudication order subject to appeal to the court of common pleas of Franklin county under section 119.12 of the Revised Code, except that the court shall consider only whether the conclusions of law the department adopts are in accordance with the law.

(10) If the department of ~~job and family services~~ health care administration, in consultation with the department of mental

retardation and developmental disabilities, determines no later than thirty days following the date the department of mental retardation and developmental disabilities receives the mediator/arbitrator's recommendation and the materials required by division (B)(8) of this section, or, if the recommendation is remanded under division (B)(9) of this section, thirty days following the date the department receives the response to the remand, that any aspect of the conflict between the parties affects the medicaid program, the department of mental retardation and developmental disabilities shall take all actions under division (B)(9) of this section in consultation with the department of ~~job and family services~~ health care administration.

(C) If the department of mental retardation and developmental disabilities is aware of a conflict between a county board of mental retardation and developmental disabilities and a person or government entity that provides or seeks to provide services to an individual with mental retardation or other developmental disability to which the mediation and arbitration procedures established by this section may be applied and that the aggrieved party has not filed a written notice of mediation and arbitration within the time required by division (B)(1) of this section, the department may require that the parties implement the mediation and arbitration procedures.

(D) Each service contract shall provide for the parties to follow the mediation and arbitration procedures established by this section if a party takes or does not take an action under the service contract that causes the aggrieved party to be aggrieved or if the provider is aggrieved by the county board's termination of the service contract.

Sec. 5126.042. (A) As used in this section, "emergency" means any situation that creates for an individual with mental

retardation or developmental disabilities a risk of substantial self-harm or substantial harm to others if action is not taken within thirty days. An "emergency" may include one or more of the following situations:

(1) Loss of present residence for any reason, including legal action;

(2) Loss of present caretaker for any reason, including serious illness of the caretaker, change in the caretaker's status, or inability of the caretaker to perform effectively for the individual;

(3) Abuse, neglect, or exploitation of the individual;

(4) Health and safety conditions that pose a serious risk to the individual or others of immediate harm or death;

(5) Change in the emotional or physical condition of the individual that necessitates substantial accommodation that cannot be reasonably provided by the individual's existing caretaker.

(B) If a county board of mental retardation and developmental disabilities determines that available resources are not sufficient to meet the needs of all individuals who request programs and services and may be offered the programs and services, it shall establish waiting lists for services. The board may establish priorities for making placements on its waiting lists according to an individual's emergency status and shall establish priorities in accordance with divisions (D) and (E) of this section.

The individuals who may be placed on a waiting list include individuals with a need for services on an emergency basis and individuals who have requested services for which resources are not available.

Except for an individual who is to receive priority for

services pursuant to division (D)(3) of this section, an individual who currently receives a service but would like to change to another service shall not be placed on a waiting list but shall be placed on a service substitution list. The board shall work with the individual, service providers, and all appropriate entities to facilitate the change in service as expeditiously as possible. The board may establish priorities for making placements on its service substitution lists according to an individual's emergency status.

In addition to maintaining waiting lists and service substitution lists, a board shall maintain a long-term service planning registry for individuals who wish to record their intention to request in the future a service they are not currently receiving. The purpose of the registry is to enable the board to document requests and to plan appropriately. The board may not place an individual on the registry who meets the conditions for receipt of services on an emergency basis.

(C) A county board shall establish a separate waiting list for each of the following categories of services, and may establish separate waiting lists within the waiting lists:

(1) Early childhood services;

(2) Educational programs for preschool and school age children;

(3) Adult services;

(4) Service and support administration;

(5) Residential services and supported living;

(6) Transportation services;

(7) Other services determined necessary and appropriate for persons with mental retardation or a developmental disability according to their individual habilitation or service plans;

(8) Family support services provided under section 5126.11 of the Revised Code.

(D) Except as provided in division (G) of this section, a county board shall do, as priorities, all of the following in accordance with the assessment component, approved under section 5123.046 of the Revised Code, of the county board's plan developed under section 5126.054 of the Revised Code:

(1) For the purpose of obtaining additional federal medicaid funds for home and community-based services and medicaid case management services, do both of the following:

(a) Give an individual who is eligible for home and community-based services and meets both of the following requirements priority over any other individual on a waiting list established under division (C) of this section for home and community-based services that include supported living, residential services, or family support services:

(i) Is twenty-two years of age or older;

(ii) Receives supported living or family support services.

(b) Give an individual who is eligible for home and community-based services and meets both of the following requirements priority over any other individual on a waiting list established under division (C) of this section for home and community-based services that include adult services:

(i) Resides in the individual's own home or the home of the individual's family and will continue to reside in that home after enrollment in home and community-based services;

(ii) Receives adult services from the county board.

(2) As federal medicaid funds become available pursuant to division (D)(1) of this section, give an individual who is eligible for home and community-based services and meets any of

the following requirements priority for such services over any other individual on a waiting list established under division (C) of this section:

(a) Does not receive residential services or supported living, either needs services in the individual's current living arrangement or will need services in a new living arrangement, and has a primary caregiver who is sixty years of age or older;

(b) Is less than twenty-two years of age and has at least one of the following service needs that are unusual in scope or intensity:

(i) Severe behavior problems for which a behavior support plan is needed;

(ii) An emotional disorder for which anti-psychotic medication is needed;

(iii) A medical condition that leaves the individual dependent on life-support medical technology;

(iv) A condition affecting multiple body systems for which a combination of specialized medical, psychological, educational, or habilitation services are needed;

(v) A condition the county board determines to be comparable in severity to any condition described in ~~division~~ divisions (D)(2)(b)(i) to (iv) of this section and places the individual at significant risk of institutionalization.

(c) Is twenty-two years of age or older, does not receive residential services or supported living, and is determined by the county board to have intensive needs for home and community-based services on an in-home or out-of-home basis.

(3) In fiscal years 2002 and 2003, give an individual who is eligible for home and community-based services, resides in an intermediate care facility for the mentally retarded or nursing

facility, chooses to move to another setting with the help of home and community-based services, and has been determined by the department of mental retardation and developmental disabilities to be capable of residing in the other setting, priority over any other individual on a waiting list established under division (C) of this section for home and community-based services who does not meet these criteria. The department of mental retardation and developmental disabilities shall identify the individuals to receive priority under division (D)(3) of this section, assess the needs of the individuals, and notify the county boards that are to provide the individuals priority under division (D)(3) of this section of the individuals identified by the department and the individuals' assessed needs.

(E) Except as provided in division (G) of this section and for a number of years and beginning on a date specified in rules adopted under division (K) of this section, a county board shall give an individual who is eligible for home and community-based services, resides in a nursing facility, and chooses to move to another setting with the help of home and community-based services, priority over any other individual on a waiting list established under division (C) of this section for home and community-based services who does not meet these criteria.

(F) If two or more individuals on a waiting list established under division (C) of this section for home and community-based services have priority for the services pursuant to division (D)(1) or (2) or (E) of this section, a county board may use, until December 31, 2007, criteria specified in rules adopted under division (K)(2) of this section in determining the order in which the individuals with priority will be offered the services. Otherwise, the county board shall offer the home and community-based services to such individuals in the order they are placed on the waiting list.

(G)(1) No individual may receive priority for services pursuant to division (D) or (E) of this section over an individual placed on a waiting list established under division (C) of this section on an emergency status.

(2) No more than four hundred individuals in the state may receive priority for services during the 2006 and 2007 biennium pursuant to division (D)(2)(b) of this section.

(3) No more than a total of seventy-five individuals in the state may receive priority for services during state fiscal years 2002 and 2003 pursuant to division (D)(3) of this section.

(4) No more than forty individuals in the state may receive priority for services pursuant to division (E) of this section for each year that priority category is in effect as specified in rules adopted under division (K) of this section.

(H) Prior to establishing any waiting list under this section, a county board shall develop and implement a policy for waiting lists that complies with this section and rules adopted under division (K) of this section.

Prior to placing an individual on a waiting list, the county board shall assess the service needs of the individual in accordance with all applicable state and federal laws. The county board shall place the individual on the appropriate waiting list and may place the individual on more than one waiting list. The county board shall notify the individual of the individual's placement and position on each waiting list on which the individual is placed.

At least annually, the county board shall reassess the service needs of each individual on a waiting list. If it determines that an individual no longer needs a program or service, the county board shall remove the individual from the waiting list. If it determines that an individual needs a program

or service other than the one for which the individual is on the waiting list, the county board shall provide the program or service to the individual or place the individual on a waiting list for the program or service in accordance with the board's policy for waiting lists.

When a program or service for which there is a waiting list becomes available, the county board shall reassess the service needs of the individual next scheduled on the waiting list to receive that program or service. If the reassessment demonstrates that the individual continues to need the program or service, the board shall offer the program or service to the individual. If it determines that an individual no longer needs a program or service, the county board shall remove the individual from the waiting list. If it determines that an individual needs a program or service other than the one for which the individual is on the waiting list, the county board shall provide the program or service to the individual or place the individual on a waiting list for the program or service in accordance with the board's policy for waiting lists. The county board shall notify the individual of the individual's placement and position on the waiting list on which the individual is placed.

(I) A child subject to a determination made pursuant to section 121.38 of the Revised Code who requires the home and community-based services provided through a medicaid component that the department of mental retardation and developmental disabilities administers under section ~~5111.871~~ 5163.651 of the Revised Code shall receive services through that medicaid component. For all other services, a child subject to a determination made pursuant to section 121.38 of the Revised Code shall be treated as an emergency by the county boards and shall not be subject to a waiting list.

(J) Not later than the fifteenth day of March of each

even-numbered year, each county board shall prepare and submit to the director of mental retardation and developmental disabilities its recommendations for the funding of services for individuals with mental retardation and developmental disabilities and its proposals for reducing the waiting lists for services.

(K)(1) The department of mental retardation and developmental disabilities shall adopt rules in accordance with Chapter 119. of the Revised Code governing waiting lists established under this section. The rules shall include procedures to be followed to ensure that the due process rights of individuals placed on waiting lists are not violated.

(2) As part of the rules adopted under this division, the department shall adopt rules establishing criteria a county board may use under division (F) of this section in determining the order in which individuals with priority for home and community-based services will be offered the services. The rules shall also specify conditions under which a county board, when there is no individual with priority for home and community-based services pursuant to division (D)(1) or (2) or (E) of this section available and appropriate for the services, may offer the services to an individual on a waiting list for the services but not given such priority for the services. The rules adopted under division (K)(2) of this section shall cease to have effect December 31, 2007.

(3) As part of the rules adopted under this division, the department shall adopt rules specifying both of the following for the priority category established under division (E) of this section:

(a) The number of years, which shall not exceed five, that the priority category will be in effect;

(b) The date that the priority category is to go into effect.

(L) The following shall take precedence over the applicable provisions of this section:

(1) Medicaid rules and regulations;

(2) Any specific requirements that may be contained within a medicaid state plan amendment or waiver program that a county board has authority to administer or with respect to which it has authority to provide services, programs, or supports.

Sec. 5126.046. (A) Each county board of mental retardation and developmental disabilities that has medicaid local administrative authority under division (A) of section 5126.055 of the Revised Code for habilitation, vocational, or community employment services provided as part of home and community-based services shall create a list of all persons and government entities eligible to provide such habilitation, vocational, or community employment services. If the county board chooses and is eligible to provide such habilitation, vocational, or community employment services, the county board shall include itself on the list. The county board shall make the list available to each individual with mental retardation or other developmental disability who resides in the county and is eligible for such habilitation, vocational, or community employment services. The county board shall also make the list available to such individuals' families.

An individual with mental retardation or other developmental disability who is eligible for habilitation, vocational, or community employment services may choose the provider of the services.

A county board that has medicaid local administrative authority under division (A) of section 5126.055 of the Revised Code for habilitation, vocational, and community employment services provided as part of home and community-based services

shall pay the nonfederal share of the habilitation, vocational, and community employment services when required by section 5126.057 of the Revised Code. The department of mental retardation and developmental disabilities shall pay the nonfederal share of such habilitation, vocational, and community employment services when required by section 5123.047 of the Revised Code.

(B) Each month, the department of mental retardation and developmental disabilities shall create a list of all persons and government entities eligible to provide residential services and supported living. The department shall include on the list all residential facilities licensed under section 5123.19 of the Revised Code and all supported living providers certified under section 5126.431 of the Revised Code. The department shall distribute the monthly lists to county boards that have local administrative authority under division (A) of section 5126.055 of the Revised Code for residential services and supported living provided as part of home and community-based services. A county board that receives a list shall make it available to each individual with mental retardation or other developmental disability who resides in the county and is eligible for such residential services or supported living. The county board shall also make the list available to the families of those individuals.

An individual who is eligible for residential services or supported living may choose the provider of the residential services or supported living.

A county board that has medicaid local administrative authority under division (A) of section 5126.055 of the Revised Code for residential services and supported living provided as part of home and community-based services shall pay the nonfederal share of the residential services and supported living when required by section 5126.057 of the Revised Code. The department shall pay the nonfederal share of the residential services and

supported living when required by section 5123.047 of the Revised Code.

(C) If a county board that has medicaid local administrative authority under division (A) of section 5126.055 of the Revised Code for home and community-based services violates the right established by this section of an individual to choose a provider that is qualified and willing to provide services to the individual, the individual shall receive timely notice that the individual may request a hearing under section ~~5101.35~~ 5160.34 of the Revised Code.

(D) The departments of mental retardation and developmental disabilities and ~~job and family services~~ health care administration shall adopt rules in accordance with Chapter 119. of the Revised Code governing the implementation of this section. The rules shall include procedures for individuals to choose their service providers. The rules shall not be limited by a provider selection system established under section 5126.42 of the Revised Code, including any pool of providers created pursuant to a provider selection system.

Sec. 5126.054. (A) Each county board of mental retardation and developmental disabilities shall, by resolution, develop a three-calendar year plan that includes the following four components:

(1) An assessment component that includes all of the following:

(a) The number of individuals with mental retardation or other developmental disability residing in the county who need the level of care provided by an intermediate care facility for the mentally retarded, may seek home and community-based services, are given priority for the services pursuant to division (D) of section 5126.042 of the Revised Code; the service needs of those

individuals; and the projected annualized cost for services;

(b) The source of funds available to the county board to pay the nonfederal share of medicaid expenditures that the county board is required by division (A) of section 5126.057 of the Revised Code to pay;

(c) Any other applicable information or conditions that the department of mental retardation and developmental disabilities requires as a condition of approving the component under section 5123.046 of the Revised Code.

(2) A component that provides for the recruitment, training, and retention of existing and new direct care staff necessary to implement services included in individualized service plans, including behavior management services and health management services such as delegated nursing and other habilitation services, and protect the health and welfare of individuals receiving services included in the individual's individualized service plan by complying with safeguards for unusual and major unusual incidents, day-to-day program management, and other requirements the department shall identify. A county board shall develop this component in collaboration with providers of medicaid-funded services with which the county board contracts. A county board shall include all of the following in the component:

(a) The source and amount of funds available for the component;

(b) A plan and timeline for implementing the component with the medicaid providers under contract with the county board;

(c) The mechanisms the county board shall use to ensure the financial and program accountability of the medicaid provider's implementation of the component.

(3) A preliminary implementation component that specifies the number of individuals to be provided, during the first year that

the plan is in effect, home and community-based services pursuant to the priority given to them under divisions (D)(1) and (2) of section 5126.042 of the Revised Code and the types of home and community-based services the individuals are to receive;

(4) A component that provides for the implementation of medicaid case management services and home and community-based services for individuals who begin to receive the services on or after the date the plan is approved under section 5123.046 of the Revised Code. A county board shall include all of the following in the component:

(a) If the department of mental retardation and developmental disabilities or department of ~~job and family services~~ health care administration requires, an agreement to pay the nonfederal share of medicaid expenditures that the county board is required by division (A) of section 5126.057 of the Revised Code to pay;

(b) How the services are to be phased in over the period the plan covers, including how the county board will serve individuals on a waiting list established under division (C) of section 5126.042 who are given priority status under division (D)(1) of that section;

(c) Any agreement or commitment regarding the county board's funding of home and community-based services that the county board has with the department at the time the county board develops the component;

(d) Assurances adequate to the department that the county board will comply with all of the following requirements:

(i) To provide the types of home and community-based services specified in the preliminary implementation component required by division (A)(3) of this section to at least the number of individuals specified in that component;

(ii) To use any additional funds the county board receives

for the services to improve the county board's resource capabilities for supporting such services available in the county at the time the component is developed and to expand the services to accommodate the unmet need for those services in the county;

(iii) To employ a business manager who is either a new employee who has earned at least a bachelor's degree in business administration or a current employee who has the equivalent experience of a bachelor's degree in business administration. If the county board will employ a new employee, the county board shall include in the component a timeline for employing the employee.

(iv) To employ or contract with a medicaid services manager who is either a new employee who has earned at least a bachelor's degree or a current employee who has the equivalent experience of a bachelor's degree. If the county board will employ a new employee, the county board shall include in the component a timeline for employing the employee. Two or three county boards that have a combined total enrollment in county board services not exceeding one thousand individuals as determined pursuant to certifications made under division (B) of section 5126.12 of the Revised Code may satisfy this requirement by sharing the services of a medicaid services manager or using the services of a medicaid services manager employed by or under contract with a regional council that the county boards establish under section 5126.13 of the Revised Code.

(e) An agreement to comply with the method, developed by rules adopted under section 5123.0413 of the Revised Code, of paying for extraordinary costs, including extraordinary costs for services to individuals with mental retardation or other developmental disability, and ensuring the availability of adequate funds in the event a county property tax levy for services for individuals with mental retardation or other

developmental disability fails;

(f) Programmatic and financial accountability measures and projected outcomes expected from the implementation of the plan;

(g) Any other applicable information or conditions that the department requires as a condition of approving the component under section 5123.046 of the Revised Code.

(B) For the purpose of obtaining the department's approval under section 5123.046 of the Revised Code of the plan the county board develops under division (A) of this section, a county board shall do all of the following:

(1) Submit the components required by divisions (A)(1) and (2) of this section to the department not later than August 1, 2001;

(2) Submit the component required by division (A)(3) of this section to the department not later than January 31, 2002;

(3) Submit the component required by division (A)(4) of this section to the department not later than July 1, 2002.

(C) A county board whose plan developed under division (A) of this section is approved by the department under section 5123.046 of the Revised Code shall update and renew the plan in accordance with a schedule the department shall develop.

Sec. 5126.055. (A) Except as provided in section 5126.056 of the Revised Code, a county board of mental retardation and developmental disabilities has medicaid local administrative authority to, and shall, do all of the following for an individual with mental retardation or other developmental disability who resides in the county that the county board serves and seeks or receives home and community-based services:

(1) Perform assessments and evaluations of the individual. As part of the assessment and evaluation process, the county board

shall do all of the following:

(a) Make a recommendation to the department of mental retardation and developmental disabilities on whether the department should approve or deny the individual's application for the services, including on the basis of whether the individual needs the level of care an intermediate care facility for the mentally retarded provides;

(b) If the individual's application is denied because of the county board's recommendation and the individual requests a hearing under section ~~5101.35~~ 5160.34 of the Revised Code, present, with the department of mental retardation and developmental disabilities or department of ~~job and family services~~ health care administration, whichever denies the application, the reasons for the recommendation and denial at the hearing;

(c) If the individual's application is approved, recommend to the departments of mental retardation and developmental disabilities and ~~job and family services~~ health care administration the services that should be included in the individual's individualized service plan and, if either department approves, reduces, denies, or terminates a service included in the individual's individualized service plan under section ~~5111.871~~ 5163.651 of the Revised Code because of the county board's recommendation, present, with the department that made the approval, reduction, denial, or termination, the reasons for the recommendation and approval, reduction, denial, or termination at a hearing under section ~~5101.35~~ 5160.34 of the Revised Code.

(2) If the individual has been identified by the department of mental retardation and developmental disabilities as an individual to receive priority for home and community-based services pursuant to division (D)(3) of section 5126.042 of the Revised Code, assist the department in expediting the transfer of

the individual from an intermediate care facility for the mentally retarded or nursing facility to the home and community-based services;

(3) In accordance with the rules adopted under section 5126.046 of the Revised Code, perform the county board's duties under that section regarding assisting the individual's right to choose a qualified and willing provider of the services and, at a hearing under section 5101.35 of the Revised Code, present evidence of the process for appropriate assistance in choosing providers;

(4) Unless the county board provides the services under division (A)(5) of this section, contract with the person or government entity the individual chooses in accordance with section 5126.046 of the Revised Code to provide the services if the person or government entity is qualified and agrees to provide the services. The contract shall contain all the provisions required by section 5126.035 of the Revised Code and require the provider to agree to furnish, in accordance with the provider's medicaid provider agreement and for the authorized reimbursement rate, the services the individual requires.

(5) If the county board is certified under section 5123.16 of the Revised Code to provide the services and agrees to provide the services to the individual and the individual chooses the county board to provide the services, furnish, in accordance with the county board's medicaid provider agreement and for the authorized reimbursement rate, the services the individual requires;

(6) Monitor the services provided to the individual and ensure the individual's health, safety, and welfare. The monitoring shall include quality assurance activities. If the county board provides the services, the department of mental retardation and developmental disabilities shall also monitor the services.

(7) Develop, with the individual and the provider of the individual's services, an effective individualized service plan that includes coordination of services, recommend that the departments of mental retardation and developmental disabilities and ~~job and family services~~ health care administration approve the plan, and implement the plan unless either department disapproves it;

(8) Have an investigative agent conduct investigations under section 5126.313 of the Revised Code that concern the individual;

(9) Have a service and support administrator perform the duties under division (B)(9) of section 5126.15 of the Revised Code that concern the individual.

(B) A county board shall perform its medicaid local administrative authority under this section in accordance with all of the following:

(1) The county board's plan that the department of mental retardation and developmental disabilities approves under section 5123.046 of the Revised Code;

(2) All applicable federal and state laws;

(3) All applicable policies of the departments of mental retardation and developmental disabilities and ~~job and family services~~ health care administration and the United States department of health and human services;

(4) The department of ~~job and family services'~~ health care administration's supervision under its authority under section ~~5111.01~~ 5161.01 of the Revised Code to act as the single state medicaid agency;

(5) The department of mental retardation and developmental disabilities' oversight.

(C) The departments of mental retardation and developmental

disabilities and ~~job and family services~~ health care administration shall communicate with and provide training to county boards regarding medicaid local administrative authority granted by this section. The communication and training shall include issues regarding audit protocols and other standards established by the United States department of health and human services that the departments determine appropriate for communication and training. County boards shall participate in the training. The departments shall assess the county board's compliance against uniform standards that the departments shall establish.

(D) A county board may not delegate its medicaid local administrative authority granted under this section but may contract with a person or government entity, including a council of governments, for assistance with its medicaid local administrative authority. A county board that enters into such a contract shall notify the director of mental retardation and developmental disabilities. The notice shall include the tasks and responsibilities that the contract gives to the person or government entity. The person or government entity shall comply in full with all requirements to which the county board is subject regarding the person or government entity's tasks and responsibilities under the contract. The county board remains ultimately responsible for the tasks and responsibilities.

(E) A county board that has medicaid local administrative authority under this section shall, through the departments of mental retardation and developmental disabilities and ~~job and family services~~ health care administration, reply to, and cooperate in arranging compliance with, a program or fiscal audit or program violation exception that a state or federal audit or review discovers. The department of ~~job and family services~~ health care administration shall timely notify the department of mental

retardation and developmental disabilities and the county board of any adverse findings. After receiving the notice, the county board, in conjunction with the department of mental retardation and developmental disabilities, shall cooperate fully with the department of ~~job and family services~~ health care administration and timely prepare and send to the department a written plan of correction or response to the adverse findings. The county board is liable for any adverse findings that result from an action it takes or fails to take in its implementation of medicaid local administrative authority.

(F) If the department of mental retardation and developmental disabilities or department of ~~job and family services~~ health care administration determines that a county board's implementation of its medicaid local administrative authority under this section is deficient, the department that makes the determination shall require that county board do the following:

(1) If the deficiency affects the health, safety, or welfare of an individual with mental retardation or other developmental disability, correct the deficiency within twenty-four hours;

(2) If the deficiency does not affect the health, safety, or welfare of an individual with mental retardation or other developmental disability, receive technical assistance from the department or submit a plan of correction to the department that is acceptable to the department within sixty days and correct the deficiency within the time required by the plan of correction.

Sec. 5126.082. (A) In addition to the rules adopted under division (A)(2) of section 5126.08 of the Revised Code establishing standards to be followed by county boards of mental retardation and developmental disabilities in administering, providing, arranging, and operating programs and services and in addition to the board accreditation system established under

section 5126.081 of the Revised Code, the director of mental retardation and developmental disabilities shall adopt rules in accordance with Chapter 119. of the Revised Code establishing standards for promoting and advancing the quality of life of individuals with mental retardation and developmental disabilities receiving any of the following:

(1) Early childhood services pursuant to section 5126.05 of the Revised Code for children under age three;

(2) Adult services pursuant to section 5126.05 and division (B) of section 5126.051 of the Revised Code for individuals age sixteen or older;

(3) Family support services pursuant to section 5126.11 of the Revised Code.

(B) The rules adopted under this section shall specify the actions county boards of mental retardation and developmental disabilities and the agencies with which they contract should take to do the following:

(1) Offer individuals with mental retardation and developmental disabilities, and their families when appropriate, choices in programs and services that are centered on the needs and desires of those individuals;

(2) Maintain infants with their families whenever possible by collaborating with other agencies that provide services to infants and their families and taking other appropriate actions;

(3) Provide families that have children with mental retardation and developmental disabilities under age eighteen residing in their homes the resources necessary to allow the children to remain in their homes;

(4) Create and implement community employment services based on the needs and desires of adults with mental retardation and

developmental disabilities;

(5) Create, in collaboration with other agencies, transportation systems that provide safe and accessible transportation within the county to individuals with disabilities;

(6) Provide services that allow individuals with disabilities to be integrated into the community by engaging in educational, vocational, and recreational activities with individuals who do not have disabilities;

(7) Provide age-appropriate retirement services for individuals age sixty-five and older with mental retardation and developmental disabilities;

(8) Establish residential services and supported living for individuals with mental retardation and developmental disabilities in accordance with their needs.

(C) To assist in funding programs and services that meet the standards established under this section, each county board of mental retardation and developmental disabilities shall make a good faith effort to acquire available federal funds, including reimbursements under ~~Title XIX of~~ the ~~"Social Security Act," 79 Stat. 286 (1965), 42 U.S.C.A. 1396, as amended~~ medicaid program.

(D) Each county board of mental retardation and developmental disabilities shall work toward full compliance with the standards established under this section, based on its available resources. Funds received under this chapter shall be used to comply with the standards. Annually, each board shall conduct a self audit to evaluate the board's progress in complying fully with the standards.

(E) The department shall complete a program quality review of each county board of mental retardation and developmental disabilities to determine the extent to which the board has complied with the standards. The review shall be conducted in

conjunction with the comprehensive accreditation review of the board that is conducted under section 5126.081 of the Revised Code.

Notwithstanding any provision of this chapter or Chapter 5123. of the Revised Code requiring the department to distribute funds to county boards of mental retardation and developmental disabilities, the department may withhold funds from a board if it finds that the board is not in substantial compliance with the standards established under this section.

(F) When the standards for accreditation from the commission on accreditation of rehabilitation facilities, or another accrediting agency, meet or exceed the standards established under this section, the director may accept accreditation from the commission or other agency as evidence that the board is in compliance with all or part of the standards established under this section. Programs and services accredited by the commission or agency are exempt from the program quality reviews required by division (E) of this section.

Sec. 5126.12. (A) As used in this section:

(1) "Approved school age class" means a class operated by a county board of mental retardation and developmental disabilities and funded by the department of education under section 3317.20 of the Revised Code.

(2) "Approved preschool unit" means a class or unit operated by a county board of mental retardation and developmental disabilities and approved under division (B) of section 3317.05 of the Revised Code.

(3) "Active treatment" means a continuous treatment program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services,

and related services, that is directed toward the acquisition of behaviors necessary for an individual with mental retardation or other developmental disability to function with as much self-determination and independence as possible and toward the prevention of deceleration, regression, or loss of current optimal functional status.

(4) "Eligible for active treatment" means that an individual with mental retardation or other developmental disability resides in an intermediate care facility for the mentally retarded certified under ~~Title XIX of~~ the ~~"Social Security Act," 79 Stat. 286 (1965), 42 U.S.C. 1396, as amended~~ medicaid program; resides in a state institution operated by the department of mental retardation and developmental disabilities; or is enrolled in home and community-based services.

(5) "Traditional adult services" means vocational and nonvocational activities conducted within a sheltered workshop or adult activity center or supportive home services.

(B) Each county board of mental retardation and developmental disabilities shall certify to the director of mental retardation and developmental disabilities all of the following:

(1) On or before the fifteenth day of October, the average daily membership for the first full week of programs and services during October receiving:

(a) Early childhood services provided pursuant to section 5126.05 of the Revised Code for children who are less than three years of age on the thirtieth day of September of the academic year;

(b) Special education for handicapped children in approved school age classes;

(c) Adult services for persons sixteen years of age and older operated pursuant to section 5126.05 and division (B) of section

5126.051 of the Revised Code. Separate counts shall be made for the following:

(i) Persons enrolled in traditional adult services who are eligible for but not enrolled in active treatment;

(ii) Persons enrolled in traditional adult services who are eligible for and enrolled in active treatment;

(iii) Persons enrolled in traditional adult services but who are not eligible for active treatment;

(iv) Persons participating in community employment services. To be counted as participating in community employment services, a person must have spent an average of no less than ten hours per week in that employment during the preceding six months.

(d) Other programs in the county for individuals with mental retardation and developmental disabilities that have been approved for payment of subsidy by the department of mental retardation and developmental disabilities.

The membership in each such program and service in the county shall be reported on forms prescribed by the department of mental retardation and developmental disabilities.

The department of mental retardation and developmental disabilities shall adopt rules defining full-time equivalent enrollees and for determining the average daily membership therefrom, except that certification of average daily membership in approved school age classes shall be in accordance with rules adopted by the state board of education. The average daily membership figure shall be determined by dividing the amount representing the sum of the number of enrollees in each program or service in the week for which the certification is made by the number of days the program or service was offered in that week. No enrollee may be counted in average daily membership for more than one program or service.

(2) By the fifteenth day of December, the number of children enrolled in approved preschool units on the first day of December;

(3) On or before the thirtieth day of March, an itemized report of all income and operating expenditures for the immediately preceding calendar year, in the format specified by the department of mental retardation and developmental disabilities;

(4) By the fifteenth day of February, a report of the total annual cost per enrollee for operation of programs and services in the preceding calendar year. The report shall include a grand total of all programs operated, the cost of the individual programs, and the sources of funds applied to each program.

(5) That each required certification and report is in accordance with rules established by the department of mental retardation and developmental disabilities and the state board of education for the operation and subsidization of the programs and services.

(C) To compute payments under this section to the board for the fiscal year, the department of mental retardation and developmental disabilities shall use the certification of average daily membership required by division (B)(1) of this section exclusive of the average daily membership in any approved school age class and the number in any approved preschool unit.

(D) The department shall pay each county board for each fiscal year an amount equal to nine hundred fifty dollars times the certified number of persons who on the first day of December of the academic year are under three years of age and are not in an approved preschool unit. For persons who are at least age sixteen and are not in an approved school age class, the department shall pay each county board for each fiscal year the following amounts:

(1) One thousand dollars times the certified average daily membership of persons enrolled in traditional adult services who are eligible for but not enrolled in active treatment;

(2) One thousand two hundred dollars times the certified average daily membership of persons enrolled in traditional adult services who are eligible for and enrolled in active treatment;

(3) No less than one thousand five hundred dollars times the certified average daily membership of persons enrolled in traditional adult services but who are not eligible for active treatment;

(4) No less than one thousand five hundred dollars times the certified average daily membership of persons participating in community employment services.

(E) The department shall distribute this subsidy to county boards in quarterly installments of equal amounts. The installments shall be made not later than the thirtieth day of September, the thirty-first day of December, the thirty-first day of March, and the thirtieth day of June.

(F) The director of mental retardation and developmental disabilities shall make efforts to obtain increases in the subsidies for early childhood services and adult services so that the amount of the subsidies is equal to at least fifty per cent of the statewide average cost of those services minus any applicable federal reimbursements for those services. The director shall advise the director of budget and management of the need for any such increases when submitting the biennial appropriations request for the department.

(G) In determining the reimbursement of a county board for the provision of service and support administration, family support services, and other services required or approved by the director for which children three through twenty-one years of age

are eligible, the department shall include the average daily membership in approved school age or preschool units. The department, in accordance with this section and upon receipt and approval of the certification required by this section and any other information it requires to enable it to determine a board's payments, shall pay the agency providing the specialized training the amounts payable under this section.

Sec. 5160.01. As used in the Revised Code:

"Children's health insurance program" means the program authorized by Title XXI of the Social Security Act of 1935 and Chapter 5167. of the Revised Code.

"Disability medical assistance program" and "disability medical assistance" mean the program authorized by Chapter 5168. of the Revised Code.

"Medicaid program" and "medicaid" mean the medical assistance program created by Title XIX of the Social Security Act of 1935 and Chapters 5161., 5162., 5163., 5164., 5165., and 5166. of the Revised Code.

"Medicare program" and "medicare" mean the health insurance program created by Title XVIII of the Social Security Act of 1935.

"Ohio's best Rx program" means the program established under Chapter 5169. of the Revised Code.

"Supplemental security income program," "SSI program," "supplemental security income," and "SSI" mean the program providing benefits to qualified aged, blind, and disabled individuals created by Title XVI of the Social Security Act of 1935.

"Residential state supplement program" means the program administered pursuant to section 5160.80 of the Revised Code.

Sec. 5160.02. As used in this chapter:

(A) "ODHCA family services duty" means a family services duty associated with an ODHCA program.

(B) "ODHCA program" means all of the following:

(1) The children's health insurance program;

(2) The disability medical assistance program;

(3) The medicaid program;

(4) The Ohio's best Rx program;

(5) The residential state supplement program;

(6) Any other program that state law permits or requires the department of health care administration to administer.

Sec. 5160.03. The director of health care administration shall do all of the following as necessary for the department's efficient administration:

(A) Organize the department of health care administration, including creating administrative subunits;

(B) Appoint employees and prescribe their titles and duties, including chiefs of administrative subunits;

(C) Establish procedures for conducting the business of the department, including procedures for the custody, use, and preservation of records, papers, documents, and property.

Sec. ~~5111.084~~ 5160.04. There is hereby established the pharmacy and therapeutics committee of the department of ~~job and family services~~ health care administration. The committee shall consist of nine members and shall be appointed by the director of ~~job and family services~~ health care administration. The membership of the committee shall include: 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. 5160.05. If the director of health care administration determines that a position with the department of health care administration can best be filled in accordance with division (A)(2) of section 124.30 of the Revised Code or without regard to a residency requirement established by a rule adopted by the director of administrative services, the director of health care administration shall provide the director of administrative services certification of the determination.

Sec. 5160.06. The director of health care administration may require any of the employees of the department of health care administration who may be charged with custody or control of any public money or property or who is required to give bond, to give a bond, properly conditioned, in a sum to be fixed by the director which when approved by the director, shall be filed in the office of the secretary of state. The cost of such bonds, when approved by the director, shall be paid from funds available for the department. The bonds required or authorized by this section may, in the discretion of the director, be individual, schedule, or blanket bonds.

Sec. 5160.08. The director of health care administration may acquire by purchase, lease, or otherwise such real and personal property rights in the name of the state as are necessary for the purposes of the department of health care administration. The director, with the approval of the governor and the attorney general, may sell, lease, or exchange portions of real and

personal property of the department when the sale, lease, or exchange is advantageous to the state. Money received from such sales, leases, or exchanges shall be credited to the general revenue fund.

Sec. 5160.10. There is hereby created in the state treasury the ODHCA support services federal operating fund. The fund shall consist of federal funds the department of health care administration receives and that the director of health care administration determines are appropriate for deposit into the fund. Money in the fund shall be used to pay the federal share of both of the following:

(A) The department's costs for computer projects;

(B) The operating costs of the parts of the department that provide general support services for the department's administrative subunits.

Sec. 5160.101. There is hereby created in the state treasury the ODHCA support services state operating fund. The fund shall consist of payments made to the fund from other appropriation items by intrastate transfer voucher. Money in the fund shall be used to pay for both of the following:

(A) The department of health care administration's costs for computer projects;

(B) The operating costs of the parts of the department that provide general support services for the department's administrative subunits.

Sec. 5160.12. The director of health care administration may expend funds appropriated or available to the department of health care administration from any person or government entity. For purposes of this section, the director may enter into contracts

with persons and government entities and make grants to persons and government entities. To the extent permitted by federal law, the director may advance funds to a grantee when necessary for the grantee to perform duties under the grant as specified by the director.

Sec. 5160.13. (A) As used in this section:

(1) "Entity" includes an agency, board, commission, or department of the state or a political subdivision of the state; a private, nonprofit entity; a school district; a private school; or a public or private institution of higher education.

(2) "Federal financial participation" means the federal government's share of expenditures made by an entity in implementing an ODHCA program.

(B) This section does not apply to contracts entered into under section 5161.05 or 5161.10 of the Revised Code.

(C) At the request of any public entity having authority to implement an ODHCA program or any private entity under contract with a public entity to implement an ODHCA program, the department may seek to obtain federal financial participation for costs incurred by the entity. Federal financial participation may be sought only for expenditures made with funds for which federal financial participation is available under federal law.

(D) All funds collected by the department pursuant to this section shall be distributed to the entities that incurred the costs, except for any amounts retained by the department pursuant to division (E)(3) of this section.

(E) In distributing federal financial participation pursuant to this section, the department may either enter into an agreement with the entity that is to receive the funds or distribute the funds in accordance with rules adopted under division (F) of this

section. If the department decides to enter into an agreement to distribute the funds, the agreement may include terms that do any of the following:

(1) Provide for the whole or partial reimbursement of any cost incurred by the entity in implementing the program;

(2) In the event that federal financial participation is disallowed or otherwise unavailable for any expenditure, require the department or the entity, whichever party caused the disallowance or unavailability of federal financial participation, to assume responsibility for the expenditures;

(3) Permit the department to retain not more than five per cent of the amount of the federal financial participation to be distributed to the entity;

(4) Require the public entity to certify the availability of sufficient unencumbered funds to match the federal financial participation it receives under this section;

(5) Establish the length of the agreement, which may be for a fixed or a continuing period of time;

(6) Establish any other requirements determined by the department to be necessary for the efficient administration of the agreement.

(F) The director of health care administration shall adopt rules as necessary to implement this section, including rules for the distribution of federal financial participation pursuant to this section. The rules shall be adopted in accordance with Chapter 119. of the Revised Code. The director may amend the state medicaid plan or state child health plan as necessary to implement this section.

(G) Federal financial participation received pursuant to this section shall not be included in any calculation made under

sections 5160.26 and 5160.261 of the Revised Code.

Sec. 5160.15. (A) The director of job and family services may enter into one or more written fiscal agreements with boards of county commissioners under which financial assistance is awarded for ODHCA family services duties. Boards of county commissioners shall select which ODHCA family services duties to include in a fiscal agreement. A fiscal agreement shall do all of the following:

(1) Specify the ODHCA family services duties included in the agreement and the private or government entity designated under section 307.981 of the Revised Code to serve as the county department of job and family services;

(2) Provide for the department of health care administration to award financial assistance for the ODHCA family services duties included in the agreement in accordance with a methodology for determining the amount of the award established by rules adopted under division (B) of this section;

(3) Specify the form of the award of financial assistance which may be an allocation, cash draw, reimbursement, property, or, to the extent authorized by an appropriation made by the general assembly and to the extent practicable and not in conflict with a federal or state law, a consolidated funding allocation for two or more of the ODHCA family services duties included in the agreement;

(4) Provide that the award of financial assistance is subject to the availability of federal funds and appropriations made by the general assembly;

(5) Specify annual financial, administrative, or other incentive awards, if any, to be provided in accordance with section 5160.20 of the Revised Code;

(6) Include the assurance of the board of county commissioners that the board will do all of the following:

(a) Ensure that the financial assistance awarded under the agreement is used, and the ODHCA family services duties included in the agreement are performed, in accordance with requirements for the duties established by the department, a federal or state law, or any of the following that concern the duties and are published under section 5160.152 of the Revised Code: the state medicaid plan, the state child health plan, grant agreements between the department and a federal agency, and executive orders issued by the governor;

(b) Ensure that the board and county department utilize a financial management system and other accountability mechanisms for the financial assistance awarded under the agreement that meet requirements the department establishes;

(c) Require the county department to do both of the following:

(i) Monitor all private and government entities that receive a payment from financial assistance awarded under the agreement to ensure that each entity uses the payment in accordance with requirements for the ODHCA family services duties included in the agreement;

(ii) Take action to recover payments that are not used in accordance with the requirements for the ODHCA family services duties included in the agreement.

(d) Require the county department to promptly reimburse the department the amount that represents the amount the county department is responsible for, pursuant to action the department takes under division (C) of section 5160.21 of the Revised Code, of funds the department pays to any entity because of an adverse audit finding, adverse quality control finding, final disallowance

of federal financial participation, or other sanction or penalty;

(e) Require the county department to take prompt corrective action, including paying amounts resulting from an adverse finding, sanction, or penalty, if the department, auditor of state, federal agency, or other entity authorized by federal or state law to determine compliance with requirements for an ODHCA family services duties included in the agreement determines compliance has not been achieved.

(7) Provide for the department taking action pursuant to division (C) of section 5160.21 of the Revised Code if authorized by division (B)(1), (2), (3), or (4) of that section;

(8) Provide for timely audits required by federal and state law and require prompt release of audit findings and prompt action to correct problems identified in an audit;

(9) Comply with all of the requirements for the ODHCA family services duties included in the agreement that have been established by the department, federal or state law, or any of the following that concern the duties and are published under section 5160.152 of the Revised Code: the state medicaid plan, the state child health plan, grant agreements between the department and a federal agency, and executive orders issued by the governor;

(10) Provide for dispute resolution procedures in accordance with section 5160.21 of the Revised Code;

(11) Establish the method of amending or terminating the agreement and an expedited process for correcting terms or conditions of the agreement that the director and the board agree are erroneous;

(12) Except as provided in rules adopted under division (C) of this section, begin on the first day of July of an odd-numbered year and end on the last day of June of the next odd-numbered year.

(B) The department shall make payments authorized by a fiscal agreement on vouchers it prepares and may include any funds appropriated or allocated to it for carrying out ODHCA family services duties included in the agreement, including funds for personal services and maintenance.

(C)(1) The director shall adopt rules in accordance with section 111.15 of the Revised Code governing fiscal agreements. The director shall adopt the rules as if they were internal management rules. Before adopting the rules, the director shall give the public an opportunity to review and comment on the proposed rules. The rules shall establish methodologies to be used to determine the amount of financial assistance to be awarded under the agreements. The rules also shall establish terms and conditions under which an agreement may be entered into after the first day of July of an odd-numbered year. The rules may do any or all of the following:

(a) Govern the establishment of allocations;

(b) Specify allowable uses of financial assistance awarded under the agreements;

(c) Establish reporting, cash management, audit, and other requirements the director determines are necessary to provide accountability for the use of financial assistance awarded under the agreements and determine compliance with requirements established by the department, a federal or state law, or any of the following that concern ODHCA family services duties included in the agreements and are published under section 5160.152 of the Revised Code: the state medicaid plan, the state child health plan, grant agreements between the department and a federal entity, and executive orders issued by the governor.

(2) A requirement of a fiscal agreement established by a rule adopted under this division is applicable to a fiscal agreement

without having to be restated in the fiscal agreement.

Sec. 5160.151. The director of health care administration may provide for a fiscal agreement entered into under section 5160.15 of the Revised Code to have a retroactive effective date of the first day of July of an odd-numbered year if both of the following are the case:

(A) The agreement is entered into after that date and before the last day of that July.

(B) The board of county commissioners requests the retroactive effective date and provides the director good cause satisfactory to the director for the reason the agreement was not entered into on or before the first day of that July.

Sec. 5160.152. The department of health care administration shall publish in a manner accessible to the public all of the following that concern ODHCA family services duties that are included in fiscal agreements entered into under section 5160.15 of the Revised Code: the state medicaid plan, the state child health plan, grant agreements between the department and a federal agency, and executive orders issued by the governor. The department may publish the materials electronically or otherwise.

Sec. 5160.16. (A) Except as provided in section 5160.151 of the Revised Code, if a fiscal agreement under section 5160.15 of the Revised Code between the director of health care administration and a board of county commissioners is not in effect, all of the following apply:

(1) The department of health care administration shall award to the county the board serves financial assistance for ODHCA family services duties in accordance with a methodology for determining the amount of the award established by rules adopted

under division (B) of this section.

(2) The financial assistance may be provided in the form of allocations, cash draws, reimbursements, and property but may not be made in the form of a consolidated funding allocation.

(3) The award of the financial assistance is subject to the availability of federal funds and appropriations made by the general assembly.

(4) The county department shall do all of the following:

(a) Use the financial assistance, and perform the ODHCA family services duties, in accordance with requirements for the duties established by the department, a federal or state law, or any of the following that concern the duties: the state medicaid plan, the child health plan, grant agreements between the department and a federal agency, and executive orders issued by the governor;

(b) Utilize a financial management system and other accountability mechanisms for the financial assistance that meet requirements the department establishes;

(c) Monitor all private and government entities that receive a payment from the financial assistance to ensure that each entity uses the payment in accordance with requirements for the ODHCA family services duties and take action to recover payments that are not used in accordance with the requirements for the ODHCA family services duties;

(d) Promptly reimburse the department the amount that represents the amount the county department is responsible for, pursuant to action the department takes under division (C) of section 5160.21 of the Revised Code, of funds the department pays to any entity because of an adverse audit finding, adverse quality control finding, final disallowance of federal financial participation, or other sanction or penalty;

(e) Take prompt corrective action, including paying amounts resulting from an adverse finding, sanction, or penalty, if the department, auditor of state, federal agency, or other entity authorized by federal or state law to determine compliance with requirements for an ODHCA family services duty determines compliance has not been achieved.

(B) The director shall adopt rules in accordance with 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. Before adopting the rules, the director shall give the public an opportunity to review and comment on the proposed rules. The rules shall establish methodologies to be used to determine the amount of financial assistance to be awarded and may do any or all of the following:

(1) Govern the establishment of funding allocations;

(2) Specify allowable uses of financial assistance the department awards under this section;

(3) Establish reporting, cash management, audit, and other requirements the director determines are necessary to provide accountability for the use of the financial assistance and determine compliance with requirements established by the department, a federal or state law, or any of the following that concern the ODHCA family services duties for which the financial assistance is awarded: the state medicaid plan, the state child health plan, grant agreements between the department and a federal entity, and executive orders issued by the governor.

Sec. 5160.17. The director of health care administration may enter into a written agreement with one or more state agencies, as defined in section 117.01 of the Revised Code, and state universities and colleges to assist in the coordination, provision, or enhancement of ODHCA family services duties. The

director also may enter into written agreements or contracts with, or issue grants to, private and government entities under which funds are provided for the enhancement or innovation of ODHCA family services duties on the state or local level.

The director may adopt internal management rules in accordance with section 111.15 of the Revised Code to implement this section.

Sec. 5160.18. The director of health care administration may enter into one or more written operational agreements with boards of county commissioners to do one or more of the following regarding ODHCA family services duties:

(A) Provide for the director to amend or rescind a rule the director previously adopted;

(B) Provide for the director to modify procedures or establish alternative procedures to accommodate special circumstances in a county;

(C) Provide for the director and board to jointly identify operational problems of mutual concern and develop a joint plan to address the problems;

(D) Establish a framework for the director and board to modify the use of existing resources in a manner that is beneficial to the department of health care administration and the county that the board serves and improves ODHCA family services duties for the recipients of the services.

Sec. 5160.19. The department of health care administration may establish performance and other administrative standards for the administration and outcomes of ODHCA family services duties and determine at intervals the department decides the degree to which a county department of job and family services complies with a performance or other administrative standard. The department may

use statistical sampling, performance audits, case reviews, or other methods it determines necessary and appropriate to determine compliance with performance and administrative standards.

Sec. 5160.191. (A) Except as provided by division (C) of this section, if the department of health care administration determines that a county department of job and family services has failed to comply with a performance or other administrative standard established under section 5160.19 of the Revised Code or by federal law for the administration or outcome of an ODHCA family services duty, the department shall require the county department to develop, submit to the department for approval, and comply with a corrective action plan.

(B) If a county department fails to develop, submit to the department, or comply with a corrective action plan under division (A) of this section, or the department disapproves the county department's corrective action plan, the department may require the county department to develop, submit to the department for approval, and comply with a corrective action plan that requires the county department to commit existing resources to the plan.

(C) The department may not require a county department to take action under this section for failure to comply with a performance or other administrative standard established for an incentive awarded by the department. Instead, the department may require a county department that fails to comply with that kind of performance or other administrative standard to take action in accordance with rules adopted by the department governing the standard.

(D) At the request of a county department, the department shall assist the county department with the development of a corrective action plan under this section and provide the county department technical assistance in the implementation of the plan.

Sec. 5160.192. The director of health care administration may adopt rules in accordance with section 111.15 of the Revised Code to implement sections 5160.19 to 5160.192 of the Revised Code. If the director adopts the rules, the director shall adopt the rules as if they were internal management rules.

Sec. 5160.20. Subject to the availability of funds, the department of health care administration may provide annual financial, administrative, or other incentive awards to county departments of job and family services. A county department may spend funds provided as a financial incentive award only for the purpose for which the funds are appropriated. The department may adopt internal management rules in accordance with section 111.15 of the Revised Code to establish the amounts of awards, methodology for distributing the awards, types of awards, and standards for administration by the department.

There is hereby created in the state treasury the medicaid local incentive fund. The director of health care administration may request that the director of budget and management transfer funds appropriated for ODHCA family services duties into the fund. If the director of budget and management determines that the funds identified by the director of health care administration are available and appropriate for transfer, the director of budget and management shall make the transfer. Money in the fund shall be used to provide incentive awards under this section.

Sec. 5160.21. (A) As used in this section, "responsible entity" means a board of county commissioners or a county department of job and family services, whichever the director of health care administration determines is appropriate to take action against under division (C) of this section.

(B) Regardless of whether an ODHCA family services duty is

performed by a county department of job and family services, private or government entity pursuant to a contract entered into under section 307.982 of the Revised Code, or private or government provider of an ODHCA family service duty, the department of health care administration may take action under division (C) of this section against the responsible entity if the department determines any of the following are the case:

(1) A requirement of a fiscal agreement entered into under section 5160.15 of the Revised Code that includes the ODHCA family services duty, including a requirement for fiscal agreements established by rules adopted under that section, is not complied with;

(2) A county department fails to develop, submit to the department, or comply with a corrective action plan under division (B) of section 5160.191 of the Revised Code, or the department disapproves the county department's corrective action plan developed under division (B) of section 5160.191 of the Revised Code;

(3) A requirement for the ODHCA family services duty established by the department or any of the following is not complied with: a federal or state law, the state medicaid plan, the state child health plan, grant agreement between the department and a federal agency, or executive order issued by the governor;

(4) The responsible entity is solely or partially responsible, as determined by the director of health care administration, for an adverse audit finding, adverse quality control finding, final disallowance of federal financial participation, or other sanction or penalty regarding the medicaid family services duty.

(C) The department may take one or more of the following

actions against the responsible entity when authorized by division (B)(1), (2), (3), or (4) of this section:

(1) Require the responsible entity to comply with a corrective action plan pursuant to a time schedule specified by the department. The corrective action plan shall be established or approved by the department and shall not require a county department to commit resources to the plan.

(2) Require the responsible entity to comply with a corrective action plan pursuant to a time schedule specified by the department. The corrective action plan shall be established or approved by the department and require a county department to commit to the plan existing resources identified by the county department.

(3) Require the responsible entity to do one of the following:

(a) Share with the department a final disallowance of federal financial participation or other sanction or penalty;

(b) Reimburse the department the final amount the department pays to the federal government or another entity that represents the amount the responsible entity is responsible for of an adverse audit finding, adverse quality control finding, final disallowance of federal financial participation, or other sanction or penalty issued by the federal government, auditor of state, or other entity;

(c) Pay the federal government or another entity the final amount that represents the amount the responsible entity is responsible for of an adverse audit finding, adverse quality control finding, final disallowance of federal financial participation, or other sanction or penalty issued by the federal government, auditor of state, or other entity;

(d) Pay the department the final amount that represents the

amount the responsible entity is responsible for of an adverse audit finding or adverse quality control finding.

(4) Impose an administrative sanction issued by the department against the responsible entity. A sanction may be increased if the department has previously taken action against the responsible entity under this division.

(5) Perform, or contract with a government or private entity for the entity to perform, the ODHCA family services duty until the department is satisfied that the responsible entity ensures that the duty will be performed satisfactorily. If the department performs or contracts with an entity to perform an ODHCA family services duty under division (C)(5) of this section, the department may do either or both of the following:

(a) Spend funds in the county treasury appropriated by the board of county commissioners for the duty;

(b) Withhold funds allocated or reimbursements due to the responsible entity for the duty and spend the funds for the duty.

(6) Request that the attorney general bring mandamus proceedings to compel the responsible entity to take or cease the action that causes division (B)(1), (2), (3), or (4) of this section to apply. The attorney general shall bring mandamus proceedings in the Franklin county court of appeals at the department's request.

(7) If the department takes action under this division because of division (B)(3) of this section, temporarily withhold funds allocated or reimbursement due to the responsible entity until the department determines that the responsible entity is in compliance with the requirement. The department shall release the funds when the department determines that compliance has been achieved.

(D) If the department proposes to take action against the

responsible entity under division (C) of this section, the department shall notify the responsible entity and county auditor. The notice shall be in writing and specify the action the department proposes to take. The department shall send the notice by regular United States mail.

Except as provided by division (E) of this section, the responsible entity may request an administrative review of a proposed action in accordance with administrative review procedures the department shall establish. The administrative review procedures shall comply with all of the following:

(1) A request for an administrative review shall state specifically all of the following:

(a) The proposed action specified in the notice from the department for which the review is requested;

(b) The reason why the responsible entity believes the proposed action is inappropriate;

(c) All facts and legal arguments that the responsible entity wants the department to consider;

(d) The name of the person who will serve as the responsible entity's representative in the review.

(2) If the department's notice specifies more than one proposed action and the responsible entity does not specify all of the proposed actions in its request pursuant to division (D)(1)(a) of this section, the proposed actions not specified in the request shall not be subject to administrative review and the parts of the notice regarding those proposed actions shall be final and binding on the responsible entity.

(3) In the case of a proposed action under division (C)(1) of this section, the responsible entity shall have fifteen calendar days after the department mails the notice to the responsible

entity to send a written request to the department for an administrative review. If it receives such a request within the required time, the department shall postpone taking action under division (C)(1) of this section for fifteen calendar days following the day it receives the request or extended period of time provided for in division (D)(5) of this section to allow a representative of the department and a representative of the responsible entity an informal opportunity to resolve any dispute during that fifteen-day or extended period.

(4) In the case of a proposed action under division (C)(2), (3), (4), (5), or (7) of this section, the responsible entity shall have thirty calendar days after the department mails the notice to the responsible entity to send a written request to the department for an administrative review. If it receives such a request within the required time, the department shall postpone taking action under division (C)(2), (3), (4), (5), or (7) of this section for thirty calendar days following the day it receives the request or extended period of time provided for in division (D)(5) of this section to allow a representative of the department and a representative of the responsible entity an informal opportunity to resolve any dispute during that thirty-day or extended period.

(5) If the informal opportunity provided in division (D)(3) or (4) of this section does not result in a written resolution to the dispute within the fifteen- or thirty-day period, the director of health care administration and representative of the responsible entity may enter into a written agreement extending the time period for attempting an informal resolution of the dispute under division (D)(3) or (4) of this section.

(6) In the case of a proposed action under division (C)(3) of this section, the responsible entity may not include in its request disputes over a finding, final disallowance of federal financial participation, or other sanction or penalty issued by

the federal government, auditor of state, or entity other than the department.

(7) If the responsible entity fails to request an administrative review within the required time, the responsible entity loses the right to request an administrative review of the proposed actions specified in the notice and the notice becomes final and binding on the responsible entity.

(8) If the informal opportunity provided in division (D)(3) or (4) of this section does not result in a written resolution to the dispute within the time provided by division (D)(3), (4), or (5) of this section, the director shall appoint an administrative review panel to conduct the administrative review. The review panel shall consist of department employees and one director or other representative of a county department that serves a different county than the county served by the responsible entity. No individual involved in the department's proposal to take action against the responsible entity may serve on the review panel. The review panel shall review the responsible entity's request. The review panel may require that the department or responsible entity submit additional information and schedule and conduct an informal hearing to obtain testimony or additional evidence. A review of a proposal to take action under division (C)(3) of this section shall be limited solely to the issue of the amount the responsible entity shall share with the department, reimburse the department, or pay to the federal government, department, or other entity under division (C)(3) of this section. The review panel is not required to make a stenographic record of its hearing or other proceedings.

(9) After finishing an administrative review, an administrative review panel appointed under division (D)(8) of this section shall submit a written report to the director setting forth its findings of fact, conclusions of law, and

recommendations for action. The director may approve, modify, or disapprove the recommendations. If the director modifies or disapproves the recommendations, the director shall state the reasons for the modification or disapproval and the actions to be taken against the responsible entity.

(10) The director's approval, modification, or disapproval under division (D)(9) of this section shall be final and binding on the responsible entity and shall not be subject to further departmental review.

(E) The responsible entity is not entitled to an administrative review under division (D) of this section for any of the following:

(1) An action taken under division (C)(6) of this section;

(2) An action taken under section 5160.211 of the Revised Code;

(3) An action taken under division (C)(3) of this section if the federal government, auditor of state, or entity other than the department has identified the county department as being solely or partially responsible for an adverse audit finding, adverse quality control finding, final disallowance of federal financial participation, or other sanction or penalty;

(4) An adjustment to an allocation, cash draw, advance, or reimbursement to a county department that the department determines necessary for budgetary reasons;

(5) Withholding of a cash draw or reimbursement due to noncompliance with a reporting requirement established in rules adopted under section 5160.22 of the Revised Code.

(F) This section does not apply to other actions the department takes against the responsible entity pursuant to authority granted by another state law unless the other state law

requires the department to take the action in accordance with this section.

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

Sec. 5160.211. The department of health care administration may certify a claim to the attorney general under section 131.02 of the Revised Code for the attorney general to take action under that section against a responsible entity to recover any funds that the department determines the responsible entity owes the department for actions taken under division (C)(2), (3), (4), or (5) of section 5160.21 of the Revised Code.

Sec. 5160.22. The director of health care administration may adopt rules in accordance with section 111.15 of the Revised Code establishing reporting requirements for ODHCA family services duties. If the director adopts the rules, the director shall adopt the rules as if they were internal management rules and, before adopting the rules, give the public an opportunity to review and comment on the proposed rules.

Sec. 5160.23. If a county department of job and family services submits an expenditure report to the department of health care administration and the department subsequently determines that an allocation, advance, or reimbursement the department makes to the county department, or a cash draw the county department 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 county department 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 5160.21 of the Revised Code.

The director of health care administration 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. 5160.24. The department of health care administration, in consultation with county representatives, shall develop annual training goals and model training curriculum regarding ODHCA family services duties for employees of county departments of job and family services and identify a variety of state funded training opportunities to meet the proposed goals.

Sec. 5160.26. (A) As used in sections 5160.26 to 5160.262 of the Revised Code:

"Disability medical assistance expenditures" means expenditures for the disability medical assistance program and county administration of the disability medical assistance program.

"Medicaid expenditures" means expenditures for county administration of the medicaid program. "Medicaid expenditures" does not include expenditures for transportation services provided under the medicaid program.

"Public assistance expenditures" has the same meaning as in section 5101.16 of the Revised Code.

"Public medical assistance expenditures" means disability medical assistance expenditures and medicaid expenditures.

(B) Except as provided in division (C) of this section, a county's share of public medical assistance expenditures is the sum of the following for each state fiscal year:

(1) The amount that is twenty-five per cent of the county's total disability medical assistance expenditures during the state fiscal year ending in the previous calendar year that the department of health care administration determines are allowable.

(2) The amount that is ten per cent, or other percentage determined under division (D) of this section, of the county's total medicaid expenditures during the state fiscal year ending in the previous calendar year that the department of health care administration determines are allowable, less the amount of federal reimbursement credited to the county under division (E) of this section for the state fiscal year ending in the previous calendar year.

(C)(1) If a county's share of public medical assistance expenditures determined under division (B) of this section and the county's share of public assistance expenditures determined under division (B) of section 5101.16 of the Revised Code for a state fiscal year exceeds one hundred ten per cent of the county's share for those expenditures for the immediately preceding state fiscal year, the department of health care administration shall reduce the county's share for public medical assistance expenditures so that the total of the county's share for public medical assistance expenditures and public assistance expenditures equals one hundred ten per cent of the county's share of those expenditures for the immediately preceding state fiscal year. The department of health care administration shall cooperate with the department of job and family services for the purpose of making reductions under division (C)(1) of this section.

(2) A county's share of public medical assistance expenditures determined under division (B) of this section may be increased pursuant to a sanction under section 5160.21 of the Revised Code.

(D)(1) If the per capita tax duplicate of a county is less

than the per capita tax duplicate of the state as a whole and division (D)(2) of this section does not apply to the county, the percentage to be used for the purpose of division (B)(2) of this section is the product of ten multiplied by a fraction of which the numerator is the per capita tax duplicate of the county and the denominator is the per capita tax duplicate of the state as a whole. The department of health care administration shall compute the per capita tax duplicate for the state and for each county by dividing the tax duplicate for the most recent available year by the current estimate of population prepared by the department of development.

(2) If the percentage of families in a county with an annual income of less than three thousand dollars is greater than the percentage of such families in the state and division (D)(1) of this section does not apply to the county, the percentage to be used for the purpose of division (B)(2) of this section is the product of ten multiplied by a fraction of which the numerator is the percentage of families in the state with an annual income of less than three thousand dollars a year and the denominator is the percentage of such families in the county. The department of health care administration shall compute the percentage of families with an annual income of less than three thousand dollars for the state and for each county by multiplying the most recent estimate of such families published by the department of development, by a fraction, the numerator of which is the estimate of average annual personal income published by the bureau of economic analysis of the United States department of commerce for the year on which the census estimate is based and the denominator of which is the most recent such estimate published by the bureau.

(3) If the per capita tax duplicate of a county is less than the per capita tax duplicate of the state as a whole and the percentage of families in the county with an annual income of less

than three thousand dollars is greater than the percentage of such families in the state, the percentage to be used for the purpose of division (B)(2) of this section shall be determined as follows:

(a) Multiply ten by the fraction determined under division (D)(1) of this section;

(b) Multiply the product determined under division (D)(3)(a) of this section by the fraction determined under division (D)(2) of this section.

(4) The department of health care administration shall determine, for each county, the percentage to be used for the purpose of division (B)(2) of this section not later than the first day of July of the year preceding the state fiscal year for which the percentage is used.

(E) The department of health care administration shall credit to a county the amount of federal reimbursement the department receives from the United States department of health and human services for the county's medicaid expenditures that the department determines are allowable administrative expenditures.

(F) The director of health care administration shall adopt rules in accordance with section 111.15 of the Revised Code to establish all of the following:

(1) The method the department of health care administration is to use to change a county's share of public medical assistance expenditures determined under division (B) of this section as provided in division (C) of this section;

(2) The allocation methodology and formula the department will use to determine the amount of funds to credit to a county under this section;

(3) The method the department will use to change the payment of the county share of public medical assistance expenditures from

a calendar-year basis to a state fiscal year basis;

(4) Other procedures and requirements necessary to implement this section.

Sec. 5160.261. Prior to the sixteenth day of May annually, the department of health care administration shall certify to the board of county commissioners of each county the amount estimated by the department to be needed in the following state fiscal year to meet the county share, as determined under section 5160.26 of the Revised Code, of public medical assistance expenditures. Each January, the board shall appropriate the amount certified by the department and an additional five per cent of that amount. Each June, the board may reappropriate, for any purpose the board determines to be appropriate, the amount appropriated in January that exceeds the total of the amount certified by the department for the last six months of the current state fiscal year and the first six months of the following state fiscal year.

Before the fifteenth day of each payment period the director of health care administration establishes by rule, the department of health care administration shall pay a county the estimated state and federal share of the county's public medical assistance expenditures for that payment period increased or decreased by the amount the department underpaid or overpaid the county for the most recent payment period that the department knows an underpayment or overpayment was made.

If the department establishes a maximum amount that it will reimburse a county for public medical assistance expenditures and a county spends more for public medical assistance expenditures than is reimbursable, the department shall not pay the county a state or, except as provided in section 5160.262 of the Revised Code, a federal share for the amount of the expenditure that exceeds the maximum allowable reimbursement amount. County

expenditures that exceed the maximum allowable reimbursement amount shall not be credited to a county's share of public medical assistance expenditures under section 5160.26 of the Revised Code. The department also shall not pay a county a state or, except as provided in section 5160.262 of the Revised Code, a federal share for an administrative expenditure that is not allowed by the department.

A county shall deposit all funds appropriated by a board of county commissioners and received from the department under this section in a special fund in the county treasury known as the public assistance fund. A county shall make payments for public medical assistance expenditures from the public assistance fund.

The attorney general shall bring mandamus proceedings in the Franklin county court of appeals against any board of county commissioners that fails to make appropriations or deposits into the public assistance fund required by this section.

The director shall adopt internal management rules in accordance with section 111.15 of the Revised Code to do all of the following:

(A) Establish the method by which the department is to make payments to counties under this section;

(B) Establish procedures for payment by counties of the county share of public medical assistance expenditures;

(C) Establish payment periods for paying a county its estimated state and federal share of public medical assistance expenditures;

(D) Allow county departments of job and family services to use the public assistance fund for other purposes and programs similar to the disability medical assistance program and medicaid program.

The director may adopt internal management rules in accordance with section 111.15 of the Revised Code to establish a maximum amount that it will reimburse a county for public medical assistance expenditures.

Sec. 5160.262. Subject to available federal funds and appropriations made by the general assembly, the department of health care administration may, at its sole discretion, use available federal funds to reimburse a county for medicaid expenditures even though the county's medicaid expenditures meet or exceed the maximum allowable reimbursement amount established by rules adopted under section 5160.261 of the Revised Code if the board of county commissioners has entered into a fiscal agreement with the director of health care administration under section 5160.15 of the Revised Code. The director may adopt internal management rules in accordance with section 111.15 of the Revised Code to implement this section.

Sec. 5160.28. The department of health care administration may make any investigations that are necessary in the performance of its duties, and to that end the department shall have the same power as a judge of a county court to administer oaths and to enforce the attendance and testimony of witnesses and the production of books or papers.

The department shall keep a record of its investigations stating the time, place, charges or subject, witnesses summoned and examined, and their conclusions.

The fees of witnesses for attendance and travel shall be the same as in the court of common pleas.

Sec. 5160.29. Any judge of any division of the court of common pleas, upon application of the department of health care administration, may compel the attendance of witnesses, the

production of books or papers, and the giving of testimony before the department, by a judgment for contempt or otherwise, in the same manner as in cases before those courts.

Sec. 5160.30. The department of health care administration may appoint and commission any competent officer, employee, agency, or person to serve as a special agent, investigator, or representative to perform a designated duty for and in behalf of the department. Specific credentials shall be given by the department to each person so designated, and each credential shall state:

(A) The person's name;

(B) Agency with which such person is connected;

(C) Purpose of appointment;

(D) Date of expiration of appointment, if appropriate;

(E) Such information as the department considers proper.

Sec. 5160.32. (A) Subject to division (B) of this section, the director of health care administration may accept applications, determine eligibility, redetermine eligibility, and perform related administrative activities for one or more of the following:

(1) The medicaid program;

(2) The children's health insurance program;

(3) 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, the face-to-face interview shall not be conducted by the department of health care administration.

(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 under 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 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.

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

Sec. 5160.34. (A) As used in this section:

(1) "Agency" means the following entities that administer an ODHCA program:

(a) The department of health care administration;

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

(c) A private or government entity administering, in whole or in part, an ODHCA program for or on behalf of the department of health care administration or a county department of job and family services.

(2) "Appellant" means an applicant, participant, former participant, recipient, or former recipient of an ODHCA 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) "ODHCA program" means the disability medical assistance program, the medicaid program, and residential state supplement program.

(B) Except as provided by division (F) of this section, an appellant who appeals under federal or state law a decision or order of an agency administering an ODHCA program shall, at the appellant's request, be granted a state hearing by the department of health care administration. This state hearing shall be conducted in accordance with rules adopted under this section. The state hearing shall be 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 health care administration or a court of common pleas.

(C) An appellant who disagrees with a state hearing decision may make an administrative appeal to the director of health care administration 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 fails to comply within these time limits, the department may take action pursuant to section 5160.21 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 health care administration 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 health care administration 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) 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.

(G) The director of health care administration 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.

(H) 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. 5160.341. The department of health care administration may employ or contract with hearing officers to draft and recommend state hearing decisions under division (B) of section 5160.34 of the Revised Code. The department may employ or contract with hearing authorities to issue state hearing decisions under division (B) of section 5160.34 of the Revised Code. Except in the case of an individual who was employed by or under contract with the department of job and family services to perform the duties of a hearing authority under division (B) of section 5101.35 of the Revised Code before July 1, 2000, an individual performing the duties of a hearing authority shall have been admitted to the practice of law in this state.

Sec. ~~5101.571~~ 5160.36. As used in sections ~~5101.571~~ 5160.36 to ~~5101.59~~ 5160.40 of the Revised Code:

(A) "Medical support" means support specified as support for the purpose of medical care by order of a court or administrative agency.

(B) "Third party" means any health insurer as defined in section 3924.41 of the Revised Code, individual, entity, or public or private program, that is or may be liable to pay all or part of the medical cost of injury, disease, or disability of an applicant or recipient. "Third party" includes any such insurer, individual,

entity, or program that would have been obligated to pay for the service, even when such third party limits or excludes payments in the case of an individual who is eligible for medicaid. "Third party" does not include the program for medically handicapped children established under section 3701.023 of the Revised Code.

Sec. ~~5101.59~~ 5160.37. (A) The application for or acceptance of ~~public~~ medicaid or disability medical assistance constitutes an automatic assignment of certain rights to the department of ~~job and family services~~ health care administration. This assignment includes the rights of the applicant~~,~~ or recipient~~, or participant~~ and also the rights of any other member of the assistance group for whom the applicant~~,~~ or recipient~~, or participant~~ can legally make an assignment.

Pursuant to this section, the applicant~~,~~ or recipient~~, or participant~~ assigns to the department any rights to medical support available to the applicant~~,~~ or recipient~~, or participant~~ or for other members of the assistance group under an order of a court or administrative agency, and any rights to payments from any third party liable to pay for the cost of medical care and services arising out of injury, disease, or disability of the applicant, recipient, ~~participant,~~ or other members of the assistance group.

Medicare benefits shall not be assigned pursuant to this section. Benefits assigned to the department by operation of this section are directly reimbursable to the department by liable third parties.

(B) Refusal by the applicant~~,~~ or recipient~~, or participant~~ to cooperate in obtaining medical support and payments for self or any other member of the assistance group renders the applicant~~,~~ or recipient~~, or participant~~ ineligible for ~~public~~ medicaid or disability medical assistance, unless cooperation is waived by the

department. Eligibility shall continue for any individual who cannot legally assign the individual's own rights and who would have been eligible for ~~public~~ medicaid or disability medical assistance but for the refusal to assign the individual's rights or to cooperate as required by this section by another person legally able to assign the individual's rights.

If the applicant~~,~~ or recipient~~, or participant~~ or any member of the assistance group becomes ineligible for ~~public~~ medicaid or disability medical assistance, the department shall restore to the applicant, recipient, ~~participant,~~ or member of the assistance group any future rights to benefits assigned under this section.

The rights of assignment given to the department under this section do not include rights to support assigned to the department of job and family services under section 5107.20 or 5115.07 of the Revised Code.

(C) The director of ~~job and family services~~ health care administration may adopt rules in accordance with Chapter 119. of the Revised Code to implement this section, including rules that specify what constitutes cooperating with efforts to obtain medical support and payments and when the cooperation requirement may be waived.

Sec. ~~5101.58~~ 5160.38. ~~As used in this section and section 5101.59 of the Revised Code, "public assistance" means aid provided under Chapter 5111. or 5115. of the Revised Code and participation in the Ohio works first program established under Chapter 5107. of the Revised Code.~~

The acceptance of ~~public~~ medicaid or disability medical assistance gives a right of recovery to the department of ~~job and family services~~ health care administration and a county department of job and family services against the liability of a third party for the cost of medical services and care arising out of injury,

disease, or disability of the ~~public~~ medicaid recipient or disability medical assistance recipient ~~or participant~~. When an action or claim is brought against a third party by a ~~public assistance~~ recipient ~~or participant~~, the entire amount of any settlement or compromise of the action or claim, or any court award or judgment, is subject to the recovery right of the department of ~~job and family services~~ health care administration or county department of job and family services. Except in the case of a recipient ~~or participant~~ who receives medical services or care through a managed care organization, the department's or county department's claim shall not exceed the amount of medical expenses paid by the departments on behalf of the recipient ~~or participant~~. In the case of a recipient ~~or participant~~ who receives medical services or care through a managed care organization, the amount of the department's or county department's claim shall be the amount the managed care organization pays for medical services or care rendered to the recipient ~~or participant~~, even if that amount is more than the amount the departments pay to the managed care organization for the recipient's ~~or participant's~~ medical services or care. Any settlement, compromise, judgment, or award that excludes the cost of medical services or care shall not preclude the departments from enforcing their rights under this section.

Prior to initiating any recovery action, the recipient ~~or participant~~, or the recipient's ~~or participant's~~ representative, shall disclose the identity of any third party against whom the recipient ~~or participant~~ has or may have a right of recovery. Disclosure shall be made to the department ~~of job and family services~~ when medical expenses have been paid pursuant to ~~Chapter 5111. or 5115. of the Revised Code~~ the medicaid program. Disclosure shall be made to both the department ~~of job and family services~~ and the appropriate county department ~~of job and family services~~ when medical expenses have been paid pursuant to ~~Chapter~~

~~5115. of the Revised Code~~ the disability medical assistance program. No settlement, compromise, judgment, or award or any recovery in any action or claim by a recipient ~~or participant~~ where the departments have a right of recovery shall be made final without first giving the appropriate departments notice and a reasonable opportunity to perfect their rights of recovery. If the departments are not given appropriate notice, the recipient ~~or participant~~ is liable to reimburse the departments for the recovery received to the extent of medical payments made by the departments. The departments shall be permitted to enforce their recovery rights against the third party even though they accepted prior payments in discharge of their rights under this section if, at the time the departments received such payments, they were not aware that additional medical expenses had been incurred but had not yet been paid by the departments. The third party becomes liable to the department ~~of job and family services~~ or county department ~~of job and family services~~ as soon as the third party is notified in writing of the valid claims for recovery under this section.

The right of recovery does not apply to that portion of any judgment, award, settlement, or compromise of a claim, to the extent of attorneys' fees, costs, or other expenses incurred by a recipient ~~or participant~~ in securing the judgment, award, settlement, or compromise, or to the extent of medical, surgical, and hospital expenses paid by such recipient ~~or participant~~ from the recipient's ~~or participant's~~ own resources. Attorney fees and costs or other expenses in securing any recovery shall not be assessed against any claims of the departments.

To enforce their recovery rights, the departments may do any of the following:

(A) Intervene or join in any action or proceeding brought by the recipient ~~or participant~~ or on the recipient's ~~or~~

~~participant's~~ behalf against any third party who may be liable for the cost of medical services and care arising out of the recipient's ~~or participant's~~ injury, disease, or disability;

(B) Institute and pursue legal proceedings against any third party who may be liable for the cost of medical services and care arising out of the recipient's ~~or participant's~~ injury, disease, or disability;

(C) Initiate legal proceedings in conjunction with the injured, diseased, or disabled recipient ~~or participant~~ or the recipient's ~~or participant's~~ legal representative.

Recovery rights created by this section may be enforced separately or jointly by the department ~~of job and family services~~ and the county department ~~of job and family services~~.

The right of recovery given to the department of health care administration under this section does not include rights to support from any other person assigned to the ~~state~~ department of job and family services under sections 5107.20 and 5115.07 of the Revised Code, but includes payments made by a third party under contract with a person having a duty to support.

The director of ~~job and family services~~ health care administration may adopt rules in accordance with Chapter 119. of the Revised Code the ~~department~~ director considers necessary to implement this section.

Sec. ~~5111.121~~ 5160.39. (A) ~~As used in this section, "third party" has the same meaning as in section 5101.571 of the Revised Code.~~

~~(B)~~ In addition to the authority granted under section ~~5101.59~~ 5160.37 of the Revised Code, the department of ~~job and family services~~ health care administration may, to the extent necessary to reimburse its costs, garnish the wages, salary, or

other employment income of, and withhold amounts from state tax refunds to, any person to whom both of the following apply:

(1) The person is required by a court or administrative order to provide coverage of the cost of health care services to a child eligible for ~~medical assistance under this chapter~~ the medicaid program.

(2) The person has received payment from a third party for the costs of such services but has not used the payment to reimburse either the other parent or guardian of the child or the provider of the services.

~~(C)~~(B) Claims for current and past due child support shall take priority over claims under division ~~(B)~~(A) of this section.

Sec. ~~5101.572~~ 5160.40. Upon the request of the department of ~~job and family services~~ health care administration, any third party ~~as defined in section 5101.571 of the Revised Code~~ shall cooperate with the department in identifying individuals for the purpose of establishing third party liability ~~pursuant to Title XIX of the Social Security Act, as amended~~ for the medicaid program. The department ~~of job and family services~~ shall limit its use of information gained from third parties to purposes directly connected with the administration of the medicaid program. ~~No third party shall disclose to other parties or make use of any information regarding recipients of aid under Chapter 5107. or 5111. of the Revised Code that it obtains from the department of job and family services, except in the manner provided for by the director of job and family services in administrative rules.~~ Any information provided by a third party to the department ~~of job and family services~~ shall not be considered a violation of any right of confidentiality or contract that the third party may have with covered persons including, but not limited to, contractees, beneficiaries, heirs, assignees, and subscribers. The third party

is immune from any liability that it may otherwise incur through its release of information to the department ~~of job and family services~~.

Sec. 5160.41. Any application for the medicaid program or disability medical assistance program gives a right of subrogation to the department of health care administration 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 payments made on the applicant's behalf under the medicaid program or disability medical assistance program. If the director of health care administration, 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 medicaid recipient or disability medical assistance recipient is receiving workers' compensation, the director shall notify the administrator of the amount of the benefit to be paid to the department of health care administration.

Sec. 5160.43. As used in sections 5160.43 to 5160.46 of the Revised Code, "public medical assistance program" means the disability medical assistance program and medicaid program.

As part of the procedure for the determination of whether benefits were incorrectly paid on behalf of public medical assistance program recipients, the director of health care administration shall furnish quarterly the name and social security number of each public medical assistance program recipient to the director of administrative services, the administrator of the bureau of workers' compensation, and each of the state's retirement boards. Within fourteen days after receiving the name and social security number of a public medical assistance program recipient, the director of administrative

services, administrator, or board shall inform the auditor of state as to whether the recipient is receiving wages or benefits, the amount of any wages or benefits being received, the social security number, and the address of the recipient. The director of administrative services, administrator, boards, and any agent or employee of those officials and boards shall comply with the rules adopted under section 5160.64 of the Revised Code restricting the disclosure of information regarding public medical assistance program recipients. Any person who violates this provision shall thereafter be disqualified from acting as an agent or employee or in any other capacity under appointment or employment of any state board, commission, or agency.

Sec. 5160.44. As part of the procedure for the determination of whether benefits were incorrectly paid on behalf of a public medical assistance program recipient, the director of health care administration shall semiannually, at times determined jointly by the auditor of state and the tax commissioner, furnish to the tax commissioner in computer format the name and social security number of each public medical assistance program recipient. Within sixty days after receiving the name and social security number of a public medical assistance program recipient, the commissioner shall inform the auditor of state whether the recipient filed an Ohio individual income tax return, separate or joint, as provided by section 5747.08 of the Revised Code, for either or both of the two taxable years preceding the year in which the director furnished the names and social security numbers to the commissioner. If the recipient did so file, at the same time the commissioner shall also inform the auditor of state of the amount of the federal adjusted gross income as reported on such returns and of the addresses on such returns. The commissioner shall also advise the auditor of state whether such returns were filed on a joint basis, as provided in section 5747.08 of the Revised Code,

in which case the federal adjusted gross income as reported may be that of the recipient or the recipient's spouse.

If the auditor of state determines that further investigation is needed, the auditor of state may ask the commissioner to determine whether the public medical assistance program recipient filed income tax returns for any previous taxable years in which the recipient received medical assistance under a public medical assistance program and for which the tax department retains income tax returns. Within fourteen days of receipt of the request, the commissioner shall inform the auditor of state whether the recipient filed an individual income tax return for the taxable years in question, of the amount of the federal adjusted gross income as reported on such returns, of the addresses on such returns, and whether the returns were filed on a joint or separate basis.

If the auditor of state determines that further investigation is needed of a public medical assistance program recipient who filed an Ohio individual income tax return, the auditor of state may request a certified copy of the Ohio individual income tax return or returns of that person for the taxable years described above, together with any other documents the commissioner has concerning the return or returns. Within fourteen days of receipt of such a request in writing, the commissioner shall forward the returns and documents to the auditor of state.

The director of health care administration, county director of job and family services, county prosecutor, attorney general, auditor of state, or any agent or employee of those officials having access to any information or documents furnished by the commissioner pursuant to this section shall not divulge or use any such information except for the purpose of determining whether benefits were incorrectly paid on behalf of a public medical assistance program recipient, or for an audit, investigation, or

prosecution, or in accordance with a proper judicial order. Any person who violates this provision shall thereafter be disqualified from acting as an agent or employee or in any other capacity under appointment or employment of any state or county board, commission, or agency.

Sec. 5160.45. The director of health care administration shall work with the tax commissioner to recover benefits incorrectly paid on behalf of public medical assistance program recipients from refunds of state income taxes that are payable to the recipients. Any benefit incorrectly paid, because of fraud or misrepresentation, as the result of an error by the recipient or by the agency making the payment, or for any other reason, may be collected under this section. Any reduction under section 5747.12 or 5747.121 of the Revised Code to an income tax refund shall be made before a reduction under this section. No reduction shall be made under this section if the amount of the refund is less than twenty-five dollars after any reduction under section 5747.12 of the Revised Code. A reduction under this section shall be made before any part of the refund is contributed under section 5747.113 of the Revised Code or is credited under section 5747.12 of the Revised Code against tax due in any subsequent year.

The director and the tax commissioner, by rules adopted in accordance with Chapter 119. of the Revised Code, shall establish procedures to implement this section. The procedures shall provide for notice to a public medical assistance program recipient and an opportunity for the recipient to be heard before the recipient's income tax refund is reduced.

Sec. 5160.46. The director of health care administration may enter into agreements with the federal government to recover benefits incorrectly paid on behalf of public medical assistance program recipients from refunds of federal income taxes that are

payable to the recipients.

Sec. 5160.50. As used in sections 5160.50 to 5160.64 of the Revised Code:

"Community control sanction" has the same meaning as in section 2929.01 of the Revised Code.

"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.

"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 health care administration, a county department of job and family services, or an entity performing duties on behalf of the department or a county department.

"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.

"Medical assistance provided under a government-funded program" means medical assistance provided under the medicaid

program, children's health insurance program, disability medical assistance program, or any other program established under the Revised Code.

"Post-release control sanction" has the same meaning as in section 2967.01 of the Revised Code.

"Public medical assistance program" means the children's health insurance program, disability medical assistance program, and medicaid program.

"Public medical assistance program recipient" means an applicant for, or recipient or former recipient of, a public medical assistance program.

Sec. 5160.51. Except as permitted by sections 5160.52 to 5160.63 of the Revised Code or the rules adopted under section 5160.64 of the Revised Code or required by federal law, no person or government entity shall solicit, disclose, receive, use, or knowingly permit, or participate in the use of any information regarding a public medical assistance program recipient for any purpose not directly connected with the administration of the public medical assistance program.

Sec. 5160.52. To the extent permitted by federal law, the department of health care administration and county departments of job and family services shall release information regarding a public medical assistance program recipient for purposes directly connected to the administration of the public medical assistance program to a government entity responsible for administering the public medical assistance program.

Sec. 5160.53. To the extent permitted by federal law, the department of health care administration and county departments of job and family services shall provide information regarding a

public medical assistance program recipient to a law enforcement agency for the purpose of any investigation, prosecution, or criminal or civil proceeding relating to the administration of the public medical assistance program.

Sec. 5160.54. (A) To the extent permitted by federal law and section 1347.08 of the Revised Code, the department of health care administration and county departments of job and family services shall provide access to information regarding a public medical assistance program recipient to all of the following:

(1) The recipient;

(2) The authorized representative;

(3) The legal guardian of the recipient;

(4) The attorney of the recipient, if the attorney has written authorization that complies with section 5160.57 of the Revised Code from the recipient.

(B) The director of health care administration may adopt rules defining "authorized representative" for the purpose of this section.

Sec. 5160.55. (A) To the extent permitted by federal law and subject to division (C) of this section, the department of health care administration and county departments of job and family services may release information regarding a public medical assistance program recipient as follows:

(1) For purposes directly connected to the administration of a state, federal, or federally assisted program that provides cash or in-kind assistance or services directly to individuals, to a government entity responsible for administering the program;

(2) For the purpose of protecting children, to a government entity responsible for administering a children's protective

services program;

(3) Subject to division (B) of this section, to any person or government entity to whom the recipient authorizes to receive the information by providing the department or county department voluntary, written authorization that complies with section 5160.57 of the Revised Code.

(B) The department and a county department shall release information pursuant to division (A)(3) of this section only in accordance with the public medical assistance program recipient's authorization. The department or county department shall provide, at no cost, a copy of each written authorization to the individual who signed it.

(C) Neither the department nor a county department may release information under this section concerning a public medical assistance program recipient's receipt of medical assistance provided under a government-funded program unless all of the following conditions are met:

(1) The release of information is for purposes directly connected to the administration of or provision of medical assistance provided under a government-funded program;

(2) The information is released to persons or government entities that are subject to standards of confidentiality and safeguarding information substantially comparable to those established for medical assistance provided under a government-funded program;

(3) The department or county department has obtained an authorization consistent with section 5160.57 of the Revised Code.

Sec. 5160.56. Information concerning the receipt of medical assistance provided under a government-funded program may be released only if the release complies with the more restrictive of

the following:

(A) Sections 5160.52 to 5160.55 of the Revised Code and rules adopted under section 5160.64 of the Revised Code;

(B) The Health Insurance Portability and Accountability Act of 1996, 110 Stat. 1955, 42 U.S.C. 1320d, et seq., as amended, and regulations adopted by the United States department of health and human services to implement the act.

Sec. 5160.57. (A) For the purposes of sections 5160.54 and 5160.55 of the Revised Code, an authorization shall be made on a form that uses language understandable to the average person and contains all of the following:

(1) A description of the information to be used or disclosed that identifies the information in a specific and meaningful fashion;

(2) The name or other specific identification of the person or class of persons authorized to make the requested use or disclosure;

(3) The name or other specific identification of the person or governmental entity to which the information may be released;

(4) A description of each purpose of the requested use or disclosure of the information;

(5) The date on which the authorization expires or an event related either to the individual who is the subject of the request or to the purposes of the requested use or disclosure, the occurrence of which will cause the authorization to expire;

(6) A statement that the information used or disclosed pursuant to the authorization may be disclosed by the recipient of the information and may no longer be protected from disclosure;

(7) The signature of the individual or the individual's

authorized representative and the date on which the authorization was signed;

(8) If signed by an authorized representative, a description of the representative's authority to act for the individual;

(9) A statement of the individual or authorized representative's right to prospectively revoke the written authorization in writing, along with one of the following:

(a) A description of how the individual or authorized representative may revoke the authorization;

(b) If the department of health care administration's privacy notice contains a description of how the individual or authorized representative may revoke the authorization, a reference to that privacy notice.

(10) A statement that treatment, payment, enrollment, or eligibility for a public medical assistance program cannot be conditioned on signing the authorization unless the authorization is necessary for determining eligibility for the program.

(B) When an individual requests information pursuant to section 5160.54 or 5160.55 of the Revised Code regarding the individual's receipt of a public medical assistance program and does not wish to provide a statement of purpose, the statement "at request of the individual" is a sufficient description for purposes of division (A)(4) of this section.

Sec. 5160.58. On request of the department of health care administration or a county department of job and family services, a law enforcement agency shall provide information regarding public medical assistance program recipients to enable the department or county department to determine, for eligibility purposes, whether a recipient or a member of a recipient's assistance group is a fugitive felon or violating a condition of

probation, a community control sanction, parole, or a post-release control sanction imposed under state or federal law.

A county department may enter into a written agreement with a local law enforcement agency establishing procedures concerning access to information and providing for compliance with this section.

The auditor of state shall prepare an annual report on the outcome of the agreements required by this section. The report shall include the number of fugitive felons, probation and parole violators, and violators of community control sanctions and post-release control sanctions apprehended during the immediately preceding year as a result of the exchange of information pursuant to this section. The auditor of state shall file the report with the governor, the president and minority leader of the senate, and the speaker and minority leader of the house of representatives. The department, county departments, and law enforcement agencies shall cooperate with the auditor of state's office in gathering the information needed for the report.

Sec. 5160.59. To the extent permitted by federal law, the department of health care administration and county departments of job and family services shall provide information, except information directly related to the receipt of medical assistance or medical services, regarding disability medical assistance program recipients to law enforcement agencies on request for the purposes of investigations, prosecutions, and criminal and civil proceedings that are within the scope of the law enforcement agencies' official duties.

Sec. 5160.60. Information about a public medical assistance program recipient shall be exchanged, obtained, or shared under sections 5160.58 and 5160.59 of the Revised Code only if the

department of health care administration, county department of job and family services, or law enforcement agency requesting the information gives sufficient information to specifically identify the recipient. In addition to the recipient's name, identifying information may include the recipient's current or last known address, social security number, other identifying number, age, gender, physical characteristics, any information specified in an agreement entered into under section 5160.58 of the Revised Code, or any information considered appropriate by the department or county department.

Sec. 5160.61. The department of health care administration and its officers and employees are not liable in damages in a civil action for any injury, death, or loss to person or property that allegedly arises from the release of information in accordance with sections 5160.58 and 5160.59 of the Revised Code. This section does not affect any immunity or defense that the department and its officers and employees may be entitled to under another section of the Revised Code or the common law of this state, including section 9.86 of the Revised Code.

Sec. 5160.62. As used in this section, "employee" has the same meaning as in division (B) of section 2744.01 of the Revised Code.

County departments of job and family services and their employees are not liable in damages in a civil action for any injury, death, or loss to person or property that allegedly arises from the release of information in accordance with sections 5160.58 and 5160.59 of the Revised Code. This section does not affect any immunity or defense that the county departments and their employees may be entitled to under another section of the Revised Code or the common law of this state, including section 2744.02 and division (A)(6) of section 2744.03 of the Revised

Code.

Sec. 5160.63. To the extent permitted by federal law, the department of health care administration and county departments of job and family services shall provide access to information to the auditor of state acting pursuant to Chapter 117. or sections 117.54, 117.55, 117.56, 5160.43, and 5160.44 of the Revised Code and to any other government entity authorized by federal law to conduct an audit of or similar activity involving a public medical assistance program.

Sec. 5160.64. The director of health care administration shall adopt rules in accordance with Chapter 119. of the Revised Code implementing sections 5160.50 to 5160.63 of the Revised Code and governing the custody, use, and preservation of the information generated or received by the department of health care administration, county departments of job and family services, other state and county entities, contractors, grantees, private entities, or officials participating in the administration of a public medical assistance program. The rules shall specify conditions and procedures for the release of information. The rules shall comply with applicable federal statutes and regulations. To the extent permitted by federal law:

(A) The rules may permit providers of services or assistance under a public medical assistance program limited access to information that is essential for the providers to render services or assistance or to bill for services or assistance rendered. The department of aging, when investigating a complaint under section 173.20 of the Revised Code, shall be granted any limited access permitted in the rules pursuant to division (A) of this section.

(B) The rules may permit a contractor, grantee, or other state or county entity limited access to information that is

essential for the contractor, grantee, or entity to perform administrative or other duties on behalf of the department or county department. A contractor, grantee, or entity given access to information pursuant to division (B) of this section is bound by the director's rules, and disclosure of the information by the contractor, grantee, or entity in a manner not authorized by the rules is a violation of section 5160.51 of the Revised Code.

Sec. 5160.65. Whenever names, addresses, or other information relating to public medical assistance program recipients is held by any agency other than the department of health care administration or a county department of job and family services, that other agency shall adopt rules consistent with sections 5160.50 to 5160.64 of the Revised Code to prevent the publication or disclosure of names, lists, or other information concerning those recipients.

Sec. ~~5101.31~~ 5160.66. 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~~ health care administration 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. 5160.70. Not later than the last day of each July and January, the department of health care administration shall complete a report on the characteristics of the individuals who receive services through the programs operated by the department

and the outcomes of the individuals' receipt of the services. The reports shall be for the six-month periods ending on the last days of June and December and shall include information regarding births to medicaid recipients.

The department shall submit the reports to the speaker and minority leader of the house of representatives, the president and minority leader of the senate, the legislative budget officer, the director of budget and management, and each board of county commissioners. The department shall provide copies of the reports to any person or government entity on request.

In designing the format for the reports, the department shall consult with individuals, organizations, and government entities interested in the programs operated by the department, so that the reports are designed to enable the general assembly and the public to evaluate the effectiveness of the programs and identify any needs that the programs are not meeting.

Sec. 5160.71. Whenever the federal government requires that the department of health care administration submit a report on a program that is operated by the department or is otherwise under the department's jurisdiction, the department shall prepare and submit the report in accordance with the federal requirements applicable to that report. To the extent possible, the department may coordinate the preparation and submission of a particular report with any other report, plan, or other document required to be submitted to the federal government, as well as with any report required to be submitted to the general assembly.

Sec. 5160.75. The department of health care administration shall create within the department the central pharmaceutical purchasing office. The office shall purchase, store, repackage, distribute, and dispense all drugs, pharmaceutical products, and

related items needed by the departments of health, job and family services, mental health, mental retardation and developmental disabilities, rehabilitation and correction, and youth services and other state agencies for which the department of administrative services purchases supplies under section 125.05 of the Revised Code. The office also shall provide professional pharmacy consultation and drug information services to those departments and other state agencies.

Notwithstanding section 125.05 of the Revised Code, purchases of drugs, pharmaceutical products, and related items under this section need not be purchased through the department of administrative services.

Sec. ~~173.35~~ 5160.80. (A) As used in this section, "PASSPORT administrative agency" means an entity under contract with the department of aging to provide administrative services regarding the PASSPORT program created under section 173.40 of the Revised Code.

(B) The department of ~~aging~~ health care administration shall administer the residential state supplement program under which the state supplements the ~~supplemental security income~~ payments received by aged, blind, or disabled adults under ~~Title XVI of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A., as amended~~ the supplemental security income program. Residential state supplement payments shall be used for the provision of accommodations, supervision, and personal care services to supplemental security income recipients who the department determines are at risk of needing institutional care.

(C) For an individual to be eligible for residential state supplement payments, all of the following must be the case:

(1) Except as provided by division (G) of this section, the individual must reside in one of the following:

(a) An adult foster home certified under section 173.36 of the Revised Code;

(b) A home or facility, other than a nursing home or nursing home unit of a home for the aging, licensed by the department of health under Chapter 3721. or 3722. of the Revised Code;

(c) A community alternative home licensed under section 3724.03 of the Revised Code;

(d) A residential facility as defined in division (A)(1)(d)(ii) of section 5119.22 of the Revised Code licensed by the department of mental health;

(e) An apartment or room used to provide community mental health housing services certified by the department of mental health under section 5119.611 of the Revised Code and approved by a board of alcohol, drug addiction, and mental health services under division (A)(14) of section 340.03 of the Revised Code.

(2) Effective July 1, 2000, a PASSPORT administrative agency must have determined that the environment in which the individual will be living while receiving the payments is appropriate for the individual's needs. If the individual is eligible for supplemental security income payments or social security disability insurance benefits because of a mental disability, the PASSPORT administrative agency shall refer the individual to a community mental health agency for the community mental health agency to issue in accordance with section 340.091 of the Revised Code a recommendation on whether the PASSPORT administrative agency should determine that the environment in which the individual will be living while receiving the payments is appropriate for the individual's needs. Division (C)(2) of this section does not apply to an individual receiving residential state supplement payments on June 30, 2000, until the individual's first eligibility redetermination after that date.

(3) The individual satisfies all eligibility requirements established by rules adopted under division (D) of this section.

(D) The ~~directors~~ director of ~~aging and job and family services~~ health care administration shall adopt rules in accordance with section 111.15 of the Revised Code as necessary to implement the residential state supplement program.

To the extent permitted by Title XVI of the "Social Security Act of 1935," and any other provision of federal law, the director of ~~job and family services~~ health care administration shall adopt rules establishing standards for adjusting the eligibility requirements concerning the level of impairment a person must have so that the amount appropriated for the program by the general assembly is adequate for the number of eligible individuals. The rules shall not limit the eligibility of disabled persons solely on a basis classifying disabilities as physical or mental. The director of ~~job and family services~~ health care administration also shall adopt rules that establish eligibility standards for aged, blind, or disabled individuals who reside in one of the homes or facilities specified in division (C)(1) of this section but who, because of their income, do not receive supplemental security income payments. The rules may provide that these individuals may include individuals who receive other types of benefits, including, social security disability insurance benefits provided under Title II of the "Social Security Act~~,~~ of 1935" ~~49 Stat. 620 (1935), 42 U.S.C.A. 401, as amended~~. Notwithstanding division (B) of this section, such payments may be made if funds are available for them.

The director of ~~aging~~ health care administration shall adopt rules establishing the method to be used to determine the amount an eligible individual will receive under the program. The amount the general assembly appropriates for the program shall be a factor included in the method that department establishes.

(E) The county department of job and family services of the county in which an applicant for the residential state supplement program resides shall determine whether the applicant meets income and resource requirements for the program.

(F) The department of ~~aging~~ health care administration shall maintain a waiting list of any individuals eligible for payments under this section but not receiving them because moneys appropriated to the department for the purposes of this section are insufficient to make payments to all eligible individuals. An individual may apply to be placed on the waiting list even though the individual does not reside in one of the homes or facilities specified in division (C)(1) of this section at the time of application. The director of ~~aging~~ health care administration, by rules adopted in accordance with Chapter 119. of the Revised Code, shall specify procedures and requirements for placing an individual on the waiting list. Individuals on the waiting list who reside in a community setting not required to be licensed or certified shall have their eligibility for the payments assessed before other individuals on the waiting list.

(G) An individual in a licensed or certified living arrangement receiving state supplementation on November 15, 1990, under former section 5101.531 of the Revised Code shall not become ineligible for payments under this section solely by reason of the individual's living arrangement as long as the individual remains in the living arrangement in which the individual resided on November 15, 1990.

(H) The department of ~~aging~~ health care administration shall notify each person denied approval for payments under this section of the person's right to a hearing. On request, the hearing shall be provided ~~by the department of job and family services~~ in accordance with section ~~5101.35~~ 5160.34 of the Revised Code.

Sec. 5160.99. Whoever violates section 5160.51 of the Revised Code is guilty of a misdemeanor of the first degree.

Sec. 5161.01. The department of health care administration shall act as the single state agency to supervise the administration of the medicaid program. As the single state agency, the department shall comply with 42 C.F.R. 431.10(e). The department's rules governing medicaid are binding on other agencies that administer components of the medicaid program. No agency may establish, by rule or otherwise, a policy governing medicaid that is inconsistent with a medicaid policy established, in rule or otherwise, by the director of health care administration.

Sec. ~~5111.98~~ 5161.02. (A) The director of ~~job and family services~~ health care administration may do all of the following as necessary for the department of ~~job and family services~~ health care administration 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~~ health care administration 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. 5161.03. The director of health care administration shall prepare and submit to the United States secretary of health and human services both of the following as necessary to accomplish the requirements of state law governing the medicaid program:

(A) A state medicaid plan.

(B) Amendments to the state medicaid plan.

Sec. ~~5111.91~~ 5161.05. The department of ~~job and family services~~ health care administration may enter into contracts with one or more other state agencies or political subdivisions to have the state agency or political subdivision administer one or more components of the medicaid program, or one or more aspects of a component, under the department's supervision. A state agency or political subdivision that enters into such a contract shall comply with the terms of the contract and any rules the director of ~~job and family services~~ health care administration has adopted governing the component, or aspect of the component, that the state agency or political subdivision is to administer, including any rules establishing review, audit, and corrective action plan requirements. A contract with a state agency shall be in the form

of an interagency agreement. The interagency agreement shall include a requirement for the state agency to submit an annual financing plan to the department.

A state agency or political subdivision that enters into a contract with the department under this section shall reimburse the department for the nonfederal share of the cost to the department of performing, or contracting for the performance of, a fiscal audit of the component of the medicaid program, or aspect of the component, that the state agency or political subdivision administers if rules governing the component, or aspect of the component, require that a fiscal audit be conducted.

There is hereby created in the state treasury the medicaid administrative reimbursement fund. The department shall use money in the fund to pay for the nonfederal share of the cost of a fiscal audit for which a state agency or political subdivision is required by this section to reimburse the department. The department shall deposit the reimbursements into the fund.

Sec. ~~5111.911~~ 5161.06. Any contract the department of ~~job and family services~~ health care administration enters into with the department of mental health or department of alcohol and drug addiction services under section ~~5111.91~~ 5161.05 of the Revised Code is subject to the approval of the director of budget and management and shall require or specify all of the following:

(A) In the case of a contract with the department of mental health, that section ~~5111.912~~ 5161.07 of the Revised Code be complied with;

(B) In the case of a contract with the department of alcohol and drug addiction services, that section ~~5111.913~~ 5161.08 of the Revised Code be complied with;

(C) How providers will be paid for providing the services;

(D) The department of mental health's or department of alcohol and drug addiction services' responsibilities for reimbursing providers, including program oversight and quality assurance.

Sec. ~~5111.912~~ 5161.07. If the department of ~~job and family services~~ health care administration enters into a contract with the department of mental health under section ~~5111.91~~ 5161.05 of the Revised Code, the department of mental health and boards of alcohol, drug addiction, and mental health services shall pay the nonfederal share of any medicaid payment to a provider for services under the component, or aspect of the component, the department of mental health administers.

Sec. ~~5111.913~~ 5161.08. If the department of ~~job and family services~~ health care administration enters into a contract with the department of alcohol and drug addiction services under section ~~5111.91~~ 5161.05 of the Revised Code, the department of alcohol and drug addiction services and boards of alcohol, drug addiction, and mental health services shall pay the nonfederal share of any medicaid payment to a provider for services under the component, or aspect of the component, the department of alcohol and drug addiction services administers.

Sec. ~~5111.90~~ 5161.10. (A) As used in sections ~~5111.90~~ 5161.10 to ~~5111.93~~ 5161.13 of the Revised Code:

(1) "Political subdivision" means a municipal corporation, township, county, school district, or other body corporate and politic responsible for governmental activities only in a geographical area smaller than that of the state.

(2) "State agency" means every organized body, office, or agency, other than the department of ~~job and family services~~ health care administration, established by the laws of the state

for the exercise of any function of state government.

(B) To the extent permitted by Title XIX of the "Social Security Act~~,~~ of 1935" ~~79 Stat. 286 (1965), 42 U.S.C.A. 1396, as amended,~~ and regulations adopted under that title, the department of ~~job and family services~~ health care administration may enter into contracts with political subdivisions to use funds of the political subdivision to pay the nonfederal share of expenditures under the medicaid program. The determination and provision of federal financial reimbursement to a subdivision entering into a contract under this section shall be determined by the department, subject to section ~~5111.92~~ 5161.12 of the Revised Code, approval by the United States secretary of health and human services, and the availability of federal financial participation.

Sec. ~~5111.92~~ 5161.12. (A)(1) Except as provided in division (B) of this section, if a state agency or political subdivision administers one or more components of the medicaid program that the United States department of health and human services approved, and for which federal financial participation was initially obtained, prior to January 1, 2002, or administers one or more aspects of such a component, the department of ~~job and family services~~ health care administration may retain or collect not more than ten per cent of the federal financial participation the state agency or political subdivision obtains through an approved, administrative claim regarding the component or aspect of the component. If the department retains or collects a percentage of such federal financial participation, the percentage the department retains or collects shall be specified in a contract the department enters into with the state agency or political subdivision under section ~~5111.91~~ 5161.05 of the Revised Code.

(2) Except as provided in division (B) of this section, if a

state agency or political subdivision administers one or more components of the medicaid program that the United States department of health and human services approved on or after January 1, 2002, or administers one or more aspects of such a component, the department of ~~job and family services~~ health care administration shall retain or collect not less than three and not more than ten per cent of the federal financial participation the state agency or political subdivision obtains through an approved, administrative claim regarding the component or aspect of the component. The percentage the department retains or collects shall be specified in a contract the department enters into with the state agency or political subdivision under section ~~5111.91~~ 5161.05 of the Revised Code.

(B) The department of ~~job and family services~~ health care administration may retain or collect a percentage of federal financial participation under divisions (A)(1) and (2) of this section only to the extent permitted by federal statutes and regulations.

(C) All amounts the department retains or collects under this section shall be deposited into the health care services administration fund created under section ~~5111.94~~ 5161.15 of the Revised Code.

Sec. ~~5111.93~~ 5161.13. The department of ~~job and family services~~ health care administration may retain or collect a percentage of the federal financial participation included in a supplemental medicaid payment to one or more medicaid providers owned or operated by a state agency or political subdivision that brings the payment to such provider or providers to the upper payment limit established by 42 C.F.R. 447.272. If the department retains or collects a percentage of that federal financial participation, the department shall adopt a rule under Chapter

119. of the Revised Code specifying the percentage the department is to retain or collect. All amounts the department retains or collects under this section shall be deposited into the health care services administration fund created under section ~~5111.94~~ 5161.15 of the Revised Code.

Sec. ~~5111.94~~ 5161.15. (A) As used in this section, "vendor offset" means a reduction of a medicaid payment to a medicaid provider to correct a previous, incorrect medicaid payment to that provider.

(B) There is hereby created in the state treasury the health care services administration fund. Except as provided in division (C) of this section, all the following shall be deposited into the fund:

(1) Amounts deposited into the fund pursuant to sections ~~5111.92~~ 5161.12 and ~~5111.93~~ 5161.13 of the Revised Code;

(2) The amount of the state share of all money the department of ~~job and family services~~ health care administration, in fiscal year 2003 and each fiscal year thereafter, recovers pursuant to a tort action under the department's right of recovery under section ~~5101.58~~ 5160.38 of the Revised Code that exceeds the state share of all money the department, in fiscal year 2002, recovers pursuant to a tort action under that right of recovery;

(3) Subject to division (D) of this section, the amount of the state share of all money the department of ~~job and family services~~ health care administration, in fiscal year 2003 and each fiscal year thereafter, recovers through audits of medicaid providers that exceeds the state share of all money the department, in fiscal year 2002, recovers through such audits;

(4) Amounts from assessments on hospitals under section ~~5112.06~~ 5166.05 of the Revised Code and intergovernmental

transfers by governmental hospitals under section ~~5112.07~~ 5166.06 of the Revised Code that are deposited into the fund in accordance with the law.

(C) No funds shall be deposited into the health care services administration fund in violation of federal statutes or regulations.

(D) In determining under division (B)(3) of this section the amount of money the department, in a fiscal year, recovers through audits of medicaid providers, the amount recovered in the form of vendor offset shall be excluded.

(E) The director of ~~job and family services~~ health care administration shall use funds available in the health care services administration fund to pay for costs associated with the administration of the medicaid program.

Sec. ~~5111.941~~ 5161.16. The medicaid revenue and collections fund is hereby created in the state treasury. Except as otherwise provided by statute or as authorized by the controlling board, the ~~non-federal~~ nonfederal share of all medicaid-related revenues, collections, and recoveries shall be credited to the fund. The department of ~~job and family services~~ health care administration shall use money credited to the fund to pay for medicaid services and contracts.

Sec. ~~5111.942~~ 5161.17. (A) The prescription drug rebates fund is hereby created in the state treasury. Both of the following shall be credited to the fund:

(1) The ~~non-federal~~ nonfederal share of all rebates paid by drug manufacturers to the department of ~~job and family services~~ health care administration in accordance with a rebate agreement required by 42 U.S.C.A. 1396r-8;

(2) The ~~non-federal~~ nonfederal share of all supplemental

rebates paid by drug manufacturers to the department of ~~job and family services~~ health care administration in accordance with the supplemental drug rebate program established under section ~~5111.081~~ 5163.26 of the Revised Code.

(B) The department of ~~job and family services~~ health care administration shall use money credited to the prescription drug rebates fund to pay for medicaid services and contracts.

Sec. ~~5111.943~~ 5161.18. (A) The health care - federal fund is hereby created in the state treasury. All of the following shall be credited to the fund:

(1) Funds that division (B) of section ~~5112.18~~ 5166.12 of the Revised Code requires be credited to the fund;

(2) The federal share of all rebates paid by drug manufacturers to the department of ~~job and family services~~ health care administration in accordance with a rebate agreement required by 42 U.S.C. 1396r-8;

(3) The federal share of all supplemental rebates paid by drug manufacturers to the department of ~~job and family services~~ health care administration in accordance with the supplemental drug rebate program established under section ~~5111.081~~ 5163.26 of the Revised Code;

(4) Except as otherwise provided by statute or as authorized by the controlling board, the federal share of all other medicaid-related revenues, collections, and recoveries.

(B) All money credited to the health care - federal fund pursuant to division (B) of section ~~5112.18~~ 5166.12 of the Revised Code shall be used solely for distributing funds to hospitals under section ~~5112.08~~ 5166.07 of the Revised Code. The department of ~~job and family services~~ health care administration shall use all other money credited to the fund to pay for other medicaid

services and contracts.

Sec. ~~5111.915~~ 5161.25. (A) The department of ~~job and family services~~ health care administration 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~~ health care administration, 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~~ September 29, 2005. The contract shall require the vendor to complete the assessment within ninety days after ~~the effective date of this section~~ September 29, 2005.

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~~ health care administration and all agencies serving medicaid recipients.

Within ninety days after ~~the effective date of this section~~ September 29, 2005, the department of ~~job and family services~~ health care administration 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~~ health care administration receives approval from the secretary of the United States department of health and human services for the ninety per cent federal match.

Sec. ~~5111.10~~ 5161.30. The director of ~~job and family services~~ health care administration 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~~ 5160.21 of the Revised Code, shall be taken in accordance with that section.

Sec. ~~5111.09~~ 5161.32. On or before the first day of January of each year, the department of ~~job and family services~~ health care administration shall submit to the speaker and minority leader of the house of representatives and the president and

minority leader of the senate, and shall make available to the public, a report on the effectiveness of ~~the Ohio works first program established under Chapter 5107. of the Revised Code and~~ the ~~medical assistance~~ medicaid program ~~established under this chapter~~ in meeting the health care needs of low-income pregnant women, infants, and children. The report shall include: the estimated number of persons eligible for health care services to pregnant women, infants, and children under the programs; the actual number of eligible persons served; the number of prenatal, postpartum, and child health visits; a report on birth outcomes, including a comparison of low-birthweight births and infant mortality rates of program participants with the general female child-bearing and infant population in this state; and a comparison of the prenatal, delivery, and child health costs of the programs with such costs of similar programs in other states, where available.

Sec. ~~5111.091~~ 5161.33. Every three months, the director of ~~job and family services~~ health care administration shall submit a report to the president and minority leader of the senate and speaker and minority leader of the house of representatives on the establishment and implementation of programs designed to control the increase of the cost of the medicaid program.

Sec. ~~5111.01~~ 5162.01. ~~As used in this chapter, "medical assistance program" or "medicaid" means the program that is authorized by this chapter and provided by the department of job and family services under this chapter, Title XIX of the "Social Security Act," 79 Stat. 286 (1965), 42 U.S.C.A. 1396, as amended, and the waivers of Title XIX requirements granted to the department by the health care financing administration of the United States department of health and human services.~~

~~The department of job and family services shall act as the~~

~~single state agency to supervise the administration of the medicaid program. As the single state agency, the department shall comply with 42 C.F.R. 431.10(e). The department's rules governing medicaid are binding on other agencies that administer components of the medicaid program. No agency may establish, by rule or otherwise, a policy governing medicaid that is inconsistent with a medicaid policy established, in rule or otherwise, by the director of job and family services.~~

~~(A)~~ The department of ~~job and family services~~ health care administration may provide medical assistance under the medicaid program as long as federal funds are provided for such assistance, to the following:

~~(1)~~(A) Families with children that meet ~~either of the following conditions:~~

~~(a) The family meets~~ the income, resource, and family composition requirements in effect on July 16, 1996, for the former aid to dependent children program as those requirements were established by Chapter 5107. of the Revised Code, federal waivers granted pursuant to requests made under former section 5101.09 of the Revised Code, and rules adopted ~~by the department~~ for that former program or any changes the department makes to those requirements in accordance with ~~paragraph (a)(2) of section 114 of the "Personal Responsibility and Work Opportunity Reconciliation Act of 1996," 110 Stat. 2177,~~ 42 U.S.C.~~A.~~ 1396u-1~~,~~ for the purpose of implementing section ~~5111.019~~ 5162.05 of the Revised Code. An adult loses eligibility for ~~medical assistance~~ medicaid under division (A)~~(1)(a)~~ of this section pursuant to division (E) of section 5107.16 of the Revised Code.

~~(b) The family does not meet the requirements specified in division (A)(1)(a) of this section but is eligible for medical assistance pursuant to section 5101.18 of the Revised Code~~.

~~(2)~~(B) Aged, blind, and disabled persons who meet either of the following conditions:

~~(a)~~(1) Receive federal ~~aid~~ benefits under ~~Title XVI of the "Social Security Act,"~~ the supplemental security income program or are eligible for but are not receiving ~~such aid~~ SSI benefits, provided that the income from all other sources for individuals with independent living arrangements shall not exceed one hundred seventy-five dollars per month. The income standards hereby established shall be adjusted annually at the rate that is used by the United States department of health and human services to adjust the ~~amounts~~ benefits payable under ~~Title XVI~~ the SSI program.

~~(b)~~(2) Do not receive ~~aid under Title XVI~~ supplemental security income benefits, but meet any of the following criteria:

~~(i)~~(a) Would be eligible ~~to receive such aid~~ for SSI benefits, except that their income, other than that excluded from consideration as income ~~under Title XVI~~ for the SSI program, exceeds the maximum under division ~~(A)(2)(a)~~(B)(1) of this section, and incurred expenses for medical care, as determined under federal regulations applicable to section 209(b) of the "Social Security Amendments of 1972," 86 Stat. 1381, 42 U.S.C.A. 1396a(f), as amended, equal or exceed the amount by which their income exceeds the maximum under division ~~(A)(2)(a)~~(B)(1) of this section;

~~(ii)~~(b) Received aid for the aged, aid to the blind, or aid for the permanently and totally disabled prior to January 1, 1974, and continue to meet all the same eligibility requirements;

~~(iii) Are eligible for medical assistance pursuant to section 5101.18 of the Revised Code~~ (c) Lost eligibility for SSI benefits due to a general increase in old-age, survivors, and disability insurance benefits under Title II of the Social Security Act of

1935.

~~(3)~~(C) Persons to whom federal law requires, as a condition of state participation in the medicaid program, that medical assistance be provided;

~~(4)~~(D) Persons under age twenty-one who meet the income requirements for the Ohio works first program established under Chapter 5107. of the Revised Code but do not meet other eligibility requirements for the program. The director shall adopt rules in accordance with Chapter 119. of the Revised Code specifying which Ohio works first requirements shall be waived for the purpose of providing medicaid eligibility under division ~~(A)(4)~~(D) of this section.

~~(B) If funds are appropriated for such purpose by the general assembly, the department may provide medical assistance to persons in groups designated by federal law as groups to which a state, at its option, may provide medical assistance under the medicaid program.~~

~~(C) The department may expand eligibility for medical assistance to include individuals under age nineteen with family incomes at or below one hundred fifty per cent of the federal poverty guidelines, except that the eligibility expansion shall not occur unless the department receives the approval of the federal government. The department may implement the eligibility expansion authorized under this division on any date selected by the department, but not sooner than January 1, 1998.~~

~~(D) In addition to any other authority or requirement to adopt rules under this chapter, the director may adopt rules in accordance with section 111.15 of the Revised Code as the director considers necessary to establish standards, procedures, and other requirements regarding the provision of medical assistance. The rules may establish requirements to be followed in applying for~~

~~medical assistance, making determinations of eligibility for medical assistance, and verifying eligibility for medical assistance. The rules may include special conditions as the department determines appropriate for making applications, determining eligibility, and verifying eligibility for any medical assistance that the department may provide pursuant to division (C) of this section and section 5111.014 or 5111.019 of the Revised Code.~~

Sec. 5162.02. If funds are appropriated for such purpose by the general assembly, the department of health care administration may expand eligibility for the medicaid program to persons in groups designated by federal law as groups to which a state, at its option, may provide medical assistance under the medicaid program.

Sec. 5162.03. The department of health care administration may expand eligibility for the medicaid program to individuals under nineteen years of age with family incomes at or below one hundred fifty per cent of the federal poverty guidelines, except that the eligibility expansion shall not occur unless the department receives the approval of the United States department of health and human services. The department may implement the eligibility expansion authorized by this section on any date selected by the department.

Sec. ~~5111.014~~ 5162.04. (A) The director of ~~job and family services~~ health care administration 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:

(1) The individual is pregnant;

(2) The individual's family income does not exceed one

hundred fifty per cent of the federal poverty guidelines;

(3) The individual satisfies all relevant requirements established by rules adopted under ~~division (D) of~~ section ~~5111.01~~ 5162.20 of the Revised Code.

(B) If approved by the United States secretary of health and human services, the director of ~~job and family services~~ health care administration shall implement the medicaid plan amendment submitted under division (A) of this section as soon as possible after receipt of notice of the approval, but not sooner than January 1, 2000.

Sec. ~~5111.019~~ 5162.05. (A) The director of ~~job and family services~~ health care administration 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 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~~ 5162.20 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.

Sec. ~~5111.0111~~ 5162.06. The director of ~~job and family services~~ health care administration may submit to the United

States secretary of health and human services an amendment to the state medicaid plan to make an individual receiving independent living services pursuant to sections 2151.81 to 2151.84 of the Revised Code eligible for medicaid. If approved by the United States secretary of health and human services, the director of ~~job and family services~~ health care administration shall implement the medicaid plan amendment submitted under this section.

Sec. ~~5111.0113~~ 5162.07. Children who are in the temporary or permanent custody of a certified public or private nonprofit agency or institution or in adoptions subsidized under division (B) of section 5153.163 of the Revised Code are eligible for ~~medical assistance through~~ the medicaid program ~~established under section 5111.01 of the Revised Code~~.

Sec. ~~5111.0110~~ 5162.08. (A) The director of ~~job and family services~~ health care administration shall submit to the United States secretary of health and human services an amendment to the state medicaid plan to implement the "Breast and Cervical Cancer Prevention and Treatment Act of 2000," 114 Stat. 1381, 42 U.S.C.A. 1396a, as amended, to provide medical assistance to women who meet all of the following requirements:

(1) Are under age sixty-five;

(2) Are not otherwise eligible for medicaid;

(3) Have been screened for breast and cervical cancer under the centers for disease control and prevention breast and cervical cancer early detection program established under 42 U.S.C.A. 300k in accordance with 42 U.S.C.A. 300n;

(4) Need treatment for breast or cervical cancer;

(5) Are not otherwise covered under creditable coverage, as defined in 42 U.S.C.A. 300gg(c).

(B) If the United States secretary of health and human services approves the state medicaid plan amendment submitted under division (A) of this section, the director of ~~job and family services~~ health care administration shall implement the amendment. The medical assistance provided under the amendment shall be limited to medical assistance provided during the period in which a woman who meets the requirements of division (A) of this section requires treatment for breast or cervical cancer.

Sec. ~~5111.0115~~ 5162.09. (A) The department of ~~job and family services~~ health care administration may provide medical assistance under 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~~ health care administration 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~~ health care administration shall adopt such rules under Chapter 119. of the Revised Code as are necessary to implement and administer the ~~medical assistance~~ medicaid program under this section.

(C) A person seeking to participate in ~~a program of medical assistance under~~ the medicaid program pursuant to 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~~ health care administration 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~~ medicaid under this section, the department shall provide assistance, to the same extent and in the same manner as ~~medical assistance~~ medicaid is provided to a person eligible for ~~medical assistance~~ medicaid pursuant to division (A)~~(1)(a)~~ of section ~~5111.01~~ 5162.01 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. ~~5111.013~~ 5162.15. (A) The provision of ~~medical assistance~~ medicaid to pregnant women and young children who are eligible for ~~medical assistance~~ medicaid under division ~~(A)(3)~~(C) of section ~~5111.01~~ 5162.01 of the Revised Code, but who are not otherwise eligible for ~~medical assistance~~ medicaid under that section, shall be known as the healthy start program.

(B) The department of ~~job and family services~~ health care administration shall do all of the following with regard to the application procedures for the healthy start program:

(1) Establish a short application form for the program that requires the applicant to provide no more information than is necessary for making determinations of eligibility for the healthy start program, except that the form may require applicants to provide their social security numbers. The form shall include a statement, which must be signed by the applicant, indicating that she does not choose at the time of making application for the program to apply for assistance provided under any other program administered by the department and that she understands that she

is permitted at any other time to apply at the county department of job and family services of the county in which she resides for any other assistance administered by the department or department of job and family services.

(2) To the extent permitted by federal law, do one or both of the following:

(a) Distribute the application form for the program to each public or private entity that serves as a women, infants, and children clinic or as a child and family health clinic and to each administrative body for such clinics and train employees of each such agency or entity to provide applicants assistance in completing the form;

(b) In cooperation with the department of health, develop arrangements under which employees of county departments of job and family services are stationed at public or private agencies or entities selected by the department of ~~job and family services~~ health care administration that serve as women, infants, and children clinics; child and family health clinics; or administrative bodies for such clinics for the purpose both of assisting applicants for the program in completing the application form and of making determinations at that location of eligibility for the program.

(3) Establish performance standards by which a county department of job and family services' level of enrollment of persons potentially eligible for the program can be measured, and establish acceptable levels of enrollment for each county department.

(4) Direct any county department of job and family services whose rate of enrollment of potentially eligible enrollees in the program is below acceptable levels established under division (B)(3) of this section to implement corrective action. Corrective

action may include but is not limited to any one or more of the following to the extent permitted by federal law:

(a) Establishing formal referral and outreach methods with local health departments and local entities receiving funding through the bureau of maternal and child health;

(b) Designating a specialized intake unit within the county department for healthy start applicants;

(c) Establishing abbreviated timeliness requirements to shorten the time between receipt of an application and the scheduling of an initial application interview;

(d) Establishing a system for telephone scheduling of intake interviews for applicants;

(e) Establishing procedures to minimize the time an applicant must spend in completing the application and eligibility determination process, including permitting applicants to complete the process at times other than the regular business hours of the county department and at locations other than the offices of the county department.

(C) To the extent permitted by federal law, local funds, whether from public or private sources, expended by a county department for administration of the healthy start program shall be considered to have been expended by the state for the purpose of determining the extent to which the state has complied with any federal requirement that the state provide funds to match federal funds for ~~medical assistance~~ medicaid, except that this division shall not affect the amount of funds the county is entitled to receive under section 5101.16~~,~~ or 5101.161~~, or 5111.012~~ of the Revised Code.

(D) The director of ~~job and family services~~ health care administration shall do one or both of the following:

(1) To the extent that federal funds are provided for such assistance, adopt a plan for granting presumptive eligibility for pregnant women applying for healthy start;

(2) To the extent permitted by federal medicaid regulations, adopt a plan for making same-day determinations of eligibility for pregnant women applying for healthy start.

(E) A county department of job and family services that maintains offices at more than one location shall accept applications for the healthy start program at all of those locations.

(F) The director of ~~job and family services~~ health care administration shall adopt rules in accordance with section 111.15 of the Revised Code as necessary to implement this section.

Sec. ~~5111.016~~ 5162.16. (A) As used in this section, "healthcheck" has the same meaning as in section 3313.714 of the Revised Code.

(B) In accordance with federal law and regulations, the department of ~~job and family services~~ health care administration shall establish a combination of written and oral methods designed to provide information about healthcheck to all persons eligible for the program or their parents or guardians. The department shall ensure that its methods of providing information are effective.

Each county department of job and family services or other entity that distributes or accepts applications for ~~medical assistance~~ medicaid shall prominently display in a conspicuous place the following notice:

"Under state and federal law, if you are a Medicaid recipient, your child is entitled to a thorough medical examination provided through Healthcheck. Once this examination is

completed, your child is entitled to receive, at no cost to you, any service determined to be medically necessary."

Sec. 5162.17. The department of health care administration shall establish a disability determination unit and develop guidelines for expediting reviews of applications for the medicaid program for persons who have been referred to the unit under division (D) of section 329.043 of the Revised Code. The department shall make determinations of eligibility for medicaid for any such person within the time prescribed by federal regulations.

Sec. ~~5111.011~~ 5162.20. (A) The director of ~~job and family services~~ health care administration shall adopt rules establishing eligibility requirements for the medicaid program. The rules shall be adopted pursuant to section 111.15 of the Revised Code and shall be consistent with federal and state law. The rules shall include rules that do all of the following:

(1) Establish requirements to be followed in applying for medicaid, making determinations of eligibility for medicaid, and verifying eligibility for medicaid;

(2) 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 medicaid;

~~(2)~~(3) Define the term "resources" as used in division (A)~~(1)~~(2) of this section;

~~(3)~~(4) Specify the number of months that is to be used for the purpose of the term "look-back date" used in section ~~5111.0116~~ 5162.21 of the Revised Code;

~~(4)~~(5) Establish processes to be used to determine both of the following:

(a) The date an institutionalized individual's ineligibility for services under section ~~5111.0116~~ 5162.21 of the Revised Code is to begin;

(b) The number of months an institutionalized individual's ineligibility for such services is to continue.

~~(5)~~(6) Establish exceptions to the period of ineligibility that an institutionalized individual would otherwise be subject to under section ~~5111.0116~~ 5162.21 of the Revised Code;

~~(6)~~(7) Define the term "other medicaid-funded long-term care services" as used in sections ~~5111.0117~~ 5162.22 and ~~5111.0118~~ 5162.23 of the Revised Code;

~~(7)~~(8) For the purpose of division (C)(2)(c) of section ~~5111.0117~~ 5162.22 of the Revised Code, establish the process to determine whether the child of an aged, blind, or disabled individual is financially dependent on the individual for housing.

(B) 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 rules adopted under division (A)~~(1)~~(2) of this section shall be used to determine eligibility for medicaid.

Sec. ~~5111.0116~~ 5162.21. (A) As used in this section:

(1) "Assets" include all of an individual's income and resources and those of the individual's spouse, including any income or resources the individual or spouse is entitled to but does not receive because of action by any of the following:

(a) The individual or spouse;

(b) A person or government entity, including a court or administrative agency, with legal authority to act in place of or on behalf of the individual or spouse;

(c) A person or government entity, including a court or administrative agency, acting at the direction or on the request of the individual or spouse.

(2) "Home and community-based services" means home and community-based services furnished under a medicaid waiver granted by the United States secretary of health and human services under 42 U.S.C. 1396n(c) or (d).

(3) "Institutionalized individual" means a resident of a nursing facility, an inpatient in a medical institution for whom a payment is made based on a level of care provided in a nursing facility, or an individual described in 42 U.S.C. 1396a(a)(10)(A)(ii)(VI).

(4) "Look-back date" means the date that is a number of months specified in rules adopted under section ~~5111.011~~ 5162.20 of the Revised Code immediately before either of the following:

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

(b) The date an individual applies for medicaid while an institutionalized individual.

(5) "Nursing facility" has the same meaning as in section ~~5111.20~~ 5164.01 of the Revised Code.

(6) "Nursing facility equivalent services" means services that are covered by the medicaid program, equivalent to nursing facility services, provided by an institution that provides the same level of care as a nursing facility, and provided to an inpatient of the institution who is a medicaid recipient eligible for medicaid-covered nursing facility equivalent services.

(7) "Nursing facility services" means nursing facility services covered by the medicaid program that a nursing facility

provides to a resident of the nursing facility who is a medicaid recipient eligible for medicaid-covered nursing facility services.

(B) Except as provided in rules adopted under section ~~5111.011~~ 5162.20 of the Revised Code, an institutionalized individual is ineligible for nursing facility services, nursing facility equivalent services, and home and community-based services if the individual or individual's spouse disposes of assets for less than fair market value on or after the look-back date. The institutionalized individual's ineligibility shall begin on a date determined in accordance with rules adopted under section ~~5111.011~~ 5162.20 of the Revised Code and shall continue for a number of months determined in accordance with such rules.

(C) To secure compliance with this section, the director of ~~job and family services~~ health care administration may require an individual, as a condition of initial or continued eligibility for medicaid, to provide documentation of the individual's assets up to five years before the 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 tax returns, records from financial institutions, and real property records.

Sec. ~~5111.0117~~ 5162.22. (A) As used in this section and section ~~5111.0118~~ 5162.23 of the Revised Code:

(1) "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.

(2) "Intermediate care facility for the mentally retarded"

has the same meaning as in section ~~5111.20~~ 5164.01 of the Revised Code.

(3) "Nursing facility" has the same meaning as in section ~~5111.20~~ 5164.01 of the Revised Code.

(4) "Nursing facility services" means nursing facility services covered by the medicaid program that a nursing facility provides to a resident of the nursing facility who is a medicaid recipient eligible for medicaid-covered nursing facility services.

(5) "Other medicaid-funded long-term care services" has the meaning specified in rules adopted under section ~~5111.011~~ 5162.20 of the Revised Code.

(B) Except as provided by division (C) of this section and for the purpose of determining whether an aged, blind, or disabled individual is eligible for nursing facility services, ICF/MR services, or other medicaid-funded long-term care services, the director of ~~job and family services~~ health care administration may consider an aged, blind, or disabled individual's real property to not be the individual's homestead or principal place of residence once the individual has resided in a nursing facility, intermediate care facility for the mentally retarded, or other medical institution for at least thirteen months.

(C) Division (B) of this section does not apply to an individual if any of the following reside in the individual's real property that, because of this division, continues to be considered the individual's homestead or principal place of residence:

(1) The individual's spouse;

(2) The individual's child if any of the following apply:

(a) The child is under twenty-one years of age.

(b) The child is considered blind or disabled under 42 U.S.C.

1382c.

(c) The child is financially dependent on the individual for housing as determined in accordance with rules adopted under section ~~5111.011~~ 5162.20 of the Revised Code.

(3) The individual's sibling if the sibling has a verified equity interest in the real property and resided in the real property for at least one year immediately before the date the individual was admitted to the nursing facility, intermediate care facility for the mentally retarded, or other medical institution.

Sec. ~~5111.0118~~ 5162.23. (A) Except as otherwise provided by this section, no individual shall qualify for nursing facility services or other medicaid-funded long-term care services if the individual's equity interest in the individual's home exceeds five hundred thousand dollars. The director of ~~job and family services~~ health care administration shall increase this amount effective January 1, 2011, and the first day of each year thereafter, by the percentage increase in the consumer price index for all urban consumers (all items; United States city average), rounded to the nearest one thousand dollars.

(B) This section does not apply to an individual if either of the following applies:

(1) Either of the following lawfully reside in the individual's home:

(a) The individual's spouse;

(b) The individual's child if the child is under twenty-one years of age or, under 42 U.S.C. 1382c, considered blind or disabled.

(2) The individual qualifies, pursuant to the process established under division (C) of this section, for a waiver of this section due to a demonstrated hardship.

(C) The director shall establish a process by which individuals may obtain a waiver of this section due to a demonstrated hardship. The process shall be consistent with the process for such waivers established by the United States secretary of health and human services under 42 U.S.C. 1396p(f)(4).

(D) Nothing in this section shall be construed as preventing an individual from using a reverse mortgage or home equity loan to reduce the individual's total equity interest in the home.

Sec. ~~5111.015~~ 5162.24. (A) If the United States secretary of health and human services grants a waiver of any contrary federal requirements governing the ~~medical assistance~~ medicaid program or the director of ~~job and family services~~ health care administration determines that there are no contrary federal requirements, divisions (A)(1) and (2) of this section apply to determinations of eligibility under this chapter:

(1) In determining the eligibility of an assistance group for assistance under this chapter, the department of ~~job and family services~~ health care administration shall exclude from the income and resources applicable to the assistance group the value of any tuition payment contract entered into under section 3334.09 of the Revised Code or any scholarship awarded under section 3334.18 of the Revised Code and the amount of payments made by the Ohio tuition trust authority under section 3334.09 of the Revised Code pursuant to the contract or scholarship.

(2) The department shall not require any person to terminate a tuition payment contract entered into under Chapter 3334. of the Revised Code as a condition of an assistance group's eligibility for ~~assistance under this chapter~~ medicaid.

(B) To the extent required by federal law, the department shall include as income any refund paid under section 3334.10 of

the Revised Code to a member of the assistance group.

(C) Not later than sixty days after July 1, 1994, the department shall apply to the United States department of health and human services for a waiver of any federal requirements that otherwise would be violated by implementation of division (A) of this section.

Sec. ~~5111.15~~ 5162.25. If a medicaid recipient ~~of medical assistance~~ is the beneficiary of a trust created pursuant to section 5815.28 of the Revised Code, then, notwithstanding any contrary provision of this chapter or of a rule adopted pursuant to this chapter, divisions (C) and (D) of that section shall apply in determining the assets or resources of the recipient, the recipient's estate, the settlor, or the settlor's estate and to claims arising under this chapter against the recipient, the recipient's estate, the settlor, or the settlor's estate.

Sec. ~~5111.151~~ 5162.26. (A) This section applies to eligibility determinations for all cases involving ~~medicaid~~ medical assistance provided ~~pursuant to this chapter~~ under the medicaid program, qualified medicare beneficiaries, specified low-income medicare beneficiaries, qualifying individuals-1, qualifying individuals-2, and ~~medical assistance~~ medicaid for covered families and children.

(B) As used in this section:

(1) "Trust" means any arrangement in which a grantor transfers real or personal property to a trust with the intention that it be held, managed, or administered by at least one trustee for the benefit of the grantor or beneficiaries. "Trust" includes any legal instrument or device similar to a trust.

(2) "Legal instrument or device similar to a trust" includes, but is not limited to, escrow accounts, investment accounts,

partnerships, contracts, and other similar arrangements that are not called trusts under state law but are similar to a trust and to which all of the following apply:

(a) The property in the trust is held, managed, retained, or administered by a trustee.

(b) The trustee has an equitable, legal, or fiduciary duty to hold, manage, retain, or administer the property for the benefit of the beneficiary.

(c) The trustee holds identifiable property for the beneficiary.

(3) "Grantor" is a person who creates a trust, including all of the following:

(a) An individual;

(b) An individual's spouse;

(c) A person, including a court or administrative body, with legal authority to act in place of or on behalf of an individual or an individual's spouse;

(d) A person, including a court or administrative body, that acts at the direction or on request of an individual or the individual's spouse.

(4) "Beneficiary" is a person or persons, including a grantor, who benefits in some way from a trust.

(5) "Trustee" is a person who manages a trust's principal and income for the benefit of the beneficiaries.

(6) "Person" has the same meaning as in section 1.59 of the Revised Code and includes an individual, corporation, business trust, estate, trust, partnership, and association.

(7) "Applicant" is an individual who applies for medicaid or the individual's spouse.

(8) "Recipient" is an individual who receives medicaid or the individual's spouse.

(9) "Revocable trust" is a trust that can be revoked by the grantor or the beneficiary, including all of the following, even if the terms of the trust state that it is irrevocable:

(a) A trust that provides that the trust can be terminated only by a court;

(b) A trust that terminates on the happening of an event, but only if the event occurs at the direction or control of the grantor, beneficiary, or trustee.

(10) "Irrevocable trust" is a trust that cannot be revoked by the grantor or terminated by a court and that terminates only on the occurrence of an event outside of the control or direction of the beneficiary or grantor.

(11) "Payment" is any disbursal from the principal or income of the trust, including actual cash, noncash or property disbursements, or the right to use and occupy real property.

(12) "Payments to or for the benefit of the applicant or recipient" is a payment to any person resulting in a direct or indirect benefit to the applicant or recipient.

(13) "Testamentary trust" is a trust that is established by a will and does not take effect until after the death of the person who created the trust.

(C) If an applicant or recipient is a beneficiary of a trust, the county department of job and family services shall determine what type of trust it is and shall treat the trust in accordance with the appropriate provisions of this section and rules adopted by the department of ~~job and family services~~ health care administration governing trusts. The county department of job and family services may determine that the trust or portion of the

trust is one of the following:

(1) A countable resource;

(2) Countable income;

(3) A countable resource and countable income;

(4) Not a countable resource or countable income.

(D)(1) A trust or legal instrument or device similar to a trust shall be considered a medicaid qualifying trust if all of the following apply:

(a) The trust was established on or prior to August 10, 1993.

(b) The trust was not established by a will.

(c) The trust was established by an applicant or recipient.

(d) The applicant or recipient is or may become the beneficiary of all or part of the trust.

(e) Payment from the trust is determined by one or more trustees who are permitted to exercise any discretion with respect to the distribution to the applicant or recipient.

(2) If a trust meets the requirement of division (D)(1) of this section, the amount of the trust that is considered by the county department of job and family services as an available resource to the applicant or recipient shall be the maximum amount of payments permitted under the terms of the trust to be distributed to the applicant or recipient, assuming the full exercise of discretion by the trustee or trustees. The maximum amount shall include only amounts that are permitted to be distributed but are not distributed from either the income or principal of the trust.

(3) Amounts that are actually distributed from a medicaid qualifying trust to a beneficiary for any purpose shall be treated in accordance with rules adopted by the department of ~~job and~~

~~family services~~ health care administration governing income.

(4) Availability of a medicaid qualifying trust shall be considered without regard to any of the following:

(a) Whether or not the trust is irrevocable or was established for purposes other than to enable a grantor to qualify for medicaid, ~~medical assistance~~ medicaid for covered families and children, or as a qualified medicare beneficiary, specified low-income medicare beneficiary, qualifying individual-1, or qualifying individual-2;

(b) Whether or not the trustee actually exercises discretion.

(5) If any real or personal property is transferred to a medicaid qualifying trust that is not distributable to the applicant or recipient, the transfer shall be considered an improper disposition of assets and shall be subject to section ~~5111.0116~~ 5162.21 of the Revised Code and rules to implement that section adopted under section ~~5111.011~~ 5162.20 of the Revised Code.

(6) The baseline date for the look-back period for disposition of assets involving a medicaid qualifying trust shall be the date on which the applicant or recipient is both institutionalized and first applies for medicaid.

(E)(1) A trust or legal instrument or device similar to a trust shall be considered a self-settled trust if all of the following apply:

(a) The trust was established on or after August 11, 1993.

(b) The trust was not established by a will.

(c) The trust was established by an applicant or recipient, spouse of an applicant or recipient, or a person, including a court or administrative body, with legal authority to act in place of or on behalf of an applicant, recipient, or spouse, or acting

at the direction or on request of an applicant, recipient, or spouse.

(2) A trust that meets the requirements of division (E)(1) of this section and is a revocable trust shall be treated by the county department of job and family services as follows:

(a) The corpus of the trust shall be considered a resource available to the applicant or recipient.

(b) Payments from the trust to or for the benefit of the applicant or recipient shall be considered unearned income of the applicant or recipient.

(c) Any other payments from the trust shall be considered an improper disposition of assets and shall be subject to section ~~5111.0116~~ 5162.21 of the Revised Code and rules to implement that section adopted under section ~~5111.011~~ 5162.20 of the Revised Code.

(3) A trust that meets the requirements of division (E)(1) of this section and is an irrevocable trust shall be treated by the county department of job and family services as follows:

(a) If there are any circumstances under which payment from the trust could be made to or for the benefit of the applicant or recipient, including a payment that can be made only in the future, the portion from which payments could be made shall be considered a resource available to the applicant or recipient. The county department of job and family services shall not take into account when payments can be made.

(b) Any payment that is actually made to or for the benefit of the applicant or recipient from either the corpus or income shall be considered unearned income.

(c) If a payment is made to someone other than to the applicant or recipient and the payment is not for the benefit of

the applicant or recipient, the payment shall be considered an improper disposition of assets and shall be subject to section ~~5111.0116~~ 5162.21 of the Revised Code and rules to implement that section adopted under section ~~5111.011~~ 5162.20 of the Revised Code.

(d) The date of the disposition shall be the later of the date of establishment of the trust or the date of the occurrence of the event.

(e) When determining the value of the disposed asset under this provision, the value of the trust shall be its value on the date payment to the applicant or recipient was foreclosed.

(f) Any income earned or other resources added subsequent to the foreclosure date shall be added to the total value of the trust.

(g) Any payments to or for the benefit of the applicant or recipient after the foreclosure date but prior to the application date shall be subtracted from the total value. Any other payments shall not be subtracted from the value.

(h) Any addition of assets after the foreclosure date shall be considered a separate disposition.

(4) If a trust is funded with assets of another person or persons in addition to assets of the applicant or recipient, the applicable provisions of this section and rules adopted by the department of ~~job and family services~~ health care administration governing trusts shall apply only to the portion of the trust attributable to the applicant or recipient.

(5) The availability of a self-settled trust shall be considered without regard to any of the following:

(a) The purpose for which the trust is established;

(b) Whether the trustees have exercised or may exercise

discretion under the trust;

(c) Any restrictions on when or whether distributions may be made from the trust;

(d) Any restrictions on the use of distributions from the trust.

(6) The baseline date for the look-back period for dispositions of assets involving a self-settled trust shall be the date on which the applicant or recipient is both institutionalized and first applies for medicaid.

(F) The principal or income from any of the following shall be exempt from being counted as a resource by a county department of job and family services:

(1)(a) A special needs trust that meets all of the following requirements:

(i) The trust contains assets of an applicant or recipient under sixty-five years of age and may contain the assets of other individuals.

(ii) The applicant or recipient is disabled as defined in rules adopted by the department of ~~job and family services~~ health care administration.

(iii) The trust is established for the benefit of the applicant or recipient by a parent, grandparent, legal guardian, or a court.

(iv) The trust requires that on the death of the applicant or recipient the state will receive all amounts remaining in the trust up to an amount equal to the total amount of medicaid paid on behalf of the applicant or recipient.

(b) If a special needs trust meets the requirements of division (F)(1)(a) of this section and has been established for a disabled applicant or recipient under sixty-five years of age, the

exemption for the trust granted pursuant to division (F) of this section shall continue after the disabled applicant or recipient becomes sixty-five years of age if the applicant or recipient continues to be disabled as defined in rules adopted by the department of ~~job and family services~~ health care administration. Except for income earned by the trust, the grantor shall not add to or otherwise augment the trust after the applicant or recipient attains sixty-five years of age. An addition or augmentation of the trust by the applicant or recipient with the applicant's own assets after the applicant or recipient attains sixty-five years of age shall be treated as an improper disposition of assets.

(c) Cash distributions to the applicant or recipient shall be counted as unearned income. All other distributions from the trust shall be treated as provided in rules adopted by the department of ~~job and family services~~ health care administration governing in-kind income.

(d) Transfers of assets to a special needs trust shall not be treated as an improper transfer of resources. Assets held prior to the transfer to the trust shall be considered as countable assets or countable income or countable assets and income.

(2)(a) A qualifying income trust that meets all of the following requirements:

(i) The trust is composed only of pension, social security, and other income to the applicant or recipient, including accumulated interest in the trust.

(ii) The income is received by the individual and the right to receive the income is not assigned or transferred to the trust.

(iii) The trust requires that on the death of the applicant or recipient the state will receive all amounts remaining in the trust up to an amount equal to the total amount of medicaid paid on behalf of the applicant or recipient.

(b) No resources shall be used to establish or augment the trust.

(c) If an applicant or recipient has irrevocably transferred or assigned the applicant's or recipient's right to receive income to the trust, the trust shall not be considered a qualifying income trust by the county department of job and family services.

(d) Income placed in a qualifying income trust shall not be counted in determining an applicant's or recipient's eligibility for medicaid. The recipient of the funds may place any income directly into a qualifying income trust without those funds adversely affecting the applicant's or recipient's eligibility for medicaid. Income generated by the trust that remains in the trust shall not be considered as income to the applicant or recipient.

(e) All income placed in a qualifying income trust shall be combined with any countable income not placed in the trust to arrive at a base income figure to be used for spend down calculations.

(f) The base income figure shall be used for post-eligibility deductions, including personal needs allowance, monthly income allowance, family allowance, and medical expenses not subject to third party payment. Any income remaining shall be used toward payment of patient liability. Payments made from a qualifying income trust shall not be combined with the base income figure for post-eligibility calculations.

(g) The base income figure shall be used when determining the spend down budget for the applicant or recipient. Any income remaining after allowable deductions are permitted as provided under rules adopted by the department of ~~job and family services~~ health care administration shall be considered the applicant's or recipient's spend down liability.

(3)(a) A pooled trust that meets all of the following

requirements:

(i) The trust contains the assets of the applicant or recipient of any age who is disabled as defined in rules adopted by the department of ~~job and family services~~ health care administration.

(ii) The trust is established and managed by a nonprofit association.

(iii) A separate account is maintained for each beneficiary of the trust but, for purposes of investment and management of funds, the trust pools the funds in these accounts.

(iv) Accounts in the trust are established by the applicant or recipient, the applicant's or recipient's parent, grandparent, or legal guardian, or a court solely for the benefit of individuals who are disabled.

(v) The trust requires that, to the extent that any amounts remaining in the beneficiary's account on the death of the beneficiary are not retained by the trust, the trust pay to the state the amounts remaining in the trust up to an amount equal to the total amount of medicaid paid on behalf of the beneficiary.

(b) Cash distributions to the applicant or recipient shall be counted as unearned income. All other distributions from the trust shall be treated as provided in rules adopted by the department of ~~job and family services~~ health care administration governing in-kind income.

(c) Transfers of assets to a pooled trust shall not be treated as an improper disposition of assets. Assets held prior to the transfer to the trust shall be considered as countable assets, countable income, or countable assets and income.

(4) A supplemental services trust that meets the requirements of section 5815.28 of the Revised Code and to which all of the

following apply:

(a) A person may establish a supplemental services trust pursuant to section 5815.28 of the Revised Code only for another person who is eligible to receive services through one of the following agencies:

(i) The department of mental retardation and developmental disabilities;

(ii) A county board of mental retardation and developmental disabilities;

(iii) The department of mental health;

(iv) A board of alcohol, drug addiction, and mental health services.

(b) A county department of job and family services shall not determine eligibility for another agency's program. An applicant or recipient shall do one of the following:

(i) Provide documentation from one of the agencies listed in division (F)(4)(a) of this section that establishes that the applicant or recipient was determined to be eligible for services from the agency at the time of the creation of the trust;

(ii) Provide an order from a court of competent jurisdiction that states that the applicant or recipient was eligible for services from one of the agencies listed in division (F)(4)(a) of this section at the time of the creation of the trust.

(c) At the time the trust is created, the trust principal does not exceed the maximum amount permitted. The maximum amount permitted in calendar year 2006 is two hundred twenty-two thousand dollars. Each year thereafter, the maximum amount permitted is the prior year's amount plus two thousand dollars.

(d) A county department of job and family services shall review the trust to determine whether it complies with the

provisions of section 5815.28 of the Revised Code.

(e) Payments from supplemental services trusts shall be exempt as long as the payments are for supplemental services as defined in rules adopted by the department of ~~job and family services~~ health care administration. All supplemental services shall be purchased by the trustee and shall not be purchased through direct cash payments to the beneficiary.

(f) If a trust is represented as a supplemental services trust and a county department of job and family services determines that the trust does not meet the requirements provided in division (F)(4) of this section and section 5815.28 of the Revised Code, the county department of job and family services shall not consider it an exempt trust.

(G)(1) A trust or legal instrument or device similar to a trust shall be considered a trust established by an individual for the benefit of the applicant or recipient if all of the following apply:

(a) The trust is created by a person other than the applicant or recipient.

(b) The trust names the applicant or recipient as a beneficiary.

(c) The trust is funded with assets or property in which the applicant or recipient has never held an ownership interest prior to the establishment of the trust.

(2) Any portion of a trust that meets the requirements of division (G)(1) of this section shall be an available resource only if the trust permits the trustee to expend principal, corpus, or assets of the trust for the applicant's or recipient's medical care, care, comfort, maintenance, health, welfare, general well being, or any combination of these purposes.

(3) A trust that meets the requirements of division (G)(1) of this section shall be considered an available resource even if the trust contains any of the following types of provisions:

(a) A provision that prohibits the trustee from making payments that would supplant or replace medicaid or other public assistance;

(b) A provision that prohibits the trustee from making payments that would impact or have an effect on the applicant's or recipient's right, ability, or opportunity to receive medicaid or other public assistance;

(c) A provision that attempts to prevent the trust or its corpus or principal from being counted as an available resource.

(4) A trust that meets the requirements of division (G)(1) of this section shall not be counted as an available resource if at least one of the following circumstances applies:

(a) If a trust contains a clear statement requiring the trustee to preserve a portion of the trust for another beneficiary or remainderman, that portion of the trust shall not be counted as an available resource. Terms of a trust that grant discretion to preserve a portion of the trust shall not qualify as a clear statement requiring the trustee to preserve a portion of the trust.

(b) If a trust contains a clear statement requiring the trustee to use a portion of the trust for a purpose other than medical care, care, comfort, maintenance, welfare, or general well being of the applicant or recipient, that portion of the trust shall not be counted as an available resource. Terms of a trust that grant discretion to limit the use of a portion of the trust shall not qualify as a clear statement requiring the trustee to use a portion of the trust for a particular purpose.

(c) If a trust contains a clear statement limiting the

trustee to making fixed periodic payments, the trust shall not be counted as an available resource and payments shall be treated in accordance with rules adopted by the department of ~~job and family services~~ health care administration governing income. Terms of a trust that grant discretion to limit payments shall not qualify as a clear statement requiring the trustee to make fixed periodic payments.

(d) If a trust contains a clear statement that requires the trustee to terminate the trust if it is counted as an available resource, the trust shall not be counted as an available resource. Terms of a trust that grant discretion to terminate the trust do not qualify as a clear statement requiring the trustee to terminate the trust.

(e) If a person obtains a judgment from a court of competent jurisdiction that expressly prevents the trustee from using part or all of the trust for the medical care, care, comfort, maintenance, welfare, or general well being of the applicant or recipient, the trust or that portion of the trust subject to the court order shall not be counted as a resource.

(f) If a trust is specifically exempt from being counted as an available resource by a provision of the Revised Code, rules, or federal law, the trust shall not be counted as a resource.

(g) If an applicant or recipient presents a final judgment from a court demonstrating that the applicant or recipient was unsuccessful in a civil action against the trustee to compel payments from the trust, the trust shall not be counted as an available resource.

(h) If an applicant or recipient presents a final judgment from a court demonstrating that in a civil action against the trustee the applicant or recipient was only able to compel limited or periodic payments, the trust shall not be counted as an

available resource and payments shall be treated in accordance with rules adopted by the department of ~~job and family services~~ health care administration governing income.

(i) If an applicant or recipient provides written documentation showing that the cost of a civil action brought to compel payments from the trust would be cost prohibitive, the trust shall not be counted as an available resource.

(5) Any actual payments to the applicant or recipient from a trust that meet the requirements of division (G)(1) of this section, including trusts that are not counted as an available resource, shall be treated as provided in rules adopted by the department of ~~job and family services~~ health care administration governing income. Payments to any person other than the applicant or recipient shall not be considered income to the applicant or recipient. Payments from the trust to a person other than the applicant or recipient shall not be considered an improper disposition of assets.

Sec. ~~5111.181~~ 5162.30. (A) The general assembly hereby finds that the state has an insurable interest in ~~medical assistance~~ medicaid recipients because of the state's statutory right to recover from the estate of a recipient state funds used to provide the recipient with medical care and services.

(B) As used in this section:

(1) "Beneficiary" means the person or entity designated in a life insurance policy to receive the proceeds of the policy on the death of the insured or maturity of the policy.

(2) "Owner" means the person who has the right to designate the beneficiary of a life insurance policy and to change the designation.

(C) Notwithstanding section ~~5111.011~~ 5162.20 of the Revised

Code, the value of a life insurance policy that would otherwise be considered a resource in determining eligibility for the ~~medical assistance~~ medicaid program shall be excluded from any determination of a person's eligibility for the ~~medical assistance~~ medicaid program if the owner designates the department of ~~job and family services~~ health care administration as beneficiary of the policy. The department may pay premiums to keep the policy in force. Premiums paid by the department are ~~medical assistance~~ medicaid payments correctly paid on behalf of a ~~medical assistance~~ medicaid recipient and subject to recovery under section ~~5111.11~~ 5162.40 of the Revised Code.

(D) The director of ~~job and family services~~ health care administration shall deposit the proceeds of a life insurance policy that do not exceed the amount the department may recover against the property and estate of the owner under section ~~5111.11~~ 5162.40 of the Revised Code into the general revenue fund. The director shall pay any remaining proceeds to the person designated by the owner. If the owner failed to designate a person, the director shall pay the remaining proceeds to the surviving spouse, or, if there is no surviving spouse, to the estate of the owner.

(E) If the owner designates the department of ~~job and family services~~ health care administration as the policy's beneficiary, the department shall notify the owner that the owner may designate a person to receive proceeds of the policy that exceed the amount the department may recover against the owner's property and estate under section ~~5111.11~~ 5162.40 of the Revised Code. The designation shall be made on a form provided by the department.

(F) The department of ~~job and family services~~ health care administration shall not implement this section if implementation would violate any federal requirement unless the department receives a waiver of the requirement from the United States department of health and human services.

Sec. ~~5111.0112~~ 5162.35. (A) Not later than July 1, 2006, the director of ~~job and family services~~ health care administration shall institute a copayment program under the medicaid program. To the extent permitted by federal law, 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. The director shall adopt rules under section ~~5111.02~~ 5163.15 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) Except as provided in division (C) of this section, 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.

(C) In the case of a provider that is a hospital, the copayment program shall permit the hospital to take action to collect a copayment by providing, at the time services are rendered to a medicaid recipient, notice that a copayment may be owed. If the hospital provides the notice and chooses not to take any further action to pursue collection of the copayment, the prohibition against waiving copayments specified in division (B)(3) of this section does not apply.

Sec. ~~5111.114~~ 5162.36. As used in this section, "nursing facility" and "intermediate care facility for the mentally retarded" have the same meanings as in section ~~5111.20~~ 5164.01 of the Revised Code.

In determining the amount of income that a medicaid 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~~ 1396a(q).

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~~ health care administration but shall not exceed one hundred five dollars.

Sec. ~~5111.113~~ 5162.37. (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~~ health care administration the money in the personal needs allowance account of a resident of the facility or home who was a medicaid 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~~ health care administration 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~~ health care administration 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~~ 5162.40 of the Revised Code.

Sec. ~~5111.11~~ 5162.40. (A) As used in this section and section ~~5111.111~~ 5162.41 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~~ 5164.01 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~~ health care administration;

(c) Cannot reasonably be expected to be discharged from the

institution and return home as determined by the department of ~~job and family services~~ health care administration.

(5) "Qualified state long-term care insurance partnership program" means the program established under section ~~5111.18~~ 5162.43 of the Revised Code.

(6) "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) To the extent permitted by federal law, the department of ~~job and family services~~ health care administration shall institute an estate recovery program under which the department shall, except as provided in divisions (C), (D), and (E) 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~~ 5162.41 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~~ 5162.41 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~~ 5162.41 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) In the case of a participant of the qualified state long-term care insurance partnership program, adjustment or recovery required by this section may be reduced in accordance with rules adopted under division (G) of this section.

(E) The department shall, in accordance with procedures and criteria established in rules adopted under division (G) of this

section, waive seeking an adjustment or recovery otherwise required by this section if the director of ~~job and family services~~ health care administration determines that adjustment or recovery would work an undue hardship. The department may limit the duration of the waiver to the period during which the undue hardship exists.

(F) 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.

(G) The director of ~~job and family services~~ health care administration shall adopt rules in accordance with Chapter 119. of the Revised Code regarding the estate recovery program, including rules that do both of the following:

(1) For the purpose of division (D) of this section and consistent with 42 U.S.C. 1396p(b)(1)(C), provide for reducing an adjustment or recovery in the case of a participant of the qualified state long-term care insurance partnership program;

(2) For the purpose of division (E) of this section and consistent with the standards specified by the United States secretary of health and human services under 42 U.S.C. 1396p(b)(3), establish procedures and criteria for waiving adjustment or recovery due to an undue hardship.

Sec. ~~5111.111~~ 5162.41. (A) Except as provided in division (B)

of this section and section ~~5111.12~~ 5162.45 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~~ health care administration may impose a lien against the real property of a medicaid recipient who is a permanently institutionalized individual and against the real property of the recipient's spouse, including any real property that is jointly held by the recipient and spouse. 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~~ health care administration or a person designated by the director shall sign a certificate to 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 in the certificate for all amounts for which adjustment or recovery may be made under section ~~5111.11~~ 5162.40 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~~ health care administration 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~~ 5162.42. The department of ~~job and family services~~ health care administration shall certify amounts due under the estate recovery program instituted under section ~~5111.11~~ 5162.40 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. ~~5111.18~~ 5162.43. Not later than September 1, 2007, the director of ~~job and family services~~ health care administration shall establish a qualified state long-term care insurance partnership program consistent with the definition of that term in 42 U.S.C. 1396p(b)(1)(C)(iii). An individual participating in the program who is subject to the medicaid estate recovery program instituted under section ~~5111.11~~ 5162.40 of the Revised Code shall be eligible for the reduced adjustment or recovery under division (D) of that section.

The director of ~~job and family services~~ health care administration may adopt rules in accordance with Chapter 119. of the Revised Code as necessary to implement this section.

Sec. ~~5111.12~~ 5162.45. (A) The director of ~~job and family~~

~~services~~ health care administration shall establish rules under which county departments of job and family services may take action to recover benefits incorrectly paid on behalf of medicaid recipients ~~of medical assistance~~. The rules shall provide for recovery by the following methods:

(1) Soliciting voluntary payments from recipients or from persons holding property in which a recipient has a legal or equitable interest;

(2) Obtaining a lien on property pursuant to division (B) of this section.

(B) A county department of job and family services may bring a civil action in a court of common pleas against a medicaid recipient ~~of medical assistance~~ for the recovery of any ~~medical assistance~~ medicaid benefits determined by the court to have been paid incorrectly on behalf of the recipient. All persons holding property in which the recipient has a legal or equitable interest may be joined as parties. The court may issue pre-judgment orders, including injunctive relief or attachment under Chapter 2715. of the Revised Code, for the preservation of real or personal property in which the recipient may have a legal or equitable interest. If the court determines that benefits were paid incorrectly and issues a judgment to that effect, the county department may obtain a lien upon property of the recipient in accordance with Chapter 2329. of the Revised Code.

(C) The county department of job and family services shall retain fifty per cent of the balance remaining after deduction from the recovery of the amount required to be returned to the federal government and shall pay the other fifty per cent of the balance to the department of ~~job and family services~~ health care administration.

(D) Recovery of ~~medical assistance~~ medicaid benefits

incorrectly paid to a recipient may not be accomplished by reducing the amount of benefits the recipient is entitled to receive under another government assistance program.

(E) The remedies provided pursuant to this section do not affect any other remedies county departments of job and family services may have to recover benefits incorrectly paid on behalf of medicaid recipients ~~of medical assistance~~.

Sec. ~~5111.06~~ 5163.01. (A)(1) As used in this section and in sections ~~5111.061~~ 5163.07 and ~~5111.062~~ 5163.09 of the Revised Code:

(a) "Provider" means any person, institution, or entity that furnishes medicaid services under a medicaid 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~~ health care administration.

(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~~ health care administration under sections ~~5111.35~~ 5164.50 to ~~5111.62~~ 5164.78 of the Revised Code.

(B) Except as provided in division (D) of this section and section ~~5111.914~~ 5163.06 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~~;

(2) 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~~ health care administration, 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~~ 5163.03 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~~ medicaid 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~~ 5164.01 of the Revised Code.

Sec. ~~5111.05~~ 5163.02. (A) The department of ~~job and family services~~ health care administration may contract with any person or persons as a fiscal agent for the examination, processing, and

determination of ~~medical assistance~~ medicaid claims ~~under this chapter~~. The contracting party may provide any of the following services, as required by the contract:

(1) Design and operate medicaid management information systems, including the provision of data processing services;

(2) Determine the amounts of payments to be made upon claims for ~~medical assistance~~ medicaid;

(3) Prepare and furnish to the department lists and computer tapes of such claims for payment;

(4) In addition to audits which may be conducted by the department and by the auditor of state, make audits of providers and the claims of medicaid providers ~~of medical assistance~~ according to the standards set forth in the contract;

(5) Assist medicaid providers ~~of medical assistance~~ in the development of procedures relating to utilization practices, make studies of the effectiveness of such procedures and methods for their improvement, implement and enforce standards of medical policy, and assist in the application of safeguards against unnecessary utilization;

(6) Assist any institution, facility, or agency to qualify as a medicaid provider ~~of medical assistance~~;

(7) Establish and maintain fiscal records for the ~~medical assistance~~ medicaid program;

(8) Perform statistical and research studies;

(9) Develop and implement programs for ~~medical assistance~~ medicaid cost containment;

(10) Perform such other duties as are necessary to carry out the ~~medical assistance~~ medicaid program.

(B) The department of ~~job and family services~~ health care administration may contract with any person or persons as an

insuring agent for the examination, processing, and determination of ~~medical assistance~~ medicaid claims, as provided in division (A) of this section, and for the payment of ~~medical assistance~~ medicaid claims through an underwritten program in which the state pays the insuring agent a monthly premium and the insuring agent pays for medical services authorized under the state's ~~medical assistance~~ medicaid program. The person with whom the department contracts, with respect to the awarding, provisions, and performance of such contract, shall not be subject to the provisions of Title XXXIX of the Revised Code or to regulation by the department of insurance, nor to taxation as an insurance company pursuant to section 5725.18 or 5729.03 of the Revised Code. A contract with an insuring agent shall specify the qualifications, including capital and surplus requirements, and other conditions with which the insuring agent must comply.

(C) In entering into a contract under this section, the department, in cooperation with the director of budget and management, shall determine that the contracting party is qualified to perform the required services and shall follow applicable procedures required of the department of administrative services in sections 125.07 to 125.11 of the Revised Code. A contract shall be awarded to the bidder who, with due consideration to the bidder's experience and financial capability, offers the lowest and best bid to the state for control of the costs of the ~~medical assistance~~ medicaid program consistent with meeting the obligations under that program for fair and equitable treatment of recipients and providers of medical services. Any arrangement whereby funds are paid to an insuring or fiscal agent for administrative functions under this section shall, for the purposes of section 125.081 of the Revised Code, be deemed to be a contract or purchase by the department of administrative services; however, money to be used by an insuring agent to pay for medical services authorized under the state's ~~medical assistance~~ medicaid

program shall not be deemed a contract or purchase within the meaning of such section.

Sec. ~~5111.03~~ 5163.03. (A) No provider of services or goods contracting with the department of ~~job and family services~~ health care administration pursuant to the medicaid program shall, by deception, obtain or attempt to obtain payments under ~~this chapter~~ the medicaid program to which the provider is not entitled pursuant to the provider agreement, or the rules of the federal government or the department of ~~job and family services~~ health care administration relating to the program. No provider shall willfully receive payments to which the provider is not entitled, or willfully receive payments in a greater amount than that to which the provider is entitled; nor shall any provider falsify any report or document required by state or federal law, rule, or provider agreement relating to medicaid payments. As used in this section, a provider engages in "deception" when the provider, acting with actual knowledge of the representation or information involved, acting in deliberate ignorance of the truth or falsity of the representation or information involved, or acting in reckless disregard of the truth or falsity of the representation or information involved, deceives another or causes another to be deceived by any false or misleading representation, by withholding information, by preventing another from acquiring information, or by any other conduct, act, or omission that creates, confirms, or perpetuates a false impression in another, including a false impression as to law, value, state of mind, or other objective or subjective fact. No proof of specific intent to defraud is required to show, for purposes of this section, that a provider has engaged in deception.

(B) Any provider who violates division (A) of this section shall be liable, in addition to any other penalties provided by law, for all of the following civil penalties:

(1) Payment of interest on the amount of the excess payments at the maximum interest rate allowable for real estate mortgages under section 1343.01 of the Revised Code on the date the payment was made to the provider for the period from the date upon which payment was made, to the date upon which repayment is made to the state;

(2) Payment of an amount equal to three times the amount of any excess payments;

(3) Payment of a sum of not less than five thousand dollars and not more than ten thousand dollars for each deceptive claim or falsification;

(4) All reasonable expenses which the court determines have been necessarily incurred by the state in the enforcement of this section.

(C) As used in this division, "intermediate care facility for the mentally retarded" and "nursing facility" have the same meanings given in section ~~5111.20~~ 5164.01 of the Revised Code.

In addition to the civil penalties provided in division (B) of this section, the director of ~~job and family services~~ health care administration, upon the conviction of, or the entry of a judgment in either a criminal or civil action against, a medicaid provider or its owner, officer, authorized agent, associate, manager, or employee in an action brought pursuant to section 109.85 of the Revised Code, shall terminate the provider agreement between the department and the provider and stop reimbursement to the provider for services rendered for a period of up to five years from the date of conviction or entry of judgment. As used in this chapter, "owner" means any person having at least five per cent ownership in the medicaid provider. No such provider, owner, officer, authorized agent, associate, manager, or employee shall own or provide services to any other medicaid provider or risk

contractor or arrange for, render, or order services for medicaid recipients during the period of termination as provided in division (C) of this section, nor, during the period of termination as provided in division (C) of this section, shall such provider, owner, officer, authorized agent, associate, manager, or employee receive reimbursement in the form of direct payments from the department or indirect payments of medicaid funds in the form of salary, shared fees, contracts, kickbacks, or rebates from or through any participating provider or risk contractor. The provider agreement shall not be terminated or reimbursement terminated if the provider or owner can demonstrate that the provider or owner did not directly or indirectly sanction the action of its authorized agent, associate, manager, or employee that resulted in the conviction or entry of a judgment in a criminal or civil action brought pursuant to section 109.85 of the Revised Code. Nothing in this division prohibits any owner, officer, authorized agent, associate, manager, or employee of a medicaid provider from entering into a medicaid provider agreement if the person can demonstrate that the person had no knowledge of an action of the medicaid provider the person was formerly associated with that resulted in the conviction or entry of a judgment in a criminal or civil action brought pursuant to section 109.85 of the Revised Code.

Nursing facility or intermediate care facility for the mentally retarded providers whose agreements are terminated pursuant to this section may continue to receive reimbursement for up to thirty days after the effective date of the termination if the provider makes reasonable efforts to transfer recipients to another facility or to alternate care and if federal funds are provided for such reimbursement.

(D) Any provider of services or goods contracting with the department of ~~job and family services pursuant to Title XIX of~~

health care administration under the ~~"Social Security Act,"~~ medicaid program who, without intent, obtains payments under ~~this chapter~~ the medicaid program in excess of the amount to which the provider is entitled, thereby becomes liable for payment of interest on the amount of the excess payments at the maximum real estate mortgage rate on the date the payment was made to the provider for the period from the date upon which payment was made to the date upon which repayment is made to the state.

(E) The attorney general on behalf of the state may commence proceedings to enforce this section in any court of competent jurisdiction; and the attorney general may settle or compromise any case brought under this section with the approval of the department of ~~job and family services~~ health care administration. Notwithstanding any other provision of law providing a shorter period of limitations, the attorney general may commence a proceeding to enforce this section at any time within six years after the conduct in violation of this section terminates.

(F) The authority, under state and federal law, of the department of ~~job and family services~~ health care administration or a county department of job and family services to recover excess payments made to a provider is not limited by the availability of remedies under sections ~~5111.11~~ 5162.40 and ~~5111.12~~ 5162.45 of the Revised Code for recovering benefits paid on behalf of medicaid recipients ~~of medical assistance~~.

The penalties under this chapter apply to any overpayment, billing, or falsification occurring on and after April 24, 1978. All moneys collected by the state pursuant to this section shall be deposited in the state treasury to the credit of the general revenue fund.

Sec. 5163.04. The department of health care administration may conduct final fiscal audits under the medicaid program 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.

Sec. 5163.05. This section does not apply to any action taken by the department of health care administration under sections 5164.78 of the Revised Code.

Except as provided in section 5163.06 of the Revised Code, the department of health care administration shall take actions based upon a final fiscal audit of a provider by issuing an order pursuant to an adjudication conducted in accordance with Chapter 119. of the Revised Code. Any party who is adversely affected by the issuance of an adjudication order under this section may appeal to the court of common pleas of Franklin county in accordance with section 119.12 of the Revised Code. If the action the department takes against a provider based on a final fiscal audit is to withhold payments from the provider, the department may withhold payments only to the extent that they equal amounts determined in the final fiscal audit as being due the state.

Sec. ~~5111.914~~ 5163.06. (A) As used in this section, "provider" has the same meaning as in section ~~5111.06~~ 5163.01 of the Revised Code.

(B) If a state agency that enters into a contract with the department of ~~job and family services~~ health care administration under section ~~5111.91~~ 5161.05 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~~ health care administration 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~~ health care administration 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~~ health care administration from adjudicating a final fiscal audit under section ~~5111.06~~ 5163.01 of the Revised Code, recovering overpayments under section ~~5111.061~~ 5163.07 of the Revised Code, or making findings or taking other actions authorized by this chapter.

Sec. ~~5111.061~~ 5163.07. (A) The department of ~~job and family services~~ health care administration may recover a medicaid payment or portion of a payment made to a provider to which the provider is not entitled if the department notifies the provider of the overpayment 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~~ 5160.36 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) 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~~ 5163.01 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~~ 5163.01 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~~ 5163.01 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. ~~5111.022~~ 5163.08. Under the medicaid program, any amount determined to be owed the state by a final fiscal audit conducted pursuant to ~~division (D) of~~ section ~~5111.021~~ 5163.04 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~~ health care administration 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. ~~5111.062~~ 5163.09. In any action taken by the department of ~~job and family services~~ health care administration under section ~~5111.06~~ 5163.01, 5163.05, or ~~5111.061~~ 5163.07 of the Revised Code or any other provision of ~~this chapter~~ law governing the medicaid program 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~~ health care administration may proceed by issuing a final adjudication order in accordance with Chapter 119. of the Revised Code.

Sec. ~~5111.101~~ 5163.12. (A) As used in this section, "federal health care programs" has the same meaning as in 42 U.S.C. 1320a-7b(f).

(B) Each person and government entity that receives or makes medicaid payments in a calendar year that total five million dollars or more shall, as a condition of receiving such payments, do all of the following:

(1) Provide each of the person or government entity's employees (including management employees), contractors, and agents, detailed, written information about the role of all of the following in preventing and detecting fraud, waste, and abuse in federal health care programs:

(a) Federal false claims law under 31 U.S.C. 3729 to 3733;

(b) Federal administrative remedies for false claims and statements available under 31 U.S.C. 3801 to 3812;

(c) Sections 124.341, 2913.40, 2913.401, and 2921.13 of the Revised Code and any other state laws pertaining to civil or criminal penalties for false claims and statements;

(d) Whistleblower protections under the laws specified in divisions (B)(1)(a) to (c) of this section.

(2) Include in the written information provided under division (B)(1) of this section detailed information about the person or government entity's policies and procedures for preventing and detecting fraud, waste, and abuse.

(3) Include in the person or government entity's employee handbook a specific discussion of the laws specified in division (B)(1) of this section, the rights of employees to be protected as whistleblowers, and the person or government entity's policies and procedures for preventing and detecting fraud, waste, and abuse.

Sec. ~~5111.02~~ 5163.15. The director of ~~job and family services~~ health care administration 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. ~~5111.021~~ 5163.16. Under the medicaid program:

(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~~ health care administration 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," 79 Stat. 286 (1965), 42 U.S.C. 1395, as amended~~.

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

(C) The department may deduct from payments for services rendered by a medicaid provider under the medicaid program any amounts the provider owes the state as the result of incorrect

medicaid payments the department has made to the provider.

(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.~~

~~(E)~~ The number of days of inpatient hospital care for which reimbursement is made on behalf of a medicaid recipient 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.

~~(F)~~(E) 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. ~~5111.025~~ 5163.17. (A) In rules adopted under section ~~5111.02~~ 5163.15 of the Revised Code, the director of ~~job and family services~~ health care administration 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 ~~5111.023~~ 5163.20 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~~ 5163.15 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~~ 5163.15 or 5119.61 of the Revised Code that are in effect on 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. ~~5111.018~~ 5163.18. (A) The ~~provision of medical assistance under this chapter~~ medicaid program shall ~~include coverage of~~ cover inpatient care and follow-up care for a mother and her newborn as follows:

(1) The ~~medical assistance~~ medicaid program shall cover a minimum of forty-eight hours of inpatient care following a normal vaginal delivery and a minimum of ninety-six hours of inpatient care following a cesarean delivery. Services covered as inpatient care shall include medical, educational, and any other services that are consistent with the inpatient care recommended in the protocols and guidelines developed by national organizations that represent pediatric, obstetric, and nursing professionals.

(2) The ~~medical assistance~~ medicaid program shall cover a physician-directed source of follow-up care. Services covered as follow-up care shall include physical assessment of the mother and newborn, parent education, assistance and training in breast or bottle feeding, assessment of the home support system, performance of any medically necessary and appropriate clinical tests, and any

other services that are consistent with the follow-up care recommended in the protocols and guidelines developed by national organizations that represent pediatric, obstetric, and nursing professionals. The coverage shall apply to services provided in a medical setting or through home health care visits. The coverage shall apply to a home health care visit only if the health care professional who conducts the visit is knowledgeable and experienced in maternity and newborn care.

When a decision is made in accordance with division (B) of this section to discharge a mother or newborn prior to the expiration of the applicable number of hours of inpatient care required to be covered, the coverage of follow-up care shall apply to all follow-up care that is provided within forty-eight hours after discharge. When a mother or newborn receives at least the number of hours of inpatient care required to be covered, the coverage of follow-up care shall apply to follow-up care that is determined to be medically necessary by the health care professionals responsible for discharging the mother or newborn.

(B) Any decision to shorten the length of inpatient stay to less than that specified under division (A)(1) of this section shall be made by the physician attending the mother or newborn, except that if a nurse-midwife is attending the mother in collaboration with a physician, the decision may be made by the nurse-midwife. Decisions regarding early discharge shall be made only after conferring with the mother or a person responsible for the mother or newborn. For purposes of this division, a person responsible for the mother or newborn may include a parent, guardian, or any other person with authority to make medical decisions for the mother or newborn.

(C) The department of ~~job and family services~~ health care administration, in administering the ~~medical assistance~~ medicaid program, may not do either of the following:

(1) Terminate the participation of a health care professional or health care facility as a provider under the program solely for making recommendations for inpatient or follow-up care for a particular mother or newborn that are consistent with the care required to be covered by this section;

(2) Establish or offer monetary or other financial incentives for the purpose of encouraging a person to decline the inpatient or follow-up care required to be covered by this section.

(D) This section does not do any of the following:

(1) Require the ~~medical assistance~~ medicaid program to cover inpatient or follow-up care that is not received in accordance with the program's terms pertaining to the health care professionals and facilities from which an individual is authorized to receive health care services.

(2) Require a mother or newborn to stay in a hospital or other inpatient setting for a fixed period of time following delivery;

(3) Require a child to be delivered in a hospital or other inpatient setting;

(4) Authorize a nurse-midwife to practice beyond the authority to practice nurse-midwifery in accordance with Chapter 4723. of the Revised Code;

(5) Establish minimum standards of medical diagnosis, care, or treatment for inpatient or follow-up care for a mother or newborn. A deviation from the care required to be covered under this section shall not, on the basis of this section, give rise to a medical claim or derivative medical claim, as those terms are defined in section 2305.113 of the Revised Code.

Sec. ~~5111.024~~ 5163.19. (A) As used in this section, "screening mammography" means a radiologic examination utilized to

detect unsuspected breast cancer at an early stage in asymptomatic women and includes the x-ray examination of the breast using equipment that is dedicated specifically for mammography, including the x-ray tube, filter, compression device, screens, film, and cassettes, and that has an average radiation exposure delivery of less than one rad mid-breast. "Screening mammography" includes two views for each breast. The term also includes the professional interpretation of the film.

"Screening mammography" does not include diagnostic mammography.

(B) ~~In addition to any other services required to be included in the program or for which federal approval is received, the medical assistance~~ The medicaid program shall ~~include~~ cover both of the following if ~~approval for use of federal funds is granted to the department by the federal agency responsible for distributing funds under Title XIX of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended~~ federal financial participation is available for them:

(1) ~~Effective July 1, 1993, screening~~ Screening mammography to detect the presence of breast cancer in adult women;

(2) ~~Effective January 1, 1993, cytologic~~ Cytologic screening for the presence of cervical cancer.

(C) The service provided under division (B)(1) of this section shall be provided in accordance with all of the following:

(1) If a woman is at least thirty-five years of age but under forty years of age, one screening mammography;

(2) If a woman is at least forty years of age but under fifty years of age, either of the following:

(a) One screening mammography every two years;

(b) If a licensed physician has determined that the woman has

risk factors to breast cancer, one screening mammography every year.

(3) If a woman is at least fifty years of age but under sixty-five years of age, one screening mammography every year.

(D) The service provided under division (B)(1) of this section shall be provided only for screening mammographies that are performed in a facility or mobile mammography screening unit that is accredited under the American college of radiology mammography accreditation program or in a hospital as defined in section 3727.01 of the Revised Code.

(E) The service provided under division (B)(2) of this section shall be provided only for cytologic screenings that are processed and interpreted in a laboratory certified by the college of American pathologists or in a hospital as defined in section 3727.01 of the Revised Code.

Sec. ~~5111.023~~ 5163.20. (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~~ health care administration.

(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~~ health care administration shall enter into a separate contract with the department of mental health under section ~~5111.91~~ 5161.05 of the Revised Code with regard to the component of the medicaid program provided for by this section.

(E) Not later than July 21, 2006, the department of ~~job and family services~~ health care administration 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~~ health care administration 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. ~~5111.04~~ 5163.21. (A) As used in this section:

(1) "Outpatient health facility" means a facility that provides comprehensive primary health services by or under the direction of a physician at least five days per week on a forty-hour per week basis to outpatients, is operated by the board of health of a city or general health district or another public agency or by a nonprofit private agency or organization under the direction and control of a governing board that has no health-related responsibilities other than the direction and control of one or more such outpatient health facilities, and receives at least seventy-five per cent of its operating funds from public sources, except that it does not include an outpatient hospital facility or a federally qualified health center as defined in Sec. 1905(l) (2)(B) of the "Social Security Act," 103 Stat. 2264 (1989), 42 U.S.C.A. 1396d(l)(2)(B).

(2) "Comprehensive primary health services" means preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services that include all of the following:

(a) Services of physicians, physician assistants, and certified nurse practitioners;

(b) Diagnostic laboratory and radiological services;

(c) Preventive health services, such as children's eye and ear examinations, perinatal services, well child services, and family planning services;

(d) Arrangements for emergency medical services;

(e) Transportation services.

(3) "Certified nurse practitioner" has the same meaning as in section 4723.01 of the Revised Code.

(B) Outpatient health facilities are a separate category of medical care provider under the rules governing the administration of the ~~medical assistance~~ medicaid program ~~established under section 5111.01 of the Revised Code~~. Rates of reimbursement for items and services provided by an outpatient health facility under this section shall be prospectively determined by the department of ~~job and family services~~ health care administration not less often than once each year, shall not be subject to retroactive adjustment based on actual costs incurred, and shall not exceed the maximum fee schedule or rates of payment, limitations based on reasonable costs or customary charges, and limitations based on combined payments received for furnishing comparable services, as are applicable to outpatient hospital facilities under ~~Title XVIII of~~ the ~~"Social Security Act~~ medicare program.~~"~~ In determining rates of reimbursement prospectively, the department shall take into account the historic expenses of the facility, the operating requirements and services offered by the facility, and the geographical location of the facility, shall provide incentives for the efficient and economical utilization of the facility's resources, and shall ensure that the facility does not discriminate between classes of persons for whom or by whom payment for items and services is made.

(C) A facility does not qualify for classification as an outpatient health facility under this section unless it:

(1) Has health and medical care policies developed with the advice of and subject to review by an advisory committee of professional personnel, including one or more physicians, one or more dentists if dental care is provided, and one or more registered nurses;

(2) Has a medical director, a dental director, if dental care

is provided, and a nursing director responsible for the execution of such policies, and has physicians, dentists, nursing, and ancillary staff appropriate to the scope of services provided;

(3) Requires that the care of every patient be under the supervision of a physician, provides for medical care in case of emergency, has in effect a written agreement with one or more hospitals and one or more other outpatient facilities, and has an established system for the referral of patients to other resources and a utilization review plan and program;

(4) Maintains clinical records on all patients;

(5) Provides nursing services and other therapeutic services in compliance with applicable laws and rules and under the supervision of a registered nurse, and has a registered nurse on duty at all times when the facility is in operation;

(6) Follows approved methods and procedures for the dispensing and administration of drugs and biologicals;

(7) Maintains the accounting and record-keeping system required under federal laws and regulations for the determination of reasonable and allowable costs.

Sec. ~~5111.14~~ 5163.22. The department of ~~job and family services~~ health care administration may require county departments of job and family services to provide case management of nonemergency transportation services provided under the ~~medical assistance~~ medicaid program. County departments shall provide the case management if required by the department in accordance with rules adopted by the director of ~~job and family services~~ health care administration.

The department shall determine, for the purposes of claiming federal reimbursement under the ~~medical assistance~~ medicaid program, whether it will claim expenditures for nonemergency

transportation services as administrative or program expenditures.

Sec. ~~5111.19~~ 5163.23. The director of ~~job and family services~~ health care administration shall adopt rules governing the calculation and payment of graduate medical education costs associated with services rendered to medicaid recipients after June 30, 1994. Subject to section ~~5111.191~~ 5163.231 of the Revised Code, the rules shall provide for reimbursement of graduate medical education costs associated with services rendered to medicaid recipients, including recipients enrolled in a managed care organization under contract with the department under section ~~5111.17~~ 5165.05 of the Revised Code, that the department determines are allowable and reasonable.

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

(A) Except as provided in section ~~5111.191~~ 5163.231 of the Revised Code, the department shall pay the provider for graduate medical education costs associated with the delivery of services to medicaid recipients enrolled in the organization;

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

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

Sec. ~~5111.191~~ 5163.231. (A) Except as provided in division (B) of this section, the department of ~~job and family services~~

health care administration 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~~ 5165.03 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~~ health care administration shall specify in the rules adopted under section ~~5111.19~~ 5163.231 of the Revised Code what constitutes good cause for a hospital to refuse to contract with a managed care organization.

Sec. ~~5111.082~~ 5163.24. (A) As used in this section:

(1) "State maximum allowable cost" means the per unit amount the department of ~~job and family services~~ health care

administration 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~~ health care administration 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. ~~5111.08~~ 5163.241. In accordance with ~~subsection (g) of section 1927 of the "Social Security Act," 49 Stat. 320 (1935),~~ 42 U.S.C.A. 1396r-8(g), ~~as amended,~~ the department of ~~job and family services~~ health care administration shall establish an outpatient drug use review program to assure that prescriptions obtained by recipients of medical assistance under this chapter are appropriate, medically necessary, and unlikely to cause adverse

medical results.

Sec. ~~5111.027~~ 5163.242. 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. ~~5111.083~~ 5163.243. (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~~ health care administration 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. ~~5111.07~~ 5163.25. Commencing in July, 1986, and every second July thereafter, the department of ~~job and family services~~ health care administration shall initiate a private survey of retail pharmacy operations in the state as the basis for establishing a current maximum dispensing fee for licensed pharmacists who are providers of drugs under this chapter. The survey shall be conducted in conformance with the requirements set forth in 42 C.F.R. 447.331 through 447.333, as amended or superseded, and shall include operational data and direct prescription expenses, professional services and personnel costs, usual and customary overhead expenses, and profit data of the retail pharmacies surveyed. The survey shall be completed and its results published no later than the last day of October of the year in which the survey is conducted, and the survey shall compute and report dispensing fees on a basis of the usual and customary charges by retail pharmacies to their customers for dispensing drugs. The director of ~~job and family services~~ health care administration shall take into account the results of the survey in establishing a dispensing fee.

Sec. ~~5111.071~~ 5163.251. Commencing in December, 1986, and every second December thereafter, the director of ~~job and family services~~ health care administration shall establish a dispensing

fee, effective the following January, for licensed pharmacists who are medicaid providers ~~under this chapter~~. The dispensing fee shall take into consideration the results of the survey conducted under section ~~5111.07~~ 5163.25 of the Revised Code.

Sec. ~~5111.081~~ 5163.26. The director of ~~job and family services~~ health care administration, in rules adopted under section ~~5111.02~~ 5163.15 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~~ health care administration 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.

Sec. ~~5111.0114~~ 5163.261. (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~~ health care administration 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. ~~5111.042~~ 5163.28. The departments of mental retardation and developmental disabilities and ~~job and family services~~ health care administration 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. 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~~ 5160.34 of the Revised Code.

Sec. ~~5111.85~~ 5163.50. (A) As used in this section and sections ~~5111.851~~ 5163.51 to ~~5111.856~~ 5163.56 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~~ 5165.03 of the Revised Code.

(B) The director of ~~job and family services~~ health care administration 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~~ health care administration 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.

Sec. ~~5111.851~~ 5163.51. (A) As used in sections ~~5111.851~~ 5163.51 to ~~5111.855~~ 5163.55 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~~ health care administration or, if a state agency or political subdivision contracts with the department under section ~~5111.91~~ 5161.05 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~~ 5164.01 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~~ 5164.01 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~~ for the medicare program.

(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~~ 5163.50 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~~ 5163.52. The department of ~~job and family services~~ health care administration may review and approve, modify, or deny written plans of care and individual service plans that section ~~5111.851~~ 5163.51 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~~ 5161.05 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~~ health care administration shall be granted full and immediate access to any records the department needs to implement its duties under this section.

Sec. ~~5111.853~~ 5163.53. Each administrative agency shall maintain, for a period of time the department of ~~job and family services~~ health care administration 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~~ 5163.54. 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~~ 5163.55. Each state agency and political subdivision that enters into a contract with the department of ~~job and family services~~ health care administration under section ~~5111.91~~ 5161.05 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~~ 5163.50 to ~~5111.854~~ 5163.54 of the Revised Code.

Sec. ~~5111.856~~ 5163.56. To the extent necessary for the efficient and economical administration of medicaid waiver components, the department of ~~job and family services~~ health care administration 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. ~~5111.86~~ 5163.60. (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~~ 5163.50 of the Revised Code.

(3) "Nursing facility" has the same meaning as in section ~~5111.20~~ 5164.01 of the Revised Code.

(4) "Ohio home care program" means the program the department of ~~job and family services~~ health care administration administers that provides state plan services and medicaid waiver component services pursuant to rules adopted under sections ~~5111.01~~ 5162.20 and ~~5111.02~~ 5163.15 of the Revised Code and a medicaid waiver that went into effect July 1, 1998.

(B) The director of ~~job and family services~~ health care administration may submit 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 are provided to eligible individuals who need the level of care provided by a nursing facility or hospital. In the requests, the director may specify the following:

(1) The maximum number of individuals who may be enrolled in each of the medicaid waiver components included in the requests;

(2) The maximum amount the medicaid program may expend each year for each individual enrolled in the medicaid waiver components;

(3) The maximum amount the medicaid program may expend each year for all individuals enrolled in the medicaid waiver components;

(4) Any other requirements the director selects for the medicaid waiver components.

(C) If the secretary approves the medicaid waivers requested under this section, the director may create and implement the medicaid waiver components in accordance with the provisions of the approved waivers. The department of ~~job and family services~~ health care administration shall administer the medicaid waiver components.

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~~ 5163.65. (A) As used in this section and section ~~5111.871~~ 5163.651 of the Revised Code:

(1) "Intermediate care facility for the mentally retarded" has the same meaning as in section ~~5111.20~~ 5164.01 of the Revised Code.

(2) "Medicaid waiver component" has the same meaning as in section ~~5111.85~~ 5163.50 of the Revised Code.

(B) The director of ~~job and family services~~ health care administration may apply to the United States secretary of health and human services for both of the following:

(1) One or more medicaid 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 waiver components under which home and community-based services are provided in the form of any of the following:

(a) Early intervention and supportive services for children under three years of age who have developmental delays or disabilities the director determines are significant;

(b) Therapeutic services for children who have autism;

(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~~ health care administration apply for one or more medicaid waivers under this section.

(E) Before applying for a waiver under this section, the director of ~~job and family services~~ health care administration shall seek, accept, and consider public comments.

Sec. ~~5111.871~~ 5163.651. The department of ~~job and family services~~ health care administration shall enter into a contract with the department of mental retardation and developmental disabilities under section ~~5111.91~~ 5161.05 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~~ health care administration under one or more of the medicaid

waivers sought under section ~~5111.87~~ 5163.65 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~~ health care administration 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~~ health care administration 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~~ 5160.34 of the Revised Code.

The departments of mental retardation and developmental disabilities and ~~job and family services~~ health care administration 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~~ 5160.34 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 5123.16 or 5126.431 of the Revised Code may provide the services.

Sec. ~~5111.872~~ 5163.652. When the department of mental retardation and developmental disabilities allocates enrollment numbers to a county board of mental retardation and developmental disabilities for home and community-based services specified in division (B)(1) of section ~~5111.87~~ 5163.65 of the Revised Code and provided under any of the components of the medicaid program that the department administers under section ~~5111.871~~ 5163.651 of the Revised Code, the department shall consider all of the following:

(A) The number of individuals with mental retardation or other developmental disability who are on a waiting list the county board establishes under division (C) of section 5126.042 of the Revised Code for those services and are given priority on the waiting list pursuant to division (D) or (E) of that section;

(B) The implementation component required by division (A)(4) of section 5126.054 of the Revised Code of the county board's plan approved under section 5123.046 of the Revised Code;

(C) Anything else the department considers necessary to enable county boards to provide those services to individuals in accordance with the priority requirements of divisions (D) and (E) of section 5126.042 of the Revised Code.

Sec. ~~5111.873~~ 5163.653. (A) Not later than the effective date of the first of any medicaid waivers the United States secretary of health and human services grants pursuant to a request made under section ~~5111.87~~ 5163.65 of the Revised Code, the director of ~~job and family services~~ health care administration shall adopt rules in accordance with Chapter 119. of the Revised Code establishing statewide fee schedules for home and community-based services specified in division (B)(1) of section ~~5111.87~~ 5163.65

of the Revised Code and provided under the components of the medicaid program that the department of mental retardation and developmental disabilities administers under section ~~5111.871~~ 5163.651 of the Revised Code. The rules shall provide for all of the following:

(1) The department of mental retardation and developmental disabilities arranging for the initial and ongoing collection of cost information from a comprehensive, statistically valid sample of persons and government entities providing the services at the time the information is obtained;

(2) The collection of consumer-specific information through an assessment instrument the department of mental retardation and developmental disabilities shall provide to the department of ~~job and family services~~ health care administration;

(3) With the information collected pursuant to divisions (A)(1) and (2) of this section, an analysis of that information, and other information the director determines relevant, methods and standards for calculating the fee schedules that do all of the following:

(a) Assure that the fees are consistent with efficiency, economy, and quality of care;

(b) Consider the intensity of consumer resource need;

(c) Recognize variations in different geographic areas regarding the resources necessary to assure the health and welfare of consumers;

(d) Recognize variations in environmental supports available to consumers.

(B) As part of the process of adopting rules under this section, the director shall consult with the director of mental retardation and developmental disabilities, representatives of

county boards of mental retardation and developmental disabilities, persons who provide the home and community-based services, and other persons and government entities the director identifies.

(C) The directors of ~~job and family services~~ health care administration and mental retardation and developmental disabilities shall review the rules adopted under this section at times they determine to ensure that the methods and standards established by the rules for calculating the fee schedules continue to do everything that division (A)(3) of this section requires.

Sec. ~~5111.88~~ 5163.66. (A) As used in sections ~~5111.88~~ 5163.66 to ~~5111.8817~~ 5163.6617 of the Revised Code:

"Administrative agency" means the department of ~~job and family services~~ health care administration 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~~ 5163.667 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~~ 5164.01 of the Revised Code.

"Medicaid waiver component" has the same meaning as in section ~~5111.85~~ 5163.50 of the Revised Code.

(B) Not later than June 30, 2007, the director of ~~job and family services~~ health care administration 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 in whole or in part 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~~ 5163.662 of the Revised Code and except as provided by section ~~5111.8811~~ 5163.6611 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~~ 5163.661. (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~~ health care administration 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~~ health care administration 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~~ 5163.66 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~~ 5163.662 of the Revised Code;

(3) Consult with the director of ~~job and family services~~

health care administration 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~~ 5163.669 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~~ 5163.669 of the Revised Code.

Sec. ~~5111.882~~ 5163.662. If the United States secretary of health and human services approves the waiver requested under division (B)(1) of section ~~5111.88~~ 5163.66 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 in whole or in part from providing ICF/MR services to providing home and community-based services as necessary to accommodate each individual participating in the program;

(C) Subject to division (A) of this section, permit individuals who reside in an intermediate care facility for the mentally retarded that converts in whole or in part to providing home and community-based services to choose whether to participate in the program or, if the facility ceases to have enough ICF/MR-certified beds for the individual, to transfer to another intermediate care facility for the mentally retarded that has an available ICF/MR-certified bed for the individual;

(D) Ensure that no individual receiving ICF/MR services

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~~ 5163.669 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~~ health care administration, 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~~ 5163.663. 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~~ 5163.664. 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~~ 5163.665. 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~~ 5163.666. 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~~ 5163.667. (A) If the United States secretary of health and human services approves the waiver requested under division (B)(1) of section ~~5111.88~~ 5163.66 of the Revised Code, the department of ~~job and family services~~ health care administration may do both of the following:

(1) Contract with the department of mental retardation and developmental disabilities under section ~~5111.91~~ 5161.05 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~~ health care administration 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~~ 5163.668. The director of ~~job and family services~~ health care administration, in consultation with the ICF/MR conversion advisory council, shall adopt rules under section ~~5111.85~~ 5163.50 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~~ 5163.669. (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 in whole or in part from providing ICF/MR services to providing home and community-based services has on the intermediate care facilities for the mentally retarded that so 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~~ 5163.6610. The ICF/MR conversion pilot program shall not be implemented statewide unless the general assembly enacts law authorizing the statewide implementation.

Sec. ~~5111.8811~~ 5163.6611. An intermediate care facility for the mentally retarded that converts in whole or in part from providing ICF/MR services to providing home and community-based services under the ICF/MR conversion pilot program may reconvert the converted beds to providing ICF/MR services after the program terminates unless any 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;

(C) The facility no longer meets the requirements for licensure as a residential facility under section 5123.19 of the Revised Code or, if the facility is eligible under section 5123.192 of the Revised Code to be licensed as a nursing home, the requirements for licensure as a nursing home under section 3721.02 or 3721.09 of the Revised Code.

Sec. ~~5111.8812~~ 5163.6612. (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 incurred for any beds of an intermediate care facility for the mentally retarded that are reconverted to providing ICF/MR services under section ~~5111.8811~~ 5163.6611 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~~ health care administration 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. ~~5111.8813~~ 5163.6613. The operator of an intermediate care facility for the mentally retarded that converts only in part from providing ICF/MR services to providing home and community-based services under the ICF/MR conversion pilot program shall place the beds that convert in a distinct part of the facility that houses the intermediate care facility for the mentally retarded.

Sec. ~~5111.8814~~ 5163.6614. An intermediate care facility for the mentally retarded that converts in whole to providing home and community-based services under the ICF/MR conversion pilot program shall either be licensed as a residential facility under section

5123.19 of the Revised Code or certified to provide supported living under section 5126.431 of the Revised Code. If an intermediate care facility for the mentally retarded converts in part to providing such home and community-based services, the distinct part of the facility that provides the home and community-based services shall either be licensed as a residential facility under section 5123.19 of the Revised Code or certified to provide supported living under section 5126.431 of the Revised Code. The facility or distinct part of the facility shall be licensed as a residential facility rather than certified to provide supported living if it meets the definition of "residential facility" in section 5123.19 of the Revised Code.

Sec. ~~5111.8815~~ 5163.6615. (A) Not later than thirty days after the date a resident of an intermediate care facility for the mentally retarded is enrolled in the ICF/MR conversion pilot program, the operator of the intermediate care facility for the mentally retarded shall do the following regardless of whether the resident resides in a distinct part of a facility that also houses the intermediate care facility for the mentally retarded:

(1) If the intermediate care facility for the mentally retarded is licensed as a residential facility under section 5123.19 of the Revised Code, notify the director of mental retardation and developmental disabilities of the resident's enrollment;

(2) If the intermediate care facility for the mentally retarded is licensed as a nursing home under section 3721.02 of the Revised Code, notify the director of health of the resident's enrollment;

(3) If the intermediate care facility for the mentally retarded is licensed as a nursing home by a political subdivision under section 3721.09 of the Revised Code, notify the officials of

the political subdivision of the resident's enrollment.

(B) The director of mental retardation and developmental disabilities, director of health, and officials of a political subdivision shall reduce the licensed capacity of a residential facility or nursing home by the number of the residential facility's or nursing home's residents who enroll in the ICF/MR conversion pilot program. The director of ~~job and family services~~ health care administration shall be notified of each reduction in licensed capacity made under this section.

Sec. ~~5111.8816~~ 5163.6616. Not later than thirty days after the date an intermediate care facility for the mentally retarded converts in whole or in part to providing home and community-based services under the ICF/MR conversion pilot program, the operator of the facility shall notify the director of ~~job and family services~~ health care administration of the number of beds that converted. The director of ~~job and family services~~ health care administration shall notify the director of health of the operator's notice. The director of health shall reduce the facility's certified capacity by the number of beds that convert. The director of health shall notify the director of ~~job and family services~~ health care administration whenever the director of health takes action under this section.

Sec. ~~5111.8817~~ 5163.6617. On receipt of notice from the director of health under section ~~5111.8816~~ 5163.6616 of the Revised Code that the director has reduced the certified capacity of an intermediate care facility for the mentally retarded, the director of ~~job and family services~~ health care administration shall amend the facility's medicaid provider agreement to reflect the facility's reduced certified capacity or, if the facility's certified capacity is reduced to zero, terminate the facility's medicaid provider agreement.

Sec. ~~5111.89~~ 5163.68. (A) As used in sections ~~5111.89~~ 5163.68 to ~~5111.893~~ 5163.683 of the Revised Code:

"Assisted living program" means the medicaid waiver component for which the director of ~~job and family services~~ health care administration 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~~ 5163.50 of the Revised Code.

"Nursing facility" has the same meaning as in section ~~5111.20~~ 5164.01 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~~ health care administration 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~~ 5163.681 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~~ health

care administration shall enter into a contract with the department of aging under section ~~5111.91~~ 5161.05 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~~ health care administration may adopt rules under section ~~5111.85~~ 5163.50 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~~ health care administration authorize the director of aging to adopt.

Sec. ~~5111.891~~ 5163.681. 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~~ health care administration 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~~ 5163.50 of the Revised Code.

Sec. ~~5111.892~~ 5163.682. 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~~ 5163.683. 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. ~~5111.971~~ 5163.69. (A) As used in this section, "long-term care 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~~ health care administration administers.

(B) The director of ~~job and family services~~ health care administration 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 home and community-based 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~~ health care

administration shall enter into a contract with the department of aging under section ~~5111.91~~ 5161.05 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 or a skilled level of care as determined under rule 5101:3-3-05 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 would remain in a nursing facility if not for the pilot program;

(b) A participant of any long-term care 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~~ 5163.50 of the Revised Code.

(E) The director of ~~job and family services~~ health care administration may adopt rules under section ~~5111.85~~ 5163.50 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. ~~5111.97~~ 5163.73. (A) As used in this section and in section ~~5111.971~~ 5163.69 of the Revised Code, "nursing facility" has the same meaning as in section ~~5111.20~~ 5164.01 of the Revised Code.

(B) To the extent funds are available, the director of ~~job and family services~~ health care administration 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~~ nonmedicaid 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 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) Need the level of care provided by nursing facilities;

(3) For participation in a ~~non-medicaid~~ nonmedicaid 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;

(4) For participation in a program established as part of a medicaid-funded home and community-based services waiver program, meet waiver enrollment criteria.

(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.

(E) If the project is established as a ~~non-medicaid~~ nonmedicaid program, no participant may receive more than two thousand dollars worth of benefits under the project.

(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. ~~5111.95~~ 5163.75. (A) As used in this section:

(1) "Applicant" means a person who is under final consideration for employment or, after ~~the effective date of this section~~ September 26, 2003, an existing employee with a waiver agency in a full-time, part-time, or temporary position that involves providing home and community-based waiver services to a person with disabilities. "Applicant" also means an existing employee with a waiver agency in a full-time, part-time, or temporary position that involves providing home and community-based waiver services to a person with disabilities after ~~the effective date of this section~~ September 26, 2003.

(2) "Criminal records check" has the same meaning as in section 109.572 of the Revised Code.

(3) "Waiver agency" means a person or government entity that is not certified under the medicare program and is accredited by the community health accreditation program or the joint commission on accreditation of health care organizations or a company that provides home and community-based waiver services to persons with disabilities through department of ~~job and family services~~ health care administration administered home and community-based waiver programs.

(4) "Home and community-based waiver services" means services furnished under the provision of 42 C.F.R. 441, subpart G, that permit individuals to live in a home setting rather than a nursing facility or hospital. Home and community-based waiver services are approved by the centers for medicare and medicaid for specific populations and are not otherwise available under the medicaid state plan.

(B)(1) The chief administrator of a waiver agency shall request that the superintendent of the bureau of criminal identification and investigation conduct a criminal records check with respect to each applicant. If an applicant for whom a criminal records check request is required under this division

does not present proof of having been a resident of this state for the five-year period immediately prior to the date the criminal records check is requested or provide evidence that within that five-year period the superintendent has requested information about the applicant from the federal bureau of investigation in a criminal records check, the chief administrator shall request that the superintendent obtain information from the federal bureau of investigation as part of the criminal records check of the applicant. Even if an applicant for whom a criminal records check request is required under this division presents proof of having been a resident of this state for the five-year period, the chief administrator may request that the superintendent include information from the federal bureau of investigation in the criminal records check.

(2) A person required by division (B)(1) of this section to request a criminal records check shall do both of the following:

(a) Provide to each applicant for whom a criminal records check request is required under division (B)(1) of this section a copy of the form prescribed pursuant to division (C)(1) of section 109.572 of the Revised Code and a standard fingerprint impression sheet prescribed pursuant to division (C)(2) of that section, and obtain the completed form and impression sheet from the applicant;

(b) Forward the completed form and impression sheet to the superintendent of the bureau of criminal identification and investigation.

(3) An applicant provided the form and fingerprint impression sheet under division (B)(2)(a) of this section who fails to complete the form or provide fingerprint impressions shall not be employed in any position in a waiver agency for which a criminal records check is required by this section.

(C)(1) Except as provided in rules adopted by the department

of ~~job and family services~~ health care administration in accordance with division (F) of this section and subject to division (C)(2) of this section, no waiver agency shall employ a person in a position that involves providing home and community-based waiver services to persons with disabilities if the person has been convicted of or pleaded guilty to any of the following:

(a) A violation of section 2903.01, 2903.02, 2903.03, 2903.04, 2903.041, 2903.11, 2903.12, 2903.13, 2903.16, 2903.21, 2903.34, 2905.01, 2905.02, 2905.05, 2905.11, 2905.12, 2907.02, 2907.03, 2907.04, 2907.05, 2907.06, 2907.07, 2907.08, 2907.09, 2907.21, 2907.22, 2907.23, 2907.25, 2907.31, 2907.32, 2907.321, 2907.322, 2907.323, 2911.01, 2911.02, 2911.11, 2911.12, 2911.13, 2913.02, 2913.03, 2913.04, 2913.11, 2913.21, 2913.31, 2913.40, 2913.43, 2913.47, 2913.51, 2919.12, 2919.24, 2919.25, 2921.36, 2923.12, 2923.13, 2923.161, 2925.02, 2925.03, 2925.04, 2925.05, 2925.06, 2925.11, 2925.13, 2925.22, 2925.23, or 3716.11 of the Revised Code, felonious sexual penetration in violation of former section 2907.12 of the Revised Code, a violation of section 2905.04 of the Revised Code as it existed prior to July 1, 1996, a violation of section 2919.23 of the Revised Code that would have been a violation of section 2905.04 of the Revised Code as it existed prior to July 1, 1996, had the violation been committed prior to that date;

(b) An existing or former law of this state, any other state, or the United States that is substantially equivalent to any of the offenses listed in division (C)(1)(a) of this section.

(2)(a) A waiver agency may employ conditionally an applicant for whom a criminal records check request is required under division (B) of this section prior to obtaining the results of a criminal records check regarding the individual, provided that the agency shall request a criminal records check regarding the

individual in accordance with division (B)(1) of this section not later than five business days after the individual begins conditional employment.

(b) A waiver agency that employs an individual conditionally under authority of division (C)(2)(a) of this section shall terminate the individual's employment if the results of the criminal records check request under division (B) of this section, other than the results of any request for information from the federal bureau of investigation, are not obtained within the period ending sixty days after the date the request is made. Regardless of when the results of the criminal records check are obtained, if the results indicate that the individual has been convicted of or pleaded guilty to any of the offenses listed or described in division (C)(1) of this section, the agency shall terminate the individual's employment unless the agency chooses to employ the individual pursuant to division (F) of this section.

(D)(1) Each waiver agency shall pay to the bureau of criminal identification and investigation the fee prescribed pursuant to division (C)(3) of section 109.572 of the Revised Code for each criminal records check conducted pursuant to a request made under division (B) of this section.

(2) A waiver agency may charge an applicant a fee not exceeding the amount the agency pays under division (D)(1) of this section. An agency may collect a fee only if the agency notifies the person at the time of initial application for employment of the amount of the fee and that, unless the fee is paid, the person will not be considered for employment.

(E) The report of any criminal records check conducted pursuant to a request made under this section is not a public record for the purposes of section 149.43 of the Revised Code and shall not be made available to any person other than the following:

(1) The individual who is the subject of the criminal records check or the individual's representative;

(2) The chief administrator of the agency requesting the criminal records check or the administrator's representative;

(3) A court, hearing officer, or other necessary individual involved in a case dealing with a denial of employment of the applicant or dealing with employment or unemployment benefits of the applicant.

(F) The department shall adopt rules in accordance with Chapter 119. of the Revised Code to implement this section. The rules shall specify circumstances under which a waiver agency may employ a person who has been convicted of or pleaded guilty to an offense listed or described in division (C)(1) of this section but meets personal character standards set by the department.

(G) The chief administrator of a waiver agency shall inform each person, at the time of initial application for a position that involves providing home and community-based waiver services to a person with a disability, that the person is required to provide a set of fingerprint impressions and that a criminal records check is required to be conducted if the person comes under final consideration for employment.

(H)(1) A person who, on ~~the effective date of this section~~ September 26, 2003, is an employee of a waiver agency in a full-time, part-time, or temporary position that involves providing home and community-based waiver services to a person with disabilities shall comply with this section within sixty days after ~~the effective date of this section~~ September 26, 2003, unless division (H)(2) of this section applies.

(2) This section shall not apply to a person to whom all of the following apply:

(a) On ~~the effective date of this section~~ September 26, 2003,

the person is an employee of a waiver agency in a full-time, part-time, or temporary position that involves providing home and community-based waiver services to a person with disabilities.

(b) The person previously had been the subject of a criminal background check relating to that position;

(c) The person has been continuously employed in that position since that criminal background check had been conducted.

Sec. ~~5111.96~~ 5163.76. (A) As used in this section:

(1) "Anniversary date" means the later of the effective date of the provider agreement relating to the independent provider or sixty days after ~~the effective date of this section~~ September 26, 2003.

(2) "Criminal records check" has the same meaning as in section 109.572 of the Revised Code.

(3) "The department" means the department of ~~job and family services~~ health care administration or its designee.

(4) "Independent provider" means a person who is submitting an application for a provider agreement or who has a provider agreement as an independent provider in a department of ~~job and family services~~ health care administration administered home and community-based services program providing home and community-based waiver services to consumers with disabilities.

(5) "Home and community-based waiver services" has the same meaning as in section ~~5111.95~~ 5163.75 of the Revised Code.

(B)(1) The department shall inform each independent provider, at the time of initial application for a provider agreement that involves providing home and community-based waiver services to consumers with disabilities, that the independent provider is required to provide a set of fingerprint impressions and that a criminal records check is required to be conducted if the person

is to become an independent provider in a department administered home and community-based waiver program.

(2) Beginning on ~~the effective date of this section~~ September 26, 2003, the department shall inform each enrolled medicaid independent provider on or before time of the anniversary date of the provider agreement that involves providing home and community-based waiver services to consumers with disabilities that the independent provider is required to provide a set of fingerprint impressions and that a criminal records check is required to be conducted.

(C)(1) The department shall require the independent provider to complete a criminal records check prior to entering into a provider agreement with the independent provider and at least annually thereafter. If an independent provider for whom a criminal records check is required under this division does not present proof of having been a resident of this state for the five-year period immediately prior to the date the criminal records check is requested or provide evidence that within that five-year period the superintendent has requested information about the applicant from the federal bureau of investigation in a criminal records check, the department shall request the independent provider obtain through the superintendent a criminal records request from the federal bureau of investigation as part of the criminal records check of the independent provider. Even if an independent provider for whom a criminal records check request is required under this division presents proof of having been a resident of this state for the five-year period, the department may request that the independent provider obtain information through the superintendent from the federal bureau of investigation in the criminal records check.

(2) The department shall do both of the following:

(a) Provide information to each independent provider for whom

a criminal records check request is required under division (C)(1) of this section about requesting a copy of the form prescribed pursuant to division (C)(1) of section 109.572 of the Revised Code and a standard fingerprint impression sheet prescribed pursuant to division (C)(2) of that section, and obtain the completed form and impression sheet and fee from the independent provider;

(b) Forward the completed form, impression sheet, and fee to the superintendent of the bureau of criminal identification and investigation.

(3) An independent provider given information about obtaining the form and fingerprint impression sheet under division (C)(2)(a) of this section who fails to complete the form or provide fingerprint impressions shall not be approved as an independent provider.

(D) Except as provided in rules adopted by the department in accordance with division (G) of this section, the department shall not issue a new provider agreement to, and shall terminate an existing provider agreement of, an independent provider if the person has been convicted of or pleaded guilty to any of the following:

(1) A violation of section 2903.01, 2903.02, 2903.03, 2903.04, 2903.041, 2903.11, 2903.12, 2903.13, 2903.16, 2903.21, 2903.34, 2905.01, 2905.02, 2905.05, 2905.11, 2905.12, 2907.02, 2907.03, 2907.04, 2907.05, 2907.06, 2907.07, 2907.08, 2907.09, 2907.21, 2907.22, 2907.23, 2907.25, 2907.31, 2907.32, 2907.321, 2907.322, 2907.323, 2911.01, 2911.02, 2911.11, 2911.12, 2911.13, 2913.02, 2913.03, 2913.04, 2913.11, 2913.21, 2913.31, 2913.40, 2913.43, 2913.47, 2913.51, 2919.12, 2919.24, 2919.25, 2921.36, 2923.12, 2923.13, 2923.161, 2925.02, 2925.03, 2925.04, 2925.05, 2925.06, 2925.11, 2925.13, 2925.22, 2925.23, or 3716.11 of the Revised Code, felonious sexual penetration in violation of former section 2907.12 of the Revised Code, a violation of section

2905.04 of the Revised Code as it existed prior to July 1, 1996, a violation of section 2919.23 of the Revised Code that would have been a violation of section 2905.04 of the Revised Code as it existed prior to July 1, 1996, had the violation been committed prior to that date;

(2) An existing or former law of this state, any other state, or the United States that is substantially equivalent to any of the offenses listed in division (D)(1) of this section.

(E) Each independent provider shall pay to the bureau of criminal identification and investigation the fee prescribed pursuant to division (C)(3) of section 109.572 of the Revised Code for each criminal records check conducted pursuant to a request made under division (C) of this section.

(F) The report of any criminal records check conducted by the bureau of criminal identification and investigation in accordance with section 109.572 of the Revised Code and pursuant to a request made under division (C) of this section is not a public record for the purposes of section 149.43 of the Revised Code and shall not be made available to any person other than the following:

(1) The person who is the subject of the criminal records check or the person's representative;

(2) The administrator at the department who is requesting the criminal records check or the administrator's representative;

(3) Any court, hearing officer, or other necessary individual involved in a case dealing with a denial or termination of a provider agreement related to the criminal records check.

(G) The department shall adopt rules in accordance with Chapter 119. of the Revised Code to implement this section. The rules shall specify circumstances under which the department may issue a provider agreement to an independent provider who has been convicted of or pleaded guilty to an offense listed or described

in division (C)(1) of this section but meets personal character standards set by the department.

Sec. ~~5111.20~~ 5164.01. As used in sections ~~5111.20~~ 5164.01 to ~~5111.34~~ 5164.47 of the Revised Code:

(A) "Allowable costs" are those costs determined by the department of ~~job and family services~~ health care administration to be reasonable and do not include fines paid under sections ~~5111.35~~ 5164.50 to ~~5111.61~~ 5164.78 and section ~~5111.99~~ 5164.99 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, habilitation supervisors, qualified mental retardation professionals, program directors, 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~~ 5163.15 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 ~~5111.251~~ 5164.08 of the Revised Code;

(iii) Except as provided in division (B) of this section, equipment;

(iv) 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 (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 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.

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

(E) "Case-mix score" means the measure determined under section 5164.051 of the Revised Code of the relative direct-care resources needed to provide care and habilitation to a resident of an intermediate care facility for the mentally retarded and the measure determined under section ~~5111.232~~ 5164.191 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~~.

(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.

(G) "Desk-reviewed" means that costs as reported on a cost report submitted under section ~~5111.26~~ 5164.37 of the Revised Code have been subjected to a desk review under division (A) of section ~~5111.27~~ 5164.38 of the Revised Code and preliminarily determined to be allowable costs.

(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, respiratory therapists, and except as provided in division (H)(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.~~ under section 5163.15 of the Revised Code, for personnel listed in divisions (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 costs of habilitation staff (other than habilitation supervisors), medical supplies, emergency oxygen, habilitation supplies, and universal precautions supplies.

(3) In addition to the costs specified in division (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, audiologists, habilitation staff (including habilitation supervisors), qualified mental retardation professionals, program directors, 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 under section ~~5111.02~~ 5163.15 of the Revised Code, for personnel listed in division (H)(3)(a) of this section.

(4) Costs of other direct-care resources that are specified as direct care costs in rules adopted under section ~~5111.02~~ 5163.15 of the Revised Code.

(I) "Fiscal year" means the fiscal year of this state, as specified in section 9.34 of the Revised Code.

(J) "Franchise permit fee" means the fee imposed by sections ~~3721.50~~ 5166.20 to ~~3721.58~~ 5166.30 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 under section ~~5111.02~~ 5163.15 of the Revised Code, for personnel listed in this division. Notwithstanding division (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.

(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. Therapeutic or hospital leave days for which payment is made under section ~~5111.33~~ 5164.35 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.

(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 medicaid program by the director of health in accordance with

Title XIX.

(N) "Maintenance and repair expenses" means, except as provided in division (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.

(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~~ 5164.35 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~~ for the medicaid program 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~~ for the medicaid program and is certified as a skilled nursing facility by the director ~~in accordance with Title XVIII~~ for the medicare program.

(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 under section ~~5111.02~~ 5163.15 of the Revised Code.

(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.

(T) "Patient" includes "resident."

(U) Except as provided in divisions (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 ~~5111.241~~ 5164.07 of the Revised Code, "per diem" means 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 ~~5111.251~~ 5164.08 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.

(V) "Provider" means an operator with a provider agreement.

(W) "Provider agreement" means a contract between the department of ~~job and family services~~ health care administration 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 medicaid program.

(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.

(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.

(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.

(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) Stepparent, stepchild, stepbrother, or 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.

(BB) "Renovation" and "extensive renovation" mean:

(1) Any betterment, improvement, or restoration of 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 intermediate care facilities for the mentally retarded started on or after July 1, 1993:

(a) "Renovation" means the betterment, improvement, or restoration of 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 (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~~ health care administration 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. ~~5111.201~~ 5164.011. Whenever "skilled nursing facility," "intermediate care facility," or "dual skilled nursing and intermediate care facility" is referred to or designated in any statute, rule, contract, provider agreement, or other document pertaining to the ~~medical assistance~~ medicaid program, the reference or designation is deemed to refer to a nursing facility, except that a reference to or designation of an "intermediate care facility for the mentally retarded" is not deemed to refer to a nursing facility.

Sec. ~~5111.21~~ 5164.02. (A) In order to be eligible for 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 of health care administration as provided in section ~~5111.22~~ 5164.03, ~~5111.671~~ 5164.841, or ~~5111.672~~ 5164.842 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)(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~~. The director of ~~job and family services~~ health care administration may adopt rules under section ~~5111.02~~ 5163.15 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~~ 5164.03. A provider agreement between the department of ~~job and family services~~ health care administration 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 provider, as provided in sections ~~5111.20~~ 5164.01 to ~~5111.33~~ 5164.47 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~~ 5164.02 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~~ 5164.38 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 residents who are or are eligible to be medicaid recipients;

(7) Comply with section ~~5111.31~~ 5164.033 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~~ health care administration, in accordance with rules adopted under section ~~5111.02~~ 5163.15 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 medicaid recipients or of the state.

Sec. ~~5111.223~~ 5164.031. 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. ~~5111.30~~ 5164.032. The department of ~~job and family services~~ health care administration shall terminate the provider agreement with a 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~~ 5164.033. (A) Every provider agreement with the provider of a nursing facility or intermediate care facility for the mentally retarded shall:

(1) Prohibit the 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. For the purposes of this division, a medicaid recipient 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~~ health care administration 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~~ 5163.15 of the Revised Code.

(2) 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 medicaid program.

(3) Prohibit the 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~~ 5164.71 of the Revised Code, prohibit the 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 if less than eighty per cent of the patients in the facility are medicaid recipients.

(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~~ 5163.65 of the Revised Code;

(c) Beds that are converted to providing home and community-based services under the ICF/MR conversion pilot program authorized by a waiver sought under division (B)(1) of section ~~5111.88~~ 5163.66 of the Revised Code.

(2) If a provider chooses to include a bed specified in division (B)(1)(a) 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 a provider that is a religious organization operating a religious or denominational nursing facility or intermediate care facility for the mentally retarded from giving preference to persons of the same religion or denomination. Nothing in this section shall bar any provider from giving preference to persons with whom the provider has contracted to provide continuing care.

(D) Nothing in this section shall bar 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.

(E) No provider of a nursing facility or intermediate care facility for the mentally retarded for which a provider agreement is in effect shall violate the provider contract obligations imposed under this section.

(F) Nothing in divisions (A) and (C) of this section shall bar 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, but refusing to accept as a patient any person who is or may, as a patient in the facility, become a medicaid recipient, if all of the following apply:

(1) The 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, except as necessary to comply with division (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~~ 5164.034. 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~~ 5164.033 of the Revised Code. The action may be commenced by the patient, or on the patient's behalf by 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~~ 5164.033 of the Revised Code has occurred, the court may enjoin the 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. ~~5111.23~~ 5164.05. (A) The department of ~~job and family services~~ health care administration shall pay a provider for each of the provider's eligible intermediate care 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 ~~5111.232~~ 5164.051 of the Revised Code for the same calendar year.

(2)(a) 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.

(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.

(c) In calculating the maximum cost per case-mix unit under divisions (B)(2)(a) ~~to~~ and (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 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 ~~5111.232~~ 5164.051 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 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.

(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~~ health care administration shall adopt rules under section ~~5111.02~~ 5163.15 of the Revised Code that specify peer groups of 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 case-mix.

(F) The department, in accordance with division ~~(D)~~(C) of section ~~5111.232~~ 5164.051 of the Revised Code and rules adopted under division ~~(E)~~(D) of that section, may assign case-mix scores or costs per case-mix unit if a provider fails to submit assessment data necessary to calculate an intermediate care facility for the mentally retarded's case-mix score in accordance with that section.

Sec. 5164.051. (A) The department of health care administration 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 under section 5163.15 of the Revised Code and expressed in case-mix values established by the department in those rules.

(B) Each calendar quarter, each provider of an intermediate care facility for the mentally retarded shall compile complete assessment data, from the resident assessment instrument specified in rules authorized by division (A) of this section, for each resident of each of the provider's intermediate care facilities for the mentally retarded, 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 shall submit the data to the department of health care administration. 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) 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 5163.15 of the Revised Code.

(C)(1) If a provider of an intermediate care facility for the mentally retarded does not timely submit information for a calendar quarter necessary to calculate the 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 5164.38 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)(1) of this section, instead of a quarterly average case-mix score calculated based on the provider's submitted information, to calculate the facility's rate for direct care costs being established under section 5164.05 of the Revised Code for one or more months, as specified in rules authorized by division (D) of this section, of the quarter for which the rate established under section 5164.05 of the Revised Code will be paid.

Before taking action under division (C)(1) of this section, the department shall permit the provider a reasonable period of time, specified in rules authorized by division (D) of this section, to correct the information. The department shall not assign a quarterly average case-mix score due to late submission of corrections to assessment information unless the provider fails to submit corrected information prior to the eighty-first day after the end of the calendar quarter to which the information pertains.

(2) If a provider is paid a rate for an intermediate care facility for the mentally retarded calculated using a quarterly average case-mix score assigned under division (C)(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 5164.05 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)(1) or (2) of this section only in accordance with rules authorized by division (D) of this section. The department shall not take an action that affects rates for prior payment periods except in accordance with sections 5164.38 and 5164.39 of the Revised Code.

(D) The director shall adopt rules under section 5163.15 of the Revised Code that do all of the following:

(1) Specify the medium or media through which the completed assessment data shall be submitted;

(2) Establish procedures under which the assessment data shall be reviewed for accuracy and providers shall be notified of any data that requires correction;

(3) Establish procedures for providers to correct assessment data and specify a reasonable period of time by which providers shall submit the corrections.

(4) Specify when and how the department will assign case-mix scores or costs per case-mix unit under division (C) of this section if information necessary to calculate the facility's case-mix score is not provided or corrected in accordance with the procedures established by the rules. Notwithstanding any other provision of sections 5164.01 to 5164.47 of the Revised Code, the rules also may provide for excluding case-mix scores assigned under division (C) of this section from calculation of 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.

Sec. ~~5111.235~~ 5164.06. The department of ~~job and family services~~ health care administration shall pay a provider for each of the provider's eligible intermediate care 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 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. ~~5111.241~~ 5164.07. (A) The department of ~~job and family services~~ health care administration shall pay a provider for each of the provider's eligible intermediate care 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~~ health care administration shall adopt rules under section ~~5111.02~~ 5163.15 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. ~~5111.251~~ 5164.08. (A) The department of ~~job and family services~~ health care administration shall pay a provider for each of the provider's eligible intermediate care 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~~ 5164.01 to ~~5111.33~~ 5164.41 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~~ health care administration in rules adopted under section ~~5111.02~~ 5163.15 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~~ health care administration. Any rules 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~~ 5164.01 to ~~5111.33~~ 5164.41 of the Revised Code is used to reimburse the government agency.

(B) The department of ~~job and family services~~ health care administration shall pay to a provider for each of the provider's eligible intermediate care 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 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~~ health care administration 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~~ health care administration. 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~~ health care administration shall adopt rules under section ~~5111.02~~ 5163.15 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~~ health care administration 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~~

health care administration 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 ~~5111.241~~ 5164.07 of the Revised Code, the director of ~~job and family services~~ health care administration may adopt rules under section ~~5111.02~~ 5163.15 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 the date on which a transaction of sale is closed, the 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 provider has operated the facility under a provider agreement and prorated according to the number of medicaid patient days for which the provider has received payment for the facility. 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 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.

(I) The department of ~~job and family services~~ health care administration shall pay a provider for each of the provider's eligible proprietary intermediate care 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~~ health care administration determines that the lease or transfer is an arm's length transaction pursuant to rules adopted under section ~~5111.02~~ 5163.15 of the Revised Code. 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. ~~5111.261~~ 5164.10. Except as otherwise provided in section ~~5111.264~~ 5164.372 of the Revised Code, the department of ~~job and family services~~ health care administration, 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 under section ~~5111.02~~ 5163.15 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 intermediate care facilities for the mentally retarded with one hundred fifty or more beds.

Sec. ~~5111.255~~ 5164.12. (A) The department of ~~job and family services~~ health care administration shall establish initial rates for 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 an intermediate care facility for the mentally retarded 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 determined as follows:

(a) If there are no cost or resident assessment data as necessary to calculate a rate under section ~~5111.23~~ 5164.05 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)(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 data that qualifies for use in calculating a case-mix score in accordance with rules authorized by division ~~(E)~~(D) of section ~~5111.232~~ 5164.051 of the Revised Code. If the facility's first two quarterly submissions do not contain assessment 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 ~~(D)~~(C) of section ~~5111.232~~ 5164.051 of the Revised Code for any subsequent submissions that do not contain assessment 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 intermediate care facilities for the mentally retarded calculated for the fiscal

year under section ~~5111.235~~ 5164.06 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 ~~5111.241~~ 5164.07 of the Revised Code.

(4) The rate for capital costs shall be determined under section ~~5111.251~~ 5164.08 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 ~~5111.20~~ 5164.01 to ~~5111.33~~ 5164.41 of the Revised Code;

(2) Following the provider's submission of the facility's cost report under division (A)(1)(b) of section ~~5111.26~~ 5164.37 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. ~~5111.291~~ 5164.13. Notwithstanding sections ~~5111.20~~ 5164.01 to ~~5111.33~~ 5164.41 of the Revised Code, the department of ~~job and family services~~ health care administration 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~~ the medicare program.

Sec. ~~5111.211~~ 5164.14. (A) The department of mental retardation and developmental disabilities is responsible for the

nonfederal share of claims submitted for services that are covered by the medicaid program and provided to an eligible medicaid recipient by an intermediate care facility for the mentally retarded if all of the following are the case:

(1) The services are provided on or after July 1, 2003;

(2) The facility receives initial certification by the director of health as an intermediate care facility for the mentally retarded on or after June 1, 2003;

(3) The facility, or a portion of the facility, is licensed by the director of mental retardation and developmental disabilities as a residential facility under section 5123.19 of the Revised Code;

(4) There is a valid provider agreement for the facility.

(B) Each month, the department of ~~job and family services~~ health care administration shall invoice the department of mental retardation and developmental disabilities by interagency transfer voucher for the claims for which the department of mental retardation and developmental disabilities is responsible pursuant to this section.

Sec. ~~5111.222~~ 5164.18. (A) Except as otherwise provided by sections ~~5111.20~~ 5164.01 to ~~5111.33~~ 5164.41 of the Revised Code and by division (B) of this section, the payments that the department of ~~job and family services~~ health care administration 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~~ 5164.19 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~~ 5164.20 of the Revised Code;

(3) The rate for tax costs determined for the nursing facility under section ~~5111.242~~ 5164.21 of the Revised Code;

(4) The rate for franchise permit fees determined for the nursing facility under section ~~5111.243~~ 5164.22 of the Revised Code;

(5) The quality incentive payment paid to the nursing facility under section ~~5111.244~~ 5164.23 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~~ 5164.24 of the Revised Code.

(B) The department shall adjust the rates otherwise determined under divisions (A)(1), (2), (3), and (6) 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 rates 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~~ 5164.01 to ~~5111.33~~ 5164.41 of the Revised Code.

Sec. ~~5111.231~~ 5164.19. (A) As used in this section, "applicable calendar year" means the following:

(1) For the purpose of the department of ~~job and family services'~~ health care administration's 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~~ health care administration shall pay a provider for each of the provider's eligible nursing facilities a per resident per day rate for direct care costs determined semiannually 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~~ 5164.191 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~~ 5164.191 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 cost per case-mix unit is more than one standard deviation from the mean cost per case-mix unit 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. ~~5111.232~~ 5164.191. (A)(1) The department of ~~job and family services~~ health care administration shall determine semiannual and annual average case-mix scores for nursing facilities by using all of the following:

(a) Data from a resident assessment instrument specified in rules adopted under section ~~5111.02~~ 5163.15 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,~~ for the following residents:

(i) When determining ~~semi-annual~~ semiannual 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~~ divisions (A)(2)(a) and (b) of this section, the case-mix values established by the United States department of health and human services;

(c) Except as modified in rules authorized by division (A)(2)(c) of this section, 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~~.

(2) The director of ~~job and family services~~ health care administration may adopt rules under section ~~5111.02~~ 5163.15 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 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 department determines are necessary.

(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 under section 5111.02 of the Revised Code and expressed in case-mix values established by the department in those rules.~~

~~(C)~~ Each calendar quarter, each provider of a nursing facility shall compile complete assessment data, from the resident assessment instrument specified in rules authorized by division (A) ~~or (B)~~ of this section, for each resident of each of the provider's nursing 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~~ health care administration. ~~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 ~~(D)~~(C) of this section, the department, every six months and after the end of each calendar year, shall calculate a semiannual and annual average case-mix score for each nursing facility 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~~ 5163.15 of the Revised Code.

~~(D)~~(C)(1) If a provider of a nursing facility does not timely submit information for a calendar quarter necessary to calculate 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~~ 5164.38 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 ~~(D)~~(C)(1) of this section, instead of a quarterly average case-mix score calculated based on the provider's submitted information, to calculate the facility's rate for direct care costs being established under section ~~5111.23 or 5111.231~~ 5164.19 of the Revised Code for one or more months, as specified in rules authorized by division ~~(E)~~(D) of this section, of the quarter for which the rate established under section ~~5111.23 or 5111.231~~ 5164.19 of the Revised Code will be paid.

Before taking action under division ~~(D)~~(C)(1) of this section, the department shall permit the provider a reasonable period of time, specified in rules authorized by division ~~(E)~~(D) 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 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~~ The department shall not assign a quarterly average case-mix score due to late submission of corrections to assessment information unless the 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.

(2) If a provider is paid a rate for a nursing facility calculated using a quarterly average case-mix score assigned under division ~~(D)~~(C)(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~~ 5164.19 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 ~~(D)~~(C)(1) or (2) of this section only in accordance with rules authorized by division ~~(E)~~(D) of this section. The department shall not take an action that affects rates for prior payment periods except in accordance with sections ~~5111.27~~ 5164.38 and ~~5111.28~~ 5164.39 of the Revised Code.

~~(E)~~(D) The director shall adopt rules under section ~~5111.02~~ 5163.15 of the Revised Code that do 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~~ health care administration;

(2) Specify the medium or media through which the completed assessment data shall be submitted;

(3) Establish procedures under which the assessment data shall be reviewed for accuracy and providers shall be notified of any data that requires correction;

(4) Establish procedures for providers to correct assessment 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.

(5) Specify when and how the department will assign case-mix scores or costs per case-mix unit under division ~~(D)~~(C) of this section if information necessary to calculate the facility's 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~~ 5164.01 to ~~5111.33~~ 5164.41 of the Revised Code, the rules also may provide for ~~the following:~~

~~(a) Exclusion of case-mix scores assigned under division (D) of this section from calculation of 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~~ excluding case-mix scores assigned under division ~~(D)~~(C) 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. ~~5111.24~~ 5164.20. (A) As used in this section, "applicable calendar year" means the following:

(1) For the purpose of the department of ~~job and family services'~~ health care administration's 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~~ health care administration 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. ~~5111.242~~ 5164.21. (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'~~ health care administration's 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~~ health care administration 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~~ 5164.22. The department of ~~job and family services~~ health care administration 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~~ 5164.23. (A) As used in this section, "deficiency" and "standard survey" have the same meanings as in section ~~5111.35~~ 5164.50 of the Revised Code.

(B) Each fiscal year, the department of ~~job and family services~~ health care administration shall pay the provider of each nursing facility a quality incentive payment. The amount of a quality incentive payment paid to a provider for a fiscal year shall be based on the number of points the provider's nursing facility is awarded under division (C) of this section for that fiscal year. The amount of a quality incentive payment paid to a provider of a nursing facility that is awarded no points may be zero. The mean payment for fiscal year 2007, weighted by medicaid days, shall be three dollars per medicaid day. The department shall adjust the mean payment for subsequent fiscal years by the same adjustment factors the department uses to adjust, pursuant to division (B) of section ~~5111.222~~ 5164.18 of the Revised Code, nursing facilities' rates otherwise determined under divisions (A)(1), (2), (3), and (6) of that section.

(C)(1) Except as provided by division (C)(2) of this section, the department shall annually award each nursing facility participating in the medicaid program one point for each of the following accountability measures the facility meets:

(a) The facility had no health deficiencies on the facility's most recent standard survey.

(b) 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.

(c) The facility's resident satisfaction is above the statewide average.

(d) The facility's family satisfaction is above the statewide average.

(e) The number of hours the facility employs nurses is above the statewide average.

(f) The facility's employee retention rate is above the average for the facility's peer group established in division (C) of section ~~5111.231~~ 5164.19 of the Revised Code.

(g) The facility's occupancy rate is above the statewide average.

(h) The facility's medicaid utilization rate is above the statewide average.

(i) The facility's case-mix score is above the statewide average.

(2) The department shall award points pursuant to division (C)(1)(c) or (d) of this section only for a fiscal year immediately following a calendar year for which a survey of resident or family satisfaction has been conducted under section 173.47 of the Revised Code.

(D) The director of ~~job and family services~~ health care administration shall adopt rules under section ~~5111.02~~ 5163.15 of the Revised Code as necessary to implement this section. The rules shall include rules establishing the system for awarding points

under division (C) of this section.

Sec. ~~5111.25~~ 5164.24. (A) As used in this section, "applicable calendar year" means the following:

(1) For the purpose of the department of ~~job and family services'~~ health care administration's 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~~ health care administration shall pay a provider for each of the provider's eligible nursing facilities a per resident per day rate for capital costs. A nursing facility's rate for capital costs shall be the median rate for capital costs for the nursing facilities in the nursing facility's peer group as determined under division (D) 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 under section ~~5111.02~~ 5163.15 of the Revised Code, consistent with the guidelines of the American hospital association, or over a different period approved by the department. Any rules 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 capital costs unless that part of the payment under sections ~~5111.20~~ 5164.01 to ~~5111.33~~ 5164.41 of the Revised Code is used to reimburse the government agency.

(F) The capital cost basis of nursing facility assets shall be determined in the following manner:

(1) Except as provided in division (F)(3) of this section, for purposes of calculating the rates to be paid 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.

(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, except as otherwise provided in sections ~~5111.20~~ 5164.01 to ~~5111.33~~ 5164.41 of the Revised Code.

(3) Except as provided in division (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 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~~ health care administration 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.

(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 (F)(3) of this section if all of the following conditions are met:

(a) The related party is a relative of owner;

(b) Except as provided in division (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~~ health care administration determines that the transfer is an arm's length transaction pursuant to rules adopted under section ~~5111.02~~ 5163.15 of the Revised Code. 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 (F)(4) of this section or actual, allowable cost of ownership was determined most recently under division (G)(9) of this section.

(G) As used in this division:

"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.

"New lease" means a lease, to a different lessee, of a nursing facility that previously was operated under a lease.

(1) Subject to division (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 during the term of the existing lease. The entire lease expense also is an actual, allowable capital cost 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 division (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 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 division (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 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 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 division (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 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 division (B) of this section, for a new lease of a facility that was operated under a lease on May 27, 1992, actual, allowable 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 division (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 capital costs shall include the lesser of annual new lease expense or the annual amount calculated for the old lease under division (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 (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 (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 (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 capital costs attributable to the lease shall be the same as before the

revision or subsequent lease.

(8) Except as provided in division (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 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 capital costs shall include the annual lease expense, subject to the limitations specified in divisions (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 (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~~ health care administration determines that the lease is an arm's length transaction pursuant to rules adopted under section ~~5111.02~~ 5163.15 of the Revised Code. 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 (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 (F)(4) of this section or actual, allowable capital costs were determined most recently under division (G)(9) of this section.

(10) This division does not apply to leases of specific items of equipment.

(H) After the date on which a transaction of sale is closed, the 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 provider has operated the facility under a provider agreement and prorated according to the number of medicaid patient days for which the provider has received payment for the facility. The provider of a facility that is sold or that voluntarily terminates participation in the 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 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 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.

Sec. ~~5111.263~~ 5164.26. (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~~ or the medicaid program as specified in rules adopted by the director of ~~job and family services~~ health care administration under section ~~5111.02~~ 5163.15 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 ~~5111.20~~ 5164.01 to ~~5111.33~~ 5164.41 of the Revised Code.

(C) The department of ~~job and family services~~ health care administration shall process no claims for payment under the 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) Providers of nursing facilities may bill the department of ~~job and family services~~ health care administration for covered therapy services the nursing facilities provide to residents of any nursing facility who are medicaid recipients 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 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 medicaid program.

(d) The claim for payment for the services under the 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 under section ~~5111.02~~ 5163.15 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 ~~5111.20~~ 5164.01 to ~~5111.33~~ 5164.41 of the Revised Code.

Sec. ~~5111.257~~ 5164.27. 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. ~~5111.265~~ 5164.28. 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~~ July 1, 2005, 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. ~~5111.34~~ 5164.30. The director of ~~job and family services~~ health care administration 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. ~~5111.254~~ 5164.32. (A) The department of ~~job and family services~~ health care administration 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~~ 5164.19 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~~ 5164.191 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~~ 5164.20 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~~ 5164.24 of the Revised Code.

(4) The rate for tax costs as defined in section ~~5111.242~~ 5164.21 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~~ 5164.20 of the Revised Code.

(5) The quality incentive payment shall be the mean payment specified in division (B) of section ~~5111.244~~ 5164.23 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~~ 5164.01 to ~~5111.33~~ 5164.41 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~~ 5164.191 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~~ 5164.191 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. ~~5111.258~~ 5164.34. (A) Notwithstanding sections ~~5111.20~~ 5164.01 to ~~5111.33~~ 5164.41 of the Revised Code, the director of ~~job and family services~~ health care administration shall adopt rules under section ~~5111.02~~ 5163.15 of the Revised Code that establish a methodology for calculating the prospective rates 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 authorized by section ~~5111.232~~ 5164.051 or 5164.191 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 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 ~~5111.20~~ 5164.01 to ~~5111.33~~ 5164.41 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~~ 5164.01 to ~~5111.33~~ 5164.41 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 under section ~~5111.02~~ 5163.15 of the Revised Code under which the department, notwithstanding any other provision of sections ~~5111.20~~ 5164.01 to ~~5111.33~~ 5164.41 of the Revised Code, may adjust the rates determined under sections ~~5111.20~~ 5164.01 to ~~5111.33~~ 5164.41 of the Revised Code for a facility that serves a resident who has a diagnosis or special care need that, in the rules 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. ~~5111.33~~ 5164.35. Reimbursement to a provider under sections ~~5111.20~~ 5164.01 to ~~5111.32~~ 5164.41 of the Revised Code shall include payments to the provider, at a rate equal to the percentage of the per resident per day rates that the department of ~~job and family services~~ health care administration has established for the provider's nursing facility or intermediate care facility for the mentally retarded under sections ~~5111.20~~ 5164.01 to ~~5111.33~~ 5164.41 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~~ health care administration shall adopt rules under section ~~5111.02~~ 5163.15 of the Revised Code establishing conditions under which prior authorization may be obtained.

Sec. ~~5111.26~~ 5164.37. (A)(1)(a) Except as provided in division (A)(1)(b) of this section, each provider shall file with the department of ~~job and family services~~ health care administration an annual cost report 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. A report shall cover a calendar year or the portion of a calendar year during which the facility participated in the medicaid program. 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 provider. The director of ~~job and family services~~ health care administration shall prescribe, in rules adopted under section ~~5111.02~~ 5163.15 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 provider at least sixty days before the reporting date.

(b) If rates for a provider's nursing facility or intermediate care facility for the mentally retarded were most recently established under section ~~5111.254~~ 5164.32 or ~~5111.255~~ 5164.12 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. 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~~ 5163.15 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~~ 5163.15 of the Revised Code, is not an ~~arms~~ arm's 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 provider required to submit a cost report for a nursing facility or intermediate care facility for the mentally retarded does not file the report within the required time 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 provider that the provider agreement for the facility will be terminated in thirty days unless the 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 provider shall be paid 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 provider shall report fines paid under sections ~~5111.35~~ 5164.50 to ~~5111.62~~ 5164.78 or section ~~5111.99~~ 5164.99 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 provider may use to set forth costs that the provider believes may be disputed by the department. Any costs reported by the 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 provider may seek reconsideration of that determination under section ~~5111.29~~ 5164.41 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 provider interest at a reasonable rate established in rules adopted under section ~~5111.02~~ 5163.15 of the Revised Code for the time that the rate paid excluded the costs.

Sec. ~~5111.266~~ 5164.371. A provider of a nursing facility filing the facility's cost report with the department of ~~job and family services~~ health care administration under section ~~5111.26~~ 5164.37 of the Revised Code shall report as a nonreimbursable expense the cost of the nursing facility's franchise permit fee.

Sec. ~~5111.264~~ 5164.372. Except as provided in section ~~5111.25~~ 5164.24 or ~~5111.251~~ 5164.08 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. ~~5111.27~~ 5164.38. (A) The department of ~~job and family services~~ health care administration shall conduct a desk review of each cost report it receives under section ~~5111.26~~ 5164.37 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 provider of whether any of the reported costs are preliminarily determined not to be allowable, the rate calculation under sections ~~5111.20~~ 5164.01 to ~~5111.33~~ 5164.41 of the Revised Code that results from that determination, and the reasons for the determination and resulting rate. The department shall allow the provider to verify the calculation and submit additional information.

(B) The department may conduct an audit, as defined by rule adopted under section ~~5111.02~~ 5163.15 of the Revised Code, of any cost report and shall notify the 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;

(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 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 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 under section ~~5111.02~~ 5163.15 of the Revised Code, may conduct an exception review of assessment data submitted under section ~~5111.232~~ 5164.051 or 5164.191 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~~ health care administration. 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;

(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 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 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 data. Where the provider is pursuing judicial or administrative remedies in good faith regarding the disallowance or finding, the department shall not withhold from the provider's current payments any amounts the department claims to be due from the provider pursuant to section ~~5111.28~~ 5164.39 of the Revised Code.

(E) The department shall not reduce rates calculated under sections ~~5111.20~~ 5164.01 to ~~5111.33~~ 5164.41 of the Revised Code on the basis that the provider charges a lower rate to any resident who is not eligible for the medicaid program.

(F) The department shall adjust the rates calculated under sections ~~5111.20~~ 5164.01 to ~~5111.33~~ 5164.41 of the Revised Code to account for reasonable additional costs that must be incurred by 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~~ 5164.39. (A) If a provider properly amends its cost report under section ~~5111.27~~ 5164.38 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~~ health care administration 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~~ 5164.38 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 a facility closure, voluntary termination, or voluntary withdrawal of participation in the medicaid program as required by section ~~5111.66~~ 5164.83 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~~ 5164.84 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 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. ~~5111.221~~ 5164.40. The department of ~~job and family services~~ health care administration shall make its best efforts each year to calculate rates under sections ~~5111.20~~ 5164.01 to ~~5111.33~~ 5164.41 of the Revised Code in time to use them to make the payments due to 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 provider the rate calculated for 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 for any facility pursuant to this

section at the request of the 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 the facility for the current fiscal year, the department shall pay the provider the difference between the two rates for the number of days for which the provider was paid for the facility pursuant to this section. If the rate paid for a facility pursuant to this section is higher than the rate calculated for it for the current fiscal year, the provider shall refund to the department the difference between the two rates for the number of days for which the provider was paid for the facility pursuant to this section.

Sec. ~~5111.29~~ 5164.41. (A) The director of ~~job and family services~~ health care administration shall adopt rules under section ~~5111.02~~ 5163.15 of the Revised Code that establish a process under which a provider, or a group or association of providers, may seek reconsideration of rates established under sections ~~5111.20~~ 5164.01 to ~~5111.33~~ 5164.41 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~~ 5164.38 of the Revised Code.

(1) Except as provided in divisions (A)(2) to (4) of this section, the only issue that a provider, group, or association may raise in the rate reconsideration shall be whether the rate was calculated in accordance with sections ~~5111.20~~ 5164.01 to ~~5111.33~~ 5164.41 of the Revised Code and the rules adopted under section ~~5111.02~~ 5163.15 of the Revised Code. The rules shall permit a provider, group, or association to submit written arguments or other materials that support its position. The rules shall specify

time frames within which the 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 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 provider the difference between the amount the provider was paid for that period for the facility and the amount 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 the rate determined for an intermediate care facility for the mentally retarded as calculated under sections ~~5111.20~~ 5164.01 to ~~5111.33~~ 5164.41 of the Revised Code if the provider of the facility demonstrates that the facility's actual, allowable costs have increased because of extreme circumstances. A facility may qualify for a rate increase only if the facility's per diem, actual, allowable costs have increased to a level that exceeds its total rate. The rules shall specify the circumstances that would justify a rate increase under division (A)(2) of this section. The rules shall provide that the extreme circumstances include natural disasters, renovations approved under division (D) of section ~~5111.251~~ 5164.08 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 ~~5111.20~~ 5164.01 to ~~5111.33~~ 5164.41 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 an intermediate care facility for the mentally retarded's rate as calculated under sections ~~5111.20~~ 5164.01 to ~~5111.33~~ 5164.41 of the Revised Code if the department, in 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 medicaid program are added to an existing intermediate care facility for the mentally retarded or replaced at the same site, the department, through the rate reconsideration process, shall increase the intermediate care facility for the mentally retarded's rate for capital costs proportionately, as limited by any applicable limitation under section ~~5111.251~~ 5164.08 of the Revised Code, to account for the costs of the beds that are added or replaced. 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 ~~5111.251~~ 5164.08 of the Revised Code that includes costs incurred for a full calendar year for the bed addition or bed replacement. 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 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) 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~~ 5164.38 of the Revised Code;

(2) Any adverse finding that results from an exception review of resident assessment information conducted under section ~~5111.27~~ 5164.38 of the Revised Code after the effective date of the facility's rate that is based on the assessment information;

(3) Any medicaid payment deemed an overpayment under section ~~5111.683~~ 5164.853 of the Revised Code;

(4) Any penalty the department imposes under division (C) of section ~~5111.28~~ 5164.39 of the Revised Code or section ~~5111.683~~ 5164.853 of the Revised Code.

Sec. ~~5111.202~~ 5164.45. (A) As used in this section:

(1) "Dementia" includes Alzheimer's disease or a related disorder.

(2) "Serious mental illness" means "serious mental illness," as defined by the United States department of health and human

services in regulations adopted under ~~section 1919(e)(7)(G)(i) of the "Social Security Act," 49 Stat. 620 (1935),~~ 42 U.S.C.A~~. 301, as amended~~ 1396r(e)(7)(G)(i).

(3) "Mentally ill individual" means an individual who has a serious mental illness other than either of the following:

(a) A primary diagnosis of dementia;

(b) A primary diagnosis that is not a primary diagnosis of dementia and a primary diagnosis of something other than a serious mental illness.

(4) "Mentally retarded individual" means an individual who is mentally retarded or has a related condition, as described in ~~section 1905(d) of the "Social Security Act~~ 42 U.S.C. 1396d(d)."

(5) "Specialized services" means the services specified by the United States department of health and human services in regulations adopted under ~~section 1919(e)(7)(G)(iii) of the "Social Security Act~~ 42 U.S.C. 1396r(e)(7)(G)(iii)."

(B)(1) Except as provided in division (D) of this section, no nursing facility shall admit as a resident any mentally ill individual unless the facility has received evidence that the department of mental health has determined both of the following under section 5119.061 of the Revised Code:

(a) That the individual requires the level of services provided by a nursing facility because of the individual's physical and mental condition;

(b) Whether the individual requires specialized services for mental illness.

(2) Except as provided in division (D) of this section, no nursing facility shall admit as a resident any mentally retarded individual unless the facility has received evidence that the department of mental retardation and developmental disabilities

has determined both of the following under section 5123.021 of the Revised Code:

(a) That the individual requires the level of services provided by a nursing facility because of the individual's physical and mental condition;

(b) Whether the individual requires specialized services for mental retardation.

(C) The department of ~~job and family services~~ health care administration shall not make payments under the ~~medical assistance~~ medicaid program to a nursing facility on behalf of any individual who is admitted to the facility in violation of division (B) of this section for the period beginning on the date of admission and ending on the date the requirements of division (B) of this section are met.

(D) A determination under division (B) of this section is not required for any individual who is exempted from the requirement that a determination be made by division (B)(2) of section 5119.061 of the Revised Code or rules adopted by the department of mental health under division (E)(3) of that section, or by division (B)(2) of section 5123.021 of the Revised Code or rules adopted by the department of mental retardation and developmental disabilities under division (E)(3) of that section.

Sec. ~~5111.203~~ 5164.46. Regardless of whether or not an applicant for admission to a nursing facility or resident of a nursing facility is an applicant for or recipient of ~~medical assistance~~ medicaid, the department of ~~job and family services~~ health care administration shall provide notice and an opportunity for a hearing to any applicant for admission to a nursing facility or resident of a nursing facility who is adversely affected by a determination made by the department of mental health under section 5119.061 of the Revised Code or by the department of

mental retardation and developmental disabilities under section 5123.021 of the Revised Code. The hearing shall be conducted in the same manner as hearings conducted under section ~~5101.35~~ 5160.34 of the Revised Code. Any decision made by the department of ~~job and family services~~ health care administration on the basis of the hearing is binding on the department of mental health and the department of mental retardation and developmental disabilities.

Sec. ~~5111.204~~ 5164.47. (A) As used in this section, "representative" means a person acting on behalf of an applicant for or recipient of 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~~ health care administration may require each applicant for or recipient of 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. 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~~ health care administration under division ~~(E)~~(D) of section ~~5111.232~~ 5164.191 of the Revised Code. The assessment shall also be based on criteria and procedures established in rules adopted under division (F) of this section and information provided by the person being assessed or the person's representative.

The department of ~~job and family services~~ health care administration, or if the assessment is performed by an agency

under contract with the department pursuant to division (G) of this section, the agency, shall, not later than the time the level of care determination based on the assessment is required to be 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~~ health care administration or 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~~ health care administration or agency under contract with the department, whichever performs the assessment, shall 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 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.

(2) In the case of 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~~ medicaid 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) A person assessed under this section or the person's representative may request a state hearing to dispute the conclusions reached by the department of ~~job and family services~~ health care administration or agency under contract with the department on the basis of the assessment. The request for a state hearing shall be made in accordance with section ~~5101.35~~ 5160.34 of the Revised Code. The department of ~~job and family services~~ health care administration or agency 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 request a state hearing. The notice shall include an explanation of the procedure for 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~~ health care administration or the agency under contract with the department, whichever performed the assessment.

(E) A nursing facility that admits or retains a person

determined pursuant to an assessment required under this section not to need the level of care provided by the nursing facility shall not be reimbursed under the medicaid program for the person's care.

(F) The director of ~~job and family services~~ health care administration 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;

(2) Information the person being assessed or the person's representative must provide to the department or 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 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~~ 5161.05 of the Revised Code, the department of ~~job and family services~~ health care administration 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. ~~5111.35~~ 5164.50. As used in this section "a resident's rights" means the rights of a nursing facility resident under

sections 3721.10 to 3721.17 of the Revised Code and subsection (c) of section 1819 or 1919 of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended, and regulations issued under those subsections.

As used in sections ~~5111.35~~ 5164.50 to ~~5111.62~~ 5164.78 of the Revised Code:

(A) "Certification requirements" means the requirements for nursing facilities established under sections 1819 and 1919 of the "Social Security Act."

(B) "Compliance" means substantially meeting all applicable certification requirements.

(C) "Contracting agency" means a state agency that has entered into a contract with the department of ~~job and family services~~ health care administration under section ~~5111.38~~ 5164.53 of the Revised Code.

(D)(1) "Deficiency" means a finding cited by the department of health during a survey, on the basis of one or more actions, practices, situations, or incidents occurring at a nursing facility, that constitutes a severity level three finding, severity level four finding, scope level three finding, or scope level four finding. Whenever the finding is a repeat finding, "deficiency" also includes any finding that is a severity level two and scope level one finding, a severity level two and scope level two finding, or a severity level one and scope level two finding.

(2) "Cluster of deficiencies" means deficiencies that result from noncompliance with two or more certification requirements and are causing or resulting from the same action, practice, situation, or incident.

(E) "Emergency" means either of the following:

(1) A deficiency or cluster of deficiencies that creates a condition of immediate jeopardy;

(2) An unexpected situation or sudden occurrence of a serious or urgent nature that creates a substantial likelihood that one or more residents of a nursing facility may be seriously harmed if allowed to remain in the facility, including the following:

(a) A flood or other natural disaster, civil disaster, or similar event;

(b) A labor strike that suddenly causes the number of staff members in a nursing facility to be below that necessary for resident care.

(F) "Finding" means a finding of noncompliance with certification requirements determined by the department of health under section ~~5111.41~~ 5164.56 of the Revised Code.

(G) "Immediate jeopardy" means that one or more residents of a nursing facility are in imminent danger of serious physical or life-threatening harm.

(H) "Medicaid eligible resident" means a person who is a resident of a nursing facility, or is applying for admission to a nursing facility, and is eligible to receive financial assistance under the ~~medical assistance~~ medicaid program for the care the person receives in such a facility.

(I) "Noncompliance" means failure to substantially meet all applicable certification requirements.

(J) "Nursing facility" has the same meaning as in section ~~5111.20~~ 5164.01 of the Revised Code.

(K) "Provider" means a person, institution, or entity that furnishes nursing facility services under a ~~medical assistance program~~ medicaid provider agreement.

(L) "Repeat finding" or "repeat deficiency" means a finding

or deficiency cited pursuant to a survey, to which both of the following apply:

(1) The finding or deficiency involves noncompliance with the same certification requirement, and the same kind of actions, practices, situations, or incidents caused by or resulting from the noncompliance, as were cited in the immediately preceding standard survey or another survey conducted subsequent to the immediately preceding standard survey of the facility. For purposes of this division, actions, practices, situations, or incidents may be of the same kind even though they involve different residents, staff, or parts of the facility.

(2) The finding or deficiency is cited subsequent to a determination by the department of health that the finding or deficiency cited on the immediately preceding standard survey, or another survey conducted subsequent to the immediately preceding standard survey, had been corrected.

(M)(1) "Scope level one finding" means a finding of noncompliance by a nursing facility in which the actions, situations, practices, or incidents causing or resulting from the noncompliance affect one or a very limited number of facility residents and involve one or a very limited number of facility staff members.

(2) "Scope level two finding" means a finding of noncompliance by a nursing facility in which the actions, situations, practices, or incidents causing or resulting from the noncompliance affect more than a limited number of facility residents or involve more than a limited number of facility staff members, but the number or percentage of facility residents affected or staff members involved and the number or frequency of the actions, situations, practices, or incidents in short succession does not establish any reasonable degree of predictability of similar actions, situations, practices, or

incidents occurring in the future.

(3) "Scope level three finding" means a finding of noncompliance by a nursing facility in which the actions, situations, practices, or incidents causing or resulting from the noncompliance affect more than a limited number of facility residents or involve more than a limited number of facility staff members, and the number or percentage of facility residents affected or staff members involved or the number or frequency of the actions, situations, practices, or incidents in short succession establishes a reasonable degree of predictability of similar actions, situations, practices, or incidents occurring in the future.

(4) "Scope level four finding" means a finding of noncompliance by a nursing facility causing or resulting from actions, situations, practices, or incidents that involve a sufficient number or percentage of facility residents or staff members or occur with sufficient regularity over time that the noncompliance can be considered systemic or pervasive in the facility.

(N)(1) "Severity level one finding" means a finding of noncompliance by a nursing facility that has not caused and, if continued, is unlikely to cause physical harm to a facility resident, mental or emotional harm to a resident, or a violation of a resident's rights that results in physical, mental, or emotional harm to the resident.

(2) "Severity level two finding" means a finding of noncompliance by a nursing facility that, if continued over time, will cause, or is likely to cause, physical harm to a facility resident, mental or emotional harm to a resident, or a violation of a resident's rights that results in physical, mental, or emotional harm to the resident.

(3) "Severity level three finding" means a finding of noncompliance by a nursing facility that has caused physical harm to a facility resident, mental or emotional harm to a resident, or a violation of a resident's rights that results in physical, mental, or emotional harm to the resident.

(4) "Severity level four finding" means a finding of noncompliance by a nursing facility that has caused life-threatening harm to a facility resident or caused a resident's death.

(O) "State agency" has the same meaning as in section 1.60 of the Revised Code.

(P) "Substandard care" means care furnished in a facility in which the department of health has cited a deficiency or deficiencies that constitute one of the following:

(1) A severity level four finding, regardless of scope;

(2) A severity level three and scope level four finding, in the quality of care provided to residents;

(3) A severity level three and scope level three finding, in the quality of care provided to residents.

(Q)(1) "Survey" means a survey of a nursing facility conducted under section ~~5111.39~~ 5164.54 of the Revised Code.

(2) "Standard survey" means a survey conducted by the department of health under division (A) of section ~~5111.39~~ 5164.54 of the Revised Code and includes an extended survey.

(3) "Follow-up survey" means a survey conducted by the department of health to determine whether a nursing facility has substantially corrected deficiencies cited in a previous survey.

Sec. ~~5111.36~~ 5164.51. The director of ~~job and family services~~ health care administration may adopt rules under Chapter 119. of

the Revised Code that are consistent with regulations, guidelines, and procedures issued by the United States secretary of health and human services under ~~sections 1819 and 1919 of the "Social Security Act," 49 Stat. 620 (1935),~~ 42 U.S.C.~~A. 301, as amended,~~ 1395i-3 and 1396r and necessary for administration and enforcement of sections ~~5111.35~~ 5164.50 to ~~5111.62~~ 5164.78 of the Revised Code. If the secretary does not issue appropriate regulations for enforcement of ~~sections 1819 and 1919 of the "Social Security Act"~~ 42 U.S.C. 1395i-3 and 1396r on or before December 13, 1990, the director of ~~job and family services~~ health care administration may adopt, under Chapter 119. of the Revised Code, rules that are consistent with those sections and with sections ~~5111.35~~ 5164.50 to ~~5111.62~~ 5164.78 of the Revised Code.

Sec. ~~5111.37~~ 5164.52. The department of ~~job and family services~~ health care administration is hereby authorized to enforce sections ~~5111.35~~ 5164.50 to ~~5111.62~~ 5164.78 of the Revised Code. The department may enforce the sections directly or through contracting agencies. The department and agencies shall enforce the sections in accordance with the requirements of ~~sections 1819 and 1919 of the "Social Security Act," 49 Stat. 620 (1935),~~ 42 U.S.C.~~A. 301, as amended,~~ 1395i-3 and 1396r that apply to nursing facilities; with regulations, guidelines, and procedures adopted by the United States secretary of health and human services for the enforcement of ~~sections 1819 and 1919 of the "Social Security Act"~~ 42 U.S.C. 1395i-3 and 1396r; and with the rules adopted under section ~~5111.36~~ 5164.51 of the Revised Code. The department and agencies shall enforce sections ~~5111.35~~ 5164.50 to ~~5111.62~~ 5164.78 of the Revised Code for purposes of the medicare program~~, Title XVIII of the "Social Security Act,"~~ only to the extent prescribed by the regulations, guidelines, and procedures issued by the secretary under ~~section 1819 of that act~~ 42 U.S.C. 1395i-3.

Sec. ~~5111.38~~ 5164.53. The department of ~~job and family services~~ health care administration may enter into contracts with other state agencies that authorize the agencies to perform all or part of the duties assigned to the department of ~~job and family services~~ health care administration under sections ~~5111.35~~ 5164.50 to ~~5111.62~~ 5164.78 of the Revised Code. Each contract shall specify the duties the agency is authorized to perform and the sections of the Revised Code under which the agency is authorized to perform those duties.

Sec. ~~5111.39~~ 5164.54. (A) The department of health shall conduct a survey, titled a standard survey, of every nursing facility in this state on a statewide average of not more than once every twelve months. Each nursing facility shall undergo a standard survey at least once every fifteen months as a condition of meeting certification requirements. The department may extend a standard survey; such a survey is titled an extended survey.

(B) The department may conduct surveys in addition to standard surveys when it considers them necessary.

(C) The department shall conduct surveys in accordance with the regulations, guidelines, and procedures issued by the United States secretary of health and human services ~~under Titles XVIII and XIX of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended~~ for the medicare and medicaid programs, sections ~~5111.40~~ 5164.55 to ~~5111.42~~ 5164.58 of the Revised Code, and rules adopted under section 3721.022 of the Revised Code.

Sec. ~~5111.40~~ 5164.55. (A) At the conclusion of each survey, the department of health survey team shall conduct an exit interview with the administrator or other person in charge of the nursing facility and any other facility staff members designated by the administrator or person in charge of the facility. During

the exit interview, at the request of the administrator or other person in charge of the facility, the survey team shall provide one of the following, as selected by the survey team:

(1) Copies of all survey notes and any other written materials created during the survey;

(2) A written summary of the survey team's recommendations regarding findings of noncompliance with certification requirements;

(3) An audio or audiovisual recording of the interview. If the survey team selects this option, at least two copies of the recording shall be made and the survey team shall select one copy to be kept by the survey team for use by the department of health.

(B) All expenses of copying under division (A)(1) of this section or recording under division (A)(3) of this section, including the cost of the copy of the recording kept by the survey team, shall be paid by the facility.

Sec. ~~5111.41~~ 5164.56. (A) Except as provided in section 3721.17 of the Revised Code, a finding shall be cited only on the basis of a survey and a determination that one or more actions, practices, situations, or incidents at a nursing facility caused or resulted from the facility's failure to comply with one or more certification requirements. The department of health shall determine whether the actions, practices, situations, or incidents can be justified by either of the following:

(1) The actions, practices, situations, or incidents resulted from a resident exercising the resident's rights guaranteed under the laws of the United States or of this state;

(2) The actions, practices, situations, or incidents resulted from a facility following the orders of a person licensed under Chapter 4731. of the Revised Code to practice medicine or surgery

or osteopathic medicine and surgery.

(B) If the department of health determines both that the actions, practices, situations, or incidents cannot be justified by the factors identified in division (A) of this section and that one or more of the following are applicable, the department shall declare that the actions, practices, situations, or incidents constitute a finding:

(1) The actions, practices, situations, or incidents could have been prevented by one or more persons involved in the facility's operation;

(2) No person involved in the facility's operation identified the actions, practices, situations, or incidents prior to the survey;

(3) Prior to the survey, no person involved in the facility's operation initiated action to correct the noncompliance caused by or resulting in the actions, practices, situations, or incidents;

(4) The facility does not have in effect, if needed, a contingency plan that is reasonably calculated to prevent physical, mental, or emotional harm to residents while permanent corrective action is being taken.

(C) The department of health shall determine the severity level and scope level of each finding.

(D) A deficiency that is substantially corrected within the time limits specified in sections ~~5111.52~~ 5164.68 to ~~5111.56~~ 5164.72 of the Revised Code and for which no remedy is imposed, shall be counted as a deficiency for the purpose of determining whether a deficiency is a repeat deficiency.

(E) Whenever the department of health determines that during the period between two surveys a finding existed at the facility, but the facility substantially corrected it prior to the second

survey, the department shall cite it. However, the department of ~~job and family services~~ health care administration or a contracting agency shall impose a remedy only as provided in division (C) of section ~~5111.46~~ 5164.62 of the Revised Code.

(F) Immediately upon determining the severity and scope of a finding at a nursing facility, the department of health shall notify the department of ~~job and family services~~ health care administration and any contracting agency of the finding, the severity and scope of the finding, and whether the finding creates immediate jeopardy. Immediately upon determining that an emergency exists at a facility that does not result from a deficiency that creates immediate jeopardy, the department of health shall notify the department of ~~job and family services~~ health care administration and any contracting agency.

Sec. ~~5111.411~~ 5164.57. The results of a survey of a nursing facility that is conducted under section ~~5111.39~~ 5164.54 of the Revised Code, including any statement of deficiencies and all findings and deficiencies cited in the statement on the basis of the survey, shall be used solely to determine the nursing facility's compliance with certification requirements or with this chapter or another chapter of the Revised Code. Those results of a survey, that statement of deficiencies, and the findings and deficiencies cited in that statement shall not be used in any court or in any action or proceeding that is pending in any court and are not admissible in evidence in any action or proceeding unless that action or proceeding is an appeal of an administrative action by the department of ~~job and family services~~ health care administration or contracting agency under this chapter or is an action by any department or agency of the state to enforce this chapter or another chapter of the Revised Code.

Nothing in this section prohibits the results of a survey, a

statement of deficiencies, or the findings and deficiencies cited in that statement on the basis of the survey under this section from being used in a criminal investigation or prosecution.

Sec. ~~5111.42~~ 5164.58. (A) Not later than ten days after an exit interview, the department of health shall deliver to the nursing facility a detailed statement, titled a statement of deficiencies, setting forth all findings and deficiencies cited on the basis of the survey, including any finding cited pursuant to division (E) of section ~~5111.41~~ 5164.56 of the Revised Code. The statement shall indicate the severity and scope level of each finding and fully describe the incidents or other facts that form the basis of the department's determination of the existence of each finding and deficiency. A failure by the survey team to completely disclose in the exit interview every finding that may result from the survey does not affect the validity of any finding or deficiency cited in the statement of deficiencies. On request of the facility, the department shall provide a copy of any written worksheet or other document produced by the survey team in making recommendations regarding scope and severity levels of findings and deficiencies.

(B) At the same time the department of health delivers a statement of deficiencies, it also shall deliver to the facility a separate written notice that states all of the following:

(1) That the department of ~~job and family services~~ health care administration or a contracting agency will issue an order under section ~~5111.57~~ 5164.73 of the Revised Code denying payment for any medicaid eligible residents admitted on and after the effective date of the order if the facility does not substantially correct, within ninety days after the exit interview, the deficiency or deficiencies cited in the statement of deficiencies in accordance with the plan of correction it submitted under

section ~~5111.43~~ 5164.59 of the Revised Code;

(2) If a condition of substandard care has been cited on the basis of a standard survey and a condition of substandard care was also cited on the immediately preceding standard survey, that the department of ~~job and family services~~ health care administration or a contracting agency will issue an order under section ~~5111.57~~ 5164.73 of the Revised Code denying payment for any medicaid eligible residents admitted on and after the effective date of the order if a condition of substandard care is cited on the basis of the next standard survey;

(3) That the department of ~~job and family services~~ health care administration or a contracting agency will issue an order under section ~~5111.58~~ 5164.74 of the Revised Code terminating the facility's participation in the ~~medical assistance~~ medicaid program if either of the following applies:

(a) The facility does not substantially correct the deficiency or deficiencies in accordance with the plan of correction it submitted under section ~~5111.43~~ 5164.59 of the Revised Code within six months after the exit interview.

(b) The facility substantially corrects the deficiency or deficiencies within the six-month period, but after correcting it, the department of health, based on a follow-up survey conducted during the remainder of the six-month period, determines that the facility has failed to maintain compliance with certification requirements.

Sec. ~~5111.43~~ 5164.59. Whenever a nursing facility receives a statement of deficiencies under section ~~5111.42~~ 5164.58 of the Revised Code, the facility shall submit to the department of health for its approval a plan of correction for each finding cited in the statement. The plan shall describe the actions the facility will take to correct each finding and specify the date by

which each finding will be corrected. In the case of a finding cited pursuant to division (E) of section ~~5111.41~~ 5164.56 of the Revised Code, the plan shall describe the actions the facility took to correct the finding and the date on which it was corrected.

The department shall approve any plan that conforms to the requirements for approval of plans of corrections established in the regulations, guidelines, and procedures issued by the United States secretary of health and human services ~~under Titles XVIII and XIX of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended~~ for the medicare and medicaid programs. The department also shall approve any modification of an existing plan submitted by a facility, if the plan as modified conforms to those regulations, guidelines, and procedures. The department shall not reject a facility's plan of correction or modification on the ground that the facility disputes the finding, if the plan is reasonably calculated to correct the finding.

A facility that complies with this section shall not be considered to have admitted the existence of a finding cited by the department.

Sec. ~~5111.44~~ 5164.60. The department of health may appoint employees of the department to conduct on-site monitoring of a nursing facility whenever a finding is cited, including any finding cited pursuant to division (E) of section ~~5111.41~~ 5164.56 of the Revised Code, or an emergency is found to exist. Appointment of monitors under this section is not subject to appeal under section ~~5111.60~~ 5164.76 or any other section of the Revised Code. No employee of a facility for which monitors are appointed, no person employed by the facility within the previous two years, and no person who currently has a consulting or other contract with the department or the facility, shall be appointed

as a monitor under this section. Every monitor appointed under this section shall have the professional qualifications necessary to monitor correction of the finding or elimination of the emergency.

Sec. ~~5111.45~~ 5164.61. (A) If the department of health cites a deficiency or deficiencies that was not substantially corrected before a survey and that does not constitute a severity level four finding or create immediate jeopardy, the department of ~~job and family services~~ health care administration or a contracting agency shall permit the nursing facility to continue participating in the ~~medical assistance~~ medicaid program for up to six months after the exit interview, if all of the following apply:

(1) The facility meets the requirements, established in regulations issued by the United States secretary of health and human services under ~~Title XIX of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended,~~ the medicaid program for certification of nursing facilities that have a deficiency.

(2) The department of health has approved a plan of correction submitted by the facility under section ~~5111.43~~ 5164.59 of the Revised Code for each deficiency.

(3) The provider agrees to repay the department of ~~job and family services~~ health care administration, in accordance with section ~~5111.58~~ 5164.74 of the Revised Code, the federal share of all payments made by the department to the facility during the six-month period following the exit interview if the facility does not within the six-month period substantially correct the deficiency or deficiencies in accordance with the plan of correction submitted under section ~~5111.43~~ 5164.59 of the Revised Code.

(B) If any of the conditions in divisions (A)(1) to (3) of

this section do not apply, the department of ~~job and family services~~ health care administration or contracting agency shall issue an order terminating the facility's participation in the ~~medical assistance~~ medicaid program. An order issued under this division is subject to appeal under Chapter 119. of the Revised Code. The order shall not take effect prior to the later of the thirtieth day after it is delivered to the facility or, if the order is appealed, the date on which a final adjudication order upholding the termination becomes effective pursuant to Chapter 119. of the Revised Code.

(C) At the time the department of ~~job and family services~~ health care administration or contracting agency issues an order under division (B) of this section terminating a nursing facility's participation in the ~~medical assistance~~ medicaid program, it may also impose, subject to section ~~5111.50~~ 5164.66 of the Revised Code, other remedies under sections ~~5111.46~~ 5164.62 to ~~5111.48~~ 5164.64 of the Revised Code.

Sec. ~~5111.46~~ 5164.62. (A) If the department of health cites a deficiency, or cluster of deficiencies, that was not substantially corrected before a survey and constitutes a severity level four finding, the department of ~~job and family services~~ health care administration or contracting agency shall, subject to sections ~~5111.52~~ 5164.68 to ~~5111.56~~ 5164.72 of the Revised Code, impose a remedy for the deficiency or cluster of deficiencies. The department or agency may act under either division (A)(1) or (2) of this section:

(1) The department or agency may impose one or more of the following remedies:

(a) Issue an order terminating the nursing facility's participation in the ~~medical assistance~~ medicaid program.

(b) Do either of the following:

(i) Regardless of whether the provider consents, appoint a temporary manager of the facility.

(ii) Apply to the common pleas court of the county in which the facility is located for such injunctive or other equitable relief as is necessary for the appointment of a special master with such powers and authority over the facility and length of appointment as the court considers necessary.

(c) Do either of the following:

(i) Issue an order denying payment to the facility under the ~~medical assistance~~ medicaid program for all medicaid eligible residents admitted after the effective date of the order;

(ii) Impose a fine.

(d) Issue an order denying payment to the facility under the ~~medical assistance~~ medicaid program for medicaid eligible residents admitted after the effective date of the order who have certain diagnoses or special care needs specified by the department or agency.

(2) The department or agency may impose one or more of the following remedies:

(a) Appoint, subject to the continuing consent of the provider, a temporary manager of the facility;

(b) Do either of the following:

(i) Regardless of whether the provider consents, appoint a temporary manager of the facility;

(ii) Apply to the common pleas court of the county in which the facility is located for such injunctive or other equitable relief as is necessary for the appointment of a special master with such powers and authority over the facility and length of appointment as the court considers necessary.

(c) Do either of the following:

(i) Issue an order denying payment to the facility under the ~~medical assistance~~ medicaid program for all medicaid eligible residents admitted after the effective date of the order;

(ii) Impose a fine.

(d) Issue an order denying payment to the facility under the ~~medical assistance~~ medicaid program for medicaid eligible residents admitted after the effective date of the order who have certain diagnoses or special care needs specified by the department or agency;

(e) Issue an order requiring the facility to correct the deficiency or cluster of deficiencies under the plan of correction submitted by the facility and approved by the department of health under section ~~5111.43~~ 5164.59 of the Revised Code.

(B) The department of ~~job and family services~~ health care administration or contracting agency shall deliver a written order issued under division (A)(1) of this section terminating a nursing facility's participation in the ~~medical assistance~~ medicaid program to the facility within five days after the exit interview. If the facility alleges, at any time prior to the later of the twentieth day after the exit interview or the fifteenth day after it receives the order, that the deficiency or cluster of deficiencies for which the order was issued has been substantially corrected, the department of health shall conduct a follow-up survey to determine whether the deficiency or cluster of deficiencies has been substantially corrected. The order shall take effect and the facility's participation shall terminate on the twentieth day after the exit interview, unless the facility has substantially corrected the deficiency or cluster of deficiencies that constituted a severity level four finding or did not receive notice from the department of ~~job and family services~~ health care administration or contracting agency within five days after the exit interview. In the latter case, the order shall take

effect and the facility's participation shall terminate on the fifteenth day after the facility received the order.

(C) If the department of health cites a deficiency or cluster of deficiencies pursuant to division (E) of section ~~5111.41~~ 5164.56 of the Revised Code that constituted a severity level four finding, the department of ~~job and family services~~ health care administration or a contracting agency shall, subject to section ~~5111.56~~ 5164.72 of the Revised Code, impose a fine. The fine shall be in effect for a period equal to the number of days the deficiency or cluster of deficiencies existed at the facility.

Sec. ~~5111.47~~ 5164.63. If the department of health cites a deficiency, or cluster of deficiencies, that was not substantially corrected before a survey and constitutes a severity level three and scope level three or four finding, the department of ~~job and family services~~ health care administration or a contracting agency may, subject to sections ~~5111.55~~ 5164.71 and ~~5111.56~~ 5164.72 of the Revised Code, impose one or more of the following remedies:

(A) Do either of the following:

(1) Issue an order denying payment to the facility under the ~~medical assistance~~ medicaid program for all medicaid eligible residents admitted after the effective date of the order;

(2) Impose a fine.

(B) Issue an order denying payment to the facility under the ~~medical assistance~~ medicaid program for medicaid eligible residents admitted after the effective date of the order who have certain diagnoses or special care needs specified by the department or agency;

(C) Issue an order requiring the facility to correct the deficiency or cluster of deficiencies under the plan of correction submitted by the facility and approved by the department of health

under section ~~5111.43~~ 5164.59 of the Revised Code.

Sec. ~~5111.48~~ 5164.64. (A) If the department of health cites a deficiency, or cluster of deficiencies, that was not substantially corrected before a survey and constitutes a severity level three and scope level two finding, the department of ~~job and family services~~ health care administration or a contracting agency may, subject to sections ~~5111.55~~ 5164.71 and ~~5111.56~~ 5164.72 of the Revised Code, impose one or more of the following remedies:

(1) Do either of the following:

(a) Issue an order denying payment to the facility under the ~~medical assistance~~ medicaid program for all medicaid eligible residents admitted after the effective date of the order;

(b) Impose a fine.

(2) Issue an order denying payment to the facility under the ~~medical assistance~~ medicaid program for medicaid eligible residents admitted after the effective date of the order who have certain diagnoses or special care needs specified by the department or agency;

(3) Issue an order requiring the facility to correct the deficiency or cluster of deficiencies under the plan of correction proposed by the facility and approved by the department of health under section ~~5111.43~~ 5164.59 of the Revised Code.

(B) If the department of health cites a deficiency, or cluster of deficiencies, that was not substantially corrected before a survey and constitutes a severity level three and scope level one finding, the department of ~~job and family services~~ health care administration or a contracting agency may, subject to sections ~~5111.55~~ 5164.71 and ~~5111.56~~ 5164.72 of the Revised Code, impose one or more of the following remedies:

(1) Impose a fine;

(2) Issue an order denying payment to the facility under the ~~medical assistance~~ medicaid program for medicaid eligible residents admitted after the effective date of the order who have certain diagnoses or special care needs specified by the department or agency;

(3) Issue an order requiring the facility to correct the deficiency or cluster of deficiencies under the plan of correction proposed by the facility and approved by the department of health under section ~~5111.43~~ 5164.59 of the Revised Code.

(C) If the department of health cites a deficiency, or cluster of deficiencies, that was not substantially corrected before a survey and constitutes a severity level two and a scope level three or four finding, the department of ~~job and family services~~ health care administration or a contracting agency may, subject to sections ~~5111.55~~ 5164.71 and ~~5111.56~~ 5164.72 of the Revised Code, impose one or more of the following remedies:

(1) Impose a fine;

(2) Issue an order denying payment to the facility under the ~~medical assistance~~ medicaid program for medicaid eligible residents admitted after the effective date of the order who have certain diagnoses or special care needs specified by the department or agency;

(3) Issue an order requiring the facility to correct the deficiency or cluster of deficiencies under the plan of correction submitted by the facility and approved by the department of health under section ~~5111.43~~ 5164.59 of the Revised Code.

(D) If the department of health cites a deficiency, or cluster of deficiencies, that was not substantially corrected before a survey, constitutes a severity level two and scope level one or two finding, and is a repeat finding, the department of ~~job and family services~~ health care administration or a contracting

agency may issue an order requiring the facility to correct the deficiency or cluster of deficiencies under the plan of correction submitted by the facility and approved by the department of health under section ~~5111.43~~ 5164.59 of the Revised Code.

(E) If the department of health cites a deficiency, or cluster of deficiencies, that was not substantially corrected before a survey and constitutes a severity level one and scope level three or four finding, the department of ~~job and family services~~ health care administration or a contracting agency may issue an order requiring the facility to correct the deficiency or cluster of deficiencies under the plan of correction submitted by the facility and approved by the department of health under section ~~5111.43~~ 5164.59 of the Revised Code.

(F) If the department of health cites a deficiency, or cluster of deficiencies, that was not substantially corrected before a survey, constitutes a severity level one and scope level two finding, and is a repeat finding, the department of ~~job and family services~~ health care administration or a contracting agency may issue an order requiring the facility to correct the deficiency or cluster of deficiencies under the plan of correction submitted by the facility and approved by the department of health under section ~~5111.43~~ 5164.59 of the Revised Code.

Sec. ~~5111.49~~ 5164.65. (A) In determining which remedies to impose under section ~~5111.46~~ 5164.62, ~~5111.47~~ 5164.63, or ~~5111.48~~ 5164.64 of the Revised Code, including whether a fine should be imposed, the department of ~~job and family services~~ health care administration or a contracting agency shall do both of the following:

(1) Impose the remedies that are most likely to achieve correction of deficiencies, encourage sustained compliance with certification requirements, and protect the health, safety, and

rights of facility residents, but that are not directed at punishment of the facility;

(2) Consider all of the following:

(a) The presence or absence of immediate jeopardy;

(b) The relationships of groups of deficiencies to each other;

(c) The facility's history of compliance with certification requirements generally and in the specific area of the deficiency or deficiencies;

(d) Whether the deficiency or deficiencies are directly related to resident care;

(e) The corrective, long-term compliance, resident protective, and nonpunitive outcomes sought by the department or agency;

(f) The nature, scope, and duration of the noncompliance with certification requirements;

(g) The existence of repeat deficiencies;

(h) The category of certification requirements with which the facility is out of compliance;

(i) Any period of noncompliance with certification requirements that occurred between two certifications by the department of health that the facility was in compliance with certification requirements;

(j) The facility's degree of culpability;

(k) The accuracy, extent, and availability of facility records;

(l) The facility's financial condition, exclusive of any moneys donated to a facility that is an organization described in subsection 501(c)(3) and is tax exempt under subsection 501(a) of

the "Internal Revenue Code of 1986," 100 Stat. 2085, 26 U.S.C.A. 1;

(m) Any adverse effect that the action or fine would have on the health and safety of facility residents;

(n) If the noncompliance that resulted in the citation of a deficiency or cluster of deficiencies existed before a change in ownership of the facility, whether the new owner or owners have had sufficient time to correct the noncompliance.

(B) Whenever the department or agency imposes remedies under section ~~5111.46~~ 5164.62, ~~5111.47~~ 5164.63, or ~~5111.48~~ 5164.64 of the Revised Code, it shall provide a written statement to the nursing facility that specifies all of the following:

(1) The effective date of each remedy;

(2) The deficiency or cluster of deficiencies for which each remedy is imposed;

(3) The severity and scope of the deficiency or cluster of deficiencies;

(4) The rationale, including all applicable factors specified in division (A) of this section, for imposing the remedies.

Sec. ~~5111.50~~ 5164.66. At the time the department of ~~job and family services~~ health care administration or a contracting agency, under section ~~5111.45~~ 5164.61, ~~5111.46~~ 5164.62, or ~~5111.51~~ 5164.67 of the Revised Code, issues an order terminating a nursing facility's participation in the ~~medical assistance~~ medicaid program, the department or agency may also impose a fine, in accordance with sections ~~5111.46~~ 5164.62 to ~~5111.48~~ 5164.64 and ~~5111.56~~ 5164.72 of the Revised Code, to be collected in the event the termination order does not take effect. The department or agency shall not collect this fine if the termination order takes effect.

Sec. ~~5111.51~~ 5164.67. (A) If the department of health finds during a survey that an emergency exists at a nursing facility, as the result of a deficiency or cluster of deficiencies that creates immediate jeopardy, the department of ~~job and family services~~ health care administration or a contracting agency shall impose one or more of the remedies described in division (A)(1) of this section and, in addition, may take one or both of the actions described in division (A)(2) of this section.

(1) The department or agency shall impose one or more of the following remedies:

(a) Appoint, subject to the continuing consent of the provider, a temporary manager of the facility;

(b) Apply to the common pleas court of the county in which the facility is located for a temporary restraining order, preliminary injunction, or such other injunctive or equitable relief as is necessary to close the facility, transfer one or more residents to other nursing facilities or other appropriate care settings, or otherwise eliminate the condition of immediate jeopardy. If the court grants such an order, injunction, or relief, it may appoint a special master empowered to implement the court's judgment under the court's direct supervision.

(c) Issue an order terminating the facility's participation in the medical assistance program;

(d) Regardless of whether the provider consents, appoint a temporary manager of the facility.

(2) The department or agency may do one or both of the following:

(a) Issue an order denying payment to the facility for all medicaid eligible residents admitted after the effective date of the order;

(b) Impose remedies under sections ~~5111.46~~ 5164.62 to ~~5111.48~~ 5164.64 of the Revised Code appropriate to the severity and scope of the deficiency or cluster of deficiencies, except that the department or agency shall not impose a fine for the same deficiency for which the department or agency has issued an order under division (A)(2)(a) of this section.

(B) If the department of health, department of ~~job and family services~~ health care administration, or a contracting agency finds on the basis of a survey or other visit to the facility by representatives of that department or agency that an emergency exists at a facility that is not the result of a deficiency or cluster of deficiencies that constitutes immediate jeopardy, the department of ~~job and family services~~ health care administration or contracting agency may do either of the following:

(1) Appoint, subject to the continuing consent of the provider, a temporary manager of the facility;

(2) Apply to the common pleas court of the county in which the facility is located for a temporary restraining order, preliminary injunction, or such other injunctive or equitable relief as is necessary to close the facility, transfer one or more residents to other nursing facilities or other appropriate care settings, or otherwise eliminate the emergency. If the court grants such an order, injunction, or relief, it may appoint a special master empowered to implement the court's judgment under the court's direct supervision.

(C)(1) Prior to acting under division (A)(1)(b), (c), (d), or (2), or (B)(2) of this section, the department of ~~job and family services~~ health care administration or contracting agency shall give written notice to the facility specifying all of the following:

(a) The nature of the emergency, including the nature of any

deficiency or deficiencies that caused the emergency;

(b) The nature of the action the department or agency intends to take unless the department of health determines that the facility, in the absence of state intervention, possesses the capacity to eliminate the emergency;

(c) The rationale for taking the action.

(2) If the department of health determines that the facility does not possess the capacity to eliminate the emergency in the absence of state intervention, the department of ~~job and family services~~ health care administration or contracting agency may immediately take action under division (A) or (B) of this section. If the department of health determines that the facility possesses the capacity to eliminate the emergency, the department of ~~job and family services~~ health care administration or contracting agency shall direct the facility to eliminate the emergency within five days after the facility's receipt of the notice. At the end of the five-day period, the department of health shall conduct a follow-up survey that focuses on the emergency. If the department of health determines that the facility has eliminated the emergency within the time period, the department of ~~job and family services~~ health care administration or contracting agency shall not act under division (A)(1)(b), (c), (d), or (2)(a), or (B)(2) of this section. If the department of health determines that the facility has failed to eliminate the emergency within the five-day period, the department of job and family services or contracting agency shall take appropriate action under division (A)(1)(b), (c), (d), or (2), or (B)(2) of this section.

(3) Until the written notice required by division (C)(1) of this section is actually delivered, no action taken by the department of ~~job and family services~~ health care administration or contracting agency under division (A)(1)(b), (c), (d), or (2), or (B)(2) of this section shall have any legal effect. In addition

to the written notice, the department of health survey team shall give oral notice to the facility, at the time of the survey, concerning any recommendations the survey team intends to make that could form the basis of a determination that an emergency exists.

(D) The department of ~~job and family services~~ health care administration or contracting agency shall deliver a written order issued under division (A)(1) of this section terminating a nursing facility's participation in the ~~medical assistance~~ medicaid program to the facility within five days after the exit interview. If the facility alleges, at any time prior to the later of the twentieth day after the exit interview or the fifteenth day after it receives the order, that the condition of immediate jeopardy for which the order was issued has been eliminated, the department of health shall conduct a follow-up survey to determine whether the immediate jeopardy has been eliminated. The order shall take effect and the facility's participation shall terminate on the twentieth day after the exit interview, unless the facility has eliminated the immediate jeopardy or did not receive notice from the department of ~~job and family services~~ health care administration or contracting agency within five days after the exit interview. In the latter case, the order shall take effect and the facility's participation shall terminate on the fifteenth day after the facility received the order.

(E) Any action taken by the department of ~~job and family services~~ health care administration or a contracting agency under division (A)(1)(c), (d), or (2)(a) of this section is subject to appeal under Chapter 119. of the Revised Code, except that the department or agency may take such action prior to and during the pendency of any proceeding under that chapter. No action taken by a facility under division (C) of this section to eliminate an emergency cited by the department of health shall be considered an

admission by the facility of the existence of an emergency.

Sec. ~~5111.52~~ 5164.68. (A) As used in this section:

(1) "Provider agreement" means a contract between the department of ~~job and family services~~ health care administration and a nursing facility for the provision of nursing facility services under the ~~medical assistance~~ medicaid program.

(2) "Terminating" includes not renewing.

(B) A nursing facility's participation in the ~~medical assistance~~ medicaid program shall be terminated under sections ~~5111.35~~ 5164.50 to ~~5111.62~~ 5164.78 of the Revised Code as follows:

(1) If the department of ~~job and family services~~ health care administration is terminating the facility's participation, it shall issue an order terminating the facility's provider agreement.

(2) If the department of health, acting as a contracting agency, is terminating the facility's participation, it shall issue an order terminating certification of the facility's compliance with certification requirements. When the department of health terminates certification, the department of ~~job and family services~~ health care administration shall terminate the facility's provider agreement. The department of ~~job and family services~~ health care administration is not required to provide an adjudication hearing when it terminates a provider agreement following termination of certification by the department of health.

(3) If a state agency other than the department of health, acting as a contracting agency, is terminating the facility's participation, it shall notify the department of ~~job and family services~~ health care administration, and the department of ~~job and family services~~ health care administration shall issue an order

terminating the facility's provider agreement. The contracting agency shall conduct any administrative proceedings concerning the order.

(C) If the following conditions are met, the department of ~~job and family services~~ health care administration may make ~~medical assistance~~ medicaid payments to a nursing facility for a period not exceeding thirty days after the effective date of termination under sections ~~5111.35~~ 5164.50 to ~~5111.62~~ 5164.78 of the Revised Code of the facility's participation in the ~~medical assistance~~ medicaid program:

(1) The payments are for medicaid eligible residents admitted to the facility prior to the effective date of the termination;

(2) The provider is making reasonable efforts to transfer medicaid eligible residents to other care settings.

The period during which payments may be made under this division begins on the later of the effective date of the termination or, if the facility has appealed a termination order, the date of issuance of the adjudication order upholding termination.

Sec. ~~5111.53~~ 5164.69. (A) Whenever a nursing facility is closed under sections ~~5111.35~~ 5164.50 to ~~5111.62~~ 5164.78 of the Revised Code, the department of ~~job and family services~~ health care administration or contracting agency shall arrange for the safe and orderly transfer of all residents, including residents who are not medicaid eligible residents, to other appropriate care settings. Whenever a facility's participation in the ~~medical assistance~~ medicaid program is terminated under sections ~~5111.35~~ 5164.50 to ~~5111.62~~ 5164.78 of the Revised Code, the department or agency shall arrange for the safe and orderly transfer of all medicaid eligible residents or, if the termination results in the closure of the facility, of all residents. The provider and all

persons involved in the facility's operation shall cooperate with and assist in the transfer of residents.

(B) After a nursing facility's participation in the ~~medical assistance~~ medicaid program is terminated under section ~~5111.45~~ 5164.61, ~~5111.46~~ 5164.62, ~~5111.51~~ 5164.67, or ~~5111.58~~ 5164.74 of the Revised Code, the department of ~~job and family services~~ health care administration or contracting agency may appoint a temporary manager subject to the continuing consent of the provider, or may apply to the common pleas court of the county in which the facility is located for such injunctive relief as is necessary for the appointment of a special master, to ensure the transfer of medicaid eligible residents to other appropriate care settings and, if applicable, the orderly closure of the facility.

Sec. ~~5111.54~~ 5164.70. (A) A temporary manager of a nursing facility appointed by the department of ~~job and family services~~ health care administration or a contracting agency under sections ~~5111.35~~ 5164.50 to ~~5111.62~~ 5164.78 of the Revised Code shall meet all of the following qualifications:

(1) Be licensed as a nursing home administrator under Chapter 4751. of the Revised Code;

(2) Have demonstrated competence as a nursing home administrator;

(3) Have had no disciplinary action taken against the temporary manager by any licensing board or professional society in this state.

(B) The salary of a temporary manager or special master appointed under sections ~~5111.35~~ 5164.50 to ~~5111.62~~ 5164.78 of the Revised Code shall be paid by the facility and set by the department of ~~job and family services~~ health care administration or contracting agency, in the case of a temporary manager, or by

the court, in the case of a special master, at a rate not to exceed the maximum allowable compensation for an administrator under the ~~medical assistance~~ medicaid program. The extent to which this compensation is allowable under the ~~medical assistance~~ medicaid program is subject to and limited by this chapter and rules of the department.

Subject to division (C) of this section, any costs incurred on behalf of a nursing facility by a temporary manager or special master appointed under sections ~~5111.35~~ 5164.50 to ~~5111.62~~ 5164.78 of the Revised Code shall be paid by the facility. The allowability of these costs under the ~~medical assistance~~ medicaid program shall be subject to and governed by this chapter and the rules of the department. This division does not prohibit a facility from applying for or receiving any waiver of cost ceilings available under rules of the department.

(C) No temporary manager or special master appointed under sections ~~5111.35~~ 5164.50 to ~~5111.62~~ 5164.78 of the Revised Code shall enter into any employment contract on behalf of a facility, or purchase any capital goods using facility funds totaling more than ten thousand dollars, unless the temporary manager or special master has obtained prior approval for the contract or purchase from either the provider or the court.

(D)(1) A temporary manager appointed for a nursing facility under section ~~5111.46~~ 5164.62 of the Revised Code is hereby vested, subject to division (C) of this section, with the legal authority necessary to correct any deficiency or cluster of deficiencies at a facility, bring the facility into compliance with certification requirements, and otherwise ensure the health and safety of the residents.

(2) A temporary manager appointed under section ~~5111.51~~ 5164.67 of the Revised Code is hereby vested, subject to division (C) of this section, with the authority necessary to eliminate the

emergency, bring the facility into compliance with certification requirements, and otherwise ensure the health and safety of the residents.

(3) A temporary manager appointed under section ~~5111.53~~ 5164.69 of the Revised Code is hereby vested, subject to division (C) of this section, with the authority necessary to ensure the transfer of medicaid eligible residents to other appropriate care settings and, if applicable, the orderly closure of the facility, and to otherwise ensure the health and safety of the residents.

(E) Prior to acting under division (A)(1)(b) or (2)(b) of section ~~5111.46~~ 5164.62 of the Revised Code to appoint a temporary manager or apply for a special master, the department of ~~job and family services~~ health care administration or contracting agency shall order the facility to substantially correct the deficiency or deficiencies within five days after receiving the statement and inform the facility, in the statement it provides pursuant to division (B) of section ~~5111.49~~ 5164.65 of the Revised Code, of the order and that it will not take that action unless the facility fails to substantially correct the deficiency or deficiencies within that five-day period. At the end of the five-day period, the department of health shall conduct a follow-up survey that focuses on the deficiency or deficiencies. If the department of health determines that the facility has substantially corrected the deficiency or deficiencies within that time, the department of ~~job and family services~~ health care administration or contracting agency shall not appoint a temporary manager or apply for a special master. If the department of health determines that the facility has failed to substantially correct the deficiency or deficiencies within that time, the department of ~~job and family services~~ health care administration or contracting agency may proceed with appointment of the temporary manager or application for a special master. Until the statement required

under division (B) of section ~~5111.49~~ 5164.65 of the Revised Code is actually delivered, no action taken by the department or agency to appoint a temporary manager or apply for a temporary manager under division (A)(1)(b) or (2)(b) of section ~~5111.46~~ 5164.62 of the Revised Code shall have any legal effect. No action taken by a facility under this division to substantially correct a deficiency or deficiencies shall be considered an admission by the facility of the existence of a deficiency or deficiencies.

(F) Appointment of a temporary manager under division (A)(1)(b) or (2)(b) of section ~~5111.46~~ 5164.62 or division (A)(1)(d) of section ~~5111.51~~ 5164.67 of the Revised Code shall expire at the end of the seventh day following the appointment. If the department of ~~job and family services~~ health care administration or contracting agency finds that the deficiency or deficiencies that prompted the appointment under division (A)(1)(b) or (2)(b) of section ~~5111.46~~ 5164.62 of the Revised Code cannot be substantially corrected, or the condition of immediate jeopardy that prompted the appointment under division (A)(1)(d) of section ~~5111.51~~ 5164.67 of the Revised Code cannot be eliminated, prior to the expiration of the appointment, it may take one of the following actions:

(1) Appoint, subject to the continuing consent of the provider, a temporary manager for the facility;

(2) Apply to the common pleas court of the county in which the facility is located for an order appointing a special master who, under the authority and direct supervision of the court and subject to divisions (B) and (C) of this section, may take such additional actions as are necessary to correct the deficiency or deficiencies or eliminate the condition of immediate jeopardy and bring the facility into compliance with certification requirements.

(G) The court, on finding that the deficiency or deficiencies

for which a special master was appointed under division (F)(2) of this section or division (A)(1)(b) or (2)(b) of section ~~5111.46~~ 5164.62 of the Revised Code has been substantially corrected, or the emergency for which a special master was appointed under division (F)(2) of this section or division (A)(1)(b) or (B)(2) of section ~~5111.51~~ 5164.67 of the Revised Code has been eliminated, that the facility has been brought into compliance with certification requirements, and that the provider has established the management capability to ensure continued compliance with the certification requirements, shall immediately terminate its jurisdiction over the facility and return control and management of the facility to the provider. If the deficiency or deficiencies cannot be substantially corrected, or the emergency cannot be eliminated practicably within a reasonable time following appointment of the special master, the court may order the special master to close the facility and transfer all residents to other nursing facilities or other appropriate care settings.

Sec. ~~5111.55~~ 5164.71. (A) An order issued under section ~~5111.46~~ 5164.62, ~~5111.47~~ 5164.63, ~~5111.48~~ 5164.64, ~~5111.51~~ 5164.67, or ~~5111.57~~ 5164.73 of the Revised Code denying payment to a nursing facility for all medicaid eligible residents admitted after its effective date, or an order issued under section ~~5111.46~~ 5164.62, ~~5111.47~~ 5164.63, or ~~5111.48~~ 5164.64 of the Revised Code denying payment to a nursing facility for medicaid eligible residents admitted after the effective date of the order who have specified diagnoses or special care needs, shall also apply to individuals admitted to the facility on and after the effective date of the order who are not medicaid eligible residents but become medicaid eligible residents after admission. Such an order shall not apply to any of the following:

(1) An individual who was a medicaid eligible resident of the facility on the day immediately preceding the effective date of

the order and continues to be a medicaid eligible resident on and after that date;

(2) An individual who was a resident of the facility on the day immediately preceding the effective date of the order, continues to be a resident on and after that date, and becomes medicaid eligible on or after that date;

(3) An individual who was a medicaid eligible resident of the facility prior to the effective date of the order, is temporarily absent from the facility on that or a subsequent date due to hospitalization or participation in therapeutic programs outside the facility, and chooses to return to the facility;

(4) An individual who was a resident of the facility prior to the effective date of the order, is temporarily absent from the facility on that or a subsequent date due to hospitalization or participation in therapeutic programs outside the facility, becomes medicaid eligible on or after that date, and chooses to return to the facility.

(B) An order issued under section ~~5111.46~~ 5164.62 of the Revised Code denying payment to a nursing facility for all medicaid eligible residents admitted after its effective date, or denying payment to a facility for medicaid eligible residents admitted after the effective date of the order who have specified diagnoses or special care needs shall not take effect prior to the fifth day after the order is delivered to the facility. Such an order issued under section ~~5111.47~~ 5164.63 or ~~5111.48~~ 5164.64 of the Revised Code shall not take effect prior to the twentieth day after it is delivered to the facility.

(C) No nursing facility that has received an order under section ~~5111.46~~ 5164.62, ~~5111.47~~ 5164.63, ~~5111.48~~ 5164.64, ~~5111.51~~ 5164.67, or ~~5111.57~~ 5164.73 of the Revised Code denying payment for all new admissions of medicaid eligible residents shall admit

a medicaid eligible resident on or after the effective date of the order, unless the resident is described in division (A)(3) or (4) of this section, until the order is terminated pursuant to this section. No nursing facility that has received an order under section ~~5111.46~~ 5164.62, ~~5111.47~~ 5164.63, or ~~5111.48~~ 5164.64 of the Revised Code denying payment to a nursing facility for new admissions of medicaid eligible residents with specified diagnoses or special care needs shall admit such a resident on or after the effective date of the order, unless the resident is described in division (A)(3) or (4) of this section, until the order is terminated pursuant to this section.

(D) In the case of an order imposed under division (B) of section ~~5111.57~~ 5164.73 of the Revised Code, the department of health care administration or contracting agency shall appoint monitors in accordance with section ~~5111.44~~ 5164.60 of the Revised Code to conduct on-site monitoring.

(E)(1) A facility may give written notice to the department of health whenever any of the following apply:

(a) With respect to an order denying payment issued under section ~~5111.46~~ 5164.62, ~~5111.47~~ 5164.63, or ~~5111.48~~ 5164.64 of the Revised Code, either of the following is the case:

(i) The facility has completed implementation of the plan of correction it submitted under section ~~5111.43~~ 5164.59 of the Revised Code and substantially corrected all deficiencies for which the order was issued.

(ii) The facility has reduced the severity or scope of all of the deficiencies to a level at which sections ~~5111.46~~ 5164.62 to ~~5111.48~~ 5164.64 of the Revised Code do not authorize the order.

(b) With respect to an order denying payment issued under section ~~5111.51~~ 5164.67 of the Revised Code, the facility has eliminated the immediate jeopardy.

(c) With respect to an order denying payment issued under division (A) of section ~~5111.57~~ 5164.73 of the Revised Code, the facility has completed implementation of the plan of correction it submitted under section ~~5111.43~~ 5164.59 of the Revised Code and substantially corrected all deficiencies for which the order was issued.

(d) With respect to an order denying payment issued under division (B) of section ~~5111.57~~ 5164.73 of the Revised Code, both of the following are the case:

(i) The facility has completed implementation of the plan of correction it submitted under section ~~5111.43~~ 5164.59 of the Revised Code and substantially corrected all deficiencies for which the order was issued.

(ii) The facility is in compliance with certification requirements and has provided adequate assurance that it will remain in compliance with them.

(2) Within ten working days after it receives the notice under division (E)(1) of this section, the department of health shall conduct a follow-up survey that focuses on the cited deficiency or deficiencies, unless the department is able to determine, on the basis of documentation provided by the facility, that the facility has completed the applicable action described in divisions (E)(1)(a) to (d) of this section. If the department of health makes that determination on the basis of the documentation, the department of ~~job and family services~~ health care administration or contracting agency shall terminate the order denying payment as of the date the facility completed the applicable action, as subsequently verified by the department of health. If the department of health conducts a follow-up survey, the department of ~~job and family services~~ health care administration or contracting agency shall terminate the order denying payment as of the date the department of health makes the

determination that the facility completed the applicable action.

(F) The department of ~~job and family services~~ health care administration or contracting agency shall provide public notice implementing an order under section ~~5111.46~~ 5164.62, ~~5111.47~~ 5164.63, ~~5111.48~~ 5164.64, ~~5111.51~~ 5164.67, or ~~5111.57~~ 5164.73 of the Revised Code denying payment to a nursing facility under the ~~medical assistance~~ medicaid program for all medicaid eligible residents by publishing in a newspaper of general circulation in the county in which the facility is located an announcement stating: "By order of the (Ohio Department of ~~Job and Family Services~~ Health Care Administration or name of contracting agency), effective on and after (effective date of order), (name of facility) is no longer authorized to admit Medicaid eligible residents." Immediately following termination of any such order, the department or agency shall publish in a newspaper of general circulation in the county in which the facility is located an announcement stating: "By order of the (Ohio Department of ~~Job and Family Services~~ Health Care Administration or name of contracting agency), effective on and after (effective date of termination), (name of facility) is hereby authorized to admit Medicaid eligible residents." Neither the department nor the contracting agency shall issue public notice of an order under section ~~5111.46~~ 5164.62, ~~5111.47~~ 5164.63, or ~~5111.48~~ 5164.64 of the Revised Code denying payment to a nursing facility for medicaid eligible residents with specified diagnoses or special care needs; public notice is not required for such an order to take effect.

(G) A facility that complies with division (E) of this section shall not be considered to have admitted to the existence of the deficiency that constitutes the basis of the department's or agency's order.

Sec. ~~5111.56~~ 5164.72. (A) As used in this section, "certified

beds" means beds certified under ~~Title XVIII or XIX of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended~~ the medicare or medicaid program.

(B) If the department of ~~job and family services~~ health care administration or a contracting agency imposes a fine on a nursing facility under section ~~5111.46~~ 5164.62, ~~5111.47~~ 5164.63, or ~~5111.48~~ 5164.64 of the Revised Code, it may impose one or more of the following:

(1) One hundred sixty per cent of the amount calculated under division (C) of this section for any deficiency or cluster of deficiencies that constitutes a severity level four and scope level four finding;

(2) One hundred forty per cent of the amount calculated under division (C) of this section for any deficiency or cluster of deficiencies that constitutes a severity level four and scope level three finding;

(3) One hundred twenty per cent of the amount calculated under division (C) of this section for any deficiency or cluster of deficiencies that constitutes a severity level four and scope level two finding;

(4) The amount calculated under division (C) of this section for any deficiency or cluster of deficiencies that constitutes a severity level four and scope level one finding or any deficiency or cluster of deficiencies that constitutes a severity level three and scope level four finding;

(5) Ninety per cent of the amount calculated under division (C) of this section for any deficiency or cluster of deficiencies that constitutes a severity level three and scope level three finding;

(6) Eighty per cent of the amount calculated under division (C) of this section for any deficiency or cluster of deficiencies

that constitutes a severity level three and scope level two finding;

(7) Seventy per cent of the amount calculated under division (C) of this section for any deficiency or cluster of deficiencies that constitutes a severity level three and scope level one finding;

(8) Fifty per cent of the amount calculated under division (C) of this section for any deficiency or cluster of deficiencies that constitutes a severity level two and scope level four finding;

(9) Forty per cent of the amount calculated under division (C) of this section for any deficiency or cluster of deficiencies that constitutes a severity level two and scope level three finding.

(C) The amount subject to division (B) of this section shall be the product of multiplying two dollars and fifty cents for each day the fine is in effect by the total number of licensed nursing home beds or certified beds, whichever is greater, in the facility as of the date the deficiency or cluster of deficiencies that is the reason for the fine was cited.

(D)(1) The department of ~~job and family services~~ health care administration or contracting agency shall not impose on a facility, at any one time, more than four fines as a result of any one survey.

(2) The department of ~~job and family services~~ health care administration or contracting agency shall not impose more than one fine based on a deficiency or cluster of deficiencies. However, if the department of health, in a follow-up or other subsequent survey, finds a change in the scope or severity of the deficiency or cluster of deficiencies, the department of ~~job and family services~~ health care administration or contracting agency

may increase or decrease the fine in accordance with division (B) of this section to reflect the change in scope or severity. The department or agency shall give the facility written notice of the change in the amount of the fine. The change shall take effect on the date the follow-up or other subsequent survey is completed.

If the department of health finds that a deficiency is a repeat deficiency, the department of ~~job and family services~~ health care administration or contracting agency may impose a fine that is one hundred per cent greater than the fine specified in division (B) of this section for the deficiency.

(E) The total amount of fines the department of ~~job and family services~~ health care administration or contracting agency may impose on a facility in a single calendar year shall not exceed five hundred dollars for each licensed nursing home bed or certified bed, whichever is greater in number, in the facility.

(F)(1) Except as provided in division (F)(2) of this section, the department of ~~job and family services~~ health care administration or contracting agency shall not impose a fine under section ~~5111.46~~ 5164.62, ~~5111.47~~ 5164.63, or ~~5111.48~~ 5164.64 of the Revised Code if the deficiency or cluster of deficiencies is substantially corrected within twenty days after the nursing facility receives the statement provided under division (B) of section ~~5111.49~~ 5164.65 of the Revised Code. The department or agency shall inform the nursing facility in that statement that the fine will not be imposed if the deficiency or cluster of deficiencies is substantially corrected within the twenty-day period.

(2) If a nursing facility has substantially corrected a deficiency or cluster of deficiencies within six months after the exit interview of a survey that was the basis for citing a deficiency or cluster of deficiencies, but after correcting it has been cited for the same deficiency or cluster of deficiencies by

the department of health on the basis of a subsequent survey conducted during the remainder of the six-month period, the department of ~~job and family services~~ health care administration or contracting agency may impose a fine beginning on the date of the exit interview of the subsequent survey.

(G) Whenever a facility believes that it has completed implementation of the plan of correction it submitted under section ~~5111.43~~ 5164.59 of the Revised Code and substantially corrected the cited deficiency or cluster of deficiencies that is the basis for a fine, it may give written notice to that effect to the department of health. After receiving the notice, the department shall conduct a follow-up survey of the facility that focuses on the deficiency or cluster, unless the department is able to determine, on the basis of documentation provided by the facility, that the facility has substantially corrected the deficiency or cluster. If, based on the follow-up survey, the department establishes that the facility had not completed implementation of the plan of correction at the time the department received the notice, any fine based on the deficiency or cluster shall be doubled effective from the date the department received the notice. A facility that complies with this division shall not be considered to have admitted the existence of the deficiency or cluster that is the basis for the fine.

(H) Except for a fine imposed under division (C) of section ~~5111.46~~ 5164.62 of the Revised Code and as provided in division (F)(2) of this section, the department of ~~job and family services~~ health care administration or contracting agency shall impose a fine only if the facility fails to give notice under division (G) of this section within twenty days after it receives the statement required by division (B) of section ~~5111.49~~ 5164.65 of the Revised Code or if the department of health determines, based on a follow-up survey, that the deficiency or cluster of deficiencies

for which the fine is proposed has not been substantially corrected within the twenty-day period. The fine shall be imposed effective on the twenty-first day after the facility receives the statement under division (B) of section ~~5111.49~~ 5164.65 of the Revised Code. The fine shall remain in effect until the earliest of the following:

(1) The date the department of health receives notice under division (G) of this section, unless the department determines, on the basis of a follow-up survey, that the deficiency or cluster of deficiencies that is the basis for the fine has not been substantially corrected as of that date;

(2) The date on which the department of health makes a determination, on the basis of a follow-up survey, that the deficiency or cluster of deficiencies has been substantially corrected;

(3) The date the facility substantially corrected the deficiency or cluster, as subsequently determined by the department of health on the basis of documentation provided by the facility.

(I) Any fine imposed by the department of ~~job and family services~~ health care administration or contracting agency under this section is subject to appeal under Chapter 119. of the Revised Code. If the facility does not request a hearing under Chapter 119. of the Revised Code and either pays or agrees in writing to pay the fine when payment becomes due under division (J) of this section, the department or agency shall reduce the fine by fifty per cent. The department or agency may compromise any claim for payment of a fine under sections ~~5111.35~~ 5164.50 to ~~5111.62~~ 5164.78 of the Revised Code.

(J) The department of ~~job and family services~~ health care administration or contracting agency shall collect interest on

fines, at the rate per calendar month that equals one-twelfth of the rate per year prescribed by section 5703.47 of the Revised Code for the calendar year that includes the month for which the interest charge accrues. Payment of a fine is due, and interest begins to accrue on the unpaid fine or balance, on the thirty-first day after the department or agency issues a final adjudication order imposing the fine. If the deficiency or deficiencies on which the fine is based have not been corrected when the final adjudication order is issued, the payment is due, and interest begins to accrue on the unpaid fine or balance, on the thirty-first day after the deficiency or deficiencies are corrected and the department or agency mails a notice specifying the amount of the fine to the facility.

(K) The department of ~~job and family services~~ health care administration or contracting agency shall collect fines and interest imposed under this section through one of the following means:

(1) A lump sum payment from the provider;

(2) Periodic payments for a period not to exceed twelve months, in accordance with a schedule approved by the department or agency;

(3) Appropriately reducing the amounts of payments made to the facility for care provided to medicaid eligible residents for a period not to exceed twelve months following the date on which payment of the fine becomes due under division (J) of this section. An amount equal to the amount by which each payment is reduced shall be deposited to the credit of the residents protection fund in accordance with section ~~5111.62~~ 5164.78 of the Revised Code.

Sec. ~~5111.57~~ 5164.73. (A) The department of ~~job and family services~~ health care administration or a contracting agency shall

issue an order denying payment to a nursing facility for all medicaid eligible residents admitted to the facility on or after the effective date of the order, if the facility has failed to substantially correct within ninety days after the exit interview a deficiency or cluster of deficiencies in accordance with the plan of correction it submitted under section ~~5111.43~~ 5164.59 of the Revised Code, as determined by the department of health on the basis of a follow-up survey.

(B) The department of ~~job and family services~~ health care administration or contracting agency shall issue an order denying payment to a nursing facility for all medicaid eligible residents admitted to the facility on or after the effective date of the order, if during three consecutive standard surveys conducted after December 13, 1990, the department of health has found a condition of substandard care in a facility.

(C) An order issued under division (A) or (B) of this section shall take effect on the later of the date the facility receives the order or the date the public notice required under division (F) of section ~~5111.55~~ 5164.71 of the Revised Code is published. The order is subject to appeal under Chapter 119. of the Revised Code; however the order may take effect prior to or during the pendency of any hearing under that chapter. In that case, the department or agency shall provide the facility an opportunity for a hearing in accordance with section ~~5111.60~~ 5164.76 of the Revised Code.

Sec. ~~5111.58~~ 5164.74. (A) If a nursing facility notifies the department of ~~job and family services~~ health care administration or a contracting agency, at any time during the six-month period following the exit interview of a survey that was the basis for citing a deficiency or deficiencies, that the deficiency or deficiencies have been substantially corrected in accordance with

the plan of correction submitted and approved under section ~~5111.43~~ 5164.59 of the Revised Code, the department of health shall conduct a follow-up survey to determine whether the deficiency or deficiencies have been substantially corrected in accordance with the plan.

(B) The department of ~~job and family services~~ health care administration or a contracting agency shall terminate a nursing facility's participation in the ~~medical assistance~~ medicaid program whenever the facility has not substantially corrected, within six months after the exit interview of the survey on the basis of which it was cited, a deficiency or deficiencies in accordance with the plan of correction submitted under section ~~5111.43~~ 5164.59 of the Revised Code, as determined by the department of health on the basis of a follow-up survey.

(C) Unless the facility has substantially corrected the deficiency or deficiencies in accordance with the plan of correction, as determined by the department of health on the basis of a follow-up survey, the department of ~~job and family services~~ health care administration or contracting agency shall deliver to the facility, at least thirty days prior to the day that is six months after the exit interview, a written order terminating the facility's participation in the ~~medical assistance~~ medicaid program. The order shall take effect and the facility's participation shall terminate on the day that is six months after the exit interview. The order shall not take effect if, after it is delivered to the facility and prior to the effective date of the order, the department of health determines on the basis of a follow-up survey that the facility has corrected the deficiency or deficiencies.

An order issued under this section is subject to appeal under Chapter 119. of the Revised Code; however, the order may take effect prior to or during the pendency of any hearing under that

chapter. In that case, the department of ~~job and family services~~ health care administration or contracting agency shall provide the facility an opportunity for a hearing in accordance with section ~~5111.60~~ 5164.76 of the Revised Code.

(D) Except as provided in division (E) of this section, whenever the department of ~~job and family services~~ health care administration or a contracting agency terminates a facility's participation in the ~~medical assistance~~ medicaid program pursuant to this section, the provider shall repay the department the federal share of all payments made by the department to the facility under the ~~medical assistance~~ medicaid program during the six-month period following the exit interview of the survey that was the basis for citing the deficiency or cluster of deficiencies. The provider shall repay the department within thirty days after the department repays to the federal government the federal share of payments made to the facility during that six-month period.

(E) A provider is not required to repay the department of ~~job and family services~~ health care administration if either of the following is the case:

(1) The facility has brought an appeal under Chapter 119. of the Revised Code of termination of its participation in the ~~medical assistance~~ medicaid program, except that the provider shall repay the department of ~~job and family services~~ health care administration within thirty days after the facility exhausts its right to appeal under that chapter.

(2) The facility complied with the plan of correction approved by the department of health and the obligation to repay resulted from the department's failure to provide timely verification to the United States department of health and human services of the facility's compliance with the plan of correction.

(F) If a provider's obligation to repay the department of ~~job and family services~~ health care administration under division (D) of this section results from disallowance of federal financial participation by the United States department of health and human services, the provider shall not be required to repay the department of ~~job and family services~~ health care administration until the federal disallowance becomes final.

(G) Any fines paid under sections ~~5111.35~~ 5164.50 to ~~5111.62~~ 5164.78 of the Revised Code during any period for which the facility is required to repay the department of ~~job and family services~~ health care administration under division (D) of this section shall be offset against the amount the provider is required to repay the department for that period.

(H) Prior to a change of ownership of a facility for which a provider has an obligation to repay the department of ~~job and family services~~ health care administration under division (D) of this section that has not become final, or has become final but not been paid, the department may do one or more of the following:

(1) Require the provider to place money in escrow, or obtain a bond, in sufficient amount to indemnify the state against the provider's failure to repay the department after the change of ownership occurs;

(2) Place a lien on the facility's real property;

(3) Use any method to recover the payments that is available to the attorney general to recover payments on behalf of the department of ~~job and family services~~ health care administration.

Sec. ~~5111.59~~ 5164.75. The department of ~~job and family services~~ health care administration, the department of health, and any contracting agency shall deliver a written notice, statement, or order to a nursing facility under sections ~~5111.35~~ 5164.50 to

~~5111.41~~ 5164.56 and ~~5111.43~~ 5164.59 to ~~5111.62~~ 5164.78 of the Revised Code by certified mail or hand delivery. If the notice, statement, or order is mailed, it shall be addressed to the administrator of the facility as indicated in the department's or agency's records. If it is hand delivered, it shall be delivered to a person at the facility who would appear to the average prudent person to have authority to accept it.

Delivery of written notice by a nursing facility to the department of health, the department of ~~job and family services~~ health care administration, or a contracting agency under sections ~~5111.35~~ 5164.50 to ~~5111.62~~ 5164.78 of the Revised Code shall be by certified mail or hand delivery to the appropriate department or the agency.

Sec. ~~5111.60~~ 5164.76. (A) Except as provided in division (B) of this section, the following remedies are subject to appeal under Chapter 119. of the Revised Code:

(1) An order issued under section ~~5111.45~~ 5164.61, ~~5111.46~~ 5164.62, ~~5111.51~~ 5164.67, or ~~5111.58~~ 5164.74 of the Revised Code terminating a nursing facility's participation in the ~~medical assistance~~ medicaid program;

(2) Appointment of a temporary manager of a facility under division (A)(1)(b) or (2)(b) of section ~~5111.46~~ 5164.62, or division (A)(1)(d) of section ~~5111.51~~ 5164.67 of the Revised Code;

(3) An order issued under section ~~5111.46~~ 5164.62, ~~5111.47~~ 5164.63, ~~5111.48~~ 5164.64, ~~5111.51~~ 5164.67, or ~~5111.57~~ 5164.73 of the Revised Code denying payment to a facility under the ~~medical assistance~~ medicaid program for all medicaid eligible residents admitted after the effective date of the order;

(4) An order issued under section ~~5111.46~~ 5164.62, ~~5111.47~~ 5164.63, or ~~5111.48~~ 5164.64 of the Revised Code denying payment to

a facility under the ~~medical assistance~~ medicaid program for medicaid eligible residents admitted after the effective date of the order who have certain diagnoses or special care needs specified by the department or agency;

(5) A fine imposed under section ~~5111.46~~ 5164.62, ~~5111.47~~ 5164.63, or ~~5111.48~~ 5164.64 of the Revised Code.

(B) The department of ~~job and family services~~ health care administration or contracting agency may do any of the following prior to or during the pendency of any proceeding under Chapter 119. of the Revised Code:

(1) Issue and execute an order under section ~~5111.46~~ 5164.62, ~~5111.51~~ 5164.67, or ~~5111.58~~ 5164.74 of the Revised Code terminating a nursing facility's participation in the ~~medical assistance~~ medicaid program;

(2) Appoint a temporary manager under division (A)(1)(b) or (2)(b) of section ~~5111.46~~ 5164.62 or division (A)(1)(d) of section ~~5111.51~~ 5164.67 of the Revised Code;

(3) Issue and execute an order under section ~~5111.46~~ 5164.62, ~~5111.47~~ 5164.63, ~~5111.51~~ 5164.67, or ~~5111.57~~ 5164.73 of the Revised Code denying payment to a facility for all medicaid eligible residents admitted after the effective date of the order;

(4) Issue and execute an order under section ~~5111.46~~ 5164.62 or ~~5111.47~~ 5164.63 or division (A), (B), or (C) of section ~~5111.48~~ 5164.64 of the Revised Code denying payment to a facility for medicaid eligible residents admitted after the effective date of the order who have specified diagnoses or special care needs.

(C) Whenever the department or agency imposes a remedy listed in division (B) of this section prior to or during the pendency of a proceeding, all of the following apply:

(1) The provider against whom the action is taken shall have

ten days after the date the facility actually receives the notice specified in section 119.07 of the Revised Code to request a hearing.

(2) The hearing shall commence within thirty days after the date the department or agency receives the provider's request for a hearing.

(3) The hearing shall continue uninterrupted from day to day, except for Saturdays, Sundays, and legal holidays, unless other interruptions are agreed to by the provider and the department or agency.

(4) If the hearing is conducted by a hearing examiner, the hearing examiner shall file a report and recommendations within ten days after the close of the hearing.

(5) The provider shall have five days after the date the hearing officer files the report and recommendations within which to file objections to the report and recommendations.

(6) Not later than fifteen days after the date the hearing officer files the report and recommendations, the director of ~~job and family services~~ health care administration or the director of the contracting agency shall issue an order approving, modifying, or disapproving the report and recommendations of the hearing examiner.

(D) If the department or agency imposes more than one remedy as the result of deficiencies cited in a single survey, the proceedings for all of the remedies shall be consolidated. If any of the remedies are imposed during the pendency of a hearing, as permitted by division (B) of this section, the consolidated hearing shall be conducted in accordance with division (C) of this section. The consolidation of the remedies for purposes of a hearing does not affect the effective dates prescribed in sections ~~5111.35~~ 5164.50 to ~~5111.58~~ 5164.74 of the Revised Code.

(E) If a contracting agency conducts administrative proceedings pertaining to remedies imposed under sections ~~5111.35~~ 5164.50 to ~~5111.62~~ 5164.78 of the Revised Code, the department of ~~job and family services~~ health care administration shall not be considered a party to the proceedings.

Sec. ~~5111.61~~ 5164.77. (A)(1) Except as required by court order, as necessary for the administration or enforcement of any statute relating to nursing facilities, or as provided in division (C) of this section, the department of ~~job and family services~~ health care administration and any contracting agency shall not release any of the following information without the permission of the individual or the individual's legal representative:

(a) The identity of any resident of a nursing facility;

(b) The identity of any individual who submits a complaint about a nursing facility;

(c) The identity of any individual who provides the department or agency with information about a nursing facility and has requested confidentiality;

(d) Any information that reasonably would tend to disclose the identity of any individual described in division (A)(1)(a) to (c) of this section.

(2) An agency or individual to whom the department or contracting agency is required, by court order or for the administration or enforcement of a statute relating to nursing facilities, to release information described in division (A)(1) of this section shall not release the information without the permission of the individual who would be or would reasonably tend to be identified, or of the individual's legal representative, unless the agency or individual is required to release it by division (C) of this section, by court order, or for the

administration or enforcement of a statute relating to nursing facilities.

(B) Except as provided in division (C) of this section, any record that identifies an individual described in division (A)(1) of this section or that reasonably would tend to identify such an individual is not a public record for the purposes of section 149.43 of the Revised Code, and is not subject to inspection and copying under section 1347.08 of the Revised Code.

(C) If the department or a contracting agency, or an agency or individual to whom the department or contracting agency was required by court order or for administration or enforcement of a statute relating to nursing facilities to release information described in division (A)(1) of this section, uses information in any administrative or judicial proceeding against a facility that reasonably would tend to identify an individual described in division (A)(1) of this section, the department, agency, or individual shall disclose that information to the facility. However, the department, agency, or individual shall not disclose information that directly identifies an individual described in divisions (A)(1)(a) to (c) of this section, unless the individual is to testify in the proceedings.

(D) No person shall knowingly register a false complaint about a nursing facility with the department or a contracting agency, or knowingly swear or affirm the truth of a false complaint, when the allegation is made for the purpose of incriminating another.

Sec. ~~5111.62~~ 5164.78. The proceeds of all fines, including interest, collected under sections ~~5111.35~~ 5164.50 to ~~5111.62~~ 5164.78 of the Revised Code shall be deposited in the state treasury to the credit of the residents protection fund, which is hereby created. 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 fund shall be maintained and administered by the department of ~~job and family services~~ health care administration under rules developed in consultation with the departments of health and aging and adopted by the director of ~~job and family services~~ health care administration under Chapter 119. of the Revised Code.

Sec. ~~5111.63~~ 5164.79. For the purposes of this section, "facility," ~~"medicare," and "medicaid" have~~ has the same ~~meanings~~ meaning as in section 3721.10 of the Revised Code.

The department of health shall be the designee of the department of ~~job and family services~~ health care administration for the purpose of conducting a hearing pursuant to section 3721.162 of the Revised Code concerning a facility's decision to transfer or discharge a resident if the resident is a medicaid recipient or medicare beneficiary.

Sec. ~~5111.65~~ 5164.82. As used in sections ~~5111.65~~ 5164.82 to ~~5111.688~~ 5164.858 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,~~ for participation in the medicaid program 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~~ 5164.01 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~~ 5164.821. Sections ~~5111.65~~ 5164.82 to ~~5111.688~~ 5164.858 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~~ 5164.83. 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~~ health care administration 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. ~~5111.67~~ 5164.84. (A) An exiting operator or owner and entering operator shall provide the department of ~~job and family services~~ health care administration 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~~ 5164.841. The department of ~~job and family services~~ health care administration 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~~ 5164.84 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~~ 5164.02 of the Revised Code.

Sec. ~~5111.672~~ 5164.842. (A) The department of ~~job and family services~~ health care administration 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~~ 5164.84 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~~ 5164.84 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~~ 5164.02 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~~ 5164.851 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~~ 5164.852 of the Revised Code;

(b) The date that the department waives the cost report requirement of section ~~5111.682~~ 5164.852 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~~ 5164.84 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~~ 5164.843. A provider that enters into a provider agreement with the department of ~~job and family services~~ health care administration under section ~~5111.671~~ 5164.841 or ~~5111.672~~ 5164.842 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~~ 5164.03 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~~ 5164.844. 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~~ 5164.841 or ~~5111.672~~ 5164.842 of the Revised Code.

Sec. ~~5111.675~~ 5164.845. The department of ~~job and family services~~ health care administration may enter into a provider agreement as provided in section ~~5111.22~~ 5164.03 of the Revised Code, rather than section ~~5111.671~~ 5164.841 or ~~5111.672~~ 5164.842 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~~ 5164.843 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~~ for participation in the medicaid program. 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~~ 5164.84 of the Revised Code is satisfied.

Sec. ~~5111.676~~ 5164.846. The director of ~~job and family services~~ health care administration 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~~ 5164.841, section ~~5111.672~~ 5164.842, or, pursuant to section ~~5111.675~~ 5164.845, section ~~5111.22~~ 5164.03 of the Revised Code.

Sec. ~~5111.677~~ 5164.847. Neither of the following shall affect the department of ~~job and family services'~~ health care administration's 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~~ 5164.841, section ~~5111.672~~ 5164.842, or, pursuant to section ~~5111.675~~ 5164.845, section ~~5111.22~~ 5164.03 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~~ 5164.85. (A) On receipt of a written notice under section ~~5111.66~~ 5164.83 of the Revised Code of a facility closure, voluntary termination, or voluntary withdrawal of participation or a written notice under section ~~5111.67~~ 5164.84 of

the Revised Code of a change of operator, the department of ~~job and family services~~ health care administration 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~~ 5164.38 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~~ 5164.851. (A) Except as provided in division (B) of this section, the department of ~~job and family services~~ health care administration 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~~ 5164.852. (A) Except as provided in division (B) of this section, an exiting operator shall file with the department of ~~job and family services~~ health care administration 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~~ 5164.37 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~~ 5164.853. If an exiting operator required by section ~~5111.682~~ 5164.852 of the Revised Code to file a cost report with the department of ~~job and family services~~ health care administration 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~~ 5164.854. The department of ~~job and family services~~ health care administration 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~~ 5164.37 and ~~5111.682~~ 5164.852 of the Revised Code.

Sec. ~~5111.685~~ 5164.855. The department of ~~job and family services~~ health care administration 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~~ 5164.852 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~~ 5164.032 of the Revised Code are subject to an adjudication conducted in accordance with Chapter 119. of the Revised Code.

Sec. ~~5111.686~~ 5164.856. The department of ~~job and family services~~ health care administration shall release the actual amount withheld under division (A) of section ~~5111.681~~ 5164.851 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~~ 5164.852 of the Revised Code unless the department issues the report required by section ~~5111.685~~ 5164.855 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~~ 5164.855 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~~ 5164.852 of the Revised Code;

(C) Ninety-one days after the date the department waives the cost report requirement of section ~~5111.682~~ 5164.852 of the Revised Code unless the department issues the report required by section ~~5111.685~~ 5164.855 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~~ 5164.855 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~~ 5164.852 of the Revised Code.

Sec. ~~5111.687~~ 5164.857. The department of ~~job and family services~~ health care administration, at its sole discretion, may release the amount withheld under division (A) of section ~~5111.681~~ 5164.851 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~~ 5164.83 or ~~5111.67~~ 5164.84 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~~ 5164.83 or ~~5111.67~~ 5164.84 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~~ 5164.83 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~~ 5164.84 of the Revised Code regarding any transactions leading to a change of operator at a future time.

Sec. ~~5111.688~~ 5164.858. The director of ~~job and family services~~ health care administration may adopt rules under section ~~5111.02~~ 5163.15 of the Revised Code to implement sections ~~5111.65~~ 5164.82 to ~~5111.688~~ 5164.858 of the Revised Code, including rules applicable to an exiting operator that provides written notification under section ~~5111.66~~ 5164.83 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. ~~5111.99~~ 5164.99. (A) Whoever violates division (B) of section ~~5111.26~~ 5164.37 or division (E) of section ~~5111.31~~ 5164.033 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~~ 5164.77 of the Revised Code is guilty of registering a false complaint, a misdemeanor of the first degree.

Sec. 5165.01. As used in this chapter:

"Care management system" means the medicaid managed care program established under section 5165.02 of the Revised Code.

"Emergency services" has the same meaning as in 42 U.S.C. 1396u-2(b)(2).

"Medicaid managed care organization" means a managed care organization that has entered into a contract with the department of health care administration under section 5165.05 of the Revised Code.

"Provider" has the same meaning as in section 5163.01 of the Revised Code.

Sec. 5165.02. The department of health care administration shall establish a care management system as part of the medicaid program. 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.

Sec. ~~5111.16~~ 5165.03. ~~(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 of health care administration 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)~~(A) 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~~ individuals 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~~ 5165.05 of the Revised Code.

~~(2)~~(B) In the case of individuals who receive medicaid on the basis of being aged, blind, or disabled, as specified in division ~~(A)(2)~~(B) of section ~~5111.01~~ 5162.01 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~~ 5165.05 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)~~(1) Individuals who are under twenty-one years of age;

~~(b)~~(2) Individuals who are institutionalized;

~~(c)~~(3) 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)~~(4) 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)~~(5) Individuals to the extent that they are receiving medicaid services through a medicaid waiver component, as defined in section ~~5111.85~~ 5163.50 of the Revised Code.

~~(3)~~(C) 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~~ addiction, and mental health services or a state agency other than the department of ~~job and family services~~ health care administration, but the recipients of those services may otherwise be designated for participation in the 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 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.~~

~~(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. 5165.04. Subject to section 5165.03 of the Revised Code, the department of health care administration may do both of the following under the care management system:

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

(B) Require or permit participants in the system to obtain health care services through managed care organizations under contract with the department pursuant to section 5165.05 of the Revised Code.

Sec. ~~5111.17~~ 5165.05. ~~(A)~~ The department of ~~job and family services~~ health care administration 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~~ medicaid 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. 5165.06. The department of health care administration shall develop and implement a financial incentive program to improve and reward positive health outcomes through the managed care organization contracts entered into under section 5165.05 of the Revised Code. 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 5165.19 of the Revised Code.

Sec. ~~5111.171~~ 5165.07. ~~(A)~~ The department of ~~job and family services~~ health care administration may provide financial incentive awards to medicaid managed care organizations ~~under contract with the department pursuant to section 5111.17 of the Revised Code~~ that meet or exceed performance standards specified in provider agreements or rules adopted ~~by the department~~ under section 5165.18 of the Revised Code. The department may specify in a contract with a managed care organization the amounts of financial incentive awards, methodology for distributing awards, types of awards, and standards for administration by the department.

~~(B) There is hereby created in the state treasury the health care compliance fund. The fund shall consist of all fines imposed on and collected from managed care organizations for failure to meet performance standards or other requirements specified in~~

~~provider agreements or rules adopted by the department. All investment earnings of the fund shall be credited to the fund. Moneys credited to the fund shall be used solely for the following purposes:~~

~~(1) To reimburse managed care organizations that have paid fines for failures to meet performance standards or other requirements and that have come into compliance by meeting requirements as specified by the department;~~

~~(2) To provide financial incentive awards established pursuant to division (A) of this section and specified in contracts between managed care organizations and the department.~~

Sec. 5165.08. There is hereby created in the state treasury the health care compliance fund. The fund shall consist of all fines imposed on and collected from medicaid managed care organizations for failure to meet performance standards or other requirements specified in provider agreements or rules under section 5165.18 of the Revised Code. All investment earnings of the fund shall be credited to the fund. Moneys credited to the fund shall be used solely for the following purposes:

(A) To reimburse medicaid managed care organizations that have paid fines for failures to meet performance standards or other requirements and that have come into compliance by meeting requirements as specified by the department;

(B) To provide financial incentive awards established pursuant to section 5165.06 of the Revised Code and specified in contracts between medicaid managed care organizations and the department.

Sec. ~~5111.172~~ 5165.09. When contracting under section ~~5111.17~~ 5165.05 of the Revised Code with a managed care organization that is a health insuring corporation, the department of ~~job and family~~

~~services~~ health care administration may require the health insuring corporation to provide coverage of prescription drugs for medicaid recipients enrolled in the health insuring corporation. In providing the required coverage, the health insuring corporation may, subject to the department's approval, use strategies for the management of drug utilization.

Sec. ~~5111.173~~ 5165.10. The department of ~~job and family services~~ health care administration shall appoint a temporary manager for a medicaid managed care organization ~~under contract with the department pursuant to section 5111.17 of the Revised Code~~ if the department determines that the medicaid managed care organization has repeatedly failed to meet substantive requirements specified in ~~section 1903(m) of the "Social Security Act," 79 Stat. 286 (1965),~~ 42 U.S.C. 1396b(m), ~~as amended; section 1932 of the Social Security Act,~~ 42 U.S.C. 1396u-2, ~~as amended;~~ or 42 C.F.R. 438 Part I. The appointment of a temporary manager does not preclude the department from imposing other sanctions available to the department against the medicaid managed care organization.

The medicaid managed care organization shall pay all costs of having the temporary manager perform the temporary manager's duties, including all costs the temporary manager incurs in performing those duties. If the temporary manager incurs costs or liabilities on behalf of the medicaid managed care organization, the medicaid managed care organization shall pay those costs and be responsible for those liabilities.

The appointment of a temporary manager is not subject to Chapter 119. of the Revised Code, but the medicaid managed care organization may request a reconsideration of the appointment. Reconsiderations shall be requested and conducted in accordance with rules ~~the director of job and family services shall adopt in~~

~~accordance with Chapter 119.~~ adopted under section 5165.18 of the Revised Code.

The appointment of a temporary manager does not cause the medicaid managed care organization to lose the right to appeal, in accordance with Chapter 119. of the Revised Code, any proposed termination or any decision not to renew the medicaid managed care organization's medicaid provider agreement or the right to initiate the sale of the medicaid managed care organization or its assets.

~~In addition to the rules required to be adopted under this section, the director may adopt any other rules necessary to implement this section. The rules shall be adopted in accordance with Chapter 119. of the Revised Code.~~

Sec. ~~5111.177~~ 5165.11. When contracting under section ~~5111.17~~ 5165.05 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~~ health care administration 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. ~~5111.174~~ 5165.12. The department of ~~job and family services~~ health care administration may disenroll some or all medicaid recipients enrolled in a medicaid managed care organization ~~under contract with the department pursuant to section 5111.17 of the Revised Code~~ if the department proposes to terminate or not to renew the contract and determines that the recipients' access to medically necessary services is jeopardized by the proposal to terminate or not to renew the contract. The disenrollment is not subject to Chapter 119. of the Revised Code, but the medicaid managed care organization may request a

reconsideration of the disenrollment. Reconsiderations shall be requested and conducted in accordance with rules ~~the director of job and family services shall adopt in accordance with Chapter 119.~~ adopted under section 5165.18 of the Revised Code. The request for, or conduct of, a reconsideration regarding a proposed disenrollment shall not delay the disenrollment.

~~In addition to the rules required to be adopted under this section, the director may adopt any other rules necessary to implement this section. The rules shall be adopted in accordance with Chapter 119. of the Revised Code.~~

Sec. ~~5111.175~~ 5165.13. For the purpose of determining the amount the department of ~~job and family services~~ health care administration pays hospitals under section ~~5112.08~~ 5166.07 of the Revised Code and the amount of disproportionate share hospital payments paid by the medicare program ~~established under Title XVIII of the "Social Security Act," 79 Stat. 286 (1965), 42 U.S.C. 1396n, as amended~~, a medicaid managed care organization ~~under contract with the department pursuant to section 5111.17 of the Revised Code authorizing the organization~~ authorized to provide, or arrange for the provision of, hospital services to medicaid recipients shall keep detailed records for each hospital with which it contracts about the cost to the hospital of providing the services, payments made by the organization to the hospital for the services, utilization of hospital services by medicaid recipients enrolled in the organization, and other utilization data required by the department.

Sec. ~~5111.162~~ 5165.14. (A) ~~As used in this section:~~

~~(1) "Emergency services" has the same meaning as in section 1932(b)(2) of the "Social Security Act," 79 Stat. 286 (1965), 42 U.S.C. 1396u-2(b)(2), as amended.~~

~~(2) "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)~~(B) 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 receive services, other than emergency services provided on or after January 1, 2007, at 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)~~(B) A hospital is not subject to division ~~(B)~~(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 ~~(C)~~(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.

~~(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~~ 5165.15. (~~A) As used in this section:~~

~~(1) "Emergency services" has the same meaning as in section 1932(b)(2) of the "Social Security Act," 79 Stat. 286 (1965), 42 U.S.C. 1396u-2(b)(2), as amended.~~

~~(2) "Medicaid managed care organization" has the same meaning as in section 5111.162 of the Revised Code.~~

~~(3) "Provider" has the same meaning as in section 5111.06 of the Revised Code.~~

~~(B)~~ 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 receives emergency services on or after January 1, 2007, from a provider that is not under contract with the organization, the provider shall accept from the organization, as payment in full, not more than the amounts (less any payments for indirect costs of medical education and direct costs of graduate medical education) that the provider could collect if the participant received medicaid other than through enrollment in a managed care organization.

Sec. ~~5111.178~~ 5165.16. (A) The director of ~~job and family services~~ health care administration 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~~ health care administration 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, instead of the prompt payment requirements of 42 C.F.R. 447.46. That date shall be specified in the notice.

Sec. 5165.17. (A) The department of health care administration 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:

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

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

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

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

Sec. 5165.18. The director of health care administration shall adopt rules in accordance with Chapter 119. of the Revised Code to implement care management system, including rules that do all of the following:

(A) Specify 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;

(B) Specify performance standards for medicaid managed care organizations;

(C) The method by which a medicaid managed care organization may request a reconsideration of the appointment of a temporary manager under section 5165.10 of the Revised Code and the method by which the reconsideration is to be conducted;

(D) The method by which a medicaid managed care organization may request a reconsideration of a disenrollment under section 5165.12 of the Revised Code and the method by which the reconsideration is to be conducted.

Sec. ~~5111.161~~ 5165.19. (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~~ 5166.60 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) One individual representing providers of services that the state has the option of providing under federal medicaid law. The individual shall be appointed by the president of the senate from among one nomination each from the Ohio optometric association, the Ohio dental association, and the Ohio podiatric

medical association.

(9) The director of ~~job and family services~~ health care administration or the director's designee;

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

(11) 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~~ health care administration may consider when entering into contracts under section ~~5111.17~~ 5165.05 of the Revised Code with managed care organizations for purposes of the care management system established under section ~~5111.16~~ 5165.03 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~~ 5165.06 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. ~~5111.13~~ 5165.30. (A) As used in this section, "cost-effective" and "group health plan" have the same meanings as in ~~section 1906 of the "Social Security Act," 49 Stat. 620 (1935),~~ 42 U.S.C.~~A.~~ 1396e~~, as amended,~~ and any regulations adopted under that section.

(B) The department of ~~job and family services~~ health care administration, pursuant to guidelines issued by the United States secretary of health and human services, shall identify cases in which enrollment of an individual otherwise eligible for ~~medical assistance under this chapter~~ the medicaid program in a group health plan in which the individual is eligible to enroll and payment of the individual's premiums, deductibles, coinsurance, and other cost-sharing expenses is cost effective.

The department shall require, as a condition of eligibility for ~~medical assistance~~ the medicaid program, individuals identified under this division, or in the case of a child, the child's parent, to apply for enrollment in the group health plan, except that the failure of a parent to enroll self or the parent's child in a group health plan does not affect the child's eligibility under the ~~medical assistance~~ medicaid program.

The department shall pay enrollee premiums and deductibles, coinsurance, and other cost-sharing obligations for services and items otherwise covered under the ~~medical assistance~~ medicaid program. The department shall treat coverage under the group health plan in the same manner as any other third-party liability under the program. If not all members of a family are eligible for ~~medical assistance~~ the medicaid program and enrollment of the eligible members in a group health plan is not possible without also enrolling the members who are ineligible for ~~medical assistance~~ the medicaid program, the department shall pay the premiums for the ineligible members if the payments are cost effective. The department shall not pay deductibles, coinsurance, or other cost-sharing obligations of enrolled members who are not eligible for ~~medical assistance~~ the medicaid program.

The department may make payments under this section to employers, insurers, or other entities. The department may make the payments without entering into a contract with employers,

insurers, or other entities.

(C) To the extent permitted by federal law and regulations, the department of ~~job and family services~~ health care administration shall coordinate the ~~medical assistance~~ medicaid program with group health plans in such a manner that the ~~medical assistance~~ medicaid program serves as a supplement to the group health plans. In its coordination efforts, the department shall consider cost-effectiveness and quality of care. The department may enter into agreements with group health plans as necessary to implement this division.

(D) The director of ~~job and family services~~ health care administration shall adopt rules in accordance with Chapter 119. of the Revised Code to implement this section.

Sec. ~~5112.01~~ 5166.01. As used in sections ~~5112.03~~ 5166.02 to ~~5112.21~~ 5166.14 of the Revised Code:

(A)(1) "Hospital" means a nonfederal hospital to which either of the following applies:

(a) The hospital is registered under section 3701.07 of the Revised Code as a general medical and surgical hospital or a pediatric general hospital, and provides inpatient hospital services, as defined in 42 C.F.R. 440.10;

(b) The hospital is recognized 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,~~ as a cancer hospital and is exempt from the medicare prospective payment system.

"Hospital" does not include a hospital operated by a health insuring corporation that has been issued a certificate of authority under section 1751.05 of the Revised Code or a hospital that does not charge patients for services.

(2) "Disproportionate share hospital" means a hospital that

meets the definition of a disproportionate share hospital in rules adopted under section ~~5112.03~~ 5166.02 of the Revised Code.

(B) "Bad debt," "charity care," "courtesy care," and "contractual allowances" have the same meanings given these terms in regulations ~~adopted under Title XVIII of the "Social Security Act~~ governing the medicare program.~~"~~

(C) "Cost reporting period" means the twelve-month period used by a hospital in reporting costs for purposes of ~~Title XVIII of the "Social Security Act~~ the medicare program.~~"~~

(D) "Governmental hospital" means a county hospital with more than five hundred registered beds or a state-owned and -operated hospital with more than five hundred registered beds.

(E) "Indigent care pool" means the sum of the following:

(1) The total of assessments to be paid in a program year by all hospitals under section ~~5112.06~~ 5166.05 of the Revised Code, less the assessments deposited into the legislative budget services fund under section ~~5112.19~~ 5166.13 of the Revised Code and into the health care services administration fund created under section ~~5111.94~~ 5161.15 of the Revised Code;

(2) The total amount of intergovernmental transfers required to be made in the same program year by governmental hospitals under section ~~5112.07~~ 5166.06 of the Revised Code, less the amount of transfers deposited into the legislative budget services fund under section ~~5112.19~~ 5166.13 of the Revised Code and into the health care services administration fund created under section ~~5111.94~~ 5161.15 of the Revised Code;

(3) The total amount of federal matching funds that will be made available in the same program year as a result of funds distributed by the department of ~~job and family services~~ health care administration to hospitals under section ~~5112.08~~ 5166.07 of the Revised Code.

(F) "Intergovernmental transfer" means any transfer of money by a governmental hospital under section ~~5112.07~~ 5166.06 of the Revised Code.

(G) ~~"Medical assistance program" means the program of medical assistance established under section 5111.01 of the Revised Code and Title XIX of the "Social Security Act."~~

~~(H)~~ "Program year" means a period beginning the first day of October, or a later date designated in rules adopted under section ~~5112.03~~ 5166.02 of the Revised Code, and ending the thirtieth day of September, or an earlier date designated in rules adopted under that section.

~~(I)~~(H) "Registered beds" means the total number of hospital beds registered with the department of health, as reported in the most recent "directory of registered hospitals" published by the department of health.

~~(J)~~(I) "Total facility costs" means the total costs for all services rendered to all patients, including the direct, indirect, and overhead cost to the hospital of all services, supplies, equipment, and capital related to the care of patients, regardless of whether patients are enrolled in a health insuring corporation, excluding costs associated with providing skilled nursing services in distinct-part nursing facility units, as shown on the hospital's cost report filed under section ~~5112.04~~ 5166.03 of the Revised Code. Effective October 1, 1993, if rules adopted under section ~~5112.03~~ 5166.02 of the Revised Code so provide, "total facility costs" may exclude costs associated with providing care to recipients of any of the governmental programs listed in division (B) of that section.

~~(K)~~(J) "Uncompensated care" means bad debt and charity care.

Sec. ~~5112.03~~ 5166.02. (A) The director of ~~job and family~~

~~services~~ health care administration 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~~ 5166.01 to ~~5112.21~~ 5166.14 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~~ 5166.03 of the Revised Code;

(3) Establish, in accordance with division (A) of section ~~5112.06~~ 5166.05 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~~ 5166.05 of the Revised Code and for governmental hospitals to pay installments on their intergovernmental transfers under section ~~5112.07~~ 5166.06 of the Revised Code;

(5) Establish procedures to notify hospitals of adjustments made under division (B)(2)(b) of section ~~5112.06~~ 5166.05 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~~ 5166.08 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~~ 5166.07 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~~ medicaid program;

(2) Recipients of financial assistance provided under Chapter 5115. of the Revised Code;

(3) Recipients of the disability medical assistance ~~provided under Chapter 5115. of the Revised Code~~ program;

(4) Recipients of the program for medically handicapped children established under section 3701.023 of the Revised Code;

(5) 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) Recipients of Title V of the "Social Security Act of 1935";

(7) 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~~ federal law, including administrative regulations, governing the medicaid program.

Sec. ~~5112.04~~ 5166.03. (A) Except as provided in division (C) of this section, each hospital, on or before the first day of July of each year or at a later date approved by the director of ~~job and family services~~ health care administration, shall submit to the department of ~~job and family services~~ health care administration a financial statement for the preceding calendar year that accurately reflects the income, expenses, assets, liabilities, and net worth of the hospital, and accompanying

notes. A hospital that has a fiscal year different from the calendar year shall file its financial statement within one hundred eighty days of the end of its fiscal year or at a later date approved by the director of ~~job and family services~~ health care administration. The financial statement shall be prepared by an independent certified public accountant and reflect an official audit report prepared in a manner consistent with generally accepted accounting principles. The financial statement shall, to the extent that the hospital has sufficient financial records, show bad debt and charity care separately from courtesy care and contractual allowances.

(B) Except as provided in division (C) of this section, each hospital, within one hundred eighty days after the end of the hospital's cost reporting period, shall submit to the department a cost report in a format prescribed in rules adopted ~~by the director of job and family services~~ under section ~~5112.03~~ 5166.02 of the Revised Code. The department shall grant a hospital an extension of the one hundred eighty day period if the health care financing administration of the United States department of health and human services extends the date by which the hospital must submit its cost report for the hospital's cost reporting period.

(C) The director of ~~job and family services~~ health care administration may adopt rules under section ~~5112.03~~ 5166.02 of the Revised Code specifying financial information that must be submitted by hospitals for which no financial statement or cost report is available. The rules shall specify deadlines for submitting the information. Each such hospital shall submit the information specified in the rules not later than the deadline specified in the rules.

Sec. ~~5112.05~~ 5166.04. The requirements of sections ~~5112.06~~ 5166.05 to ~~5112.09~~ 5166.08 of the Revised Code apply only as long

as the United States ~~health care financing administration~~ department of health and human services determines that the assessment imposed under section ~~5112.06~~ 5166.05 of the Revised Code is a permissible health care-related tax pursuant to ~~section 1903(w) of the "Social Security Act," 49 Stat. 620 (1935),~~ 42 U.S.C.~~A.~~ 1396b(w)~~, as amended~~. Whenever the department of ~~job and family services~~ health care administration is informed that the assessment is an impermissible health care-related tax, the department shall promptly refund to each hospital the amount of money currently in the hospital care assurance program fund created by section ~~5112.18~~ 5166.12 of the Revised Code that has been paid by the hospital under section ~~5112.06~~ 5166.05 or ~~5112.07~~ 5166.06 of the Revised Code, plus any investment earnings on that amount.

Sec. ~~5112.06~~ 5166.05. (A) For the purpose of distributing funds to hospitals under the ~~medical assistance~~ medicaid program pursuant to sections ~~5112.01~~ 5166.01 to ~~5112.21~~ 5166.14 of the Revised Code and depositing funds into the legislative budget services fund under section ~~5112.19~~ 5166.13 of the Revised Code and into the health care services administration fund created under section ~~5111.94~~ 5161.15 of the Revised Code, there is hereby imposed an assessment on all hospitals. Each hospital's assessment shall be based on total facility costs. All hospitals shall be assessed according to the rate or rates established each program year by the department of ~~job and family services~~ health care administration in rules adopted under section ~~5112.03~~ 5166.02 of the Revised Code. The department shall assess all hospitals uniformly and in a manner consistent with federal statutes and regulations. During any program year, the department shall not assess any hospital more than two per cent of the hospital's total facility costs.

The department shall establish an assessment rate or rates

each program year that will do both of the following:

(1) Yield funds that, when combined with intergovernmental transfers and federal matching funds, will produce a program of sufficient size to pay a substantial portion of the indigent care provided by hospitals;

(2) Yield funds that, when combined with intergovernmental transfers and federal matching funds, will produce amounts for distribution to disproportionate share hospitals that do not exceed, in the aggregate, the limits prescribed by the United States ~~health care financing administration~~ department of health and human services under ~~subsection (f) of section 1923 of the "Social Security Act," 49 Stat. 620 (1935),~~ 42 U.S.C.~~A.~~ 1396r-4(f)~~, as amended~~.

(B)(1) Except as provided in division (B)(3) of this section, each hospital shall pay its assessment in periodic installments in accordance with a schedule established by the director of ~~job and family services~~ health care administration in rules adopted under section ~~5112.03~~ 5166.02 of the Revised Code.

(2) The installments shall be equal in amount, unless either of the following applies:

(a) The department makes adjustments during a program year under division (D) of section ~~5112.09~~ 5166.08 of the Revised Code in the total amount of hospitals' assessments;

(b) The director of ~~job and family services~~ health care administration determines that adjustments in the amounts of installments are necessary for the administration of sections ~~5112.01~~ 5166.01 to ~~5112.21~~ 5166.14 of the Revised Code and that unequal installments will not create cash flow difficulties for hospitals.

(3) The director may adopt rules under section ~~5112.03~~ 5166.02 of the Revised Code establishing alternate schedules for

hospitals to pay assessments under this section in order to reduce hospitals' cash flow difficulties.

Sec. ~~5112.07~~ 5166.06. (A) The department of ~~job and family services~~ health care administration may require governmental hospitals to make intergovernmental transfers each program year for the purpose of distributing funds to hospitals under the ~~medical assistance~~ medicaid program pursuant to sections ~~5112.01~~ 5166.01 to ~~5112.21~~ 5166.14 of the Revised Code and depositing funds into the legislative budget services fund under section ~~5112.19~~ 5166.13 of the Revised Code and into the health care services administration fund created under section ~~5111.94~~ 5161.15 of the Revised Code. The department shall not require transfers in an amount that, when combined with hospital assessments paid under section ~~5112.06~~ 5166.05 of the Revised Code and federal matching funds, produce amounts for distribution to disproportionate share hospitals that, in the aggregate, exceed limits prescribed by the United States ~~health care financing administration~~ department of health and human services under ~~subsection (f) of section 1923 of the "Social Security Act," 49 Stat. 620 (1935),~~ 42 U.S.C.~~A.~~ 1396r-4(f)~~, as amended~~.

(B) Before or during each program year, the department shall notify each governmental hospital of the amount of the intergovernmental transfer it is required to make during the program year. Each governmental hospital shall make intergovernmental transfers as required by the department under this section in periodic installments, executed by electronic fund transfer, in accordance with a schedule established in rules adopted under section ~~5112.03~~ 5166.02 of the Revised Code.

Sec. ~~5112.08~~ 5166.07. The director of ~~job and family services~~ health care administration shall adopt rules under section ~~5112.03~~ 5166.02 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~~ health care administration 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 medicaid 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 medicaid recipients ~~of the medical assistance program~~, which may include recipients of Title V of the "Social Security Act of 1935," ~~49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended, and~~ recipients of financial ~~or medical~~ assistance provided under Chapter 5115. of the Revised Code, and recipients of the disability medical assistance program;

(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~~ and 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~~ 5166.05 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 created under section ~~5112.18~~ 5166.12 of the Revised Code and the portion of the health care - federal fund created under section ~~5111.943~~ 5161.18 of the Revised Code that is credited to that fund pursuant to division (B) of section ~~5112.18~~ 5166.12 of the Revised Code are 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 and portion are 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. ~~5112.09~~ 5166.08. (A) Before or during each program year, the department of ~~job and family services~~ health care administration shall mail to each hospital by certified mail, return receipt requested, the preliminary determination of the amount that the hospital is assessed under section ~~5112.06~~ 5166.05 of the Revised Code during the program year. The preliminary

determination of a hospital's assessment shall be calculated for a cost-reporting period that is specified in rules adopted under section ~~5112.03~~ 5166.02 of the Revised Code.

The department shall consult with hospitals each year when determining the date on which it will mail the preliminary determinations in order to minimize hospitals' cash flow difficulties.

If no hospital submits a request for reconsideration under division (B) of this section, the preliminary determination constitutes the final reconciliation of each hospital's assessment under section ~~5112.06~~ 5166.05 of the Revised Code. The final reconciliation is subject to adjustments under division (D) of this section.

(B) Not later than fourteen days after the preliminary determinations are mailed, any hospital may submit to the department a written request to reconsider the preliminary determinations. The request shall be accompanied by written materials setting forth the basis for the reconsideration. If one or more hospitals submit a request, the department shall hold a public hearing not later than thirty days after the preliminary determinations are mailed to reconsider the preliminary determinations. The department shall mail to each hospital a written notice of the date, time, and place of the hearing at least ten days prior to the hearing. On the basis of the evidence submitted to the department or presented at the public hearing, the department shall reconsider and may adjust the preliminary determinations. The result of the reconsideration is the final reconciliation of the hospital's assessment under section ~~5112.06~~ 5166.05 of the Revised Code. The final reconciliation is subject to adjustments under division (D) of this section.

(C) The department shall mail to each hospital a written notice of its assessment for the program year under the final

reconciliation. A hospital may appeal the final reconciliation of its assessment to the court of common pleas of Franklin county. While a judicial appeal is pending, the hospital shall pay, in accordance with the schedules required by division (B) of section ~~5112.06~~ 5166.05 of the Revised Code, any amount of its assessment that is not in dispute into the hospital care assurance program fund created in section ~~5112.18~~ 5166.12 of the Revised Code.

(D) In the course of any program year, the department may adjust the assessment rate or rates established in rules pursuant to section ~~5112.06~~ 5166.05 of the Revised Code or adjust the amounts of intergovernmental transfers required under section ~~5112.07~~ 5166.06 of the Revised Code and, as a result of the adjustment, adjust each hospital's assessment and intergovernmental transfer, to reflect refinements made by the United States ~~health care financing administration~~ department of health and human services during that program year to the limits it prescribed under ~~subsection (f) of section 1923 of the "Social Security Act," 49 Stat. 620 (1935),~~ 42 U.S.C.~~A.~~ 1396r-4(f)~~, as amended~~. When adjusted, the assessment rate or rates must comply with division (A) of section ~~5112.06~~ 5166.05 of the Revised Code. An adjusted intergovernmental transfer must comply with division (A) of section ~~5112.07~~ 5166.06 of the Revised Code. The department shall notify hospitals of adjustments made under this division and adjust for the remainder of the program year the installments paid by hospitals under sections ~~5112.06~~ 5166.05 and ~~5112.07~~ 5166.06 of the Revised Code in accordance with rules adopted under section ~~5112.03~~ 5166.02 of the Revised Code.

Sec. ~~5112.10~~ 5166.09. The department of ~~job and family services~~ health care administration shall operate the hospital care assurance program established by sections ~~5112.01~~ 5166.01 to ~~5112.21~~ 5166.14 of the Revised Code on a program year basis. The department shall complete all program requirements on or before

the thirtieth day of September each year.

Sec. ~~5112.11~~ 5166.10. Except for moneys deposited into the legislative budget services fund under section ~~5112.19~~ 5166.13 of the Revised Code and the health care services administration fund created under section ~~5111.94~~ 5161.15 of the Revised Code, the department of ~~job and family services~~ health care administration shall not use money paid to the department under sections ~~5112.06~~ 5166.05 and ~~5112.07~~ 5166.06 of the Revised Code or money that the department pays to hospitals under section ~~5112.08~~ 5166.07 of the Revised Code to replace any funds appropriated by the general assembly for the ~~medical assistance~~ medicaid program.

Sec. ~~5112.17~~ 5166.11. (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~~ 5166.01 to ~~5112.21~~ 5166.14 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~~ medicaid 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 and recipients of the disability medical assistance program qualify for services under this section. The director of ~~job and family services~~ health care administration shall adopt rules under section ~~5112.03~~ 5166.02 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~~ medicaid 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~~ medicaid program, in accordance with Chapter ~~5111.~~ 5163. of the Revised Code and the rules adopted under ~~that chapter~~ section 5163.15 of the Revised Code, 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~~ 5166.02 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. ~~5112.18~~ 5166.12. (A) Except as provided in section ~~5112.19~~ 5166.13 of the Revised Code, all payments of assessments by hospitals under section ~~5112.06~~ 5166.05 of the Revised Code and all intergovernmental transfers under section ~~5112.07~~ 5166.06 of the Revised Code shall be deposited in the state treasury to the credit of the hospital care assurance program fund, hereby created. All investment earnings of the hospital care assurance program fund shall be credited to the fund. The department of ~~job and family services~~ health care administration shall maintain records that show the amount of money in the hospital care

assurance program fund at any time that has been paid by each hospital and the amount of any investment earnings on that amount. All moneys credited to the hospital care assurance program fund shall be used solely to make payments to hospitals under division (D) of this section and section ~~5112.08~~ 5166.07 of the Revised Code.

(B) All federal matching funds received as a result of the department distributing funds from the hospital care assurance program fund to hospitals under section ~~5112.08~~ 5166.07 of the Revised Code shall be credited to the health care - federal fund created under section ~~5111.943~~ 5161.18 of the Revised Code.

(C) All distributions of funds to hospitals under section ~~5112.08~~ 5166.07 of the Revised Code are conditional on:

(1) Expiration of the time for appeals under section ~~5112.09~~ 5166.08 of the Revised Code without the filing of an appeal, or on court determinations, in the event of appeals, that the hospital is entitled to the funds;

(2) The sum of the following being sufficient to distribute the funds after the final determination of any appeals:

(a) The available money in the hospital care assurance program fund;

(b) The available portion of the money in the health care - federal fund that is credited to that fund pursuant to division (B) of this section.

(3) The hospital's compliance with section ~~5112.17~~ 5166.11 of the Revised Code.

(D) If an audit conducted by the department of the amounts of payments made and funds received by hospitals under sections ~~5112.06, 5112.07, and 5112.08~~ 5166.05, 5166.06, and 5166.07 of the Revised Code identifies amounts that, due to errors by the

department, a hospital should not have been required to pay but did pay, should have been required to pay but did not pay, should not have received but did receive, or should have received but did not receive, the department shall:

(1) Make payments to any hospital that the audit reveals paid amounts it should not have been required to pay or did not receive amounts it should have received;

(2) Take action to recover from a hospital any amounts that the audit reveals it should have been required to pay but did not pay or that it should not have received but did receive.

Payments made under division (D)(1) of this section shall be made from the hospital care assurance program fund. Amounts recovered under division (D)(2) of this section shall be deposited to the credit of that fund. Any hospital may appeal the amount the hospital is to be paid under division (D)(1) or the amount that is to be recovered from the hospital under division (D)(2) of this section to the court of common pleas of Franklin county.

Sec. ~~5112.19~~ 5166.13. From the first installment of assessments paid under section ~~5112.06~~ 5166.05 of the Revised Code and intergovernmental transfers made under section ~~5112.07~~ 5166.06 of the Revised Code during each program year beginning in an odd-numbered calendar year, the department of ~~job and family services~~ health care administration shall deposit into the state treasury to the credit of the legislative budget services fund, which is hereby created, a total amount equal to the amount by which the biennial appropriation from that fund exceeds the amount of unexpended, unencumbered moneys in that fund. All investment earnings of the legislative budget services fund shall be credited to that fund. Money in the legislative budget services fund shall be used solely to pay the expenses of the legislative budget office of the legislative service commission.

Sec. ~~5112.21~~ 5166.14. Except as specifically required by sections ~~5112.01~~ 5166.01 to ~~5112.19~~ 5166.13 of the Revised Code, information filed under those sections shall not include any patient-identifying material. Information that includes patient-identifying material is not a public record under section 149.43 of the Revised Code, and no patient-identifying material shall be released publicly by the department of ~~job and family services~~ health care administration or by any person under contract with the department who has access to such information.

Sec. ~~3721.50~~ 5166.20. As used in sections ~~3721.50~~ 5166.20 to ~~3721.58~~ 5166.30 of the Revised Code:

(A) "Hospital" has the same meaning as in section 3727.01 of the Revised Code.

(B) "Inpatient days" means all days during which a resident of a nursing facility, regardless of payment source, occupies a bed in the nursing facility that is included in the facility's certified capacity under ~~Title XIX~~ the medicaid program. Therapeutic or hospital leave days for which payment is made under section ~~5111.26~~ 5164.37 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.

(C) ~~"Medicaid" has the same meaning as in section 5111.01 of the Revised Code.~~

~~(D)~~ "Medicaid day" means all days during which a resident who is a medicaid recipient occupies a bed in a nursing facility that is included in the facility's certified capacity under ~~Title XIX~~ the medicaid program. Therapeutic or hospital leave days for which payment is made under section ~~5111.26~~ 5164.37 of the Revised Code are considered medicaid days proportionate to the percentage of the nursing facility's per resident per day rate for those days.

~~(E)~~(D) "Nursing facility" has the same meaning as in section ~~5111.20~~ 5164.01 of the Revised Code.

~~(F)~~(E)(1) "Nursing home" means all of the following:

(a) A nursing home licensed under section 3721.02 or 3721.09 of the Revised Code, including any part of a home for the aging licensed as a nursing home;

(b) A facility or part of a facility, other than a hospital, that is certified as a skilled nursing facility under ~~Title XVIII~~ the medicare program;

(c) A nursing facility, other than a portion of a hospital certified as a nursing facility.

(2) "Nursing home" does not include any of the following:

(a) A county home, county nursing home, or district home operated pursuant to Chapter 5155. of the Revised Code;

(b) A nursing home maintained and operated by the Ohio veterans' home agency under section 5907.01 of the Revised Code;

(c) A nursing home or part of a nursing home licensed under section 3721.02 or 3721.09 of the Revised Code that is certified as an intermediate care facility for the mentally retarded under ~~Title XIX~~ the medicaid program.

~~(G) "Title XIX" means Title XIX of the "Social Security Act," 79 Stat. 286 (1965), 42 U.S.C. 1396, as amended.~~

~~(H) "Title XVIII" means Title XVIII of the "Social Security Act," 79 Stat. 286 (1965), 42 U.S.C. 1395, as amended.~~

Sec. ~~3721.51~~ 5166.21. The department of ~~job and family services~~ health care administration shall do all of the following:

(A) Subject to division (C) of this section and for the purposes specified in sections ~~3721.56~~ 5166.27 and ~~3721.561~~ 5166.28 of the Revised Code, determine an annual franchise permit

fee on each nursing home in an amount equal to six dollars and twenty-five cents for fiscal years 2006 and 2007 and one dollar for each fiscal year thereafter, multiplied by the product of the following:

(1) The number of beds licensed as nursing home beds, plus any other beds certified as skilled nursing facility beds under ~~Title XVIII~~ the medicare program or nursing facility beds under ~~Title XIX~~ the medicaid program on the first day of May of the calendar year in which the fee is determined pursuant to division (A) of section ~~3721.53~~ 5166.23 of the Revised Code;

(2) The number of days in the fiscal year beginning on the first day of July of the calendar year in which the fee is determined pursuant to division (A) of section ~~3721.53~~ 5166.23 of the Revised Code.

(B) Subject to division (C) of this section and for the purposes specified in sections ~~3721.56~~ 5166.27 and ~~3721.561~~ 5166.28 of the Revised Code, determine an annual franchise permit fee on each hospital in an amount equal to six dollars and twenty-five cents for fiscal years 2006 and 2007 and one dollar for each fiscal year thereafter, multiplied by the product of the following:

(1) The number of beds registered pursuant to section 3701.07 of the Revised Code as skilled nursing facility beds or long-term care beds, plus any other beds licensed as nursing home beds under section 3721.02 or 3721.09 of the Revised Code, on the first day of May of the calendar year in which the fee is determined pursuant to division (A) of section ~~3721.53~~ 5166.23 of the Revised Code;

(2) The number of days in the fiscal year beginning on the first day of July of the calendar year in which the fee is determined pursuant to division (A) of section ~~3721.53~~ 5166.23 of

the Revised Code.

(C) If the United States centers for medicare and medicaid services determines that the franchise permit fee established by sections ~~3721.50~~ 5166.20 to ~~3721.58~~ 5166.30 of the Revised Code is an impermissible health care related tax under ~~section 1903(w) of the "Social Security Act," 49 Stat. 620 (1935),~~ 42 U.S.C. 1396b(w), ~~as amended,~~ take all necessary actions to cease implementation of sections ~~3721.50~~ 5166.20 to ~~3721.58~~ 5166.30 of the Revised Code in accordance with rules adopted under section ~~3721.58~~ 5166.30 of the Revised Code.

Sec. ~~3721.52~~ 5166.22. (A) For the purpose of the fee under division (A) of section ~~3721.51~~ 5166.21 of the Revised Code, the department of health shall, not later than the first day of each June, report to the department of ~~job and family services~~ health care administration the number of beds in each nursing home licensed on the preceding first day of May under section 3721.02 or 3721.09 of the Revised Code or certified on that date under ~~Title XVIII or XIX~~ the medicare or medicaid program.

(B) For the purpose of the fee under division (B) of section ~~3721.51~~ 5166.21 of the Revised Code, the department of health shall, not later than the first day of each June, report to the department of ~~job and family services~~ health care administration the number of beds in each hospital registered on the preceding first day of May pursuant to section 3701.07 of the Revised Code as skilled nursing facility or long-term care beds or licensed on that date under section 3721.02 or 3721.09 of the Revised Code as nursing home beds.

Sec. ~~3721.53~~ 5166.23. (A) Not later than the fifteenth day of August of each year, the department of ~~job and family services~~ health care administration shall determine the annual franchise

permit fee for each nursing home in accordance with division (A) of section ~~3721.51~~ 5166.21 of the Revised Code and the annual franchise permit fee for each hospital in accordance with division (B) of that section.

(B) Not later than the first day of September of each year, the department shall mail to each nursing home and hospital notice of the amount of the franchise permit fee that has been determined for the nursing home or hospital.

(C) Each nursing home and hospital shall pay its fee under section ~~3721.51~~ 5166.21 of the Revised Code to the department in quarterly installment payments not later than forty-five days after the last day of each September, December, March, and June.

(D) No nursing home or hospital shall directly bill its residents for the fee paid under this section, or otherwise directly pass the fee through to its residents.

Sec. ~~3721.54~~ 5166.24. If a nursing home or hospital fails to pay the full amount of a franchise permit fee installment when due, the department of ~~job and family services~~ health care administration may assess a five per cent penalty on the amount due for each month or fraction thereof the installment is overdue.

Sec. ~~3721.541~~ 5166.25. (A) In addition to assessing a penalty pursuant to section ~~3721.54~~ 5166.24 of the Revised Code, the department of ~~job and family services~~ health care administration may do either of the following if a nursing facility or hospital 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 ~~3721.54~~ 5166.24 of the Revised Code from a medicaid payment due the nursing facility or hospital until the nursing facility or hospital pays the installment and penalty;

(2) Terminate the nursing facility or hospital's medicaid provider agreement.

(B) The department may withhold a medicaid payment under division (A)(1) of this section without providing notice to the nursing facility or hospital and without conducting an adjudication under Chapter 119. of the Revised Code.

Sec. ~~3721.55~~ 5166.26. (A) A nursing home or hospital may appeal the fee imposed under section ~~3721.51~~ 5166.21 of the Revised Code solely on the grounds that the department of ~~job and family services~~ health care administration committed a material error in determining the amount of the fee. A request for an appeal must be received by the department not later than fifteen days after the date the department mails the notice of the fee and must include written materials setting forth the basis for the appeal.

(B) If a nursing home or hospital submits a request for an appeal within the time required under division (A) of this section, the department of ~~job and family services~~ health care administration shall hold a public hearing in Columbus not later than thirty days after the date the department receives the request for an appeal. The department shall, not later than ten days before the date of the hearing, mail a notice of the date, time, and place of the hearing to the nursing home or hospital. The department may hear all the requested appeals in one public hearing.

(C) On the basis of the evidence presented at the hearing or any other evidence submitted by the nursing home or hospital, the department may adjust a fee. The department's decision is final.

Sec. ~~3721.56~~ 5166.27. There is hereby created in the state treasury the home- and community-based services for the aged fund.

Sixteen per cent of all payments and penalties paid by nursing homes and hospitals under sections ~~3721.53~~ 5166.23 and ~~3721.54~~ 5166.24 of the Revised Code for fiscal years 2006 and 2007, and all such payments and penalties paid for subsequent fiscal years, shall be deposited into the fund. The departments of ~~job and family services~~ health care administration and aging shall use the moneys in the fund to fund the following in accordance with rules adopted under section ~~3721.58~~ 5166.30 of the Revised Code:

(A) The medicaid program ~~established under Chapter 5111. of the Revised Code~~, including the PASSPORT program established under section 173.40 of the Revised Code;

(B) The residential state supplement program established under section ~~173.35~~ 5160.80 of the Revised Code.

Sec. ~~3721.561~~ 5166.28. (A) There is hereby created in the state treasury the nursing facility stabilization fund. All payments and penalties paid by nursing homes and hospitals under sections ~~3721.53~~ 5166.23 and ~~3721.54~~ 5166.24 of the Revised Code that are not deposited into the home and community-based services for the aged fund shall be deposited into the fund. The department of ~~job and family services~~ health care administration shall use the money in the fund to make medicaid payments to nursing facilities.

(B) Any money remaining in the nursing facility stabilization fund after payments specified in division (A) of this section are made shall be retained in the fund. Any interest or other investment proceeds earned on money in the fund shall be credited to the fund and used to make medicaid payments in accordance with division (A) of this section.

Sec. ~~3721.57~~ 5166.29. The department of ~~job and family services~~ health care administration may make any investigation it

considers appropriate to obtain information necessary to fulfill its duties under sections ~~3721.50~~ 5166.20 to ~~3721.58~~ 5166.30 of the Revised Code. At the request of the department, the attorney general shall aid in any such investigations. The attorney general shall institute and prosecute all necessary actions for the enforcement of sections ~~3721.50~~ 5166.20 to ~~3721.58~~ 5166.30 of the Revised Code, except that at the request of the attorney general, the county prosecutor of the county in which a nursing home or hospital that has failed to comply with sections ~~3721.50~~ 5166.20 to ~~3721.58~~ 5166.30 of the Revised Code is located shall institute and prosecute any necessary action against the nursing home or hospital.

Sec. ~~3721.58~~ 5166.30. The director of ~~job and family services~~ health care administration shall adopt rules in accordance with Chapter 119. of the Revised Code to do all of the following:

(A) Prescribe the actions the department of ~~job and family services~~ health care administration will take to cease implementation of sections ~~3721.50~~ 5166.20 through ~~3721.57~~ 5166.29 of the Revised Code if the United States centers for medicare and medicaid services determines that the franchise permit fee established by those sections is an impermissible health-care related tax under ~~section 1903(w) of the "Social Security Act," 49 Stat. 620 (1935),~~ 42 U.S.C. 1396b(w)~~, as amended~~;

(B) Establish the method of distributing moneys in the home and community-based services for the aged fund created under section ~~3721.56~~ 5166.27 of the Revised Code;

(C) Establish any requirements or procedures the director considers necessary to implement sections ~~3721.50~~ 5166.20 to ~~3721.58~~ 5166.30 of the Revised Code.

Sec. ~~5112.30~~ 5166.40. As used in sections ~~5112.30~~ 5166.40 to ~~5112.39~~ 5166.50 of the Revised Code~~:~~

~~(A) "Intermediate,~~ "intermediate care facility for the mentally retarded" has the same meaning as in section ~~5111.20~~ 5164.01 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~~ 5166.41. The department of ~~job and family services~~ health care administration 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, except as adjusted under section ~~5112.311~~ 5166.42 of the Revised Code, by the product of the following:

(1) The number of beds certified ~~under Title XIX of the "Social Security Act"~~ for the medicaid program on the first day of May of the calendar year in which the assessment is determined pursuant to division (A) of section ~~5112.33~~ 5166.44 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, 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~~ 5166.50 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~~ 5166.40 to ~~5112.39~~ 5166.50 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,~~ take all necessary actions to cease implementation of those sections in accordance with rules adopted under section ~~5112.39~~ 5166.50 of the Revised Code.

Sec. ~~5112.311~~ 5166.42. If, under section ~~5111.8816~~ 5163.6616 of the Revised Code, the certified capacity of an intermediate care facility for the mentally retarded is reduced, the department of ~~job and family services~~ health care administration shall adjust the franchise permit fee the facility was assessed under section ~~5112.31~~ 5166.41 of the Revised Code accordingly. If, under section ~~5111.8811~~ 5163.6611 of the Revised Code, the certified capacity of an intermediate care facility for the mentally retarded is increased, the department may adjust the franchise permit fee the facility was assessed under section ~~5112.31~~ 5166.41 of the Revised Code accordingly.

Sec. ~~5112.32~~ 5166.43. For the purpose of the franchise permit fee imposed under section ~~5112.31~~ 5166.41 of the Revised Code, the department of mental retardation and developmental disabilities shall:

(A) Not later than August 1, 1993, report to the department of ~~job and family services~~ health care administration the number of beds in each intermediate care facility for the mentally retarded certified on July 1, 1993, ~~under Title XIX of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended~~ for the medicaid program;

(B) Not later than June 1, 1994, and the first day of each

June thereafter, report to the department of ~~job and family services~~ health care administration the number of beds in each such facility certified on the preceding first day of May under that title.

Sec. ~~5112.33~~ 5166.44. (A) Not later than the fifteenth day of August of each year, the department of ~~job and family services~~ health care administration shall determine the annual franchise permit fee for each intermediate care facility for the mentally retarded in accordance with section ~~5112.31~~ 5166.41 of the Revised Code.

(B) Not later than the first day of September of each year, the department shall mail to each intermediate care facility for the mentally retarded notice of the amount of the franchise permit fee the facility has been assessed under section ~~5112.31~~ 5166.41 of the Revised Code.

(C) Each intermediate care facility for the mentally retarded shall pay its fee under section ~~5112.31~~ 5166.41 of the Revised Code to the department in quarterly installment payments not later than forty-five days after the last day of each September, December, March, and June.

Sec. ~~5112.34~~ 5166.45. If an intermediate care facility for the mentally retarded fails to pay the full amount of an installment when due, the department of ~~job and family services~~ health care administration may assess a five per cent penalty on the amount due for each month or fraction thereof the installment is overdue.

Sec. ~~5112.341~~ 5166.46. (A) In addition to assessing a penalty pursuant to section ~~5112.34~~ 5166.45 of the Revised Code, the department of ~~job and family services~~ health care administration 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~~ 5166.45 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. ~~5112.35~~ 5166.47. (A) An intermediate care facility for the mentally retarded may appeal the franchise permit fee imposed under section ~~5112.31~~ 5166.41 of the Revised Code solely on the grounds that the department of ~~job and family services~~ health care administration committed a material error in determining the amount of the fee. A request for an appeal must be received by the department not later than fifteen days after the date the department mails the notice of the fee and must include written materials setting forth the basis for the appeal.

(B) If an intermediate care facility for the mentally retarded submits a request for an appeal within the time required under division (A) of this section, the department shall hold a public hearing in Columbus not later than thirty days after the date the department receives the request for an appeal. The department shall, not later than ten days before the date of the hearing, mail a notice of the date, time, and place of the hearing to the facility. The department may hear all requested appeals in one public hearing.

(C) On the basis of the evidence presented at the hearing or

any other evidence submitted by the intermediate care facility for the mentally retarded, the department may adjust a fee. The department's decision is final.

Sec. ~~5112.37~~ 5166.48. All installment payments and penalties paid by an intermediate care facility for the mentally retarded under sections ~~5112.33~~ 5166.44 and ~~5112.34~~ 5166.45 of the Revised Code shall be deposited into the "home and community-based services for the mentally retarded and developmentally disabled fund," which is hereby created in the state treasury. The department of ~~job and family services~~ health care administration shall distribute the money in the fund in accordance with rules adopted under section ~~5112.39~~ 5166.50 of the Revised Code. The departments of ~~job and family services~~ health care administration and mental retardation and developmental disabilities shall use the money for the ~~medical assistance~~ medicaid program ~~established under Chapter 5111. of the Revised Code and~~, including home and community-based services to ~~mentally retarded and developmentally disabled~~ persons with mental retardation or a developmental disability.

Sec. ~~5112.38~~ 5166.49. The department of ~~job and family services~~ health care administration may make any investigation it considers appropriate to obtain information necessary to fulfill its duties under sections ~~5112.30~~ 5166.40 to ~~5112.39~~ 5166.50 of the Revised Code. At the request of the department, the attorney general shall aid in any such investigations. The attorney general shall institute and prosecute all necessary actions for the enforcement of sections ~~5112.30~~ 5166.40 to ~~5112.39~~ 5166.50 of the Revised Code, except that at the request of the attorney general, the county prosecutor of the county in which an intermediate care facility for the mentally retarded that has failed to comply with those sections is located shall institute and prosecute any

necessary action against the facility.

Sec. ~~5112.39~~ 5166.50. The director of ~~job and family services~~ health care administration shall adopt rules in accordance with Chapter 119. of the Revised Code to do all of the following:

(A) Establish a composite inflation factor with which to adjust franchise permit fees under section ~~5112.31~~ 5166.41 of the Revised Code;

(B) Prescribe the actions the department will take to cease implementation of sections ~~5112.30~~ 5166.40 to ~~5112.39~~ 5166.50 of the Revised Code if the United States secretary of health and human services determines that the franchise permit fee imposed under section ~~5112.31~~ 5166.41 of the Revised Code is an impermissible health care-related tax under ~~section 1903(w) of the "Social Security Act," 49 Stat. 620 (1935),~~ 42 U.S.C.~~A.~~ 1396b(w)~~, as amended~~;

(C) Establish the method of distributing the money in the home and community-based services for the mentally retarded and developmentally disabled fund created by section ~~5112.37~~ 5166.48 of the Revised Code;

(D) Establish any other requirements or procedures the director considers necessary to implement sections ~~5112.30~~ 5166.40 to ~~5112.39~~ 5166.50 of the Revised Code.

Sec. ~~5111.176~~ 5166.60. (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~~ health care administration pursuant to section ~~5111.17~~ 5165.05 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~~ health care administration a franchise permit fee for the period December 1, 2005, through December 31, 2005, and each calendar quarter occurring thereafter.

(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 period December 1, 2005, through December 31, 2005, and in the subsequent 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 the period December 1, 2005, through December 31, 2005, or the subsequent quarter to which the fee applies.

(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 period December 1, 2005, through December 31, 2005, or 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 the period December 1, 2005, through December 31, 2005, or a particular calendar quarter, at any time during the five years following the date the franchise permit fee payment for that period or 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;

(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~~ 5163.01 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~~ health care administration may adopt rules to implement and administer this section. The rules shall be adopted in accordance with Chapter 119. of the Revised Code.

Sec. ~~5112.99~~ 5166.99. (A) The director of ~~job and family services~~ health care administration shall impose a penalty for each day that a hospital fails to report the information required under section ~~5112.04~~ 5166.03 of the Revised Code on or before the dates specified in that section. The amount of the penalty shall

be established by the director in rules adopted under section ~~5112.03~~ 5166.02 of the Revised Code.

(B) In addition to any other remedy available to the department of ~~job and family services~~ health care administration under law to collect unpaid assessments and transfers, the director shall impose a penalty of ten per cent of the amount due on any hospital that fails to pay assessments or make intergovernmental transfers by the dates required by rules adopted under section ~~5112.03~~ 5166.02 of the Revised Code.

(C) The director shall waive the penalties provided for in divisions (A) and (B) of this section for good cause shown by the hospital.

(D) All penalties imposed under this section shall be deposited into the health care administration fund created by section ~~5111.94~~ 5161.15 of the Revised Code.

Sec. 5167.01. As used in this chapter, "federal poverty guidelines" has the same meaning as in section 5101.46 of the Revised Code.

Sec. ~~5101.50~~ 5167.05. ~~(A) As used in this section and in sections 5101.51 to 5101.5110 of the Revised Code:~~

~~(1) "Children's health insurance program" means the program authorized by Title XXI of the "Social Security Act," 111 Stat. 552 (1997), 42 U.S.C.A. 1397aa.~~

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

~~(B)~~ The director of ~~job and family services~~ health care administration may continue to operate the children's health insurance program initially authorized by an executive order issued under section 107.17 of the Revised Code as long as federal

financial participation is available for the program. If operated, the program shall provide health assistance to uninsured individuals under nineteen years of age with family incomes not exceeding one hundred fifty per cent of the federal poverty guidelines. In accordance with 42 U.S.C.A. 1397aa, the director may provide for the health assistance to meet the requirements of 42 U.S.C.~~A.~~ 1397cc, to be provided under the medicaid program ~~established under Chapter 5111. of the Revised Code~~, or to be a combination of both.

Sec. ~~5101.501~~ 5167.06. Health assistance provided under section ~~5101.50~~ 5167.05 of the Revised Code shall be known as the children's health insurance program part I.

Sec. ~~5101.502~~ 5167.07. The director of ~~job and family services~~ health care administration may adopt rules in accordance with Chapter 119. of the Revised Code as necessary for the efficient administration of the children's health insurance program part I, including rules that establish all of the following:

(A) The conditions under which health assistance services will be reimbursed;

(B) The method of reimbursement applicable to services reimbursable under the program;

(C) The amount of reimbursement, or the method by which the amount is to be determined, for each reimbursable service.

Sec. ~~5101.503~~ 5167.08. A completed application for ~~medical assistance under Chapter 5111. of the Revised Code~~ the medicaid program shall be treated as an application for health assistance under the children's health insurance program part I if the application is for an assistance group that includes a child under

nineteen years of age and is denied.

Sec. ~~5101.51~~ 5167.10. In accordance with federal law governing the children's health insurance program, the director of ~~job and family services~~ health care administration may submit a state child health plan to the United States secretary of health and human services to provide, except as provided in section ~~5101.516~~ 5167.16 of the Revised Code, health assistance to uninsured individuals under nineteen years of age with family incomes above one hundred fifty per cent of the federal poverty guidelines but not exceeding two hundred per cent of the federal poverty guidelines. If the director submits the plan, the director shall include both of the following in the plan:

(A) The health assistance will not begin before January 1, 2000.

(B) The health assistance will be available only while federal financial participation is available for it.

Sec. ~~5101.511~~ 5167.11. Health assistance provided under section ~~5101.51~~ 5167.10 of the Revised Code shall be known as the children's health insurance program part II.

Sec. ~~5101.512~~ 5167.12. If the director of ~~job and family services~~ health care administration submits a state child health plan to the United States secretary of health and human services under section ~~5101.51~~ 5167.10 of the Revised Code and the secretary approves the plan, the director shall implement the children's health insurance program part II in accordance with the plan. The director may adopt rules in accordance with Chapter 119. of the Revised Code as necessary for the efficient administration of the program, including rules that establish all of the following:

(A) The conditions under which health assistance services will be reimbursed;

(B) The method of reimbursement applicable to services reimbursable under the program;

(C) The amount of reimbursement, or the method by which the amount is to be determined, for each reimbursable service.

Sec. ~~5101.513~~ 5167.13. The director of ~~job and family services~~ health care administration may contract with a government entity or person to perform the director's administrative duties regarding the children's health insurance program part II, other than the duty to submit a state child health plan to the United States secretary of health and human services under section ~~5101.51~~ 5167.10 of the Revised Code and the duty to adopt rules under section ~~5101.512~~ 5167.12 of the Revised Code.

Sec. ~~5101.514~~ 5167.14. In accordance with 42 U.S.C.~~A.~~ 1397aa, the director of health care administration may provide for health assistance under the children's health insurance program part II to meet the requirements of 42 U.S.C.~~A.~~ 1397cc, to be provided under the medicaid program ~~established under Chapter 5111. of the Revised Code~~, or to be a combination of both.

Sec. ~~5101.515~~ 5167.15. The director of ~~job and family services~~ health care administration may determine applicants' eligibility for the children's health insurance program part II by any of the following means:

(A) Using employees of the department of ~~job and family services~~ health care administration;

(B) Assigning the duty to county departments of job and family services;

(C) Contracting with a government entity or person.

Sec. ~~5101.516~~ 5167.16. If the director of ~~job and family services~~ health care administration determines that federal financial participation for the children's health insurance program part II is insufficient to provide health assistance to all the individuals the director anticipates are eligible for the program, the director may refuse to accept new applications for the program or may make the program's eligibility requirements more restrictive.

Sec. ~~5101.517~~ 5167.17. To the extent permitted by 42 U.S.C.~~A.~~ 1397cc(e), the director of ~~job and family services~~ health care administration may require an individual receiving health assistance under the children's health insurance program part II to pay a premium, deductible, coinsurance payment, or other cost-sharing expense.

Sec. ~~5101.518~~ 5167.18. The director of ~~job and family services~~ health care administration shall establish an appeal process for individuals aggrieved by a decision made regarding eligibility for the children's health insurance program part II. The process may be identical to, similar to, or different from the appeal process established by section ~~5101.35~~ 5160.34 of the Revised Code.

Sec. ~~5101.519~~ 5167.19. A completed application for ~~medical assistance under Chapter 5111. of the Revised Code~~ the medicaid program shall be treated as an application for health assistance under the children's health insurance program part II if the application is for an assistance group that includes a child under nineteen years of age and is denied.

Sec. ~~5101.5110~~ 5167.25. (A) The director of ~~job and family services~~ health care administration may submit a waiver request to

the United States secretary of health and human services to provide health assistance to any individual who meets all of the following requirements:

(1) Is the parent of a child under nineteen years of age who resides with the parent and is eligible for health assistance under the children's health insurance program part I or II or the medicaid program ~~established under Chapter 5111. of the Revised Code~~;

(2) Is uninsured;

(3) Has a family income that does not exceed one hundred per cent of the federal poverty guidelines.

(B) A waiver request the director submits under division (A) of this section may seek federal funds allotted to the state under ~~Title XXI of the "Social Security Act," 111 Stat. 558 (1997),~~ 42 U.S.C.~~A.~~ 1397dd~~, as amended,~~ that are not otherwise used to fund the children's health insurance program parts I and II.

(C) If a waiver request the director submits under division (A) of this section is granted, the director may adopt rules in accordance with Chapter 119. of the Revised Code as necessary for the efficient administration of the program authorization by the waiver.

Sec. ~~5115.10~~ 5168.01. (A) The director of ~~job and family services~~ health care administration shall establish a disability medical assistance program.

(B) Subject to all other eligibility requirements established by this chapter and the rules adopted under it for the disability medical assistance program, a person may be eligible for disability medical assistance only if the person is medication dependent, as determined by the department of ~~job and family services~~ health care administration.

(C) The director shall adopt rules under section 111.15 of the Revised Code for purposes of implementing division (B) of this section. The rules may specify or establish any or all of the following:

(1) Standards for determining whether a person is medication dependent, including standards under which a person may qualify as being medication dependent only if it is determined that both of the following are the case:

(a) The person is receiving ongoing treatment for a chronic medical condition that requires continuous prescription medication for an indefinite, long-term period of time;

(b) Loss of the medication would result in a significant risk of medical emergency and loss of employability lasting at least nine months.

(2) A requirement that a person's medical condition be certified by an individual authorized under Chapter 4731. of the Revised Code to practice medicine and surgery or osteopathic medicine and surgery;

(3) Limitations on the chronic medical conditions and prescription medications that may qualify a person as being medication dependent.

Sec. ~~5115.11~~ 5168.02. An individual who qualifies for the ~~medical assistance~~ medicaid program ~~established under Chapter 5111. of the Revised Code~~ shall receive medical assistance through that program rather than through the disability medical assistance program.

An individual is ineligible for disability medical assistance if, for the purpose of avoiding consideration of property in determinations of the individual's eligibility for disability medical assistance or a greater amount of assistance, the person

has transferred property during the two years preceding application for or most recent redetermination of eligibility for disability medical assistance.

Sec. 5168.03. Each applicant for or recipient of disability medical assistance who, in the judgment of the department of health care administration or a county department of job and family services might be eligible for benefits under the supplemental security program, shall, as a condition of eligibility for assistance, apply for such benefits if directed to do so by the department or county department.

Sec. 5168.04. As a condition of eligibility for 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 department of health care administration or county department of job and family services may provide assistance to the applicant or recipient in securing other forms of assistance.

Sec. ~~5115.12~~ 5168.05. (A) The director of ~~job and family services~~ health care administration shall adopt rules in accordance with section 111.15 of the Revised Code governing the disability medical assistance program. The rules may establish or specify any or all of the following:

(1) Income, resource, citizenship, age, residence, living arrangement, and other eligibility requirements;

(2) Health services to be included in the program;

(3) The maximum authorized amount, scope, duration, or limit of payment for services;

(4) Limits on the length of time an individual may receive disability medical assistance;

(5) Limits on the total number of individuals in the state who may receive disability medical assistance.

(B) For purposes of limiting the cost of the disability medical assistance program, the director may do either of the following:

(1) Adopt rules in accordance with section 111.15 of the Revised Code that revise the program's eligibility requirements; the maximum authorized amount, scope, duration, or limit of payment for services included in the program; or any other requirement or standard established or specified by rules adopted under division (A) of this section or under section ~~5115.10~~ 5168.01 of the Revised Code;

(2) Suspend acceptance of applications for disability medical assistance. While a suspension is in effect, no person shall receive a determination or redetermination of eligibility for disability medical assistance unless the person was receiving the assistance during the month immediately preceding the suspension's effective date or the person submitted an application prior to the suspension's effective date and receives a determination of eligibility based on that application. The director may adopt rules in accordance with section 111.15 of the Revised Code establishing requirements and specifying procedures applicable to the suspension of acceptance of applications.

Sec. ~~5115.14~~ 5168.06. (A) The director of ~~job and family services~~ health care administration shall adopt rules in accordance with section 111.15 of the Revised Code establishing

application and verification procedures, reapplication procedures, and other requirements the director considers necessary in the administration of the application process for disability medical assistance.

(B) Any person who applies for disability medical assistance shall receive a voter registration application under section 3503.10 of the Revised Code.

Sec. ~~5115.13~~ 5168.07. (A) The department of ~~job and family services~~ health care administration shall supervise and administer the disability medical program, except as follows:

(1) The department may require county departments of job and family services to perform any administrative function specified in rules adopted by the director of ~~job and family services~~ health care administration.

(2) The director may contract with any private or public entity in this state to perform any administrative function or to administer any or all of the program.

(B) If the department requires county departments to perform administrative functions, the director of ~~job and family services~~ health care administration shall adopt rules in accordance with section 111.15 of the Revised Code governing the performance of the functions to be performed by county departments. County departments shall perform the functions in accordance with the rules.

If the director contracts with a private or public entity to perform administrative functions or to administer any or all of the program, the director may either adopt rules in accordance with section 111.15 of the Revised Code or include provisions in the contract governing the performance of the functions by the private or public entity. Entities under contract shall perform

the functions in accordance with the requirements established by the director.

(C) Whenever division (A)(1) or (2) of this section is implemented, the director shall conduct investigations to determine whether disability medical assistance is being administered in compliance with the Revised Code and rules adopted by the director or in accordance with the terms of the contract.

Sec. 5168.08. If a recipient of 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 department of health care administration or county department of job and family services within the time limits specified in rules adopted by the director of health care administration 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 5168.09 of the Revised Code.

Sec. 5168.09. As used in this section, "erroneous payments" means 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 health care administration 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.

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 health care administration shall receive the remaining fifty per cent.

Sec. 5168.10. Whenever 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.

Sec. ~~173.71~~ 5169.01. As used in ~~sections 173.71 to 173.91 of the Revised Code~~ this chapter:

(A) ~~"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.~~

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

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

~~(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.

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

~~(F)~~(C) "Participating manufacturer" means a drug manufacturer participating in the Ohio's best Rx program pursuant to a manufacturer agreement entered into under section ~~173.81~~ 5169.11 of the Revised Code.

~~(G)~~(D) "Participating terminal distributor" means a terminal distributor of dangerous drugs participating in the Ohio's best Rx program pursuant to an agreement entered into under section ~~173.79~~ 5169.09 of the Revised Code.

~~(H)~~(E) "Political subdivision" has the same meaning as in section 9.23 of the Revised Code.

~~(I)~~(F) "State agency" has the same meaning as in section 9.23 of the Revised Code.

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

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

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

~~(M)~~(J) "Usual and customary charge" means the amount a participating terminal distributor or the drug mail order system included in the Ohio's best Rx program pursuant to section ~~173.78~~ 5169.08 of the Revised Code charges when a drug included in the program is purchased by 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 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.

Sec. ~~173.72~~ 5169.02. There is hereby established the Ohio's best Rx program for the purpose of providing outpatient prescription drug discounts to individuals residing in this state who are enrolled in the program by meeting the eligibility requirements specified in section ~~173.76~~ 5169.06 of the Revised Code, including eligible individuals who are sixty years of age or older, eligible individuals who have low incomes but are not eligible for medicaid, and other eligible individuals who do not have health benefits that cover outpatient drugs. The program shall include all drugs that are included in a manufacturer agreement entered into under section ~~173.81~~ 5169.11 of the Revised Code and all other drugs that may be dispensed only pursuant to a prescription issued by a licensed health professional authorized to prescribe drugs, as defined in section 4729.01 of the Revised Code.

Sec. ~~173.721~~ 5169.021. (A) Except as provided in division (B) of this section, the Ohio's best Rx program shall be administered by the department of ~~aging~~ health care administration.

(B)(1) The department may enter into a contract with any person under which the person serves as the administrator of the Ohio's best Rx program. Before entering into a contract for a program administrator, the department shall issue a request for proposals from persons seeking to be considered. The department shall develop a process to be used in issuing the request for proposals, receiving responses to the request, and evaluating the

responses on a competitive basis. In accordance with that process, the department shall select the person to be awarded the contract.

(2) Subject to divisions (B)(5) and (6) of this section, the department may delegate to the person awarded the contract any of the department's powers or duties specified in sections ~~173.71~~ 5169.01 to ~~173.91~~ 5169.21 of the Revised Code or any other provision of the Revised Code pertaining to the Ohio's best Rx program. The terms of the contract shall specify the extent to which the powers or duties are delegated to the program administrator.

(3) In exercising powers or performing duties delegated under the contract, the program administrator is subject to the same provisions of sections ~~173.71~~ 5169.01 to ~~173.91~~ 5169.21 of the Revised Code or other provisions of the Revised Code that grant the powers or duties to the department, as well as any limitations or restrictions that are applicable to or associated with those powers or duties.

(4) Wherever the department is referred to in sections ~~173.71~~ 5169.01 to ~~173.91~~ 5169.21 of the Revised Code or another provision of the Revised Code relative to a power or duty delegated to the program administrator, both of the following apply:

(a) If the department has delegated the power or duty in whole to the program administrator, the reference to the department is, instead, a reference to the administrator.

(b) If the department retains any part of the power or duty that is delegated to the program administrator, the reference to the department is a reference to both the department and the administrator.

(5) The terms of a contract for a program administrator shall include provisions for offering the drug mail order system included in the Ohio's best Rx program pursuant to section ~~173.78~~

5169.08 of the Revised Code. The terms of the contract may permit the administrator to offer the drug mail order system by contracting with another person.

(6) The department shall not delegate to a program administrator the department's powers or duties to do any of the following:

(a) Enter into contracts under this section other than a contract to offer a drug mail order system;

(b) Receive verification of drug pricing information under section ~~173.742~~ 5169.042 of the Revised Code or verification of drug manufacturer payment information under section ~~173.814~~ 5169.114 of the Revised Code from the pharmacy benefit manager selected under section ~~173.731~~ 5169.031 of the Revised Code to serve as the Ohio's best Rx program's consulting pharmacy benefit manager;

(c) Request the program's consulting pharmacy benefit manager to provide for an audit under section ~~173.732~~ 5169.032 of the Revised Code;

(d) Review or use any information contained in or pertaining to an audit provided for by the program's consulting pharmacy benefit manager other than the audit's findings of whether the consulting pharmacy benefit manager provided valid information when providing drug pricing verification services or drug manufacturer payment verification services;

(e) Adopt rules under section ~~173.83~~ 5169.13 or ~~173.84~~ 5169.14 of the Revised Code;

(f) Employ an ombudsperson pursuant to section ~~173.723~~ 5169.023 of the Revised Code.

Sec. ~~173.722~~ 5169.022. The department of ~~aging~~ health care administration shall undertake outreach efforts to publicize the

Ohio's best Rx program and maximize participation in the program.

Sec. ~~173.723~~ 5169.023. The department of ~~aging~~ health care administration shall employ an ombudsperson to assist terminal distributors of dangerous drugs with grievances regarding the Ohio's best Rx program.

Sec. ~~173.724~~ 5169.024. The department of ~~aging~~ health care administration may coordinate the Ohio's best Rx program with either of the following:

(A) ~~The~~ In cooperation with the department of aging, the golden buckeye card program established under section 173.06 of the Revised Code. In coordinating the programs, the ~~department~~ departments may establish a card that serves as both a golden buckeye card provided under section 173.06 of the Revised Code and an Ohio's best Rx program enrollment card issued under section ~~173.773~~ 5169.073 of the Revised Code. The ~~department~~ departments may identify the card by including the names of both programs on the card or by selecting a combined name for inclusion on the card.

(B) Any health benefit plan offered to the employees of state agencies and the eligible dependents of those employees, for purposes of enhancing efficiency, reducing the cost of drugs, and maximizing the benefits of the Ohio's best Rx program and the health benefit plan.

Sec. ~~173.73~~ 5169.03. (A) Any entity that provides services as a pharmacy benefit manager relative to the outpatient drug coverage included in a health benefit plan offered to the employees or retirees of a state agency or political subdivision and the eligible dependents of those employees or retirees shall provide drug pricing verification services under section ~~173.742~~ 5169.042 of the Revised Code and drug manufacturer payment

verification services under section ~~173.814~~ 5169.114 of the Revised Code if the entity is selected under section ~~173.731~~ 5169.031 of the Revised Code by the department of ~~aging~~ health care administration to serve as the Ohio's best Rx program's consulting pharmacy benefit manager for purposes of providing the verification services.

(B) Both of the following apply to the entity selected to serve as the Ohio's best Rx program's consulting pharmacy benefit manager:

(1) The entity shall provide the drug pricing verification services and drug manufacturer payment verification services without charge, either to the Ohio's best Rx program or to the state agency or political subdivision for which it provides services as a pharmacy benefit manager.

(2) The entity shall provide the verification services for the entire year for which it is selected to serve as the program's consulting pharmacy benefit manager, regardless of the duration or termination of its responsibility to the state agency or political subdivision for which it provides services as a pharmacy benefit manager.

(C) If the entity selected to serve as the consulting pharmacy benefit manager fails to provide the program with drug pricing verification services or drug manufacturer payment verification services, or fails to provide for an audit when requested to do so under section ~~173.732~~ 5169.032 of the Revised Code, the department may ask the attorney general to bring an action for injunctive relief in any court of competent jurisdiction. On the filing of an appropriate petition in the court, the court shall conduct a hearing on the petition. If it is demonstrated in the proceedings that the pharmacy benefit manager has failed to provide the verification services or has failed to provide for the audit, the court shall grant a temporary or

permanent injunction enjoining the pharmacy benefit manager from continuing to fail to provide the verification services or from continuing to fail to provide for the audit.

(D) This section does not impose any duty on the state agency or political subdivision for which an entity provides services as a pharmacy benefit manager.

Sec. ~~173.731~~ 5169.031. Annually, the department of ~~aging~~ health care administration shall select a pharmacy benefit manager, from among the pharmacy benefit managers subject to section ~~173.73~~ 5169.03 of the Revised Code, to serve as the Ohio's best Rx program's consulting pharmacy benefit manager for purposes of providing drug pricing verification services under section ~~173.742~~ 5169.042 of the Revised Code and drug manufacturer payment verification services under section ~~173.814~~ 5169.114 of the Revised Code. The department shall select the pharmacy benefit manager that the department considers to be the most appropriate pharmacy benefit manager to provide the verification services for the Ohio's best Rx program. In making the selection, the department shall consider the pharmacy benefit manager that provides services relative to the outpatient drug coverage included in the health benefit plan offered to the greatest number of employees or retirees of a state agency or political subdivision and the eligible dependents of those employees or retirees.

The department shall provide written notice to the pharmacy benefit manager that it has been selected to serve as the Ohio's best Rx program's consulting pharmacy benefit manager. The notice shall specify the date on which the pharmacy benefit manager is to begin serving as the program's consulting pharmacy benefit manager for the ensuing year.

Before the end of the one-year period during which a pharmacy

benefit manager is to serve as the program's consulting pharmacy benefit manager, the department shall make another selection in accordance with this section. In making the selection, the department may select the same pharmacy benefit manager to serve as the program's consulting pharmacy benefit manager or may select another pharmacy benefit manager.

Sec. ~~173.732~~ 5169.032. (A) To determine whether the pharmacy benefit manager selected under section ~~173.731~~ 5169.031 of the Revised Code to serve as the Ohio's best Rx program's consulting pharmacy benefit manager has provided valid information when providing drug pricing verification services under section ~~173.742~~ 5169.042 of the Revised Code or drug manufacturer payment verification services under section ~~173.814~~ 5169.114 of the Revised Code, the department of ~~aging~~ health care administration may request that the consulting pharmacy benefit manager provide for an audit of its relevant contracts with drug manufacturers and terminal distributors of dangerous drugs.

In making audit requests under this section, both of the following apply:

(1) The department may request an audit on a regularly occurring basis, but not more frequently than once every three years.

(2) The department may request an audit at any time it has a reasonable basis to believe that the consulting pharmacy benefit manager is not acting in good faith in providing drug pricing verification services or drug manufacturer payment verification services. Notice of the request shall be made in writing and signed by the director of ~~aging~~ health care administration. The notice may specify the basis for the belief that the consulting pharmacy benefit manager is not acting in good faith. If the basis for the belief is not specified and the audit findings demonstrate

that the consulting pharmacy benefit manager acted in good faith, the department shall pay the cost incurred by the consulting pharmacy benefit manager in providing for the audit.

(B) An audit provided for under this section shall be performed only by an auditor that is mutually satisfactory to the department and consulting pharmacy benefit manager and independent of both the department and consulting pharmacy benefit manager.

(C) If the findings of an audit provided for under this section demonstrate that the verification services provided by the consulting pharmacy benefit manager did not result in valid information, the department shall use the audit findings for purposes of confirming the validity of the one or more drug pricing formulas designated under section ~~173.741~~ 5169.041 of the Revised Code and entering into agreements with drug manufacturers under section ~~173.81~~ 5169.11 of the Revised Code.

Sec. ~~173.74~~ 5169.04. Annually, the department of ~~aging~~ health care administration shall establish a base price for each drug included in the Ohio's best Rx program. In the case of drugs dispensed by a terminal distributor of dangerous drugs that has entered into an agreement under section ~~173.79~~ 5169.09 of the Revised Code, the base price shall be established by using the one or more formulas designated under section ~~173.741~~ 5169.041 of the Revised Code. In the case of the drug mail order system included in the program pursuant to section ~~173.78~~ 5169.08 of the Revised Code, the base price shall be established in accordance with the rules adopted under section ~~173.83~~ 5169.13 of the Revised Code governing the drug mail order system.

Sec. ~~173.741~~ 5169.041. Annually, the department of ~~aging~~ health care administration shall designate one or more formulas for use in establishing under section ~~173.74~~ 5169.04 of the

Revised Code the Ohio's best Rx program's base price for drugs dispensed by a terminal distributor of dangerous drugs that has entered into an agreement under section ~~173.79~~ 5169.09 of the Revised Code. Each formula shall include a drug pricing discount component that is expressed as a percentage discount. The formula used for generic drugs may include the maximum allowable cost limits that apply to generic drugs under the medicaid program.

In designating the one or more formulas, the department shall use the best information on drug pricing that is available to the department, including information obtained through the drug pricing verification services provided under section ~~173.742~~ 5169.042 of the Revised Code by the Ohio's best Rx program's consulting pharmacy benefit manager selected under section ~~173.731~~ 5169.031 of the Revised Code. Based on the available information, the department shall modify the one or more formulas as it considers appropriate to maximize the benefits provided to Ohio's best Rx program participants.

Sec. ~~173.742~~ 5169.042. For purposes of section ~~173.741~~ 5169.041 of the Revised Code, the department of ~~aging~~ health care administration shall obtain verification of drug pricing information from the Ohio's best Rx program's consulting pharmacy benefit manager selected under section ~~173.731~~ 5169.031 of the Revised Code. The information shall be obtained in accordance with the following procedures:

(A) For brand name drugs, excluding generic drugs marketed under brand names, the department shall submit to the consulting pharmacy benefit manager the formula the department proposes to use to establish the program's base price for brand name drugs during the year.

The consulting pharmacy benefit manager shall review the formula submitted by the department. In conducting the review, the

consulting pharmacy benefit manager shall compare the drug pricing discount percentage included in the department's formula to the drug pricing discount percentage included in the formula most commonly used by the consulting pharmacy benefit manager to establish part of its payment rate for brand name drugs dispensed by terminal distributors of dangerous drugs other than drug mail order systems. If the formulas are not expressed in equivalent terms, the consulting pharmacy benefit manager shall make all accommodations necessary to make the comparison of the discount percentages.

After conducting the review, the consulting pharmacy benefit manager shall provide information to the department verifying whether the discount percentage included in the department's formula is more than two percentage points below the discount percentage included in the formula used by the consulting pharmacy benefit manager. The information provided to the department shall be certified by signature of an officer of the consulting pharmacy benefit manager.

(B) For generic drugs, the department shall identify the fifty generic drugs most frequently purchased by Ohio's best Rx program participants in the immediately preceding year from terminal distributors of dangerous drugs other than the drug mail order system included in the program pursuant to section ~~173.78~~ 5169.08 of the Revised Code. The department shall submit to the consulting pharmacy benefit manager the names of the fifty drugs, the number of prescriptions filled for each of the drugs, the formula used to compute the base price for the drugs during the year, and the weighted average base price for the drugs that resulted for the year.

The consulting pharmacy benefit manager shall review the submitted information. In conducting the review, the consulting pharmacy benefit manager shall compare the department's weighted

average base price to the equivalent part of the consulting pharmacy benefit manager's weighted average payment rate for the same drugs when dispensed by terminal distributors of dangerous drugs other than drug mail order systems. For purposes of the comparison, the department and consulting pharmacy benefit manager shall express the weighted average base price and payment rate in terms of a discount percentage that is taken from the drugs' average wholesale price, as identified by a national drug price reporting service selected by the department and the consulting pharmacy benefit manager.

After conducting the review, the consulting pharmacy benefit manager shall provide information to the department verifying whether the discount percentage reflected in the department's weighted average base price for the drugs is more than two percentage points below the equivalent part of the consulting pharmacy benefit manager's weighted average payment rate for the same drugs. The information provided to the department shall be certified by signature of an officer of the consulting pharmacy benefit manager.

Sec. ~~173.75~~ 5169.05. (A) Subject to division (B) of this section, the amount that an Ohio's best Rx program participant is to be charged for a quantity of a drug purchased under the program shall be established in accordance with all of the following:

(1) If the drug is not included in a manufacturer agreement entered into under section ~~173.81~~ 5169.11 of the Revised Code, the participant shall be charged an amount that is computed according to the drug's base price established under section ~~173.74~~ 5169.04 of the Revised Code.

(2) If the drug is included in a manufacturer agreement entered into under section ~~173.81~~ 5169.11 of the Revised Code, the participant shall be charged an amount that is computed by

subtracting from the drug's base price established under section ~~173.74~~ 5169.04 of the Revised Code the amount of the manufacturer payment that applies to the transaction, as established under section ~~173.812~~ 5169.112 of the Revised Code.

(3) If an administrative fee is specified in rules adopted under section ~~173.83~~ 5169.13 of the Revised Code, the participant shall be charged the amount of the administrative fee.

(4) If the drug is dispensed by a terminal distributor of dangerous drugs under an agreement entered into under section ~~173.79~~ 5169.09 of the Revised Code, and the terminal distributor charges a professional fee pursuant to the agreement, the participant shall be charged the amount of the professional fee.

(5) If the drug is dispensed through the drug mail order system included in the program pursuant to section ~~173.78~~ 5169.08 of the Revised Code, the participant shall not be charged a professional fee.

(B) When a quantity of a drug is purchased by an Ohio's best Rx program participant, the participating terminal distributor or drug mail order system dispensing the drug shall charge the lesser of the amount that applies to the transaction, as established in accordance with division (A) of this section, or the usual and customary charge that otherwise would apply to the transaction. When a drug is purchased at the usual and customary charge pursuant to this division, the transaction is not subject to sections ~~173.71~~ 5169.01 to ~~173.91~~ 5169.21 of the Revised Code as the purchase or dispensing of a drug under the program.

Sec. ~~173.751~~ 5169.051. The department of ~~aging~~ health care administration shall report the following to each participating terminal distributor and the drug mail order system included in the Ohio's best Rx program pursuant to section ~~173.78~~ 5169.08 of the Revised Code in a manner enabling the distributor and system

to comply with section ~~173.75~~ 5169.05 of the Revised Code:

(A) For each drug included in the program, the amount to be charged under division (A)(1) or (2) of section ~~173.75~~ 5169.05 of the Revised Code;

(B) The administrative fee, if any, specified by the department in rules adopted under section ~~173.83~~ 5169.13 of the Revised Code.

Sec. ~~173.752~~ 5169.052. The amount that an Ohio's best Rx program participant saves when a drug is purchased under the program shall be determined by subtracting the amount that the participant is charged in accordance with division (A) of section ~~173.75~~ 5169.05 of the Revised Code from the usual and customary charge that otherwise would apply to the transaction.

Sec. ~~173.753~~ 5169.053. Not later than the first day of March of each year, the department of ~~aging~~ health care administration 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 participants are charged under the program, on a date selected by the department, 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 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 Ohio's best Rx program participants receive for each drug included on the list created under division (A) of this section.

Sec. ~~173.76~~ 5169.06. (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 for the program:

(1) The individual must be a resident of this state.

(2) One of the following must be the case:

(a) The individual has family income, as determined under rules adopted pursuant to section ~~173.83~~ 5169.13 of the Revised Code, that does not exceed three hundred 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;

(b) The individual is sixty years of age or older;

(c) The individual is a person with a disability, as defined in section 173.06 of the Revised Code.

(3) Except as provided in division (B) of this section, the individual must not have coverage for outpatient drugs paid for in whole or in part by any of the following:

(a) A third-party payer, including an employer;

(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 drugs.

(4) The individual must not have had coverage for outpatient drugs paid for by any of the entities or programs specified in division (A)(3) of this section during any of the four months preceding the month in which the application 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, including an employer, that paid for 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, children's health insurance program, or disability medical assistance program.

(e) The individual is either temporarily or permanently discharged from employment due to a business reorganization.

(B) An individual is not subject to division (A)(3) of this section if the individual has coverage for outpatient drugs paid for in whole or in part by either of the following:

(1) The workers' compensation program;

(2) A medicare prescription drug plan offered pursuant to the "Medicare Prescription Drug, Improvement, and Modernization Act of 2003," 117 Stat. 2071, 42 U.S.C. 1395w-101, as amended, but only if all of the following are the case with respect to the particular drug being purchased through the Ohio's best Rx program:

(a) The individual is responsible for the full cost of the drug.

(b) The drug is not subject to a rebate from the manufacturer under the individual's medicare prescription drug plan.

(c) The manufacturer of the drug has agreed to the Ohio's best Rx program's inclusion of individuals who have coverage through a medicare prescription drug plan.

Sec. ~~173.77~~ 5169.07. Application for participation in the Ohio's best Rx program shall be made in accordance with rules adopted by the department of ~~aging~~ health care administration under section ~~173.83~~ 5169.13 of the Revised Code. When applying for participation, an individual may include application for participation by the individual's spouse and children. An individual's guardian or custodian may apply on behalf of the individual.

When submitting an application, the applicant shall include the information and documentation specified in the department's rules as necessary to verify eligibility for the program. The application may be submitted on a paper form prescribed and supplied by the department or pursuant to any other application method the department makes available for the program, including methods that permit an individual to apply by telephone or through the internet.

An applicant shall attest that the information and documentation the applicant submits with an application is accurate to the best knowledge and belief of the applicant. In the case of a paper application form, the applicant's signature shall be used to certify that the applicant has attested to the accuracy of the information and documentation. In the case of other application methods, the application certification process specified in the department's rules shall be used to certify that the applicant has attested to the accuracy of the information and documentation.

The department shall inform each applicant that knowingly making a false statement in an application is falsification under section 2921.13 of the Revised Code, a misdemeanor of the first degree. In the case of a paper application form, the department shall provide the information by including on the form a statement printed in bold letters.

Sec. ~~173.771~~ 5169.071. The department of ~~aging~~ health care administration shall provide each applicant for the Ohio's best Rx program information about the medicaid program in accordance with rules adopted under section ~~173.83~~ 5169.13 of the Revised Code. The information shall include general eligibility requirements, application procedures, and benefits. The information shall also explain the ways in which the medicaid program's drug benefits are better than the Ohio's best Rx program.

Sec. ~~173.772~~ 5169.072. On receipt of applications, the department of ~~aging~~ health care administration shall make eligibility determinations for the Ohio's best Rx program in accordance with procedures established in rules adopted under section ~~173.83~~ 5169.13 of the Revised Code.

An eligibility determination under this section may not be appealed under Chapter 119., section 5101.35, or any other provision of the Revised Code.

Sec. ~~173.773~~ 5169.073. (A) The department of ~~aging~~ health care administration shall issue Ohio's best Rx program enrollment cards to or on behalf of individuals determined eligible to participate. One enrollment card may cover each member of a family determined eligible to participate.

The department shall determine the information to be included on the card, including an identification number, and shall determine the card's size and format. If the department

establishes an application method that permits individuals to apply through the internet, the department may issue the enrollment card by sending the applicant an electronic version of the card in a printable format.

(B) Each time a drug is purchased under the program, the entity dispensing the drug shall confirm whether the individual for whom the drug is dispensed is enrolled in the program. If the drug is being purchased from a participating terminal distributor rather than the drug mail order system included in the program pursuant to section ~~173.78~~ 5169.08 of the Revised Code, and the individual's enrollment card is available for presentation at the time of the purchase, the purchaser shall present the card to the participating terminal distributor as confirmation of the individual's enrollment in the program. If the drug is being purchased through the drug mail order system and the individual's program identification number is available, the purchaser shall present the identification number as confirmation of enrollment. Otherwise, the terminal distributor or mail order system shall confirm the individual's enrollment through the department. The department shall establish the methods to be used in confirming enrollment through the department, including confirmation by telephone, through the internet, or by any other electronic means.

(C) Purchasing a drug under the program by using an enrollment card or any other method shall serve as an attestation by the participant for whom the drug is dispensed that the participant meets the eligibility requirements specified in division (A)(3) of section ~~173.76~~ 5169.06 of the Revised Code regarding not having coverage for outpatient drugs.

Sec. ~~173.78~~ 5169.08. (A) For purposes of making drugs included in the Ohio's best Rx program available to participants by mail, the department of ~~aging~~ health care administration shall

include a drug mail order system within the program. Not more than one drug mail order system shall be included in the program. Subject to division (B) of this section, the program's drug mail order system shall be provided in accordance with rules adopted under section ~~173.83~~ 5169.13 of the Revised Code.

(B) Neither the department nor the drug mail order system shall promote the purchase of drugs through the system by using information collected under the program regarding the drugs purchased by participants from participating terminal distributors. This division does not preclude the use of the information for purposes of limiting the amount that a participant may be charged for a quantity of a drug purchased through the drug mail order system to an amount that is not more than the amount that would be charged if the same quantity of the drug were purchased from a participating terminal distributor.

Sec. ~~173.79~~ 5169.09. (A) For purposes of making drugs included in the Ohio's best Rx program available to participants from terminal distributors of dangerous drugs other than the drug mail order system included in the program pursuant to section ~~173.78~~ 5169.08 of the Revised Code, the department of ~~aging~~ health care administration shall enter into agreements under this section with terminal distributors of dangerous drugs. Any terminal distributor of dangerous drugs may enter into an agreement with the department to participate in the program pursuant to this section.

Before entering into an agreement with a terminal distributor, the department shall provide the terminal distributor with one of the following:

(1) A formula that allows the terminal distributor to calculate for each drug included in the program the amount to be charged under division (A)(1) or (2) of section ~~173.75~~ 5169.05 of

the Revised Code by participating terminal distributors.

(2) A statistically valid sampling of drug prices that includes the amount to be charged under division (A)(1) or (2) of section ~~173.75~~ 5169.05 of the Revised Code by participating terminal distributors for not fewer than two brand name drugs and two generic drugs from each category of drugs included in the program.

(3) The current amount to be charged under division (A)(1) or (2) of section ~~173.75~~ 5169.05 of the Revised Code by participating terminal distributors for each drug included in the program.

(B) An agreement entered into under this section shall do all of the following:

(1) Except as provided in division (B)(3) of this section, be in effect for not less than one year;

(2) Specify the dates that the agreement is to begin and end;

(3) Permit the terminal distributor to terminate the agreement before the date the agreement would otherwise end as specified pursuant to division (B)(2) of this section by providing the department notice of early termination at least thirty days before the effective date of the early termination;

(4) Require that the terminal distributor comply with section ~~173.75~~ 5169.05 of the Revised Code when charging for a drug purchased under the program;

(5) Permit the terminal distributor to add to the amount to be charged under division (A)(1) or (2) of section ~~173.75~~ 5169.05 of the Revised Code a professional fee in an amount not to exceed, except as provided in rules adopted under section ~~173.83~~ 5169.13 of the Revised Code, three dollars;

(6) Require the terminal distributor to disclose to each participant the amount the participant saves under the program as

determined in accordance with section ~~173.752~~ 5169.052 of the Revised Code;

(7) Require the terminal distributor to submit a claim to the department under section ~~173.80~~ 5169.10 of the Revised Code for each sale of a drug to a participant;

(8) Permit the terminal distributor to deliver drugs to Ohio's best Rx program participants by mail, but not by using a drug mail order system operated in the same manner as the system included in the program pursuant to section ~~173.78~~ 5169.08 of the Revised Code.

Sec. ~~173.791~~ 5169.091. A terminal distributor of dangerous drugs shall not be prohibited from participating in any program or any network of health care providers on the basis that the terminal distributor has not entered into an agreement under section ~~173.79~~ 5169.09 of the Revised Code to participate in the Ohio's best Rx program.

Sec. ~~173.80~~ 5169.10. For each drug dispensed under the Ohio's best Rx program, a claim shall be submitted to the department of ~~aging~~ health care administration. The participating terminal distributor or the drug mail order system included in the program pursuant to section ~~173.78~~ 5169.08 of the Revised Code that dispensed the drug shall submit the claim not later than thirty days after the drug is dispensed. The claim shall be submitted in accordance with the electronic method provided for in rules adopted under section ~~173.83~~ 5169.13 of the Revised Code.

The claim shall specify all of the following:

(A) The prescription number of the participant's prescription under which the drug was dispensed to the participant;

(B) The name of, and national drug code number for, the drug dispensed to the participant;

(C) The number of units of the drug dispensed to the participant;

(D) The amount the participant was charged for the drug;

(E) The date the drug was dispensed to the participant;

(F) Any additional information required by rules adopted under section ~~173.83~~ 5169.13 of the Revised Code.

Sec. ~~173.801~~ 5169.101. (A) In accordance with rules adopted under section ~~173.83~~ 5169.13 of the Revised Code and subject to section ~~173.803~~ 5169.103 of the Revised Code, the department of ~~aging~~ health care administration shall make payments under the Ohio's best Rx program for complete and timely claims submitted under section ~~173.80~~ 5169.10 of the Revised Code for drugs included in the program that are also included in a manufacturer agreement entered into under section ~~173.81~~ 5169.11 of the Revised Code. The payment for a complete and timely claim shall be made by a date that is not later than two weeks after the department receives the claim from the participating terminal distributor or the drug mail order system included in the program pursuant to section ~~173.78~~ 5169.08 of the Revised Code.

(B) Subject to division (D) of this section, the amount to be paid for a claim for a drug dispensed under the program shall be determined as follows:

(1) Compute the manufacturer payment amount that applies to the transaction, based on quantity of the drug dispensed and the drug's national drug code number, in accordance with the provisions of division (B) of section ~~173.812~~ 5169.112 of the Revised Code;

(2) If rules adopted under section ~~173.83~~ 5169.13 of the Revised Code require that program participants be charged an administrative fee for each transaction in which a quantity of the

drug was dispensed, subtract from the amount computed under division (B)(1) of this section the administrative fee amount specified in those rules.

(C) The department may combine the claims submitted by a participating terminal distributor or the program's drug mail order system to make aggregate payments under this section to the distributor or system.

(D) If the total of the amounts computed under division (B) of this section for any period for which payments are due is a negative number, the participating terminal distributor or the program's drug mail order system that submitted the claims has been overpaid for the claims. When there is an overpayment, the department shall reduce future payments made under this section to the distributor or system or collect an amount from the distributor or system sufficient to reimburse the department for the overpayment.

Sec. ~~173.802~~ 5169.102. Neither a participating terminal distributor nor the drug mail order system included in the Ohio's best Rx program pursuant to section ~~173.78~~ 5169.08 of the Revised Code may be charged by the department of ~~aging~~ health care administration for the submission of a claim under section ~~173.80~~ 5169.10 of the Revised Code or the processing of a claim under section ~~173.801~~ 5169.101 of the Revised Code.

Sec. ~~173.803~~ 5169.103. The department of ~~aging~~ health care administration may not make a payment under section ~~173.801~~ 5169.101 of the Revised Code for a claim submitted under section ~~173.80~~ 5169.10 of the Revised Code if any of the following are the case:

(A) The claim is submitted by either a terminal distributor of dangerous drugs that is not a participating terminal

distributor or a drug mail order system that is not the system included in the Ohio's best Rx program pursuant to section ~~173.78~~ 5169.08 of the Revised Code.

(B) The claim is for a drug that is not included in the program.

(C) The claim is for a drug included in the program but the drug is dispensed to an individual who is not covered by an Ohio's best Rx program enrollment card.

(D) A person or government entity has paid the participating terminal distributor or the program's drug mail order system through any other prescription drug coverage program or prescription drug discount program for dispensing the drug, unless the payment is reimbursement for redeeming a coupon or is an amount directly paid by a drug manufacturer to the distributor or system for dispensing drugs to residents of a long-term care facility.

Sec. ~~173.81~~ 5169.11. For purposes of participating in the Ohio's best Rx program, any drug manufacturer may enter into an agreement with the department of ~~aging~~ health care administration under which the manufacturer agrees to make payments to the department with respect to one or more of the manufacturer's drugs when the one or more drugs are dispensed under the program. The terms of the agreement shall comply with section ~~173.811~~ 5169.111 of the Revised Code.

Sec. ~~173.811~~ 5169.111. (A) A manufacturer agreement entered into under section ~~173.81~~ 5169.11 of the Revised Code by a drug manufacturer and the department of ~~aging~~ health care administration shall include terms that do all of the following:

(1) Specify the time the agreement is to be in effect, which shall be not less than one year from the date the agreement is

entered into;

(2) Specify which of the manufacturer's drugs are included in the agreement;

(3) Permit the department to remove a drug from the agreement in the event of a dispute over the drug's utilization;

(4) Require that the manufacturer specify a per unit amount that will be paid to the department for each drug included in the agreement that is dispensed to an Ohio's best Rx program participant;

(5) Require that the per unit amount specified by the manufacturer be an amount that the manufacturer believes is greater than or comparable to the per unit amount generally payable by the manufacturer for the same drug when the drug is dispensed to an individual using the outpatient drug coverage included in a health benefit plan offered in this state or another state to public employees or retirees and the eligible dependents of those employees or retirees;

(6) Require the manufacturer to make payments in accordance with the amounts computed under division (A) of section ~~173.812~~ 5169.112 of the Revised Code;

(7) Require that the manufacturer make the payments on a quarterly basis or in accordance with a schedule established by rules adopted under section ~~173.83~~ 5169.13 of the Revised Code.

(B) For any drug included in a manufacturer agreement, the terms of the agreement may provide for the establishment of a process for referring Ohio's best Rx program applicants and participants to a patient assistance program operated or sponsored by the manufacturer. The referral process may be included only if the manufacturer agrees to refer to the Ohio's best Rx program residents of this state who apply but are found to be ineligible for the patient assistance program.

Sec. ~~173.812~~ 5169.112. When a drug included in a manufacturer agreement entered into under section ~~173.81~~ 5169.11 of the Revised Code is dispensed under the Ohio's best Rx program, the manufacturer payment amount that applies to the transaction shall be established in accordance with the following:

(A) For purposes of the amount to be paid by the manufacturer, the manufacturer payment amount shall be computed by multiplying the per unit amount specified for the drug in the manufacturer agreement by the number of units dispensed.

(B) For purposes of the amount that a participant is to be charged under section ~~173.75~~ 5169.05 of the Revised Code and the amount to be paid for claims under section ~~173.801~~ 5169.101 of the Revised Code, both of the following apply:

(1) If a program administration percentage is not determined by the department of ~~aging~~ health care administration in rules adopted under section ~~173.83~~ 5169.13 of the Revised Code, the manufacturer payment amount shall be the same as the manufacturer payment amount computed under division (A) of this section.

(2) If a program administration percentage is determined by the department, the manufacturer payment amount shall be computed as follows:

(a) Multiply the per unit amount specified for the drug in the agreement by the program administration percentage;

(b) Subtract the product determined under division (B)(2)(a) of this section from the per unit amount specified for the drug in the agreement;

(c) Multiply the per unit amount resulting from the computation under division (B)(2)(b) of this section by the number of units dispensed.

Sec. ~~173.813~~ 5169.113. In its negotiations with a drug manufacturer proposing to enter into an agreement under section ~~173.81~~ 5169.11 of the Revised Code, the department of ~~aging~~ health care administration shall use the best information on manufacturer payments that is available to the department, including information obtained from the verifications made under section ~~173.814~~ 5169.114 of the Revised Code by the Ohio's best Rx program's consulting pharmacy benefit manager selected under section ~~173.731~~ 5169.031 of the Revised Code. The department shall use the information in an attempt to obtain manufacturer payments that maximize the benefits provided to Ohio's best Rx program participants.

Sec. ~~173.814~~ 5169.114. Annually, the department of ~~aging~~ health care administration shall select a sample of not more than ten of the drugs that were included in the manufacturer agreements entered into under section ~~173.81~~ 5169.11 of the Revised Code in the immediately preceding year. The department shall submit to the program's consulting pharmacy benefit manager selected under section ~~173.731~~ 5169.031 of the Revised Code information that identifies the per unit amount of the manufacturer payments that applied to each of the drugs in the sample.

The consulting pharmacy benefit manager shall review the submitted information. After the review, the consulting pharmacy benefit manager shall provide information to the department verifying whether any of the per unit payment amounts that applied to the selected drugs were more than two per cent lower than the per unit payment amounts negotiated by the consulting pharmacy benefit manager for the same drugs in connection with health benefit plans that generally do not use formularies to restrict the outpatient drug coverage included in the plans. The consulting pharmacy benefit manager shall specify which, if any, of the drugs

in the sample were subject to the lower per unit payment amounts. The information provided to the department shall be certified by signature of an officer of the consulting pharmacy benefit manager.

Sec. ~~173.815~~ 5169.115. (A) The department of ~~aging~~ health care administration shall seek from the centers for medicare and medicaid services of the United States department of health and human services written confirmation that manufacturer payments made pursuant to an agreement entered into under section ~~173.81~~ 5169.11 of the Revised Code are exempt from the medicaid best price computation applicable under Title XIX of the "Social Security Act," 79 Stat. 286 (1965), 42 U.S.C. 1396r-8, as amended.

(B) Entering into a manufacturer agreement under section ~~173.81~~ 5169.11 of the Revised Code does not require a drug manufacturer to make a manufacturer payment that would establish the manufacturer's medicaid best price for a drug.

Sec. ~~173.82~~ 5169.12. A drug manufacturer that enters into an agreement under section ~~173.81~~ 5169.11 of the Revised Code may submit a request to the department of ~~aging~~ health care administration to audit claims submitted under section ~~173.80~~ 5169.10 of the Revised Code. On submission of a request that the department considers reasonable, the department shall permit the manufacturer to audit the claims.

Sec. ~~173.83~~ 5169.13. The department of ~~aging~~ health care administration shall adopt rules in accordance with Chapter 119. of the Revised Code to implement the Ohio's best Rx program. The rules shall provide for all of the following:

(A) Standards and procedures for establishing, pursuant to section ~~173.74~~ 5169.04 of the Revised Code, the base price for

each drug included in the program;

(B) Determination of family income for the purpose of division (A)(2)(a) of section ~~173.76~~ 5169.06 of the Revised Code;

(C) For the purpose of section ~~173.77~~ 5169.07 of the Revised Code, the application process for the program, including the information and documentation to be submitted with applications to verify eligibility and a process to be used in certifying that an applicant has attested to the accuracy of the submitted information and documentation;

(D) The method of providing information about the medicaid program to applicants under section ~~173.771~~ 5169.071 of the Revised Code;

(E) For the purpose of section ~~173.772~~ 5169.072 of the Revised Code, eligibility determination procedures;

(F) Standards and procedures governing the drug mail order system included in the program pursuant to section ~~173.78~~ 5169.08 of the Revised Code;

(G) Subject to section ~~173.831~~ 5169.131 of the Revised Code, periodically increasing the maximum professional fee that participating terminal distributors may charge Ohio's best Rx program participants pursuant to an agreement entered into under section ~~173.79~~ 5169.09 of the Revised Code;

(H) Subject to section ~~173.832~~ 5169.132 of the Revised Code, the amount of the administrative fee, if any, that Ohio's best Rx program participants are to be charged under the program;

(I) The electronic method for submission of claims to the department under section ~~173.80~~ 5169.10 of the Revised Code;

(J) Additional information to be included on claims submitted under section ~~173.80~~ 5169.10 of the Revised Code that the department determines is necessary for the department to be able

to make payments under section ~~173.801~~ 5169.101 of the Revised Code;

(K) The method for making payments under section ~~173.801~~ 5169.101 of the Revised Code;

(L) Subject to section ~~173.833~~ 5169.133 of the Revised Code, the percentage, if any, that is the program administration percentage;

(M) If the department determines it is best that participating manufacturers make payments pursuant to manufacturer agreements entered into under section ~~173.81~~ 5169.11 of the Revised Code on a basis other than quarterly, a schedule for making the payments;

(N) Procedures for making computations under sections ~~173.75~~ 5169.05 and ~~173.812~~ 5169.112 of the Revised Code;

(O) Standards and procedures for the use and preservation of records regarding the Ohio's best Rx program pursuant to section ~~173.91~~ 5169.21 of the Revised Code;

(P) The efficient administration of other provisions of sections ~~173.71~~ 5169.01 to ~~173.91~~ 5169.21 of the Revised Code for which the department determines rules are necessary.

Sec. ~~173.831~~ 5169.131. As used in this section, "medicaid dispensing fee" means the dispensing fee established under section ~~5111.071~~ 5163.251 of the Revised Code for the medicaid program.

In adopting a rule under division (G) of section ~~173.83~~ 5169.13 of the Revised Code increasing the maximum amount of the professional fee participating terminal distributors may charge Ohio's best Rx program participants pursuant to an agreement entered into under section ~~173.79~~ 5169.09 of the Revised Code, the department of ~~aging~~ health care administration shall review the amount of the professional fee once a year or, at the department's

discretion, at more frequent intervals. The department shall not increase the professional fee to an amount exceeding the medicaid dispensing fee.

A participating terminal distributor 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. ~~173.832~~ 5169.132. (A) Once a year or, at the discretion of the department of ~~aging~~ health care administration, at more frequent intervals, the department shall determine the amount, if any, that each Ohio's best Rx program participant will be charged as an administrative fee to be used in paying the administrative costs of the program. The fee, which shall not exceed one dollar per transaction, shall be specified in rules adopted under section ~~173.83~~ 5169.13 of the Revised Code. In adopting the rules, the department shall specify a fee that results in an amount that equals or is less than the amount needed to cover the administrative costs of the Ohio's best Rx program when added to the sum of the following:

(1) The amount resulting from the program administration percentage, if the department determines a program administration percentage in rules adopted under section ~~173.83~~ 5169.13 of the Revised Code;

(2) The investment earnings of the Ohio's best Rx program fund created by section ~~173.85~~ 5169.15 of the Revised Code;

(3) Any amounts accepted by the department as donations to the Ohio's best Rx program fund.

(B) Once a year or, at the discretion of the department, at

more frequent intervals, the department shall report the methodology underlying the determination of the administrative fee to the Ohio's best Rx program council.

Sec. ~~173.833~~ 5169.133. (A) At least once a year or, at the discretion of the department of ~~aging~~ health care administration, at more frequent intervals, the department shall determine the percentage, if any, of each manufacturer payment made under an agreement entered into under section ~~173.81~~ 5169.11 of the Revised Code that will be retained by the department for use in paying the administrative costs of the Ohio's best Rx program. The percentage, which shall not exceed five per cent, shall be specified in rules adopted under section ~~173.83~~ 5169.13 of the Revised Code. In adopting the rules, the department shall specify a percentage that results in an amount that equals or is less than the amount needed to cover the administrative costs of the Ohio's best Rx program when added to the sum of the following:

(1) The amount resulting from administrative fees, if the department determines an administrative fee in rules adopted under section ~~173.83~~ 5169.13 of the Revised Code;

(2) The investment earnings of the Ohio's best Rx program fund created by section ~~173.85~~ 5169.15 of the Revised Code;

(3) Any amounts accepted by the department as donations to the Ohio's best Rx program fund.

(B) Once a year or, at the discretion of the department, at more frequent intervals, the department shall report the methodology underlying the determination of the program administration percentage to the Ohio's best Rx program council.

Sec. ~~173.84~~ 5169.14. Notwithstanding any conflicting provision of sections ~~173.71~~ 5169.01 to ~~173.91~~ 5169.21 of the Revised Code, the department of ~~aging~~ health care administration

may adopt rules in accordance with Chapter 119. of the Revised Code to make adjustments to the Ohio's best Rx program that the department considers appropriate to conform the program to, or coordinate it with, any federally funded prescription drug program created after October 1, 2003.

Sec. ~~173.85~~ 5169.15. (A) The Ohio's best Rx program fund is hereby created. The fund shall be in the custody of the treasurer of state, but shall not be part of the state treasury. The fund shall consist of the following:

(1) Manufacturer payments made by participating manufacturers pursuant to agreements entered into under section ~~173.81~~ 5169.11 of the Revised Code;

(2) Administrative fees, if an administrative fee is determined by the department of ~~aging~~ health care administration in rules adopted under section ~~173.83~~ 5169.13 of the Revised Code;

(3) Any amounts donated to the fund and accepted by the department;

(4) The fund's investment earnings.

(B) Money in the Ohio's best Rx program fund shall be used to make payments under section ~~173.801~~ 5169.101 of the Revised Code and to make transfers to the Ohio's best Rx administration fund in accordance with section ~~173.86~~ 5169.16 of the Revised Code.

Sec. ~~173.86~~ 5169.16. (A) The Ohio's best Rx administration fund is hereby created in the state treasury. The treasurer of state shall transfer from the Ohio's best Rx program fund to the Ohio's best Rx administration fund amounts equal to the following:

(1) Amounts resulting from application of the program administration percentage, if a program administration percentage is determined by the department of ~~aging~~ health care

administration in rules adopted under section ~~173.83~~ 5169.13 of the Revised Code;

(2) The amount of the administrative fees charged Ohio's best Rx participants, if an administrative fee is determined by the department of ~~aging~~ health care administration in rules adopted under section ~~173.83~~ 5169.13 of the Revised Code;

(3) The amount of any donations credited to the Ohio's best Rx program fund;

(4) The amount of investment earnings credited to the Ohio's best Rx program fund.

The treasurer of state shall make the transfers in accordance with a schedule developed by the treasurer of state and the department of ~~aging~~ health care administration.

(B) The department of ~~aging~~ health care administration shall use money in the Ohio's best Rx administration fund to pay the administrative costs of the Ohio's best Rx program, including, but not limited to, costs associated with contracted services, staff, outreach activities, computers and network services, and the Ohio's best Rx program council. If the fund includes an amount that exceeds the amount necessary to pay the administrative costs of the program, the department may use the excess amount to pay the cost of subsidies provided to Ohio's best Rx program participants under any subsidy program established pursuant to section ~~173.861~~ 5169.161 of the Revised Code.

Sec. ~~173.861~~ 5169.161. The department of ~~aging~~ health care administration may establish a component of the Ohio's best Rx program under which subsidies are provided to participants to assist them with the cost of purchasing drugs under the program, including the cost of any professional fees charged for dispensing the drugs. The subsidies shall be provided only when the Ohio's

best Rx administration fund created under section ~~173.86~~ 5169.16 of the Revised Code includes an amount that exceeds the amount necessary to pay the administrative costs of the program.

Sec. ~~173.87~~ 5169.17. There is hereby created the Ohio's best Rx program council. The council shall advise the department of ~~aging~~ health care administration on the Ohio's best Rx program. With the approval of a majority of the council's appointed members, the council may initiate studies to determine whether there are more effective ways to administer the program and provide the department with suggestions for improvements.

Sec. ~~173.871~~ 5169.171. The Ohio's best Rx program council shall consist of the following members:

(A) The president of the senate;

(B) The speaker of the house of representatives;

(C) The minority leader of the senate;

(D) The minority leader of the house of representatives;

(E) A representative of the Ohio chapter of the American federation of labor-congress of industrial organizations, appointed by the governor from a list of names submitted to the governor by that organization;

(F) A representative of the Ohio chapter of the American association of retired persons, appointed by the governor from a list of names submitted to the governor by that organization;

(G) A representative of a disability advocacy organization located in the state of Ohio, appointed by the governor from a list of names submitted to the governor by disability advocacy organizations located in the state of Ohio;

(H) A representative of the Ohio chapter of the united way, appointed by the governor from a list of names submitted to the

governor by that organization;

(I) A representative of the Ohio alliance of retired Americans, appointed by the governor from a list of names submitted to the governor by that organization;

(J) Three representatives of research-based drug manufacturers, appointed by the governor from a list of names submitted to the governor by the pharmaceutical research and manufacturers of America;

(K) A pharmacist licensed under Chapter 4729. of the Revised Code, appointed by the governor from a list of names submitted to the governor by the Ohio pharmacists association.

Sec. ~~173.872~~ 5169.172. The governor shall make initial appointments to the Ohio's best Rx program council not later than thirty days after December 18, 2003. The members appointed by the governor shall serve at the pleasure of the governor. If an appointed member's seat becomes vacant, the governor shall fill the vacancy not later than thirty days after the vacancy occurs and in the manner provided for the initial appointment.

Sec. ~~173.873~~ 5169.173. The president of the senate and speaker of the house of representatives shall serve as co-chairs of the Ohio's best Rx program council.

The president of the senate, the minority leader of the senate, the speaker of the house of representatives, and the minority leader of the house of representatives may each appoint a member of the general assembly to attend any meeting of the Ohio's best Rx program council on behalf of the president of the senate, the minority leader of the senate, the speaker of the house of representatives, or the minority leader of the house of representatives, respectively.

Sec. ~~173.874~~ 5169.174. Members of the Ohio's best Rx program council shall serve without compensation and shall not be reimbursed for any expenses associated with their duties on the council.

Sec. ~~173.875~~ 5169.175. Except for any part of records that contain a trade secret, the Ohio's best Rx program council's records are a public record for the purpose of section 149.43 of the Revised Code.

Sec. ~~173.876~~ 5169.176. Sections 101.82 to 101.87 of the Revised Code do not apply to the Ohio's best Rx program council.

Sec. ~~173.88~~ 5169.18. (A) The department of ~~aging~~ health care administration shall compile both of the following lists regarding the Ohio's best Rx program:

(1) A list consisting of the name of each drug manufacturer that enters into a manufacturer agreement under section ~~173.791~~ 5169.091 of the Revised Code and the names of the drugs included in each manufacturer agreement;

(2) A list consisting of the name of each participating terminal distributor and the name of the drug mail order system included in the program pursuant to section ~~173.78~~ 5169.08 of the Revised Code.

(B) As part of the list compiled under division (A)(1) of this section, the department may include aggregate information regarding the drugs selected under section ~~173.814~~ 5169.114 of the Revised Code that were verified under that section as having per unit manufacturer payment amounts that were not more than two per cent lower than the per unit payment amounts negotiated for the same drugs by the program's consulting pharmacy benefit manager selected under section ~~173.731~~ 5169.031 of the Revised Code. The

information shall not identify a specific drug and shall be expressed only as a percentage of the sample of drugs selected under section ~~173.814~~ 5169.114 of the Revised Code.

(C) The lists compiled under this section are public records for the purpose of section 149.43 of the Revised Code. The department shall specifically make the lists available to physicians, participating terminal distributors, and other health professionals.

Sec. ~~173.89~~ 5169.19. Information transmitted by or to any of the following for any purpose related to the Ohio's best Rx program is confidential to the extent required by federal and state law:

(A) Drug manufacturers;

(B) Terminal distributors of dangerous drugs;

(C) The department of ~~aging~~ health care administration;

(D) The program's consulting pharmacy benefit manager selected under section ~~173.731~~ 5169.031 of the Revised Code;

(E) Ohio's best Rx program participants;

(F) Any other government entity or person.

Sec. ~~173.891~~ 5169.191. (A) Except as provided by section ~~173.892~~ 5169.192 of the Revised Code, all of the following are trade secrets, are not public records for the purposes of section 149.43 of the Revised Code, and shall not be used, released, published, or disclosed in a form that reveals a specific drug or the identity of a drug manufacturer:

(1) The amounts determined under section ~~173.801~~ 5169.101 of the Revised Code for payment of claims submitted by participating terminal distributors and the drug mail order system included in the Ohio's best Rx program pursuant to section ~~173.78~~ 5169.08 of

the Revised Code;

(2) Information disclosed in a manufacturer agreement entered into under section ~~173.81~~ 5169.11 of the Revised Code or in communications related to an agreement;

(3) Drug pricing and drug manufacturer payment information verified under sections ~~173.742~~ 5169.042 and ~~173.814~~ 5169.114 of the Revised Code by the program's consulting pharmacy benefit manager selected under section ~~173.731~~ 5169.031 of the Revised Code;

(4) Information contained in or pertaining to an audit provided for by the program's consulting pharmacy benefit manager under section ~~173.732~~ 5169.032 of the Revised Code;

(5) The elements of the computations made pursuant to sections ~~173.75~~ 5169.05, ~~173.801~~ 5169.101, and ~~173.812~~ 5169.112 of the Revised Code and any results of those computations that reveal or could be used to reveal the manufacturer payment amounts used to make the computations.

(B) No person or government entity shall use or reveal any information specified in division (A) of this section except as required for the implementation of sections ~~173.71~~ 5169.01 to ~~173.91~~ 5169.21 of the Revised Code.

Sec. ~~173.892~~ 5169.192. Sections ~~173.89~~ 5169.19 and ~~173.891~~ 5169.191 of the Revised Code shall not preclude the department of ~~aging~~ health care administration from disclosing information necessary for the implementation of sections ~~173.71~~ 5169.01 to ~~173.91~~ 5169.21 of the Revised Code, including the amount an Ohio's best Rx program participant is to be charged when the amount is disclosed under section ~~173.751~~ 5169.051 of the Revised Code to participating terminal distributors or the drug mail order system included in the program pursuant to section ~~173.78~~ 5169.08 of the

Revised Code.

Sec. ~~173.90~~ 5169.20. (A) As used in this section, "identifying information" means information that identifies or could be used to identify an Ohio's best Rx program applicant or participant. "Identifying information" does not include aggregate information about applicants and participants that does not identify and could not be used to identify an individual applicant or participant.

(B) Except as provided in divisions (C), (D), and (E) of this section, no person or government entity shall sell, solicit, disclose, receive, or use identifying information or knowingly permit the use of identifying information.

(C)(1) The department of ~~aging~~ health care administration may solicit, disclose, receive, or use identifying information or knowingly permit the use of identifying information for a purpose directly connected to the administration of the Ohio's best Rx program, including disclosing and knowingly permitting the use of identifying information included in a claim that a participating manufacturer audits pursuant to section ~~173.82~~ 5169.12 of the Revised Code, contacting Ohio's best Rx program applicants or participants regarding participation in the program, and notifying applicants and participants regarding participating terminal distributors and the drug mail order system included in the program pursuant to section ~~173.78~~ 5169.08 of the Revised Code.

(2) The department may solicit, disclose, receive, or use identifying information or knowingly permit the use of identifying information to the extent required by federal law.

(3) The department may disclose identifying information to the Ohio's best Rx program applicant or participant who is the subject of that information or to the parent, spouse, guardian, or custodian of that applicant or participant.

(D)(1) A participating terminal distributor may solicit, disclose, receive, or use identifying information or knowingly permit the use of identifying information to the extent required or permitted by an agreement the distributor enters into under section ~~173.79~~ 5169.09 of the Revised Code.

(2) Subject to division (B) of section ~~173.78~~ 5169.08 of the Revised Code, the drug mail order system included in the program pursuant to section ~~173.78~~ 5169.08 of the Revised Code may solicit, disclose, receive, or use identifying information or knowingly permit the use of identifying information to the extent required or permitted by the department.

(E) A participating manufacturer may, for the purpose of auditing a claim pursuant to section ~~173.82~~ 5169.12 of the Revised Code, solicit, receive, and use identifying information included in the claim.

Sec. ~~173.91~~ 5169.21. (A) Except as provided in division (B) of this section, the department of ~~aging~~ health care administration shall use and preserve records regarding the Ohio's best Rx program in accordance with rules adopted under section ~~173.83~~ 5169.13 of the Revised Code. The department shall use and preserve the records in accordance with those rules, regardless of whether the department generated the records or received them from another government entity or any person.

(B) All records received by the department under sections ~~173.742~~ 5169.042 and ~~173.814~~ 5169.114 of the Revised Code from the program's consulting pharmacy benefit manager selected under section ~~173.731~~ 5169.031 of the Revised Code shall be destroyed promptly after the department has completed the purpose for which the information contained in the records was obtained.

Sec. 5169.99. Whoever violates division (B) of section

5169.20 of the Revised Code is guilty of a misdemeanor of the first degree.

Sec. 5505.04. (A)(1) The general administration and management of the state highway patrol retirement system and the making effective of this chapter are hereby vested in the state highway patrol retirement board. The board may sue and be sued, plead and be impleaded, contract and be contracted with, and do all things necessary to carry out this chapter.

The board shall consist of the following members:

(a) The superintendent of the state highway patrol;

(b) Two retirant members who reside in this state;

(c) Five employee-members;

(d) One member, known as the treasurer of state's investment designee, who shall be appointed by the treasurer of state for a term of four years and who shall have the following qualifications:

(i) The member is a resident of this state.

(ii) Within the three years immediately preceding the appointment, the member has not been employed by the public employees retirement system, police and fire pension fund, state teachers retirement system, school employees retirement system, or state highway patrol retirement system or by any person, partnership, or corporation that has provided to one of those retirement systems services of a financial or investment nature, including the management, analysis, supervision, or investment of assets.

(iii) The member has direct experience in the management, analysis, supervision, or investment of assets.

(iv) The member is not currently employed by the state or a

political subdivision of the state.

(e) Two investment expert members, who shall be appointed to four-year terms. One investment expert member shall be appointed by the governor, and one investment expert member shall be jointly appointed by the speaker of the house of representatives and the president of the senate. Each investment expert member shall have the following qualifications:

(i) Each investment expert member shall be a resident of this state.

(ii) Within the three years immediately preceding the appointment, each investment expert member shall not have been employed by the public employees retirement system, police and fire pension fund, state teachers retirement system, school employees retirement system, or state highway patrol retirement system or by any person, partnership, or corporation that has provided to one of those retirement systems services of a financial or investment nature, including the management, analysis, supervision, or investment of assets.

(iii) Each investment expert member shall have direct experience in the management, analysis, supervision, or investment of assets.

(2) The board shall annually elect a chairperson and vice-chairperson from among its members. The vice-chairperson shall act as chairperson in the absence of the chairperson. A majority of the members of the board shall constitute a quorum and any action taken shall be approved by a majority of the members of the board. The board shall meet not less than once each year, upon sufficient notice to the members. All meetings of the board shall be open to the public except executive sessions as set forth in division (G) of section 121.22 of the Revised Code, and any portions of any sessions discussing medical records or the degree

of disability of a member excluded from public inspection by this section.

(3) Any investment expert member appointed to fill a vacancy occurring prior to the expiration of the term for which the member's predecessor was appointed holds office until the end of such term. The member continues in office subsequent to the expiration date of the member's term until the member's successor takes office, or until a period of sixty days has elapsed, whichever occurs first.

(B) The attorney general shall prescribe procedures for the adoption of rules authorized under this chapter, consistent with the provision of section 111.15 of the Revised Code under which all rules shall be filed in order to be effective. Such procedures shall establish methods by which notice of proposed rules are given to interested parties and rules adopted by the board published and otherwise made available. When it files a rule with the joint committee on agency rule review pursuant to section 111.15 of the Revised Code, the board shall submit to the Ohio retirement study council a copy of the full text of the rule, and if applicable, a copy of the rule summary and fiscal analysis required by division (B) of section 127.18 of the Revised Code.

(C)(1) As used in this division, "personal history record" means information maintained by the board on an individual who is a member, former member, retirant, or beneficiary that includes the address, telephone number, social security number, record of contributions, correspondence with the system, and other information the board determines to be confidential.

(2) The records of the board shall be open to public inspection, except for the following which shall be excluded: the member's, former member's, retirant's, or beneficiary's personal history record and the amount of a monthly allowance or benefit paid to a retirant, beneficiary, or survivor, except with the

written authorization of the individual concerned. All medical reports and recommendations are privileged except that copies of such medical reports or recommendations shall be made available to the individual's personal physician, attorney, or authorized agent upon written release received from such individual or such individual's agent, or when necessary for the proper administration of the fund to the board-assigned physician.

(D) Notwithstanding the exceptions to public inspection in division (C)(2) of this section, the board may furnish the following information:

(1) If a member, former member, or retirant is subject to an order issued under section 2907.15 of the Revised Code or is convicted of or pleads guilty to a violation of section 2921.41 of the Revised Code, on written request of a prosecutor as defined in section 2935.01 of the Revised Code, the board shall furnish to the prosecutor the information requested from the individual's personal history record.

(2) Pursuant to a court order issued under Chapters 3119., 3121., and 3123. of the Revised Code, the board shall furnish to a court or child support enforcement agency the information required under those chapters.

(3) At the written request of any nonprofit organization or association providing services to retirement system members, retirants, or beneficiaries, the board shall provide to the organization or association a list of the names and addresses of members, former members, retirants, or beneficiaries if the organization or association agrees to use such information solely in accordance with its stated purpose of providing services to such individuals and not for the benefit of other persons, organizations, or associations. The costs of compiling, copying, and mailing the list shall be paid by such entity.

(4) Within fourteen days after receiving ~~from the director of job and family services~~ a list of the names and social security numbers of recipients of public assistance pursuant to section 5101.181 of the Revised Code or a list of the names and social security numbers of public medical assistance recipients pursuant to section 5160.43 of the Revised Code, the board shall inform the auditor of state of the name, current or most recent employer address, and social security number of each member whose name and social security number are the same as those of a person whose name or social security number ~~was submitted by the director~~ is included on the list. The board and its employees, except for purposes of furnishing the auditor of state with information required by this section, shall preserve the confidentiality of recipients of public assistance in compliance with ~~division (A) of~~ section 5101.181 of the Revised Code and preserve the confidentiality of public medical assistance program recipients in compliance with section 5160.43 of the Revised Code.

(5) The system shall comply with orders issued under section 3105.87 of the Revised Code.

On the written request of an alternate payee, as defined in section 3105.80 of the Revised Code, the system shall furnish to the alternate payee information on the amount and status of any amounts payable to the alternate payee under an order issued under section 3105.171 or 3105.65 of the Revised Code.

(6) At the request of any person, the board shall make available to the person copies of all documents, including resumes, in the board's possession regarding filling a vacancy of an employee member or retirant member of the board. The person who made the request shall pay the cost of compiling, copying, and mailing the documents. The information described in this division is a public record.

(E) A statement that contains information obtained from the

system's records that is certified and signed by an officer of the retirement system and to which the system's official seal is affixed, or copies of the system's records to which the signature and seal are attached, shall be received as true copies of the system's records in any court or before any officer of this state.

Sec. 5725.18. (A) An annual franchise tax on the privilege of being an insurance company is hereby levied on each domestic insurance company. In the month of May, annually, the treasurer of state shall charge for collection from each domestic insurance company a franchise tax in the amount computed in accordance with the following, as applicable:

(1) With respect to a domestic insurance company that is a health insuring corporation, one per cent of all premium rate payments received, exclusive of payments received under 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 pursuant to the ~~medical assistance~~ medicaid program ~~established under Chapter 5111. of the Revised Code~~, as reflected in its annual report for the preceding calendar year;

(2) With respect to a domestic insurance company that is not a health insuring corporation, one and four-tenths per cent of the gross amount of premiums received from policies covering risks within this state, exclusive of premiums received under 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 pursuant to the ~~medical assistance~~ medicaid program ~~established under Chapter 5111. of the Revised Code~~, as reflected in its annual statement for the preceding calendar year, and, if the company operates a health insuring corporation as a line of business, one per cent of all premium rate payments received from that line of business, exclusive of payments received under 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 pursuant to the ~~medical assistance~~ medicaid program ~~established under Chapter 5111. of the Revised Code~~, as reflected in its annual statement for the preceding calendar year.

(B) The gross amount of premium rate payments or premiums used to compute the applicable tax in accordance with division (A) of this section is subject to the deductions prescribed by section 5729.03 of the Revised Code for foreign insurance companies. The objects of such tax are those declared in section 5725.24 of the Revised Code, to which only such tax shall be applied.

(C) In no case shall such tax be less than two hundred fifty dollars.

Sec. 5729.03. (A) If the superintendent of insurance finds the annual statement required by section 5729.02 of the Revised Code to be correct, the superintendent shall compute the following amount, as applicable, of the balance of such gross amount, after deducting such return premiums and considerations received for reinsurance, and charge such amount to such company as a tax upon the business done by it in this state for the period covered by such annual statement:

(1) If the company is a health insuring corporation, one per cent of the balance of premium rate payments received, exclusive of payments received under 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 pursuant to the ~~medical assistance~~ medicaid program ~~established under Chapter 5111. of the Revised Code~~, as reflected in its annual report;

(2) If the company is not a health insuring corporation, one and four-tenths per cent of the balance of premiums received, exclusive of premiums received under 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 pursuant to the ~~medical assistance~~ medicaid program ~~established under Chapter 5111. of the Revised Code~~, as reflected in its annual statement, and, if the company operates a health insuring corporation as a line of business, one per cent of the balance of premium rate payments received from that line of business, exclusive of payments received under 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 pursuant to the ~~medical assistance~~ medicaid program ~~established under Chapter 5111. of the Revised Code~~, as reflected in its annual statement.

(B) Any insurance policies that were not issued in violation of Title XXXIX of the Revised Code and that were issued prior to April 15, 1967, by a life insurance company organized and operated without profit to any private shareholder or individual, exclusively for the purpose of aiding educational or scientific institutions organized and operated without profit to any private shareholder or individual, are not subject to the tax imposed by this section. All taxes collected pursuant to this section shall be credited to the general revenue fund.

(C) In no case shall the tax imposed under this section be less than two hundred fifty dollars.

Sec. 5731.39. (A) No corporation organized or existing under the laws of this state shall transfer on its books or issue a new certificate for any share of its capital stock registered in the name of a decedent, or in trust for a decedent, or in the name of a decedent and another person or persons, without the written consent of the tax commissioner.

(B) No safe deposit company, trust company, financial institution as defined in division (A) of section 5725.01 of the

Revised Code or other corporation or person, having in possession, control, or custody a deposit standing in the name of a decedent, or in trust for a decedent, or in the name of a decedent and another person or persons, shall deliver or transfer an amount in excess of three-fourths of the total value of such deposit, including accrued interest and dividends, as of the date of decedent's death, without the written consent of the tax commissioner. The written consent of the tax commissioner need not be obtained prior to the delivery or transfer of amounts having a value of three-fourths or less of said total value.

(C) No life insurance company shall pay the proceeds of an annuity or matured endowment contract, or of a life insurance contract payable to the estate of a decedent, or of any other insurance contract taxable under Chapter 5731. of the Revised Code, without the written consent of the tax commissioner. Any life insurance company may pay the proceeds of any insurance contract not specified in this division (C) without the written consent of the tax commissioner.

(D) No trust company or other corporation or person shall pay the proceeds of any death benefit, retirement, pension or profit sharing plan in excess of two thousand dollars, without the written consent of the tax commissioner. Such trust company or other corporation or person, however, may pay the proceeds of any death benefit, retirement, pension, or profit-sharing plan which consists of insurance on the life of the decedent payable to a beneficiary other than the estate of the insured without the written consent of the tax commissioner.

(E) No safe deposit company, trust company, financial institution as defined in division (A) of section 5725.01 of the Revised Code, or other corporation or person, having in possession, control, or custody securities, assets, or other property (including the shares of the capital stock of, or other

interest in, such safe deposit company, trust company, financial institution as defined in division (A) of section 5725.01 of the Revised Code, or other corporation), standing in the name of a decedent, or in trust for a decedent, or in the name of a decedent and another person or persons, and the transfer of which is taxable under Chapter 5731. of the Revised Code, shall deliver or transfer any such securities, assets, or other property which have a value as of the date of decedent's death in excess of three-fourths of the total value thereof, without the written consent of the tax commissioner. The written consent of the tax commissioner need not be obtained prior to the delivery or transfer of any such securities, assets, or other property having a value of three-fourths or less of said total value.

(F) No safe deposit company, financial institution as defined in division (A) of section 5725.01 of the Revised Code, or other corporation or person having possession or control of a safe deposit box or similar receptacle standing in the name of a decedent or in the name of the decedent and another person or persons, or to which the decedent had a right of access, except when such safe deposit box or other receptacle stands in the name of a corporation or partnership, or in the name of the decedent as guardian or executor, shall deliver any of the contents thereof unless the safe deposit box or similar receptacle has been opened and inventoried in the presence of the tax commissioner or the commissioner's agent, and a written consent to transfer issued; provided, however, that a safe deposit company, financial institution, or other corporation or person having possession or control of a safe deposit box may deliver wills, deeds to burial lots, and insurance policies to a representative of the decedent, but that a representative of the safe deposit company, financial institution, or other corporation or person must supervise the opening of the box and make a written record of the wills, deeds, and policies removed. Such written record shall be included in the

tax commissioner's inventory records.

(G) Notwithstanding any provision of this section:

(1) The tax commissioner may authorize any delivery or transfer or waive any of the foregoing requirements under such terms and conditions as the commissioner may prescribe;

(2) An adult care facility, as defined in section 3722.01 of the Revised Code, or a home, as defined in section 3721.10 of the Revised Code, may transfer or use the money in a personal needs allowance account in accordance with section ~~5111.113~~ 5162.37 of the Revised Code without the written consent of the tax commissioner, and without the account having been opened and inventoried in the presence of the commissioner or the commissioner's agent.

Failure to comply with this section shall render such safe deposit company, trust company, life insurance company, financial institution as defined in division (A) of section 5725.01 of the Revised Code, or other corporation or person liable for the amount of the taxes and interest due under the provisions of Chapter 5731. of the Revised Code on the transfer of such stock, deposit, proceeds of an annuity or matured endowment contract or of a life insurance contract payable to the estate of a decedent, or other insurance contract taxable under Chapter 5731. of the Revised Code, proceeds of any death benefit, retirement, pension, or profit sharing plan in excess of two thousand dollars, or securities, assets, or other property of any resident decedent, and in addition thereto, to a penalty of not less than five hundred or more than five thousand dollars.

Sec. 5747.01. Except as otherwise expressly provided or clearly appearing from the context, any term used in this chapter that is not otherwise defined in this section has the same meaning as when used in a comparable context in the laws of the United

States relating to federal income taxes or if not used in a comparable context in those laws, has the same meaning as in section 5733.40 of the Revised Code. Any reference in this chapter to the Internal Revenue Code includes other laws of the United States relating to federal income taxes.

As used in this chapter:

(A) "Adjusted gross income" or "Ohio adjusted gross income" means federal adjusted gross income, as defined and used in the Internal Revenue Code, adjusted as provided in this section:

(1) Add interest or dividends on obligations or securities of any state or of any political subdivision or authority of any state, other than this state and its subdivisions and authorities.

(2) Add interest or dividends on obligations of any authority, commission, instrumentality, territory, or possession of the United States to the extent that the interest or dividends are exempt from federal income taxes but not from state income taxes.

(3) Deduct interest or dividends on obligations of the United States and its territories and possessions or of any authority, commission, or instrumentality of the United States to the extent that the interest or dividends are included in federal adjusted gross income but exempt from state income taxes under the laws of the United States.

(4) Deduct disability and survivor's benefits to the extent included in federal adjusted gross income.

(5) Deduct benefits under Title II of the Social Security Act and tier 1 railroad retirement benefits to the extent included in federal adjusted gross income under section 86 of the Internal Revenue Code.

(6) In the case of a taxpayer who is a beneficiary of a trust

that makes an accumulation distribution as defined in section 665 of the Internal Revenue Code, add, for the beneficiary's taxable years beginning before 2002, the portion, if any, of such distribution that does not exceed the undistributed net income of the trust for the three taxable years preceding the taxable year in which the distribution is made to the extent that the portion was not included in the trust's taxable income for any of the trust's taxable years beginning in 2002 or thereafter. "Undistributed net income of a trust" means the taxable income of the trust increased by (a)(i) the additions to adjusted gross income required under division (A) of this section and (ii) the personal exemptions allowed to the trust pursuant to section 642(b) of the Internal Revenue Code, and decreased by (b)(i) the deductions to adjusted gross income required under division (A) of this section, (ii) the amount of federal income taxes attributable to such income, and (iii) the amount of taxable income that has been included in the adjusted gross income of a beneficiary by reason of a prior accumulation distribution. Any undistributed net income included in the adjusted gross income of a beneficiary shall reduce the undistributed net income of the trust commencing with the earliest years of the accumulation period.

(7) Deduct the amount of wages and salaries, if any, not otherwise allowable as a deduction but that would have been allowable as a deduction in computing federal adjusted gross income for the taxable year, had the targeted jobs credit allowed and determined under sections 38, 51, and 52 of the Internal Revenue Code not been in effect.

(8) Deduct any interest or interest equivalent on public obligations and purchase obligations to the extent that the interest or interest equivalent is included in federal adjusted gross income.

(9) Add any loss or deduct any gain resulting from the sale,

exchange, or other disposition of public obligations to the extent that the loss has been deducted or the gain has been included in computing federal adjusted gross income.

(10) Deduct or add amounts, as provided under section 5747.70 of the Revised Code, related to contributions to variable college savings program accounts made or tuition units purchased pursuant to Chapter 3334. of the Revised Code.

(11)(a) Deduct, to the extent not otherwise allowable as a deduction or exclusion in computing federal or Ohio adjusted gross income for the taxable year, the amount the taxpayer paid during the taxable year for medical care insurance and qualified long-term care insurance for the taxpayer, the taxpayer's spouse, and dependents. No deduction for medical care insurance under division (A)(11) of this section shall be allowed either to any taxpayer who is eligible to participate in any subsidized health plan maintained by any employer of the taxpayer or of the taxpayer's spouse, or to any taxpayer who is entitled to, or on application would be entitled to, benefits under part A of ~~Title XVIII of~~ the ~~"Social Security Act," 49 Stat. 620 (1935), 42 U.S.C. 301, as amended~~ medicare program. For the purposes of division (A)(11)(a) of this section, "subsidized health plan" means a health plan for which the employer pays any portion of the plan's cost. The deduction allowed under division (A)(11)(a) of this section shall be the net of any related premium refunds, related premium reimbursements, or related insurance premium dividends received during the taxable year.

(b) Deduct, to the extent not otherwise deducted or excluded in computing federal or Ohio adjusted gross income during the taxable year, the amount the taxpayer paid during the taxable year, not compensated for by any insurance or otherwise, for medical care of the taxpayer, the taxpayer's spouse, and dependents, to the extent the expenses exceed seven and one-half

per cent of the taxpayer's federal adjusted gross income.

(c) For purposes of division (A)(11) of this section, "medical care" has the meaning given in section 213 of the Internal Revenue Code, subject to the special rules, limitations, and exclusions set forth therein, and "qualified long-term care" has the same meaning given in section 7702B(c) of the Internal Revenue Code.

(12)(a) Deduct any amount included in federal adjusted gross income solely because the amount represents a reimbursement or refund of expenses that in any year the taxpayer had deducted as an itemized deduction pursuant to section 63 of the Internal Revenue Code and applicable United States department of the treasury regulations. The deduction otherwise allowed under division (A)(12)(a) of this section shall be reduced to the extent the reimbursement is attributable to an amount the taxpayer deducted under this section in any taxable year.

(b) Add any amount not otherwise included in Ohio adjusted gross income for any taxable year to the extent that the amount is attributable to the recovery during the taxable year of any amount deducted or excluded in computing federal or Ohio adjusted gross income in any taxable year.

(13) Deduct any portion of the deduction described in section 1341(a)(2) of the Internal Revenue Code, for repaying previously reported income received under a claim of right, that meets both of the following requirements:

(a) It is allowable for repayment of an item that was included in the taxpayer's adjusted gross income for a prior taxable year and did not qualify for a credit under division (A) or (B) of section 5747.05 of the Revised Code for that year;

(b) It does not otherwise reduce the taxpayer's adjusted gross income for the current or any other taxable year.

(14) Deduct an amount equal to the deposits made to, and net investment earnings of, a medical savings account during the taxable year, in accordance with section 3924.66 of the Revised Code. The deduction allowed by division (A)(14) of this section does not apply to medical savings account deposits and earnings otherwise deducted or excluded for the current or any other taxable year from the taxpayer's federal adjusted gross income.

(15)(a) Add an amount equal to the funds withdrawn from a medical savings account during the taxable year, and the net investment earnings on those funds, when the funds withdrawn were used for any purpose other than to reimburse an account holder for, or to pay, eligible medical expenses, in accordance with section 3924.66 of the Revised Code;

(b) Add the amounts distributed from a medical savings account under division (A)(2) of section 3924.68 of the Revised Code during the taxable year.

(16) Add any amount claimed as a credit under section 5747.059 of the Revised Code to the extent that such amount satisfies either of the following:

(a) The amount was deducted or excluded from the computation of the taxpayer's federal adjusted gross income as required to be reported for the taxpayer's taxable year under the Internal Revenue Code;

(b) The amount resulted in a reduction of the taxpayer's federal adjusted gross income as required to be reported for any of the taxpayer's taxable years under the Internal Revenue Code.

(17) Deduct the amount contributed by the taxpayer to an individual development account program established by a county department of job and family services pursuant to sections 329.11 to 329.14 of the Revised Code for the purpose of matching funds deposited by program participants. On request of the tax

commissioner, the taxpayer shall provide any information that, in the tax commissioner's opinion, is necessary to establish the amount deducted under division (A)(17) of this section.

(18) Beginning in taxable year 2001 but not for any taxable year beginning after December 31, 2005, if the taxpayer is married and files a joint return and the combined federal adjusted gross income of the taxpayer and the taxpayer's spouse for the taxable year does not exceed one hundred thousand dollars, or if the taxpayer is single and has a federal adjusted gross income for the taxable year not exceeding fifty thousand dollars, deduct amounts paid during the taxable year for qualified tuition and fees paid to an eligible institution for the taxpayer, the taxpayer's spouse, or any dependent of the taxpayer, who is a resident of this state and is enrolled in or attending a program that culminates in a degree or diploma at an eligible institution. The deduction may be claimed only to the extent that qualified tuition and fees are not otherwise deducted or excluded for any taxable year from federal or Ohio adjusted gross income. The deduction may not be claimed for educational expenses for which the taxpayer claims a credit under section 5747.27 of the Revised Code.

(19) Add any reimbursement received during the taxable year of any amount the taxpayer deducted under division (A)(18) of this section in any previous taxable year to the extent the amount is not otherwise included in Ohio adjusted gross income.

(20)(a)(i) Add five-sixths of the amount of depreciation expense allowed by subsection (k) of section 168 of the Internal Revenue Code, including the taxpayer's proportionate or distributive share of the amount of depreciation expense allowed by that subsection to a pass-through entity in which the taxpayer has a direct or indirect ownership interest.

(ii) Add five-sixths of the amount of qualifying section 179 depreciation expense, including a person's proportionate or

distributive share of the amount of qualifying section 179 depreciation expense allowed to any pass-through entity in which the person has a direct or indirect ownership. For the purposes of this division, "qualifying section 179 depreciation expense" means the difference between (I) the amount of depreciation expense directly or indirectly allowed to the taxpayer under section 179 of the Internal Revenue Code, and (II) the amount of depreciation expense directly or indirectly allowed to the taxpayer under section 179 of the Internal Revenue Code as that section existed on December 31, 2002.

The tax commissioner, under procedures established by the commissioner, may waive the add-backs related to a pass-through entity if the taxpayer owns, directly or indirectly, less than five per cent of the pass-through entity.

(b) Nothing in division (A)(20) of this section shall be construed to adjust or modify the adjusted basis of any asset.

(c) To the extent the add-back required under division (A)(20)(a) of this section is attributable to property generating nonbusiness income or loss allocated under section 5747.20 of the Revised Code, the add-back shall be situsedto the same location as the nonbusiness income or loss generated by the property for the purpose of determining the credit under division (A) of section 5747.05 of the Revised Code. Otherwise, the add-back shall be apportioned, subject to one or more of the four alternative methods of apportionment enumerated in section 5747.21 of the Revised Code.

(d) For the purposes of division (A) of this section, net operating loss carryback and carryforward shall not include five-sixths of the allowance of any net operating loss deduction carryback or carryforward to the taxable year to the extent such loss resulted from depreciation allowed by section 168(k) of the Internal Revenue Code and by the qualifying section 179

depreciation expense amount.

(21)(a) If the taxpayer was required to add an amount under division (A)(20)(a) of this section for a taxable year, deduct one-fifth of the amount so added for each of the five succeeding taxable years.

(b) If the amount deducted under division (A)(21)(a) of this section is attributable to an add-back allocated under division (A)(20)(c) of this section, the amount deducted shall be sitused to the same location. Otherwise, the add-back shall be apportioned using the apportionment factors for the taxable year in which the deduction is taken, subject to one or more of the four alternative methods of apportionment enumerated in section 5747.21 of the Revised Code.

(c) No deduction is available under division (A)(21)(a) of this section with regard to any depreciation allowed by section 168(k) of the Internal Revenue Code and by the qualifying section 179 depreciation expense amount to the extent that such depreciation resulted in or increased a federal net operating loss carryback or carryforward to a taxable year to which division (A)(20)(d) of this section does not apply.

(22) Deduct, to the extent not otherwise deducted or excluded in computing federal or Ohio adjusted gross income for the taxable year, the amount the taxpayer received during the taxable year as reimbursement for life insurance premiums under section 5919.31 of the Revised Code.

(23) Deduct, to the extent not otherwise deducted or excluded in computing federal or Ohio adjusted gross income for the taxable year, the amount the taxpayer received during the taxable year as a death benefit paid by the adjutant general under section 5919.33 of the Revised Code.

(24) Deduct, to the extent included in federal adjusted gross

income and not otherwise allowable as a deduction or exclusion in computing federal or Ohio adjusted gross income for the taxable year, military pay and allowances received by the taxpayer during the taxable year for active duty service in the United States army, air force, navy, marine corps, or coast guard or reserve components thereof or the national guard. The deduction may not be claimed for military pay and allowances received by the taxpayer while the taxpayer is stationed in this state.

(B) "Business income" means income, including gain or loss, arising from transactions, activities, and sources in the regular course of a trade or business and includes income, gain, or loss from real property, tangible property, and intangible property if the acquisition, rental, management, and disposition of the property constitute integral parts of the regular course of a trade or business operation. "Business income" includes income, including gain or loss, from a partial or complete liquidation of a business, including, but not limited to, gain or loss from the sale or other disposition of goodwill.

(C) "Nonbusiness income" means all income other than business income and may include, but is not limited to, compensation, rents and royalties from real or tangible personal property, capital gains, interest, dividends and distributions, patent or copyright royalties, or lottery winnings, prizes, and awards.

(D) "Compensation" means any form of remuneration paid to an employee for personal services.

(E) "Fiduciary" means a guardian, trustee, executor, administrator, receiver, conservator, or any other person acting in any fiduciary capacity for any individual, trust, or estate.

(F) "Fiscal year" means an accounting period of twelve months ending on the last day of any month other than December.

(G) "Individual" means any natural person.

(H) "Internal Revenue Code" means the "Internal Revenue Code of 1986," 100 Stat. 2085, 26 U.S.C.A. 1, as amended.

(I) "Resident" means any of the following, provided that division (I)(3) of this section applies only to taxable years of a trust beginning in 2002 or thereafter:

(1) An individual who is domiciled in this state, subject to section 5747.24 of the Revised Code;

(2) The estate of a decedent who at the time of death was domiciled in this state. The domicile tests of section 5747.24 of the Revised Code are not controlling for purposes of division (I)(2) of this section.

(3) A trust that, in whole or part, resides in this state. If only part of a trust resides in this state, the trust is a resident only with respect to that part.

For the purposes of division (I)(3) of this section:

(a) A trust resides in this state for the trust's current taxable year to the extent, as described in division (I)(3)(d) of this section, that the trust consists directly or indirectly, in whole or in part, of assets, net of any related liabilities, that were transferred, or caused to be transferred, directly or indirectly, to the trust by any of the following:

(i) A person, a court, or a governmental entity or instrumentality on account of the death of a decedent, but only if the trust is described in division (I)(3)(e)(i) or (ii) of this section;

(ii) A person who was domiciled in this state for the purposes of this chapter when the person directly or indirectly transferred assets to an irrevocable trust, but only if at least one of the trust's qualifying beneficiaries is domiciled in this state for the purposes of this chapter during all or some portion

of the trust's current taxable year;

(iii) A person who was domiciled in this state for the purposes of this chapter when the trust document or instrument or part of the trust document or instrument became irrevocable, but only if at least one of the trust's qualifying beneficiaries is a resident domiciled in this state for the purposes of this chapter during all or some portion of the trust's current taxable year. If a trust document or instrument became irrevocable upon the death of a person who at the time of death was domiciled in this state for purposes of this chapter, that person is a person described in division (I)(3)(a)(iii) of this section.

(b) A trust is irrevocable to the extent that the transferor is not considered to be the owner of the net assets of the trust under sections 671 to 678 of the Internal Revenue Code.

(c) With respect to a trust other than a charitable lead trust, "qualifying beneficiary" has the same meaning as "potential current beneficiary" as defined in section 1361(e)(2) of the Internal Revenue Code, and with respect to a charitable lead trust "qualifying beneficiary" is any current, future, or contingent beneficiary, but with respect to any trust "qualifying beneficiary" excludes a person or a governmental entity or instrumentality to any of which a contribution would qualify for the charitable deduction under section 170 of the Internal Revenue Code.

(d) For the purposes of division (I)(3)(a) of this section, the extent to which a trust consists directly or indirectly, in whole or in part, of assets, net of any related liabilities, that were transferred directly or indirectly, in whole or part, to the trust by any of the sources enumerated in that division shall be ascertained by multiplying the fair market value of the trust's assets, net of related liabilities, by the qualifying ratio, which shall be computed as follows:

(i) The first time the trust receives assets, the numerator of the qualifying ratio is the fair market value of those assets at that time, net of any related liabilities, from sources enumerated in division (I)(3)(a) of this section. The denominator of the qualifying ratio is the fair market value of all the trust's assets at that time, net of any related liabilities.

(ii) Each subsequent time the trust receives assets, a revised qualifying ratio shall be computed. The numerator of the revised qualifying ratio is the sum of (1) the fair market value of the trust's assets immediately prior to the subsequent transfer, net of any related liabilities, multiplied by the qualifying ratio last computed without regard to the subsequent transfer, and (2) the fair market value of the subsequently transferred assets at the time transferred, net of any related liabilities, from sources enumerated in division (I)(3)(a) of this section. The denominator of the revised qualifying ratio is the fair market value of all the trust's assets immediately after the subsequent transfer, net of any related liabilities.

(iii) Whether a transfer to the trust is by or from any of the sources enumerated in division (I)(3)(a) of this section shall be ascertained without regard to the domicile of the trust's beneficiaries.

(e) For the purposes of division (I)(3)(a)(i) of this section:

(i) A trust is described in division (I)(3)(e)(i) of this section if the trust is a testamentary trust and the testator of that testamentary trust was domiciled in this state at the time of the testator's death for purposes of the taxes levied under Chapter 5731. of the Revised Code.

(ii) A trust is described in division (I)(3)(e)(ii) of this section if the transfer is a qualifying transfer described in any

of divisions (I)(3)(f)(i) to (vi) of this section, the trust is an irrevocable inter vivos trust, and at least one of the trust's qualifying beneficiaries is domiciled in this state for purposes of this chapter during all or some portion of the trust's current taxable year.

(f) For the purposes of division (I)(3)(e)(ii) of this section, a "qualifying transfer" is a transfer of assets, net of any related liabilities, directly or indirectly to a trust, if the transfer is described in any of the following:

(i) The transfer is made to a trust, created by the decedent before the decedent's death and while the decedent was domiciled in this state for the purposes of this chapter, and, prior to the death of the decedent, the trust became irrevocable while the decedent was domiciled in this state for the purposes of this chapter.

(ii) The transfer is made to a trust to which the decedent, prior to the decedent's death, had directly or indirectly transferred assets, net of any related liabilities, while the decedent was domiciled in this state for the purposes of this chapter, and prior to the death of the decedent the trust became irrevocable while the decedent was domiciled in this state for the purposes of this chapter.

(iii) The transfer is made on account of a contractual relationship existing directly or indirectly between the transferor and either the decedent or the estate of the decedent at any time prior to the date of the decedent's death, and the decedent was domiciled in this state at the time of death for purposes of the taxes levied under Chapter 5731. of the Revised Code.

(iv) The transfer is made to a trust on account of a contractual relationship existing directly or indirectly between

the transferor and another person who at the time of the decedent's death was domiciled in this state for purposes of this chapter.

(v) The transfer is made to a trust on account of the will of a testator.

(vi) The transfer is made to a trust created by or caused to be created by a court, and the trust was directly or indirectly created in connection with or as a result of the death of an individual who, for purposes of the taxes levied under Chapter 5731. of the Revised Code, was domiciled in this state at the time of the individual's death.

(g) The tax commissioner may adopt rules to ascertain the part of a trust residing in this state.

(J) "Nonresident" means an individual or estate that is not a resident. An individual who is a resident for only part of a taxable year is a nonresident for the remainder of that taxable year.

(K) "Pass-through entity" has the same meaning as in section 5733.04 of the Revised Code.

(L) "Return" means the notifications and reports required to be filed pursuant to this chapter for the purpose of reporting the tax due and includes declarations of estimated tax when so required.

(M) "Taxable year" means the calendar year or the taxpayer's fiscal year ending during the calendar year, or fractional part thereof, upon which the adjusted gross income is calculated pursuant to this chapter.

(N) "Taxpayer" means any person subject to the tax imposed by section 5747.02 of the Revised Code or any pass-through entity that makes the election under division (D) of section 5747.08 of

the Revised Code.

(O) "Dependents" means dependents as defined in the Internal Revenue Code and as claimed in the taxpayer's federal income tax return for the taxable year or which the taxpayer would have been permitted to claim had the taxpayer filed a federal income tax return.

(P) "Principal county of employment" means, in the case of a nonresident, the county within the state in which a taxpayer performs services for an employer or, if those services are performed in more than one county, the county in which the major portion of the services are performed.

(Q) As used in sections 5747.50 to 5747.55 of the Revised Code:

(1) "Subdivision" means any county, municipal corporation, park district, or township.

(2) "Essential local government purposes" includes all functions that any subdivision is required by general law to exercise, including like functions that are exercised under a charter adopted pursuant to the Ohio Constitution.

(R) "Overpayment" means any amount already paid that exceeds the figure determined to be the correct amount of the tax.

(S) "Taxable income" or "Ohio taxable income" applies only to estates and trusts, and means federal taxable income, as defined and used in the Internal Revenue Code, adjusted as follows:

(1) Add interest or dividends, net of ordinary, necessary, and reasonable expenses not deducted in computing federal taxable income, on obligations or securities of any state or of any political subdivision or authority of any state, other than this state and its subdivisions and authorities, but only to the extent that such net amount is not otherwise includible in Ohio taxable

income and is described in either division (S)(1)(a) or (b) of this section:

(a) The net amount is not attributable to the S portion of an electing small business trust and has not been distributed to beneficiaries for the taxable year;

(b) The net amount is attributable to the S portion of an electing small business trust for the taxable year.

(2) Add interest or dividends, net of ordinary, necessary, and reasonable expenses not deducted in computing federal taxable income, on obligations of any authority, commission, instrumentality, territory, or possession of the United States to the extent that the interest or dividends are exempt from federal income taxes but not from state income taxes, but only to the extent that such net amount is not otherwise includible in Ohio taxable income and is described in either division (S)(1)(a) or (b) of this section;

(3) Add the amount of personal exemption allowed to the estate pursuant to section 642(b) of the Internal Revenue Code;

(4) Deduct interest or dividends, net of related expenses deducted in computing federal taxable income, on obligations of the United States and its territories and possessions or of any authority, commission, or instrumentality of the United States to the extent that the interest or dividends are exempt from state taxes under the laws of the United States, but only to the extent that such amount is included in federal taxable income and is described in either division (S)(1)(a) or (b) of this section;

(5) Deduct the amount of wages and salaries, if any, not otherwise allowable as a deduction but that would have been allowable as a deduction in computing federal taxable income for the taxable year, had the targeted jobs credit allowed under sections 38, 51, and 52 of the Internal Revenue Code not been in

effect, but only to the extent such amount relates either to income included in federal taxable income for the taxable year or to income of the S portion of an electing small business trust for the taxable year;

(6) Deduct any interest or interest equivalent, net of related expenses deducted in computing federal taxable income, on public obligations and purchase obligations, but only to the extent that such net amount relates either to income included in federal taxable income for the taxable year or to income of the S portion of an electing small business trust for the taxable year;

(7) Add any loss or deduct any gain resulting from sale, exchange, or other disposition of public obligations to the extent that such loss has been deducted or such gain has been included in computing either federal taxable income or income of the S portion of an electing small business trust for the taxable year;

(8) Except in the case of the final return of an estate, add any amount deducted by the taxpayer on both its Ohio estate tax return pursuant to section 5731.14 of the Revised Code, and on its federal income tax return in determining federal taxable income;

(9)(a) Deduct any amount included in federal taxable income solely because the amount represents a reimbursement or refund of expenses that in a previous year the decedent had deducted as an itemized deduction pursuant to section 63 of the Internal Revenue Code and applicable treasury regulations. The deduction otherwise allowed under division (S)(9)(a) of this section shall be reduced to the extent the reimbursement is attributable to an amount the taxpayer or decedent deducted under this section in any taxable year.

(b) Add any amount not otherwise included in Ohio taxable income for any taxable year to the extent that the amount is attributable to the recovery during the taxable year of any amount

deducted or excluded in computing federal or Ohio taxable income in any taxable year, but only to the extent such amount has not been distributed to beneficiaries for the taxable year.

(10) Deduct any portion of the deduction described in section 1341(a)(2) of the Internal Revenue Code, for repaying previously reported income received under a claim of right, that meets both of the following requirements:

(a) It is allowable for repayment of an item that was included in the taxpayer's taxable income or the decedent's adjusted gross income for a prior taxable year and did not qualify for a credit under division (A) or (B) of section 5747.05 of the Revised Code for that year.

(b) It does not otherwise reduce the taxpayer's taxable income or the decedent's adjusted gross income for the current or any other taxable year.

(11) Add any amount claimed as a credit under section 5747.059 of the Revised Code to the extent that the amount satisfies either of the following:

(a) The amount was deducted or excluded from the computation of the taxpayer's federal taxable income as required to be reported for the taxpayer's taxable year under the Internal Revenue Code;

(b) The amount resulted in a reduction in the taxpayer's federal taxable income as required to be reported for any of the taxpayer's taxable years under the Internal Revenue Code.

(12) Deduct any amount, net of related expenses deducted in computing federal taxable income, that a trust is required to report as farm income on its federal income tax return, but only if the assets of the trust include at least ten acres of land satisfying the definition of "land devoted exclusively to agricultural use" under section 5713.30 of the Revised Code,

regardless of whether the land is valued for tax purposes as such land under sections 5713.30 to 5713.38 of the Revised Code. If the trust is a pass-through entity investor, section 5747.231 of the Revised Code applies in ascertaining if the trust is eligible to claim the deduction provided by division (S)(12) of this section in connection with the pass-through entity's farm income.

Except for farm income attributable to the S portion of an electing small business trust, the deduction provided by division (S)(12) of this section is allowed only to the extent that the trust has not distributed such farm income. Division (S)(12) of this section applies only to taxable years of a trust beginning in 2002 or thereafter.

(13) Add the net amount of income described in section 641(c) of the Internal Revenue Code to the extent that amount is not included in federal taxable income.

(14) Add or deduct the amount the taxpayer would be required to add or deduct under division (A)(20) or (21) of this section if the taxpayer's Ohio taxable income were computed in the same manner as an individual's Ohio adjusted gross income is computed under this section. In the case of a trust, division (S)(14) of this section applies only to any of the trust's taxable years beginning in 2002 or thereafter.

(T) "School district income" and "school district income tax" have the same meanings as in section 5748.01 of the Revised Code.

(U) As used in divisions (A)(8), (A)(9), (S)(6), and (S)(7) of this section, "public obligations," "purchase obligations," and "interest or interest equivalent" have the same meanings as in section 5709.76 of the Revised Code.

(V) "Limited liability company" means any limited liability company formed under Chapter 1705. of the Revised Code or under the laws of any other state.

(W) "Pass-through entity investor" means any person who, during any portion of a taxable year of a pass-through entity, is a partner, member, shareholder, or equity investor in that pass-through entity.

(X) "Banking day" has the same meaning as in section 1304.01 of the Revised Code.

(Y) "Month" means a calendar month.

(Z) "Quarter" means the first three months, the second three months, the third three months, or the last three months of the taxpayer's taxable year.

(AA)(1) "Eligible institution" means a state university or state institution of higher education as defined in section 3345.011 of the Revised Code, or a private, nonprofit college, university, or other post-secondary institution located in this state that possesses a certificate of authorization issued by the Ohio board of regents pursuant to Chapter 1713. of the Revised Code or a certificate of registration issued by the state board of career colleges and schools under Chapter 3332. of the Revised Code.

(2) "Qualified tuition and fees" means tuition and fees imposed by an eligible institution as a condition of enrollment or attendance, not exceeding two thousand five hundred dollars in each of the individual's first two years of post-secondary education. If the individual is a part-time student, "qualified tuition and fees" includes tuition and fees paid for the academic equivalent of the first two years of post-secondary education during a maximum of five taxable years, not exceeding a total of five thousand dollars. "Qualified tuition and fees" does not include:

(a) Expenses for any course or activity involving sports, games, or hobbies unless the course or activity is part of the

individual's degree or diploma program;

(b) The cost of books, room and board, student activity fees, athletic fees, insurance expenses, or other expenses unrelated to the individual's academic course of instruction;

(c) Tuition, fees, or other expenses paid or reimbursed through an employer, scholarship, grant in aid, or other educational benefit program.

(BB)(1) "Modified business income" means the business income included in a trust's Ohio taxable income after such taxable income is first reduced by the qualifying trust amount, if any.

(2) "Qualifying trust amount" of a trust means capital gains and losses from the sale, exchange, or other disposition of equity or ownership interests in, or debt obligations of, a qualifying investee to the extent included in the trust's Ohio taxable income, but only if the following requirements are satisfied:

(a) The book value of the qualifying investee's physical assets in this state and everywhere, as of the last day of the qualifying investee's fiscal or calendar year ending immediately prior to the date on which the trust recognizes the gain or loss, is available to the trust.

(b) The requirements of section 5747.011 of the Revised Code are satisfied for the trust's taxable year in which the trust recognizes the gain or loss.

Any gain or loss that is not a qualifying trust amount is modified business income, qualifying investment income, or modified nonbusiness income, as the case may be.

(3) "Modified nonbusiness income" means a trust's Ohio taxable income other than modified business income, other than the qualifying trust amount, and other than qualifying investment income, as defined in section 5747.012 of the Revised Code, to the

extent such qualifying investment income is not otherwise part of modified business income.

(4) "Modified Ohio taxable income" applies only to trusts, and means the sum of the amounts described in divisions (BB)(4)(a) to (c) of this section:

(a) The fraction, calculated under section 5747.013, and applying section 5747.231 of the Revised Code, multiplied by the sum of the following amounts:

(i) The trust's modified business income;

(ii) The trust's qualifying investment income, as defined in section 5747.012 of the Revised Code, but only to the extent the qualifying investment income does not otherwise constitute modified business income and does not otherwise constitute a qualifying trust amount.

(b) The qualifying trust amount multiplied by a fraction, the numerator of which is the sum of the book value of the qualifying investee's physical assets in this state on the last day of the qualifying investee's fiscal or calendar year ending immediately prior to the day on which the trust recognizes the qualifying trust amount, and the denominator of which is the sum of the book value of the qualifying investee's total physical assets everywhere on the last day of the qualifying investee's fiscal or calendar year ending immediately prior to the day on which the trust recognizes the qualifying trust amount. If, for a taxable year, the trust recognizes a qualifying trust amount with respect to more than one qualifying investee, the amount described in division (BB)(4)(b) of this section shall equal the sum of the products so computed for each such qualifying investee.

(c)(i) With respect to a trust or portion of a trust that is a resident as ascertained in accordance with division (I)(3)(d) of this section, its modified nonbusiness income.

(ii) With respect to a trust or portion of a trust that is not a resident as ascertained in accordance with division (I)(3)(d) of this section, the amount of its modified nonbusiness income satisfying the descriptions in divisions (B)(2) to (5) of section 5747.20 of the Revised Code, except as otherwise provided in division (BB)(4)(c)(ii) of this section. With respect to a trust or portion of a trust that is not a resident as ascertained in accordance with division (I)(3)(d) of this section, the trust's portion of modified nonbusiness income recognized from the sale, exchange, or other disposition of a debt interest in or equity interest in a section 5747.212 entity, as defined in section 5747.212 of the Revised Code, without regard to division (A) of that section, shall not be allocated to this state in accordance with section 5747.20 of the Revised Code but shall be apportioned to this state in accordance with division (B) of section 5747.212 of the Revised Code without regard to division (A) of that section.

If the allocation and apportionment of a trust's income under divisions (BB)(4)(a) and (c) of this section do not fairly represent the modified Ohio taxable income of the trust in this state, the alternative methods described in division (C) of section 5747.21 of the Revised Code may be applied in the manner and to the same extent provided in that section.

(5)(a) Except as set forth in division (BB)(5)(b) of this section, "qualifying investee" means a person in which a trust has an equity or ownership interest, or a person or unit of government the debt obligations of either of which are owned by a trust. For the purposes of division (BB)(2)(a) of this section and for the purpose of computing the fraction described in division (BB)(4)(b) of this section, all of the following apply:

(i) If the qualifying investee is a member of a qualifying controlled group on the last day of the qualifying investee's

fiscal or calendar year ending immediately prior to the date on which the trust recognizes the gain or loss, then "qualifying investee" includes all persons in the qualifying controlled group on such last day.

(ii) If the qualifying investee, or if the qualifying investee and any members of the qualifying controlled group of which the qualifying investee is a member on the last day of the qualifying investee's fiscal or calendar year ending immediately prior to the date on which the trust recognizes the gain or loss, separately or cumulatively own, directly or indirectly, on the last day of the qualifying investee's fiscal or calendar year ending immediately prior to the date on which the trust recognizes the qualifying trust amount, more than fifty per cent of the equity of a pass-through entity, then the qualifying investee and the other members are deemed to own the proportionate share of the pass-through entity's physical assets which the pass-through entity directly or indirectly owns on the last day of the pass-through entity's calendar or fiscal year ending within or with the last day of the qualifying investee's fiscal or calendar year ending immediately prior to the date on which the trust recognizes the qualifying trust amount.

(iii) For the purposes of division (BB)(5)(a)(iii) of this section, "upper level pass-through entity" means a pass-through entity directly or indirectly owning any equity of another pass-through entity, and "lower level pass-through entity" means that other pass-through entity.

An upper level pass-through entity, whether or not it is also a qualifying investee, is deemed to own, on the last day of the upper level pass-through entity's calendar or fiscal year, the proportionate share of the lower level pass-through entity's physical assets that the lower level pass-through entity directly or indirectly owns on the last day of the lower level pass-through

entity's calendar or fiscal year ending within or with the last day of the upper level pass-through entity's fiscal or calendar year. If the upper level pass-through entity directly and indirectly owns less than fifty per cent of the equity of the lower level pass-through entity on each day of the upper level pass-through entity's calendar or fiscal year in which or with which ends the calendar or fiscal year of the lower level pass-through entity and if, based upon clear and convincing evidence, complete information about the location and cost of the physical assets of the lower pass-through entity is not available to the upper level pass-through entity, then solely for purposes of ascertaining if a gain or loss constitutes a qualifying trust amount, the upper level pass-through entity shall be deemed as owning no equity of the lower level pass-through entity for each day during the upper level pass-through entity's calendar or fiscal year in which or with which ends the lower level pass-through entity's calendar or fiscal year. Nothing in division (BB)(5)(a)(iii) of this section shall be construed to provide for any deduction or exclusion in computing any trust's Ohio taxable income.

(b) With respect to a trust that is not a resident for the taxable year and with respect to a part of a trust that is not a resident for the taxable year, "qualifying investee" for that taxable year does not include a C corporation if both of the following apply:

(i) During the taxable year the trust or part of the trust recognizes a gain or loss from the sale, exchange, or other disposition of equity or ownership interests in, or debt obligations of, the C corporation.

(ii) Such gain or loss constitutes nonbusiness income.

(6) "Available" means information is such that a person is able to learn of the information by the due date plus extensions,

if any, for filing the return for the taxable year in which the trust recognizes the gain or loss.

(CC) "Qualifying controlled group" has the same meaning as in section 5733.04 of the Revised Code.

(DD) "Related member" has the same meaning as in section 5733.042 of the Revised Code.

(EE)(1) For the purposes of division (EE) of this section:

(a) "Qualifying person" means any person other than a qualifying corporation.

(b) "Qualifying corporation" means any person classified for federal income tax purposes as an association taxable as a corporation, except either of the following:

(i) A corporation that has made an election under subchapter S, chapter one, subtitle A, of the Internal Revenue Code for its taxable year ending within, or on the last day of, the investor's taxable year;

(ii) A subsidiary that is wholly owned by any corporation that has made an election under subchapter S, chapter one, subtitle A of the Internal Revenue Code for its taxable year ending within, or on the last day of, the investor's taxable year.

(2) For the purposes of this chapter, unless expressly stated otherwise, no qualifying person indirectly owns any asset directly or indirectly owned by any qualifying corporation.

(FF) For purposes of this chapter and Chapter 5751. of the Revised Code:

(1) "Trust" does not include a qualified pre-income tax trust.

(2) A "qualified pre-income tax trust" is any pre-income tax trust that makes a qualifying pre-income tax trust election as described in division (FF)(3) of this section.

(3) A "qualifying pre-income tax trust election" is an election by a pre-income tax trust to subject to the tax imposed by section 5751.02 of the Revised Code the pre-income tax trust and all pass-through entities of which the trust owns or controls, directly, indirectly, or constructively through related interests, five per cent or more of the ownership or equity interests. The trustee shall notify the tax commissioner in writing of the election on or before April 15, 2006. The election, if timely made, shall be effective on and after January 1, 2006, and shall apply for all tax periods and tax years until revoked by the trustee of the trust.

(4) A "pre-income tax trust" is a trust that satisfies all of the following requirements:

(a) The document or instrument creating the trust was executed by the grantor before January 1, 1972;

(b) The trust became irrevocable upon the creation of the trust; and

(c) The grantor was domiciled in this state at the time the trust was created.

Sec. 5747.122. (A) The tax commissioner, in accordance with section 5101.184 of the Revised Code, shall cooperate with the director of job and family services to collect overpayments of assistance under Chapter 5107.~~, 5111.,~~ or 5115., former Chapter 5113., or section 5101.54 of the Revised Code from refunds of state income taxes for taxable year 1992 and thereafter that are payable to the recipients of such overpayments. The tax commissioner, in accordance with section 5160.45 of the Revised Code, shall cooperate with the director of health care administration to collect overpayments of assistance under the disability medical assistance program or medicaid program from refunds of state income taxes for taxable year 1992 and thereafter

that are payable to disability medical assistance recipients or medicaid recipients.

(B) At the request of the department of job and family services or department of health care administration in connection with the collection of an overpayment of assistance from a refund of state income taxes pursuant to this section and section 5101.184 or 5160.45 of the Revised Code, the tax commissioner shall release to the department the home address and social security number of any recipient of assistance whose overpayment may be collected from a refund of state income taxes under those sections.

(C) In the case of a joint income tax return for two people who were not married to each other at the time one of them received an overpayment of assistance, only the portion of a refund that is due to the recipient of the overpayment shall be available for collection of the overpayment under this section and section 5101.184 or 5160.45 of the Revised Code. The tax commissioner shall determine such portion. A recipient's spouse who objects to the portion as determined by the commissioner may file a complaint with the commissioner within twenty-one days after receiving notice of the collection, and the commissioner shall afford the spouse an opportunity to be heard on the complaint. The commissioner shall waive or extend the twenty-one-day period if the recipient's spouse establishes that such action is necessary to avoid unjust, unfair, or unreasonable results. After the hearing, the commissioner shall make a final determination of the portion of the refund available for collection of the overpayment.

(D) The welfare overpayment intercept fund is hereby created in the state treasury. The tax commissioner shall deposit amounts collected from income tax refunds under this section to the credit of the welfare overpayment intercept fund. The director of job and

family services and director of health care administration shall distribute money in the fund in accordance with appropriate federal or state laws and procedures regarding collection of welfare overpayments and disability medical assistance program and medicaid payments.

Sec. 5747.18. The tax commissioner shall enforce and administer this chapter. In addition to any other powers conferred upon the commissioner by law, the commissioner may:

(A) Prescribe all forms required to be filed pursuant to this chapter;

(B) Adopt such rules as the commissioner finds necessary to carry out this chapter;

(C) Appoint and employ such personnel as are necessary to carry out the duties imposed upon the commissioner by this chapter.

Any information gained as the result of returns, investigations, hearings, or verifications required or authorized by this chapter is confidential, and no person shall disclose such information, except for official purposes, or as provided by section 3125.43, 4123.271, 4123.591, 4507.023, ~~or~~ 5101.182, or 5160.44, division (B) of section 5703.21 of the Revised Code, or in accordance with a proper judicial order. The tax commissioner may furnish the internal revenue service with copies of returns or reports filed and may furnish the officer of a municipal corporation charged with the duty of enforcing a tax subject to Chapter 718. of the Revised Code with the names, addresses, and identification numbers of taxpayers who may be subject to such tax. A municipal corporation shall use this information for tax collection purposes only. This section does not prohibit the publication of statistics in a form which does not disclose information with respect to individual taxpayers.

Sec. 5751.081. As used in this section, "debt to this state" means unpaid taxes due the state, unpaid workers' compensation premiums due under section 4123.35 of the Revised Code, unpaid unemployment compensation contributions due under section 4141.25 of the Revised Code, unpaid unemployment compensation payment in lieu of contribution under section 4141.241 of the Revised Code, unpaid fee payable to the state or to the clerk of courts pursuant to section 4505.06 of the Revised Code, incorrect ~~medical assistance~~ medicaid payments ~~under section 5111.02 of the Revised Code~~, or any unpaid charge, penalty, or interest arising from any of the foregoing.

If a taxpayer entitled to a refund under section 5751.08 of the Revised Code owes any debt to this state, the amount refundable may be applied in satisfaction of the debt. If the amount refundable is less than the amount of the debt, it may be applied in partial satisfaction of the debt. If the amount refundable is greater than the amount of the debt, the amount remaining after satisfaction of the debt shall be refunded. This section applies only to debts that have become final. For the purposes of this section, a debt becomes final when, under the applicable law, any time provided for petition for reassessment, request for reconsideration, or other appeal of the legality or validity of the amount giving rise to the debt expires without an appeal having been filed in the manner provided by law.

Sec. 5815.28. (A) As used in this section:

(1) "Ascertainable standard" includes a standard in a trust instrument requiring the trustee to provide for the care, comfort, maintenance, welfare, education, or general well-being of the beneficiary.

(2) "Disability" means any substantial, medically

determinable impairment that can be expected to result in death or that has lasted or can be expected to last for a continuous period of at least twelve months, except that "disability" does not include an impairment that is the result of abuse of alcohol or drugs.

(3) "Political subdivision" and "state" have the same meanings as in section 2744.01 of the Revised Code.

(4) "Supplemental services" means services specified by rule of the department of mental health under section 5119.01 of the Revised Code or the department of mental retardation and developmental disabilities under section 5123.04 of the Revised Code that are provided to an individual with a disability in addition to services the individual is eligible to receive under programs authorized by federal or state law.

(B) Any person may create a trust under this section to provide funding for supplemental services for the benefit of another individual who meets either of the following conditions:

(1) The individual has a physical or mental disability and is eligible to receive services through the department of mental retardation and developmental disabilities or a county board of mental retardation and developmental disabilities;

(2) The individual has a mental disability and is eligible to receive services through the department of mental health or a board of alcohol, drug addiction, and mental health services.

The trust may confer discretion upon the trustee and may contain specific instructions or conditions governing the exercise of the discretion.

(C) The general division of the court of common pleas and the probate court of the county in which the beneficiary of a trust authorized by division (B) of this section resides or is confined have concurrent original jurisdiction to hear and determine

actions pertaining to the trust. In any action pertaining to the trust in a court of common pleas or probate court and in any appeal of the action, all of the following apply to the trial or appellate court:

(1) The court shall render determinations consistent with the testator's or other settlor's intent in creating the trust, as evidenced by the terms of the trust instrument.

(2) The court may order the trustee to exercise discretion that the trust instrument confers upon the trustee only if the instrument contains specific instructions or conditions governing the exercise of that discretion and the trustee has failed to comply with the instructions or conditions. In issuing an order pursuant to this division, the court shall require the trustee to exercise the trustee's discretion only in accordance with the instructions or conditions.

(3) The court may order the trustee to maintain the trust and distribute assets in accordance with rules adopted by the director of mental health under section 5119.01 of the Revised Code or the director of mental retardation and developmental disabilities under section 5123.04 of the Revised Code if the trustee has failed to comply with such rules.

(D) To the extent permitted by federal law and subject to the provisions of division (C)(2) of this section pertaining to the enforcement of specific instructions or conditions governing a trustee's discretion, a trust authorized by division (B) of this section that confers discretion upon the trustee shall not be considered an asset or resource of the beneficiary, the beneficiary's estate, the settlor, or the settlor's estate and shall be exempt from the claims of creditors, political subdivisions, the state, other governmental entities, and other claimants against the beneficiary, the beneficiary's estate, the settlor, or the settlor's estate, including claims based on

provisions of Chapters ~~5111.,~~ 5121.~~,~~ or 5123. of the Revised Code or the medicaid program and claims sought to be satisfied by way of a civil action, subrogation, execution, garnishment, attachment, judicial sale, or other legal process, if all of the following apply:

(1) At the time the trust is created, the trust principal does not exceed the maximum amount determined under division (E) of this section;

(2) The trust instrument contains a statement of the settlor's intent, or otherwise clearly evidences the settlor's intent, that the beneficiary does not have authority to compel the trustee under any circumstances to furnish the beneficiary with minimal or other maintenance or support, to make payments from the principal of the trust or from the income derived from the principal, or to convert any portion of the principal into cash, whether pursuant to an ascertainable standard specified in the instrument or otherwise;

(3) The trust instrument provides that trust assets can be used only to provide supplemental services, as defined by rule of the director of mental health under section 5119.01 of the Revised Code or the director of mental retardation and developmental disabilities under section 5123.04 of the Revised Code, to the beneficiary;

(4) The trust is maintained and assets are distributed in accordance with rules adopted by the director of mental health under section 5119.01 of the Revised Code or the director of mental retardation and developmental disabilities under section 5123.04 of the Revised Code;

(5) The trust instrument provides that on the death of the beneficiary, a portion of the remaining assets of the trust, which shall be not less than fifty per cent of such assets, will be

deposited to the credit of the services fund for individuals with mental illness created by section 5119.17 of the Revised Code or the services fund for individuals with mental retardation and developmental disabilities created by section 5123.40 of the Revised Code.

(E) In 1994, the trust principal maximum amount for a trust created under this section shall be two hundred thousand dollars. The maximum amount for a trust created under this section prior to November 11, 1994, may be increased to two hundred thousand dollars.

In 1995, the maximum amount for a trust created under this section shall be two hundred two thousand dollars. Each year thereafter, the maximum amount shall be the prior year's amount plus two thousand dollars.

(F) This section does not limit or otherwise affect the creation, validity, interpretation, or effect of any trust that is not created under this section.

(G) Once a trustee takes action on a trust created by a settlor under this section and disburses trust funds on behalf of the beneficiary of the trust, then the trust may not be terminated or otherwise revoked by a particular event or otherwise without payment into the services fund created pursuant to section 5119.17 or 5123.40 of the Revised Code of an amount that is equal to the disbursements made on behalf of the beneficiary for medical care by the state from the date the trust vests but that is not more than fifty per cent of the trust corpus.

Sec. 5907.04. All members of the armed forces, who served in the regular or volunteer forces of the United States or the Ohio national guard or members of the naval militia during the war with Spain, the Philippine insurrection, the China relief expedition, the Indian war, the Mexican expedition, World War I, World War II,

or during the period beginning June 25, 1950 and ending July 19, 1953, known as the Korean conflict, or during the period beginning August 5, 1964, and ending July 1, 1973, known as the Vietnam conflict, or any person who is awarded either the armed forces expeditionary medal established by presidential executive order 10977 dated December 4, 1961, or the Vietnam service medal established by presidential executive order 11231 dated July 8, 1965, who have been honorably discharged or separated under honorable conditions therefrom, or any discharged members of the Polish and Czechoslovakian armed forces who served in armed conflict with an enemy of the United States in World War I or World War II who have been citizens of the United States for at least ten years, provided that the above-mentioned persons have been citizens of this state for five consecutive years or more at the date of making application for admission, are disabled by disease, wounds, or otherwise, and are by reason of such disability incapable of earning their living, and all members of the Ohio national guard or naval militia who have lost an arm or leg, or their sight, or become permanently disabled from any cause, while in the line and discharge of duty, and are not able to support themselves, may be admitted to a veterans' home under such rules as the board of trustees of the Ohio veterans' home agency adopts.

The superintendent of the Ohio veterans' home agency shall promptly and diligently pursue the establishment of the eligibility for ~~medical assistance under Chapter 5111. of the Revised Code~~ the medicaid program of all persons admitted to a veterans' home and all residents of a home who appear to qualify and shall promptly and diligently pursue and maintain the certification of each home's compliance with federal laws and regulations governing participation in the ~~medical assistance~~ medicaid program to include as large as possible a part of the home's bed capacity.

Veterans' homes may reserve a bed during the temporary absence of a resident or patient from the home, including a nursing home within it, under conditions prescribed by the board of trustees, to include hospitalization for an acute condition, visits with relatives and friends, and participation in therapeutic programs outside the home. A home shall not reserve a bed for more than thirty days, except that absences for more than thirty days due to hospitalization may be authorized.

Section 2. That existing sections 9.231, 9.239, 9.24, 101.39, 101.391, 103.144, 109.572, 109.85, 117.10, 119.01, 121.02, 121.03, 122.15, 124.30, 124.301, 124.821, 127.16, 131.23, 145.27, 145.58, 149.431, 169.02, 173.14, 173.20, 173.21, 173.26, 173.35, 173.394, 173.40, 173.42, 173.45, 173.47, 173.50, 173.71, 173.72, 173.721, 173.722, 173.723, 173.724, 173.73, 173.731, 173.732, 173.74, 173.741, 173.742, 173.75, 173.751, 173.752, 173.753, 173.76, 173.77, 173.771, 173.772, 173.773, 173.78, 173.79, 173.791, 173.80, 173.801, 173.802, 173.803, 173.81, 173.811, 173.812, 173.813, 173.814, 173.815, 173.82, 173.83, 173.831, 173.832, 173.833, 173.84, 173.85, 173.86, 173.861, 173.87, 173.871, 173.872, 173.873, 173.874, 173.875, 173.876, 173.88, 173.89, 173.891, 173.892, 173.90, 173.91, 173.99, 317.08, 317.36, 323.01, 329.04, 329.051, 329.06, 329.14, 340.03, 340.091, 340.16, 341.192, 505.84, 742.41, 955.201, 1337.11, 1347.08, 1731.04, 1739.061, 1751.01, 1751.04, 1751.05, 1751.11, 1751.111, 1751.12, 1751.13, 1751.15, 1751.16, 1751.17, 1751.18, 1751.20, 1751.271, 1751.31, 1751.34, 1751.53, 1751.60, 1751.88, 1751.89, 2108.01, 2113.041, 2113.06, 2117.061, 2117.25, 2133.01, 2151.3514, 2305.234, 2307.65, 2335.39, 2505.02, 2705.02, 2744.05, 2903.33, 2913.40, 2913.401, 2921.01, 2921.13, 2945.401, 3101.051, 3107.083, 3111.04, 3111.72, 3119.54, 3121.441, 3121.898, 3125.36, 3307.20, 3309.22, 3313.714, 3313.715, 3317.023, 3323.021, 3599.45, 3701.023, 3701.024, 3701.027, 3701.043, 3701.132, 3701.243, 3701.507, 3701.74,

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5747.18, 5751.081, 5815.28, and 5907.04 and section 5111.012 of 38145
the Revised Code are hereby repealed. 38146

Section 3. The organization of the Department of Health Care Administration as established by this act shall be in accordance with the business model, organization structure, cross-functional practices, information technology, state and local impact, fiscal and budget, transition, and long-term care recommendations as detailed in the Ohio Medicaid Administrative Study Council Final Report and Recommendations, as completed by the Ohio Medicaid Administrative Study Council in accordance with Am. Sub. H.B. 66 of the 126th General Assembly.

Section 4. On July 1, 2007, the Medicaid Program, Hospital Care Assurance Program, Children's Health Insurance Program Parts I and II, and Disability Medical Assistance Program and all of the programs' functions, assets, and liabilities are transferred from the Department of Job and Family Services to the Department of Health Care Administration. The transferred programs are thereupon and thereafter successor to, assume the obligations of, and otherwise constitute the continuation of the programs as they were operated under Chapters 5101., 5111., 5112., and 5115. of the Revised Code immediately prior to July 1, 2007.

Any business of the programs commenced but not completed before July 1, 2007, shall be completed by the Department of Health Care Administration under Chapters 5160., 5161., 5162., 5163., 5164., 5165., 5166., 5167., and 5168. of the Revised Code. The business shall be completed in the same manner, and with the same effect, as if completed by the Department of Job and Family Services under Chapters 5101., 5111., 5112., and 5115. of the Revised Code immediately prior to July 1, 2007.

No validation, cure, right, privilege, remedy, obligation, or liability pertaining to the programs is lost or impaired by reason of the programs' transfer from the Department of Job and Family Services to the Department of Health Care Administration. Each

such validation, cure, right, privilege, remedy, obligation, or liability shall be administered by the Department of Health Care Administration pursuant to Chapters 5160., 5161., 5162., 5163., 5164., 5165., 5166., 5167., and 5168. of the Revised Code.

All rules, orders, and determinations pertaining to the programs as they were operated under Chapters 5101., 5111., 5112., and 5115. of the Revised Code immediately prior to July 1, 2007, continue in effect as rules, orders, and determinations of the programs under Chapters 5160., 5161., 5162., 5163., 5164., 5165., 5166., 5167., and 5168. of the Revised Code, until modified or rescinded by the Department of Health Care Administration. If necessary to ensure the integrity of the numbering of the Administrative Code, the Director of the Legislative Service Commission shall renumber the rules to reflect the transfer of the programs from the Department of Job and Family Services to the Department of Health Care Administration.

Subject to the lay-off provisions of sections 124.321 to 124.328 of the Revised Code, all of the programs' employees in the Department of Job and Family Services shall be transferred to the Department of Health Care Administration. The transferred employees shall retain their positions and all of the benefits accruing to those positions.

The Director of Budget and Management shall determine the amount of the unexpended balances in the appropriation accounts that pertain to the programs as they were operated under Chapters 5101., 5111., 5112., and 5115. of the Revised Code immediately prior to July 1, 2007, and shall recommend to the Controlling Board their transfer to the appropriation accounts that pertain to the Department of Health Care Administration. The Department of Job and Family Services shall provide full and timely information to the Controlling Board to facilitate this transfer. Any funds transferred under this section are hereby appropriated.

Section 5. On July 1, 2007, the Residential State Supplement Program and all of the program's functions, assets, and liabilities are transferred from the Department of Aging to the Department of Health Care Administration. The transferred program is thereupon and thereafter successor to, assumes the obligations of, and otherwise constitutes the continuation of the program as it was operated under section 173.35 of the Revised Code immediately prior to July 1, 2007.

Any business of the program commenced but not completed before July 1, 2007, shall be completed by the Department of Health Care Administration under section 5160.80 of the Revised Code. The business shall be completed in the same manner, and with the same effect, as if completed by the Department of Aging under section 173.35 of the Revised Code immediately prior to July 1, 2007.

No validation, cure, right, privilege, remedy, obligation, or liability pertaining to the program is lost or impaired by reason of the program's transfer from the Department of Aging to the Department of Health Care Administration. Each such validation, cure, right, privilege, remedy, obligation, or liability shall be administered by the Department of Health Care Administration pursuant to section 5160.80 of the Revised Code.

All rules, orders, and determinations pertaining to the program as it was operated under section 173.35 of the Revised Code immediately prior to July 1, 2007, continue in effect as rules, orders, and determinations of the program under section 5160.80 of the Revised Code, until modified or rescinded by the Department of Health Care Administration. If necessary to ensure the integrity of the numbering of the Administrative Code, the Director of the Legislative Service Commission shall renumber the rules to reflect the transfer of the program from the Department

of Aging to the Department of Health Care Administration.

Subject to the lay-off provisions of sections 124.321 to 124.328 of the Revised Code, all of the program's employees in the Department of Aging shall be transferred to the Department of Health Care Administration. The transferred employees shall retain their positions and all of the benefits accruing to those positions.

The Director of Budget and Management shall determine the amount of the unexpended balances in the appropriation accounts that pertain to the program as it was operated under section 173.35 of the Revised Code immediately prior to July 1, 2007, and shall recommend to the Controlling Board their transfer to the appropriation accounts that pertain to the Department of Health Care Administration. The Department of Aging shall provide full and timely information to the Controlling Board to facilitate this transfer. Any funds transferred under this section are hereby appropriated.

Section 6. That Section 7 of Am. Sub. H.B. 468 of the 126th General Assembly be amended to read as follows:

Sec. 7. On July 1, 2007, the Ohio's Best Rx Program and all of its functions, assets, and liabilities are transferred from the Department of Job and Family Services to the Department of ~~Aging~~ Health Care Administration. The transferred Program is thereupon and thereafter successor to, assumes the obligations of, and otherwise constitutes the continuation of the Program as it was operated under Chapter 5110. of the Revised Code immediately prior to July 1, 2007.

Any Program business commenced but not completed before July 1, 2007, shall be completed by the Department of ~~Aging~~ Health Care Administration under ~~sections 173.71 to 173.91~~ Chapter 5169. of

the Revised Code. The business shall be completed in the same manner, and with the same effect, as if completed by the Department of Job and Family Services under Chapter 5110. of the Revised Code immediately prior to July 1, 2007.

No validation, cure, right, privilege, remedy, obligation, or liability pertaining to the Program is lost or impaired by reason of the Program's transfer from the Department of Job and Family Services to the Department of ~~Aging~~ Health Care Administration. Each such validation, cure, right, privilege, remedy, obligation, or liability shall be administered by the Department of ~~Aging~~ Health Care Administration pursuant to ~~sections 173.71 to 173.91~~ Chapter 5169. of the Revised Code.

All rules, orders, and determinations pertaining to the Program as it was operated under Chapter 5110. of the Revised Code immediately prior to July 1, 2007, continue in effect as rules, orders, and determinations of the Program under ~~sections 173.71 to 173.91~~ Chapter 5169. of the Revised Code, until modified or rescinded by the Department of ~~Aging~~ Health Care Administration. If necessary to ensure the integrity of the numbering of the Administrative Code, the Director of the Legislative Service Commission shall renumber the rules to reflect the transfer of the Program from the Department of Job and Family Services to the Department of ~~Aging~~ Health Care Administration.

Subject to the lay-off provisions of sections 124.321 to 124.328 of the Revised Code, all of the Program's employees in the Department of Job and Family Services shall be transferred to the Department of ~~Aging~~ Health Care Administration. The transferred employees shall retain their positions and all of the benefits accruing to those positions.

The Director of Budget and Management shall determine the amount of the unexpended balances in the appropriation accounts that pertain to the Program as it was operated under Chapter 5110.

of the Revised Code immediately prior to July 1, 2007, and shall recommend to the Controlling Board their transfer to the appropriation accounts that pertain to the Department of ~~Aging~~ Health Care Administration. The Department of Job and Family Services shall provide full and timely information to the Controlling Board to facilitate this transfer. Any funds transferred under this section are hereby appropriated.

In anticipation of the Program's transfer to the Department of ~~Aging~~ Health Care Administration, the Department may negotiate or enter into a contract with a person to serve as the Program administrator beginning on or after July 1, 2007. When negotiating or entering into the contract, the Department shall comply with the same provisions that apply to the Department of Job and Family Services under section 5110.021 of the Revised Code.

Section 7. That existing Section 7 of Am. Sub. H.B. 468 of the 126th General Assembly is hereby repealed.

Section 8. The amendments of sections 4723.063, 5112.01, 5112.03, 5112.04, 5112.05, 5112.06, 5112.07, 5112.08, 5112.09, 5112.10, 5112.11, 5112.18, 5112.19, 5112.21, and 5112.99 of the Revised Code are not intended to supersede the earlier repeals, with delayed effective dates, of those sections.

Section 9. The sections of law amended, enacted, or repealed by this act, and the items of law of which such sections are composed, are not subject to the referendum. Therefore, under Ohio Constitution, Article II, Section 1d and section 1.471 of the Revised Code, the sections go into effect July 1, 2007.

Section 10. The General Assembly, applying the principle stated in division (B) of section 1.52 of the Revised Code that amendments are to be harmonized if reasonably capable of

simultaneous operation, finds that the following sections, presented in this act as composites of the sections as amended by the acts indicated, are the resulting versions of the sections in effect prior to the effective date of the sections as presented in this act:

Section 109.572 of the Revised Code as amended by both Am. Sub. S.B. 185 and Am. Sub. S.B. 238 of the 126th General Assembly.

Section 2505.02 of the Revised Code as amended by both Am. Sub. H.B. 516 and Am. Sub. S.B. 80 of the 125th General Assembly.

Section 11. Section 1337.11 of the Revised Code was amended by both Am. H.B. 72 and Am. Sub. H.B. 95 of the 125th General Assembly. Comparison of these amendments in pursuance of section 1.52 of the Revised Code discloses that while certain of the amendments of these acts are reconcilable, certain other of the amendments are substantively irreconcilable. Am. H.B. 72 was passed on June 10, 2003; Am. Sub. H.B. 95 was passed on June 19, 2003. Section 1337.11 of the Revised Code is therefore presented in this act as it results from Am. Sub. H.B. 95 and such of the amendments of Am. H.B. 72 as are not in conflict with the amendments of Am. Sub. H.B. 95. The General Assembly, applying the principle stated in division (B) of section 1.52 of the Revised Code that amendments are to be harmonized if reasonably capable of simultaneous operation, finds that the composite is the resulting version of the section in effect prior to the effective date of the section as presented in this act.