

As Introduced

**127th General Assembly
Regular Session
2007-2008**

S. B. No. 194

Senator Miller, R.

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

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A B I L L

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5168.08, 5168.09, 5168.10, and 5169.99, and to 272
repeal section 5111.012 of the Revised Code; to 273
amend Section 7 of Am. Sub. H.B. 468 of the 126th 274
General Assembly; to create the Department of 275
Health Care Administration; to transfer the 276
Medicaid Program, Children's Health Insurance 277
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Supplement Program to the new department; to 281
require the new department to create a central 282
pharmaceutical purchasing office; and to make an 283
appropriation. 284

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,	285
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(5168.07), 5115.14 (5168.06) be amended for the purpose of	480
adopting a new section number as indicated in parentheses, and	481

that sections 117.54, 117.55, 117.56, 117.57, 329.043, 5160.01, 482
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5165.08, 5165.17, 5165.18, 5167.01, 5168.03, 5168.04, 5168.08, 493
5168.09, 5168.10, and 5169.99 of the Revised Code be enacted to 494
read as follows: 495

Sec. 9.231. (A)(1) Subject to divisions (A)(2) and (3) of 496
this section, a governmental entity shall not disburse money 497
totaling twenty-five thousand dollars or more to any person for 498
the provision of services for the primary benefit of individuals 499
or the public and not for the primary benefit of a governmental 500
entity or the employees of a governmental entity, unless the 501
contracting authority of the governmental entity first enters into 502
a written contract with the person that is signed by the person or 503
by an officer or agent of the person authorized to legally bind 504
the person and that embodies all of the requirements and 505
conditions set forth in sections 9.23 to 9.236 of the Revised 506
Code. If the disbursement of money occurs over the course of a 507
governmental entity's fiscal year, rather than in a lump sum, the 508
contracting authority of the governmental entity shall enter into 509
the written contract with the person at the point during the 510
governmental entity's fiscal year that at least seventy-five 511
thousand dollars has been disbursed by the governmental entity to 512
the person. Thereafter, the contracting authority of the 513

governmental entity shall enter into the written contract with the 514
person at the beginning of the governmental entity's fiscal year, 515
if, during the immediately preceding fiscal year, the governmental 516
entity disbursed to that person an aggregate amount totaling at 517
least seventy-five thousand dollars. 518

(2) If the money referred to in division (A)(1) of this 519
section is disbursed by or through more than one state agency to 520
the person for the provision of services to the same population, 521
the contracting authorities of those agencies shall determine 522
which one of them will enter into the written contract with the 523
person. 524

(3) The requirements and conditions set forth in divisions 525
(A), (B), (C), and (F) of section 9.232, divisions (A)(1) and (2) 526
and (B) of section 9.234, divisions (A)(2) and (B) of section 527
9.235, and sections 9.233 and 9.236 of the Revised Code do not 528
apply with respect to the following: 529

(a) Contracts to which all of the following apply: 530

(i) The amount received for the services is a set fee for 531
each time the services are provided, is determined in accordance 532
with a fixed rate per unit of time or per service, or is a 533
capitated rate, and the fee or rate is established by competitive 534
bidding or by a market rate survey of similar services provided in 535
a defined market area. The market rate survey may be one conducted 536
by or on behalf of the governmental entity or an independent 537
survey accepted by the governmental entity as statistically valid 538
and reliable. 539

(ii) The services are provided in accordance with standards 540
established by state or federal law, or by rules or regulations 541
adopted thereunder, for their delivery, which standards are 542
enforced by the federal government, a governmental entity, or an 543
accrediting organization recognized by the federal government or a 544

governmental entity. 545

(iii) Payment for the services is made after the services are 546
delivered and upon submission to the governmental entity of an 547
invoice or other claim for payment as required by any applicable 548
local, state, or federal law or, if no such law applies, by the 549
terms of the contract. 550

(b) Contracts under which the services are reimbursed through 551
or in a manner consistent with a federal program that meets all of 552
the following requirements: 553

(i) The program calculates the reimbursement rate on the 554
basis of the previous year's experience or in accordance with an 555
alternative method set forth in rules adopted by the Ohio 556
department of job and family services. 557

(ii) The reimbursement rate is derived from a breakdown of 558
direct and indirect costs. 559

(iii) The program's guidelines describe types of expenditures 560
that are allowable and not allowable under the program and 561
delineate which costs are acceptable as direct costs for purposes 562
of calculating the reimbursement rate. 563

(iv) The program includes a uniform cost reporting system 564
with specific audit requirements. 565

(c) Contracts under which the services are reimbursed through 566
or in a manner consistent with a federal program that calculates 567
the reimbursement rate on a fee for service basis in compliance 568
with United States office of management and budget Circular A-87, 569
as revised May 10, 2004. 570

(d) Contracts for services that are paid pursuant to the 571
earmarking of an appropriation made by the general assembly for 572
that purpose. 573

(B) Division (A) of this section does not apply if the money 574

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 606
under Chapter 3314. of the Revised Code, or any nonpublic school 607
for which the state board of education prescribes minimum 608
education standards under section 3301.07 of the Revised Code. 609

(e) Services provided by a foster home as defined in section 610
5103.02 of the Revised Code; 611

(f) "Routine business services other than administrative or 612
management services," as that term is defined by the attorney 613
general by rule adopted in accordance with Chapter 119. of the 614
Revised Code; 615

(g) Services to protect the environment or promote 616
environmental education that are provided by a nonprofit entity or 617
services to protect the environment that are funded with federal 618
grants or revolving loan funds and administered in accordance with 619
federal law. 620

(3) The person receives the money solely in return for the 621
performance of services intended to help preserve public health or 622
safety under circumstances requiring immediate action as a result 623
of a natural or man-made emergency. 624

(C) With respect to a nonprofit association, corporation, or 625
organization established for the purpose of providing educational, 626
technical, consulting, training, financial, or other services to 627
its members in exchange for membership dues and other fees, any of 628
the services provided to a member that is a governmental entity 629
shall, for purposes of this section, be considered services "for 630
the primary benefit of a governmental entity or the employees of a 631
governmental entity." 632

Sec. 9.239. (A) There is hereby created the government 633
contracting advisory council. The attorney general and auditor of 634
state shall consult with the council on the performance of their 635

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; 663
664

(19) The president of the Ohio united way; 665

(20) One additional member appointed by the attorney general; 666

(21) One additional member appointed by the auditor of state. 667

(B) If an agency or organization represented on the council 668
ceases to exist in the form it has on ~~the effective date of this~~ 669
~~section~~ September 29, 2005, the successor agency or organization 670
shall be represented in its place. If there is no successor agency 671
or organization, or if it is not clear what agency or organization 672
is the successor, the attorney general shall designate an agency 673
or organization to be represented in place of the agency or 674
organization originally represented on the council. 675

(C) The two members appointed to the council shall serve 676
three-year terms. Original appointments shall be made not later 677
than sixty days after ~~the effective date of this section~~ September 678
29, 2005. Vacancies on the council shall be filled in the same 679
manner as the original appointment. 680

(D) The attorney general or the attorney general's designee 681
shall be the chairperson of the council. The council shall meet at 682
least once every two years to review the rules adopted under 683
sections 9.237 and 9.238 of the Revised Code and to make 684
recommendations to the attorney general and auditor of state 685
regarding the adoption, amendment, or repeal of those rules. The 686
council shall also meet at other times as requested by the 687
attorney general or auditor of state. 688

(E) Members of the council shall serve without compensation 689
or reimbursement. 690

(F) The office of the attorney general shall provide 691
necessary staff, facilities, supplies, and services to the 692

council. 693

(G) Sections 101.82 to 101.87 of the Revised Code do not 694
apply to the council. 695

Sec. 9.24. (A) Except as may be allowed under division (F) of 696
this section, no state agency and no political subdivision shall 697
award a contract as described in division (G)(1) of this section 698
for goods, services, or construction, paid for in whole or in part 699
with state funds, to a person against whom a finding for recovery 700
has been issued by the auditor of state on and after January 1, 701
2001, if the finding for recovery is unresolved. 702

A contract is considered to be awarded when it is entered 703
into or executed, irrespective of whether the parties to the 704
contract have exchanged any money. 705

(B) For purposes of this section, a finding for recovery is 706
unresolved unless one of the following criteria applies: 707

(1) The money identified in the finding for recovery is paid 708
in full to the state agency or political subdivision to whom the 709
money was owed; 710

(2) The debtor has entered into a repayment plan that is 711
approved by the attorney general and the state agency or political 712
subdivision to whom the money identified in the finding for 713
recovery is owed. A repayment plan may include a provision 714
permitting a state agency or political subdivision to withhold 715
payment to a debtor for goods, services, or construction provided 716
to or for the state agency or political subdivision pursuant to a 717
contract that is entered into with the debtor after the date the 718
finding for recovery was issued. 719

(3) The attorney general waives a repayment plan described in 720
division (B)(2) of this section for good cause; 721

(4) The debtor and state agency or political subdivision to 722

whom the money identified in the finding for recovery is owed have 723
agreed to a payment plan established through an enforceable 724
settlement agreement. 725

(5) The state agency or political subdivision desiring to 726
enter into a contract with a debtor certifies, and the attorney 727
general concurs, that all of the following are true: 728

(a) Essential services the state agency or political 729
subdivision is seeking to obtain from the debtor cannot be 730
provided by any other person besides the debtor; 731

(b) Awarding a contract to the debtor for the essential 732
services described in division (B)(5)(a) of this section is in the 733
best interest of the state; 734

(c) Good faith efforts have been made to collect the money 735
identified in the finding of recovery. 736

(6) The debtor has commenced an action to contest the finding 737
for recovery and a final determination on the action has not yet 738
been reached. 739

(C) The attorney general shall submit an initial report to 740
the auditor of state, not later than December 1, 2003, indicating 741
the status of collection for all findings for recovery issued by 742
the auditor of state for calendar years 2001, 2002, and 2003. 743
Beginning on January 1, 2004, the attorney general shall submit to 744
the auditor of state, on the first day of every January, April, 745
July, and October, a list of all findings for recovery that have 746
been resolved in accordance with division (B) of this section 747
during the calendar quarter preceding the submission of the list 748
and a description of the means of resolution. The attorney general 749
shall notify the auditor of state when a judgment is issued 750
against an entity described in division (F)(1) of this section. 751

(D) The auditor of state shall maintain a database, 752
accessible to the public, listing persons against whom an 753

unresolved finding for recovery has been issued, and the amount of 754
the money identified in the unresolved finding for recovery. The 755
auditor of state shall have this database operational on or before 756
January 1, 2004. The initial database shall contain the 757
information required under this division for calendar years 2001, 758
2002, and 2003. 759

Beginning January 15, 2004, the auditor of state shall update 760
the database by the fifteenth day of every January, April, July, 761
and October to reflect resolved findings for recovery that are 762
reported to the auditor of state by the attorney general on the 763
first day of the same month pursuant to division (C) of this 764
section. 765

(E) Before awarding a contract as described in division 766
(G)(1) of this section for goods, services, or construction, paid 767
for in whole or in part with state funds, a state agency or 768
political subdivision shall verify that the person to whom the 769
state agency or political subdivision plans to award the contract 770
has no unresolved finding for recovery issued against the person. 771
A state agency or political subdivision shall verify that the 772
person does not appear in the database described in division (D) 773
of this section or shall obtain other proof that the person has no 774
unresolved finding for recovery issued against the person. 775

(F) The prohibition of division (A) of this section and the 776
requirement of division (E) of this section do not apply with 777
respect to the companies or agreements described in divisions 778
(F)(1) and (2) of this section, or in the circumstance described 779
in division (F)(3) of this section. 780

(1) A bonding company or a company authorized to transact the 781
business of insurance in this state, a self-insurance pool, joint 782
self-insurance pool, risk management program, or joint risk 783
management program, unless a court has entered a final judgment 784
against the company and the company has not yet satisfied the 785

final judgment. 786

(2) To ~~medicaid~~ provider agreements under ~~Chapter 5111. of~~ 787
~~the Revised Code~~ the medicaid program or payments or provider 788
agreements under the disability assistance medical assistance 789
~~established under Chapter 5115. of the Revised Code~~ program. 790

(3) When federal law dictates that a specified entity provide 791
the goods, services, or construction for which a contract is being 792
awarded, regardless of whether that entity would otherwise be 793
prohibited from entering into the contract pursuant to this 794
section. 795

(G)(1) This section applies only to contracts for goods, 796
services, or construction that satisfy the criteria in either 797
division (G)(1)(a) or (b) of this section. This section may apply 798
to contracts for goods, services, or construction that satisfy the 799
criteria in division (G)(1)(c) of this section, provided that the 800
contracts also satisfy the criteria in either division (G)(1)(a) 801
or (b) of this section. 802

(a) The cost for the goods, services, or construction 803
provided under the contract is estimated to exceed twenty-five 804
thousand dollars. 805

(b) The aggregate cost for the goods, services, or 806
construction provided under multiple contracts entered into by the 807
particular state agency and a single person or the particular 808
political subdivision and a single person within the fiscal year 809
preceding the fiscal year within which a contract is being entered 810
into by that same state agency and the same single person or the 811
same political subdivision and the same single person, exceeded 812
fifty thousand dollars. 813

(c) The contract is a renewal of a contract previously 814
entered into and renewed pursuant to that preceding contract. 815

(2) This section does not apply to employment contracts. 816

(H) As used in this section:	817
(1) "State agency" has the same meaning as in section 9.66 of the Revised Code.	818 819
(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.	820 821 822 823
(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.	824 825 826 827 828 829 830
(4) "Debtor" means a person against whom a finding for recovery has been issued.	831 832
(5) "Person" means the person named in the finding for recovery.	833 834
(6) "State money" does not include funds the state receives from another source and passes through to a political subdivision.	835 836
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 <u>medicaid</u> program established under Chapter 5111. of the Revised Code or other government health programs.	837 838 839 840 841 842 843 844 845
The department of <u>health care administration, department of</u>	846

job and family services, department of health, department of 847
aging, department of mental health, department of mental 848
retardation and developmental disabilities, department of alcohol 849
and drug addiction services, and other state agencies shall 850
cooperate with the committee in its study and review of health 851
care issues. On request, the departments shall provide the 852
committee with reports and other information sufficient for the 853
committee to fulfill its duties. 854

The committee may issue recommendations as it determines 855
appropriate. The recommendations may be made to the general 856
assembly, state agencies, private industry, or any other entity. 857

(B) The committee shall consist of the following members of 858
the general assembly: the chairperson of the senate's standing 859
committee with primary responsibility for health legislation, the 860
chairperson of the house of representatives' standing committee 861
with primary responsibility for health legislation, four members 862
of the house of representatives appointed by the speaker of the 863
house of representatives, and four members of the senate appointed 864
by the president of the senate. Not more than two members 865
appointed by the speaker of the house of representatives and not 866
more than two members appointed by the president of the senate may 867
be of the same political party. Except in 1995, appointments shall 868
be made not later than fifteen days after the commencement of the 869
first regular session of each general assembly. The chairpersons 870
of the standing committees with primary responsibility for health 871
legislation shall serve as co-chairpersons of the committee. 872

873

Each member of the committee shall hold office during the 874
general assembly in which the member is appointed and until a 875
successor has been appointed, notwithstanding the adjournment sine 876
die of the general assembly in which the member was appointed or 877
the expiration of the member's term as a member of the general 878

assembly. Any vacancies occurring among the members of the 879
committee shall be filled in the manner of the original 880
appointment. 881

The committee shall meet at least quarterly and at the call 882
of the co-chairpersons. The co-chairpersons shall determine the 883
time, place, and agenda for each meeting of the committee. 884

The committee has the same powers as other standing or select 885
committees of the general assembly. The committee may request 886
assistance from the legislative service commission ~~and the~~ 887
~~legislative budget office of the legislative service commission.~~ 888

Sec. 101.391. (A) There is hereby created the joint 889
legislative committee on medicaid technology and reform. The 890
committee may review or study any matter that it considers 891
relevant to the operation of the medicaid program ~~established~~ 892
~~under Chapter 5111. of the Revised Code,~~ with priority given to 893
the study or review of mechanisms to enhance the program's 894
effectiveness through improved technology systems and program 895
reform. 896

(B) The committee shall consist of five members of the house 897
of representatives appointed by the speaker of the house of 898
representatives and five members of the senate appointed by the 899
president of the senate. Not more than three members appointed by 900
the speaker of the house of representatives and not more than 901
three members appointed by the president of the senate may be of 902
the same political party. 903

Each member of the committee shall hold office during the 904
general assembly in which the member is appointed and until a 905
successor has been appointed, notwithstanding the adjournment sine 906
die of the general assembly in which the member was appointed or 907
the expiration of the member's term as a member of the general 908
assembly. Any vacancies occurring among the members of the 909

committee shall be filled in the manner of the original 910
appointment. 911

(C) The committee has the same powers as other standing or 912
select committees of the general assembly. The committee may 913
employ an executive director. 914

Sec. 103.144. As used in sections 103.144 to 103.146 of the 915
Revised Code: 916

(A) "Mandated benefit" means the following, when considered 917
in the context of a sickness and accident insurance policy or a 918
health insuring corporation policy, contract, or agreement: 919

(1) Any required coverage for a specific medical or 920
health-related service, treatment, medication, or practice; 921

(2) Any required coverage for the services of specific health 922
care providers; 923

(3) Any requirement that an insurer or health insuring 924
corporation offer coverage to specific individuals or groups; 925

(4) Any requirement that an insurer or health insuring 926
corporation offer specific medical or health-related services, 927
treatments, medications, or practices to existing insureds or 928
enrollees; 929

(5) Any required expansion of, or addition to, existing 930
coverage; 931

(6) Any mandated reimbursement amount to specific health care 932
providers. 933

(B) "Mandated benefit" does not include any required coverage 934
or offer of coverage, any required expansion of, or addition to, 935
existing coverage, or any mandated reimbursement amount to 936
specific providers, as described in division (A) of this section, 937
within the context of any public health benefits arrangement, 938

including but not limited to, the coverage of beneficiaries 939
enrolled in ~~Title XVIII of the "Social Security Act," 49 Stat. 620~~ 940
~~(1935), 42 U.S.C.A. 301, as amended~~ medicare program, pursuant to 941
a medicare risk contract or medicare cost contract, or to the 942
coverage of ~~beneficiaries enrolled in Title XIX of the "Social~~ 943
~~Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended,~~ 944
~~known as recipients of the medical assistance program or medicaid,~~ 945
~~provided by the Ohio department of job and family services under~~ 946
~~Chapter 5111. of the Revised Code~~ program. 947

Sec. 109.572. (A)(1) Upon receipt of a request pursuant to 948
section 121.08, 3301.32, 3301.541, 3319.39, 5104.012, or 5104.013 949
of the Revised Code, a completed form prescribed pursuant to 950
division (C)(1) of this section, and a set of fingerprint 951
impressions obtained in the manner described in division (C)(2) of 952
this section, the superintendent of the bureau of criminal 953
identification and investigation shall conduct a criminal records 954
check in the manner described in division (B) of this section to 955
determine whether any information exists that indicates that the 956
person who is the subject of the request previously has been 957
convicted of or pleaded guilty to any of the following: 958

(a) A violation of section 2903.01, 2903.02, 2903.03, 959
2903.04, 2903.11, 2903.12, 2903.13, 2903.16, 2903.21, 2903.34, 960
2905.01, 2905.02, 2905.05, 2907.02, 2907.03, 2907.04, 2907.05, 961
2907.06, 2907.07, 2907.08, 2907.09, 2907.21, 2907.22, 2907.23, 962
2907.25, 2907.31, 2907.32, 2907.321, 2907.322, 2907.323, 2911.01, 963
2911.02, 2911.11, 2911.12, 2919.12, 2919.22, 2919.24, 2919.25, 964
2923.12, 2923.13, 2923.161, 2925.02, 2925.03, 2925.04, 2925.05, 965
2925.06, or 3716.11 of the Revised Code, felonious sexual 966
penetration in violation of former section 2907.12 of the Revised 967
Code, a violation of section 2905.04 of the Revised Code as it 968
existed prior to July 1, 1996, a violation of section 2919.23 of 969
the Revised Code that would have been a violation of section 970

2905.04 of the Revised Code as it existed prior to July 1, 1996, 971
had the violation been committed prior to that date, or a 972
violation of section 2925.11 of the Revised Code that is not a 973
minor drug possession offense; 974

(b) A violation of an existing or former law of this state, 975
any other state, or the United States that is substantially 976
equivalent to any of the offenses listed in division (A)(1)(a) of 977
this section. 978

(2) On receipt of a request pursuant to section 5123.081 of 979
the Revised Code with respect to an applicant for employment in 980
any position with the department of mental retardation and 981
developmental disabilities, pursuant to section 5126.28 of the 982
Revised Code with respect to an applicant for employment in any 983
position with a county board of mental retardation and 984
developmental disabilities, or pursuant to section 5126.281 of the 985
Revised Code with respect to an applicant for employment in a 986
direct services position with an entity contracting with a county 987
board for employment, a completed form prescribed pursuant to 988
division (C)(1) of this section, and a set of fingerprint 989
impressions obtained in the manner described in division (C)(2) of 990
this section, the superintendent of the bureau of criminal 991
identification and investigation shall conduct a criminal records 992
check. The superintendent shall conduct the criminal records check 993
in the manner described in division (B) of this section to 994
determine whether any information exists that indicates that the 995
person who is the subject of the request has been convicted of or 996
pleaded guilty to any of the following: 997

(a) A violation of section 2903.01, 2903.02, 2903.03, 998
2903.04, 2903.11, 2903.12, 2903.13, 2903.16, 2903.21, 2903.34, 999
2903.341, 2905.01, 2905.02, 2905.04, 2905.05, 2907.02, 2907.03, 1000
2907.04, 2907.05, 2907.06, 2907.07, 2907.08, 2907.09, 2907.12, 1001
2907.21, 2907.22, 2907.23, 2907.25, 2907.31, 2907.32, 2907.321, 1002

2907.322, 2907.323, 2911.01, 2911.02, 2911.11, 2911.12, 2919.12, 1003
2919.22, 2919.24, 2919.25, 2923.12, 2923.13, 2923.161, 2925.02, 1004
2925.03, or 3716.11 of the Revised Code; 1005

(b) An existing or former municipal ordinance or law of this 1006
state, any other state, or the United States that is substantially 1007
equivalent to any of the offenses listed in division (A)(2)(a) of 1008
this section. 1009

(3) On receipt of a request pursuant to section 173.27, 1010
173.394, 3712.09, 3721.121, or 3722.151 of the Revised Code, a 1011
completed form prescribed pursuant to division (C)(1) of this 1012
section, and a set of fingerprint impressions obtained in the 1013
manner described in division (C)(2) of this section, the 1014
superintendent of the bureau of criminal identification and 1015
investigation shall conduct a criminal records check with respect 1016
to any person who has applied for employment in a position for 1017
which a criminal records check is required by those sections. The 1018
superintendent shall conduct the criminal records check in the 1019
manner described in division (B) of this section to determine 1020
whether any information exists that indicates that the person who 1021
is the subject of the request previously has been convicted of or 1022
pleaded guilty to any of the following: 1023

(a) A violation of section 2903.01, 2903.02, 2903.03, 1024
2903.04, 2903.11, 2903.12, 2903.13, 2903.16, 2903.21, 2903.34, 1025
2905.01, 2905.02, 2905.11, 2905.12, 2907.02, 2907.03, 2907.05, 1026
2907.06, 2907.07, 2907.08, 2907.09, 2907.12, 2907.25, 2907.31, 1027
2907.32, 2907.321, 2907.322, 2907.323, 2911.01, 2911.02, 2911.11, 1028
2911.12, 2911.13, 2913.02, 2913.03, 2913.04, 2913.11, 2913.21, 1029
2913.31, 2913.40, 2913.43, 2913.47, 2913.51, 2919.25, 2921.36, 1030
2923.12, 2923.13, 2923.161, 2925.02, 2925.03, 2925.11, 2925.13, 1031
2925.22, 2925.23, or 3716.11 of the Revised Code; 1032

(b) An existing or former law of this state, any other state, 1033
or the United States that is substantially equivalent to any of 1034

the offenses listed in division (A)(3)(a) of this section. 1035

(4) On receipt of a request pursuant to section 3701.881 of 1036
the Revised Code with respect to an applicant for employment with 1037
a home health agency as a person responsible for the care, 1038
custody, or control of a child, a completed form prescribed 1039
pursuant to division (C)(1) of this section, and a set of 1040
fingerprint impressions obtained in the manner described in 1041
division (C)(2) of this section, the superintendent of the bureau 1042
of criminal identification and investigation shall conduct a 1043
criminal records check. The superintendent shall conduct the 1044
criminal records check in the manner described in division (B) of 1045
this section to determine whether any information exists that 1046
indicates that the person who is the subject of the request 1047
previously has been convicted of or pleaded guilty to any of the 1048
following: 1049

(a) A violation of section 2903.01, 2903.02, 2903.03, 1050
2903.04, 2903.11, 2903.12, 2903.13, 2903.16, 2903.21, 2903.34, 1051
2905.01, 2905.02, 2905.04, 2905.05, 2907.02, 2907.03, 2907.04, 1052
2907.05, 2907.06, 2907.07, 2907.08, 2907.09, 2907.12, 2907.21, 1053
2907.22, 2907.23, 2907.25, 2907.31, 2907.32, 2907.321, 2907.322, 1054
2907.323, 2911.01, 2911.02, 2911.11, 2911.12, 2919.12, 2919.22, 1055
2919.24, 2919.25, 2923.12, 2923.13, 2923.161, 2925.02, 2925.03, 1056
2925.04, 2925.05, 2925.06, or 3716.11 of the Revised Code or a 1057
violation of section 2925.11 of the Revised Code that is not a 1058
minor drug possession offense; 1059

(b) An existing or former law of this state, any other state, 1060
or the United States that is substantially equivalent to any of 1061
the offenses listed in division (A)(4)(a) of this section. 1062

(5) On receipt of a request pursuant to section ~~5111.95~~ 1063
5163.75 or ~~5111.96~~ 5163.76 of the Revised Code with respect to an 1064
applicant for employment with a waiver agency participating in a 1065
department of job and family services administered home and 1066

community-based waiver program or an independent provider 1067
participating in a department administered home and 1068
community-based waiver program in a position that involves 1069
providing home and community-based waiver services to consumers 1070
with disabilities, a completed form prescribed pursuant to 1071
division (C)(1) of this section, and a set of fingerprint 1072
impressions obtained in the manner described in division (C)(2) of 1073
this section, the superintendent of the bureau of criminal 1074
identification and investigation shall conduct a criminal records 1075
check. The superintendent shall conduct the criminal records check 1076
in the manner described in division (B) of this section to 1077
determine whether any information exists that indicates that the 1078
person who is the subject of the request previously has been 1079
convicted of or pleaded guilty to any of the following: 1080

(a) A violation of section 2903.01, 2903.02, 2903.03, 1081
2903.04, 2903.041, 2903.11, 2903.12, 2903.13, 2903.16, 2903.21, 1082
2903.34, 2905.01, 2905.02, 2905.05, 2905.11, 2905.12, 2907.02, 1083
2907.03, 2907.04, 2907.05, 2907.06, 2907.07, 2907.08, 2907.09, 1084
2907.21, 2907.22, 2907.23, 2907.25, 2907.31, 2907.32, 2907.321, 1085
2907.322, 2907.323, 2911.01, 2911.02, 2911.11, 2911.12, 2911.13, 1086
2913.02, 2913.03, 2913.04, 2913.11, 2913.21, 2913.31, 2913.40, 1087
2913.43, 2913.47, 2913.51, 2919.12, 2919.24, 2919.25, 2921.36, 1088
2923.12, 2923.13, 2923.161, 2925.02, 2925.03, 2925.04, 2925.05, 1089
2925.06, 2925.11, 2925.13, 2925.22, 2925.23, or 3716.11 of the 1090
Revised Code, felonious sexual penetration in violation of former 1091
section 2907.12 of the Revised Code, a violation of section 1092
2905.04 of the Revised Code as it existed prior to July 1, 1996, a 1093
violation of section 2919.23 of the Revised Code that would have 1094
been a violation of section 2905.04 of the Revised Code as it 1095
existed prior to July 1, 1996, had the violation been committed 1096
prior to that date; 1097

(b) An existing or former law of this state, any other state, 1098

or the United States that is substantially equivalent to any of 1099
the offenses listed in division (A)(5)(a) of this section. 1100

(6) On receipt of a request pursuant to section 3701.881 of 1101
the Revised Code with respect to an applicant for employment with 1102
a home health agency in a position that involves providing direct 1103
care to an older adult, a completed form prescribed pursuant to 1104
division (C)(1) of this section, and a set of fingerprint 1105
impressions obtained in the manner described in division (C)(2) of 1106
this section, the superintendent of the bureau of criminal 1107
identification and investigation shall conduct a criminal records 1108
check. The superintendent shall conduct the criminal records check 1109
in the manner described in division (B) of this section to 1110
determine whether any information exists that indicates that the 1111
person who is the subject of the request previously has been 1112
convicted of or pleaded guilty to any of the following: 1113

(a) A violation of section 2903.01, 2903.02, 2903.03, 1114
2903.04, 2903.11, 2903.12, 2903.13, 2903.16, 2903.21, 2903.34, 1115
2905.01, 2905.02, 2905.11, 2905.12, 2907.02, 2907.03, 2907.05, 1116
2907.06, 2907.07, 2907.08, 2907.09, 2907.12, 2907.25, 2907.31, 1117
2907.32, 2907.321, 2907.322, 2907.323, 2911.01, 2911.02, 2911.11, 1118
2911.12, 2911.13, 2913.02, 2913.03, 2913.04, 2913.11, 2913.21, 1119
2913.31, 2913.40, 2913.43, 2913.47, 2913.51, 2919.25, 2921.36, 1120
2923.12, 2923.13, 2923.161, 2925.02, 2925.03, 2925.11, 2925.13, 1121
2925.22, 2925.23, or 3716.11 of the Revised Code; 1122

(b) An existing or former law of this state, any other state, 1123
or the United States that is substantially equivalent to any of 1124
the offenses listed in division (A)(6)(a) of this section. 1125

(7) When conducting a criminal records check upon a request 1126
pursuant to section 3319.39 of the Revised Code for an applicant 1127
who is a teacher, in addition to the determination made under 1128
division (A)(1) of this section, the superintendent shall 1129
determine whether any information exists that indicates that the 1130

person who is the subject of the request previously has been 1131
convicted of or pleaded guilty to any offense specified in section 1132
3319.31 of the Revised Code. 1133

(8) On a request pursuant to section 2151.86 of the Revised 1134
Code, a completed form prescribed pursuant to division (C)(1) of 1135
this section, and a set of fingerprint impressions obtained in the 1136
manner described in division (C)(2) of this section, the 1137
superintendent of the bureau of criminal identification and 1138
investigation shall conduct a criminal records check in the manner 1139
described in division (B) of this section to determine whether any 1140
information exists that indicates that the person who is the 1141
subject of the request previously has been convicted of or pleaded 1142
guilty to any of the following: 1143

(a) A violation of section 2903.01, 2903.02, 2903.03, 1144
2903.04, 2903.11, 2903.12, 2903.13, 2903.16, 2903.21, 2903.34, 1145
2905.01, 2905.02, 2905.05, 2907.02, 2907.03, 2907.04, 2907.05, 1146
2907.06, 2907.07, 2907.08, 2907.09, 2907.21, 2907.22, 2907.23, 1147
2907.25, 2907.31, 2907.32, 2907.321, 2907.322, 2907.323, 2909.02, 1148
2909.03, 2911.01, 2911.02, 2911.11, 2911.12, 2919.12, 2919.22, 1149
2919.24, 2919.25, 2923.12, 2923.13, 2923.161, 2925.02, 2925.03, 1150
2925.04, 2925.05, 2925.06, or 3716.11 of the Revised Code, a 1151
violation of section 2905.04 of the Revised Code as it existed 1152
prior to July 1, 1996, a violation of section 2919.23 of the 1153
Revised Code that would have been a violation of section 2905.04 1154
of the Revised Code as it existed prior to July 1, 1996, had the 1155
violation been committed prior to that date, a violation of 1156
section 2925.11 of the Revised Code that is not a minor drug 1157
possession offense, or felonious sexual penetration in violation 1158
of former section 2907.12 of the Revised Code; 1159

(b) A violation of an existing or former law of this state, 1160
any other state, or the United States that is substantially 1161
equivalent to any of the offenses listed in division (A)(8)(a) of 1162

this section. 1163

(9) When conducting a criminal records check on a request 1164
pursuant to section 5104.013 of the Revised Code for a person who 1165
is an owner, licensee, or administrator of a child day-care center 1166
or type A family day-care home, an authorized provider of a 1167
certified type B family day-care home, or an adult residing in a 1168
type A or certified type B home, or when conducting a criminal 1169
records check or a request pursuant to section 5104.012 of the 1170
Revised Code for a person who is an applicant for employment in a 1171
center, type A home, or certified type B home, the superintendent, 1172
in addition to the determination made under division (A)(1) of 1173
this section, shall determine whether any information exists that 1174
indicates that the person has been convicted of or pleaded guilty 1175
to any of the following: 1176

(a) A violation of section 2913.02, 2913.03, 2913.04, 1177
2913.041, 2913.05, 2913.06, 2913.11, 2913.21, 2913.31, 2913.32, 1178
2913.33, 2913.34, 2913.40, 2913.41, 2913.42, 2913.43, 2913.44, 1179
2913.441, 2913.45, 2913.46, 2913.47, 2913.48, 2913.49, 2921.11, 1180
2921.13, or 2923.01 of the Revised Code, a violation of section 1181
2923.02 or 2923.03 of the Revised Code that relates to a crime 1182
specified in this division or division (A)(1)(a) of this section, 1183
or a second violation of section 4511.19 of the Revised Code 1184
within five years of the date of application for licensure or 1185
certification. 1186

(b) A violation of an existing or former law of this state, 1187
any other state, or the United States that is substantially 1188
equivalent to any of the offenses or violations described in 1189
division (A)(9)(a) of this section. 1190

(10) Upon receipt of a request pursuant to section 5153.111 1191
of the Revised Code, a completed form prescribed pursuant to 1192
division (C)(1) of this section, and a set of fingerprint 1193
impressions obtained in the manner described in division (C)(2) of 1194

this section, the superintendent of the bureau of criminal 1195
identification and investigation shall conduct a criminal records 1196
check in the manner described in division (B) of this section to 1197
determine whether any information exists that indicates that the 1198
person who is the subject of the request previously has been 1199
convicted of or pleaded guilty to any of the following: 1200

(a) A violation of section 2903.01, 2903.02, 2903.03, 1201
2903.04, 2903.11, 2903.12, 2903.13, 2903.16, 2903.21, 2903.34, 1202
2905.01, 2905.02, 2905.05, 2907.02, 2907.03, 2907.04, 2907.05, 1203
2907.06, 2907.07, 2907.08, 2907.09, 2907.21, 2907.22, 2907.23, 1204
2907.25, 2907.31, 2907.32, 2907.321, 2907.322, 2907.323, 2909.02, 1205
2909.03, 2911.01, 2911.02, 2911.11, 2911.12, 2919.12, 2919.22, 1206
2919.24, 2919.25, 2923.12, 2923.13, 2923.161, 2925.02, 2925.03, 1207
2925.04, 2925.05, 2925.06, or 3716.11 of the Revised Code, 1208
felonious sexual penetration in violation of former section 1209
2907.12 of the Revised Code, a violation of section 2905.04 of the 1210
Revised Code as it existed prior to July 1, 1996, a violation of 1211
section 2919.23 of the Revised Code that would have been a 1212
violation of section 2905.04 of the Revised Code as it existed 1213
prior to July 1, 1996, had the violation been committed prior to 1214
that date, or a violation of section 2925.11 of the Revised Code 1215
that is not a minor drug possession offense; 1216

(b) A violation of an existing or former law of this state, 1217
any other state, or the United States that is substantially 1218
equivalent to any of the offenses listed in division (A)(10)(a) of 1219
this section. 1220

(11) On receipt of a request for a criminal records check 1221
from an individual pursuant to section 4749.03 or 4749.06 of the 1222
Revised Code, accompanied by a completed copy of the form 1223
prescribed in division (C)(1) of this section and a set of 1224
fingerprint impressions obtained in a manner described in division 1225
(C)(2) of this section, the superintendent of the bureau of 1226

criminal identification and investigation shall conduct a criminal 1227
records check in the manner described in division (B) of this 1228
section to determine whether any information exists indicating 1229
that the person who is the subject of the request has been 1230
convicted of or pleaded guilty to a felony in this state or in any 1231
other state. If the individual indicates that a firearm will be 1232
carried in the course of business, the superintendent shall 1233
require information from the federal bureau of investigation as 1234
described in division (B)(2) of this section. The superintendent 1235
shall report the findings of the criminal records check and any 1236
information the federal bureau of investigation provides to the 1237
director of public safety. 1238

(12) On receipt of a request pursuant to section 1322.03, 1239
1322.031, or 4763.05 of the Revised Code, a completed form 1240
prescribed pursuant to division (C)(1) of this section, and a set 1241
of fingerprint impressions obtained in the manner described in 1242
division (C)(2) of this section, the superintendent of the bureau 1243
of criminal identification and investigation shall conduct a 1244
criminal records check with respect to any person who has applied 1245
for a license, permit, or certification from the department of 1246
commerce or a division in the department. The superintendent shall 1247
conduct the criminal records check in the manner described in 1248
division (B) of this section to determine whether any information 1249
exists that indicates that the person who is the subject of the 1250
request previously has been convicted of or pleaded guilty to any 1251
of the following: a violation of section 2913.02, 2913.11, 1252
2913.31, 2913.51, or 2925.03 of the Revised Code; any other 1253
criminal offense involving theft, receiving stolen property, 1254
embezzlement, forgery, fraud, passing bad checks, money 1255
laundering, or drug trafficking, or any criminal offense involving 1256
money or securities, as set forth in Chapters 2909., 2911., 2913., 1257
2915., 2921., 2923., and 2925. of the Revised Code; or any 1258
existing or former law of this state, any other state, or the 1259

United States that is substantially equivalent to those offenses. 1260

(13) Not later than thirty days after the date the 1261
superintendent receives the request, completed form, and 1262
fingerprint impressions, the superintendent shall send the person, 1263
board, or entity that made the request any information, other than 1264
information the dissemination of which is prohibited by federal 1265
law, the superintendent determines exists with respect to the 1266
person who is the subject of the request that indicates that the 1267
person previously has been convicted of or pleaded guilty to any 1268
offense listed or described in division (A)(1), (2), (3), (4), 1269
(5), (6), (7), (8), (9), (10), (11), or (12) of this section, as 1270
appropriate. The superintendent shall send the person, board, or 1271
entity that made the request a copy of the list of offenses 1272
specified in division (A)(1), (2), (3), (4), (5), (6), (7), (8), 1273
(9), (10), (11), or (12) of this section, as appropriate. If the 1274
request was made under section 3701.881 of the Revised Code with 1275
regard to an applicant who may be both responsible for the care, 1276
custody, or control of a child and involved in providing direct 1277
care to an older adult, the superintendent shall provide a list of 1278
the offenses specified in divisions (A)(4) and (6) of this 1279
section. 1280

(B) The superintendent shall conduct any criminal records 1281
check requested under section 121.08, 173.27, 173.394, 1322.03, 1282
1322.031, 2151.86, 3301.32, 3301.541, 3319.39, 3701.881, 3712.09, 1283
3721.121, 3722.151, 4749.03, 4749.06, 4763.05, 5104.012, 5104.013, 1284
~~5111.95, 5111.96,~~ 5123.081, 5126.28, 5126.281, ~~or~~ 5153.111, 1285
5163.75, or 5163.76 of the Revised Code as follows: 1286

(1) The superintendent shall review or cause to be reviewed 1287
any relevant information gathered and compiled by the bureau under 1288
division (A) of section 109.57 of the Revised Code that relates to 1289
the person who is the subject of the request, including any 1290
relevant information contained in records that have been sealed 1291

under section 2953.32 of the Revised Code; 1292

(2) If the request received by the superintendent asks for 1293
information from the federal bureau of investigation, the 1294
superintendent shall request from the federal bureau of 1295
investigation any information it has with respect to the person 1296
who is the subject of the request and shall review or cause to be 1297
reviewed any information the superintendent receives from that 1298
bureau. 1299

(3) The superintendent or the superintendent's designee may 1300
request criminal history records from other states or the federal 1301
government pursuant to the national crime prevention and privacy 1302
compact set forth in section 109.571 of the Revised Code. 1303

(C)(1) The superintendent shall prescribe a form to obtain 1304
the information necessary to conduct a criminal records check from 1305
any person for whom a criminal records check is required by 1306
section 121.08, 173.27, 173.394, 1322.03, 1322.031, 2151.86, 1307
3301.32, 3301.541, 3319.39, 3701.881, 3712.09, 3721.121, 3722.151, 1308
4749.03, 4749.06, 4763.05, 5104.012, 5104.013, ~~5111.95, 5111.96,~~ 1309
5123.081, 5126.28, 5126.281, ~~or~~ 5153.111, 5163.75, or 5163.76 of 1310
the Revised Code. The form that the superintendent prescribes 1311
pursuant to this division may be in a tangible format, in an 1312
electronic format, or in both tangible and electronic formats. 1313

(2) The superintendent shall prescribe standard impression 1314
sheets to obtain the fingerprint impressions of any person for 1315
whom a criminal records check is required by section 121.08, 1316
173.27, 173.394, 1322.03, 1322.031, 2151.86, 3301.32, 3301.541, 1317
3319.39, 3701.881, 3712.09, 3721.121, 3722.151, 4749.03, 4749.06, 1318
4763.05, 5104.012, 5104.013, ~~5111.95, 5111.96,~~ 5123.081, 5126.28, 1319
5126.281, ~~or~~ 5153.111, 5163.75, or 5163.76 of the Revised Code. 1320
Any person for whom a records check is required by any of those 1321
sections shall obtain the fingerprint impressions at a county 1322
sheriff's office, municipal police department, or any other entity 1323

with the ability to make fingerprint impressions on the standard 1324
impression sheets prescribed by the superintendent. The office, 1325
department, or entity may charge the person a reasonable fee for 1326
making the impressions. The standard impression sheets the 1327
superintendent prescribes pursuant to this division may be in a 1328
tangible format, in an electronic format, or in both tangible and 1329
electronic formats. 1330

(3) Subject to division (D) of this section, the 1331
superintendent shall prescribe and charge a reasonable fee for 1332
providing a criminal records check requested under section 121.08, 1333
173.27, 173.394, 1322.03, 1322.031, 2151.86, 3301.32, 3301.541, 1334
3319.39, 3701.881, 3712.09, 3721.121, 3722.151, 4749.03, 4749.06, 1335
4763.05, 5104.012, 5104.013, ~~5111.95, 5111.96~~, 5123.081, 5126.28, 1336
5126.281, ~~or~~ 5153.111, 5163.75, or 5163.76 of the Revised Code. 1337
The person making a criminal records request under section 121.08, 1338
173.27, 173.394, 1322.03, 1322.031, 2151.86, 3301.32, 3301.541, 1339
3319.39, 3701.881, 3712.09, 3721.121, 3722.151, 4749.03, 4749.06, 1340
4763.05, 5104.012, 5104.013, ~~5111.95, 5111.96~~, 5123.081, 5126.28, 1341
5126.281, ~~or~~ 5153.111, 5163.75, or 5163.76 of the Revised Code 1342
shall pay the fee prescribed pursuant to this division. A person 1343
making a request under section 3701.881 of the Revised Code for a 1344
criminal records check for an applicant who may be both 1345
responsible for the care, custody, or control of a child and 1346
involved in providing direct care to an older adult shall pay one 1347
fee for the request. 1348

(4) The superintendent of the bureau of criminal 1349
identification and investigation may prescribe methods of 1350
forwarding fingerprint impressions and information necessary to 1351
conduct a criminal records check, which methods shall include, but 1352
not be limited to, an electronic method. 1353

(D) A determination whether any information exists that 1354
indicates that a person previously has been convicted of or 1355

pleaded guilty to any offense listed or described in division 1356
(A)(1)(a) or (b), (A)(2)(a) or (b), (A)(3)(a) or (b), (A)(4)(a) or 1357
(b), (A)(5)(a) or (b), (A)(6)(a) or (b), (A)(7), (A)(8)(a) or (b), 1358
(A)(9)(a) or (b), (A)(10)(a) or (b), or (A)(12) of this section 1359
that is made by the superintendent with respect to information 1360
considered in a criminal records check in accordance with this 1361
section is valid for the person who is the subject of the criminal 1362
records check for a period of one year from the date upon which 1363
the superintendent makes the determination. During the period in 1364
which the determination in regard to a person is valid, if another 1365
request under this section is made for a criminal records check 1366
for that person, the superintendent shall provide the information 1367
that is the basis for the superintendent's initial determination 1368
at a lower fee than the fee prescribed for the initial criminal 1369
records check. 1370

(E) As used in this section: 1371

(1) "Criminal records check" means any criminal records check 1372
conducted by the superintendent of the bureau of criminal 1373
identification and investigation in accordance with division (B) 1374
of this section. 1375

(2) "Home and community-based waiver services" and "waiver 1376
agency" have the same meanings as in section ~~5111.95~~ 5163.75 of 1377
the Revised Code. 1378

(3) "Independent provider" has the same meaning as in section 1379
~~5111.96~~ 5163.76 of the Revised Code. 1380

(4) "Minor drug possession offense" has the same meaning as 1381
in section 2925.01 of the Revised Code. 1382

(5) "Older adult" means a person age sixty or older. 1383

Sec. 109.85. (A) Upon the written request of the governor, 1384
the general assembly, the auditor of state, the director of ~~job~~ 1385

~~and family services~~ health care administration, the director of 1386
health, or the director of budget and management, or upon the 1387
attorney general's becoming aware of criminal or improper activity 1388
related to Chapter 3721. and the ~~medical assistance~~ medicaid 1389
program ~~established under section 5111.01 of the Revised Code~~, the 1390
attorney general shall investigate any criminal or civil violation 1391
of law related to Chapter 3721. of the Revised Code or the ~~medical~~ 1392
~~assistance~~ medicaid program. 1393

(B) When it appears to the attorney general, as a result of 1394
an investigation under division (A) of this section, that there is 1395
cause to prosecute for the commission of a crime or to pursue a 1396
civil remedy, the attorney general may refer the evidence to the 1397
prosecuting attorney having jurisdiction of the matter, or to a 1398
regular grand jury drawn and impaneled pursuant to sections 1399
2939.01 to 2939.24 of the Revised Code, or to a special grand jury 1400
drawn and impaneled pursuant to section 2939.17 of the Revised 1401
Code, or the attorney general may initiate and prosecute any 1402
necessary criminal or civil actions in any court or tribunal of 1403
competent jurisdiction in this state. When proceeding under this 1404
section, the attorney general, and any assistant or special 1405
counsel designated by the attorney general for that purpose, have 1406
all rights, privileges, and powers of prosecuting attorneys. The 1407
attorney general shall have exclusive supervision and control of 1408
all investigations and prosecutions initiated by the attorney 1409
general under this section. The forfeiture provisions of Chapter 1410
2981. of the Revised Code apply in relation to any such criminal 1411
action initiated and prosecuted by the attorney general. 1412

(C) Nothing in this section shall prevent a county 1413
prosecuting attorney from investigating and prosecuting criminal 1414
activity related to Chapter 3721. of the Revised Code and the 1415
~~medical assistance~~ medicaid program ~~established under section~~ 1416
~~5111.01 of the Revised Code~~. The forfeiture provisions of Chapter 1417

2981. of the Revised Code apply in relation to any prosecution of 1418
criminal activity related to the ~~medical assistance~~ medicaid 1419
program undertaken by the prosecuting attorney. 1420

Sec. 117.10. The auditor of state shall audit all public 1421
offices as provided in this chapter. The auditor of state also may 1422
audit the accounts of private institutions, associations, boards, 1423
and corporations receiving public money for their use and may 1424
require of them annual reports in such form as the auditor of 1425
state prescribes. 1426

If the auditor of state performs or contracts for the 1427
performance of an audit, including a special audit, of the public 1428
employees retirement system, school employees retirement system, 1429
state teachers retirement system, state highway patrol retirement 1430
system, or Ohio police and fire pension fund, the auditor of state 1431
shall make a timely report of the results of the audit to the Ohio 1432
retirement study council. 1433

The auditor of state may audit the accounts of any provider 1434
as defined in section ~~5111.06~~ 5163.01 of the Revised Code. 1435

If a public office has been audited by an agency of the 1436
United States government, the auditor of state may, if satisfied 1437
that the federal audit has been conducted according to principles 1438
and procedures not contrary to those of the auditor of state, use 1439
and adopt the federal audit and report in lieu of an audit by the 1440
auditor of state's own office. 1441

Within thirty days after the creation or dissolution or the 1442
winding up of the affairs of any public office, that public office 1443
shall notify the auditor of state in writing that this action has 1444
occurred. 1445

Sec. 117.54. The auditor of state may enter into agreements 1446
with the director of health care administration, director of job 1447

and family services, and comparable officers of other states for 1448
the exchange of names, current or most recent addresses, and 1449
social security numbers of medicaid recipients and participants 1450
and recipients of Title IV-A programs as defined in section 1451
5101.80 of the Revised Code. 1452

Sec. 117.55. The auditor of state shall retain, for not less 1453
than two years, at least one copy of all materials containing 1454
information received under sections 117.54, 117.56, 145.27, 1455
742.41, 3307.21, 3309.22, 4123.27, 5101.181, 5101.182, 5160.43, 1456
5160.44, and 5505.04 of the Revised Code. The auditor of state 1457
shall review the information to determine whether overpayments 1458
were made to participants and recipients of public assistance 1459
under Chapters 5107., 5108., and 5115. of the Revised Code and 1460
whether benefits were incorrectly paid on behalf of medicaid 1461
recipients and disability medical assistance recipients. The 1462
auditor of state shall initiate action leading to prosecution, 1463
where warranted, of participants and recipients who received 1464
overpayments or had benefits incorrectly paid on their behalf by 1465
forwarding the name of each such participant or recipient, 1466
together with other pertinent information, to the following: 1467

(A) The attorney general; 1468

(B) The director of job and family services or director of 1469
health care administration, as appropriate; 1470

(C) In the case of public assistance under Chapters 5107., 1471
5108., and 5115. of the Revised Code, the district director of job 1472
and family services of the district through which the public 1473
assistance was received; 1474

(D) The county director of job and family services and county 1475
prosecutor of the county through which the public assistance, 1476
medicaid, or disability medical assistance was received. 1477

Sec. 117.56. The auditor of state and the attorney general 1478
and persons acting at their direction may examine any records, 1479
whether in computer or printed format, in the possession of the 1480
department of health care administration, the department of job 1481
and family services, or a county department of job and family 1482
services. The auditor of state and attorney general shall provide 1483
safeguards that restrict access to the records to purposes 1484
directly connected with an audit or investigation, prosecution, or 1485
criminal or civil proceeding conducted in connection with the 1486
administration of the medicaid program, the disability medical 1487
assistance program, or a public assistance program under Chapter 1488
5107., 5108., or 5115. of the Revised Code. Persons acting under 1489
this section shall comply with the rules of the director of job 1490
and family services restricting the disclosure of information 1491
regarding participants and recipients of public assistance and 1492
rules of the director of health care administration restricting 1493
the disclosure of information regarding medicaid and disability 1494
medical assistance recipients. A person determined to have failed 1495
to comply with these rules shall thereafter be disqualified from 1496
acting as an agent or employee or in any other capacity under 1497
appointment or employment of any state board, commission, or 1498
agency. 1499

Sec. 117.57. The auditor of state is responsible for the 1500
costs incurred by the auditor of state in carrying out the auditor 1501
of state's duties under sections 117.55 and 117.56 of the Revised 1502
Code. 1503

Sec. 119.01. As used in sections 119.01 to 119.13 of the 1504
Revised Code: 1505

(A)(1) "Agency" means, except as limited by this division, 1506
any official, board, or commission having authority to promulgate 1507

rules or make adjudications in the civil service commission, the 1508
division of liquor control, the department of taxation, the 1509
industrial commission, the bureau of workers' compensation, the 1510
functions of any administrative or executive officer, department, 1511
division, bureau, board, or commission of the government of the 1512
state specifically made subject to sections 119.01 to 119.13 of 1513
the Revised Code, and the licensing functions of any 1514
administrative or executive officer, department, division, bureau, 1515
board, or commission of the government of the state having the 1516
authority or responsibility of issuing, suspending, revoking, or 1517
canceling licenses. 1518

Except as otherwise provided in division (I) of this section, 1519
sections 119.01 to 119.13 of the Revised Code do not apply to the 1520
public utilities commission. Sections 119.01 to 119.13 of the 1521
Revised Code do not apply to the utility radiological safety 1522
board; to the controlling board; to actions of the superintendent 1523
of financial institutions and the superintendent of insurance in 1524
the taking possession of, and rehabilitation or liquidation of, 1525
the business and property of banks, savings and loan associations, 1526
savings banks, credit unions, insurance companies, associations, 1527
reciprocal fraternal benefit societies, and bond investment 1528
companies; to any action taken by the division of securities under 1529
section 1707.201 of the Revised Code; or to any action that may be 1530
taken by the superintendent of financial institutions under 1531
section 1113.03, 1121.06, 1121.10, 1125.09, 1125.12, 1125.18, 1532
1157.01, 1157.02, 1157.10, 1165.01, 1165.02, 1165.10, 1349.33, 1533
1733.35, 1733.361, 1733.37, or 1761.03 of the Revised Code. 1534

Sections 119.01 to 119.13 of the Revised Code do not apply to 1535
actions of the industrial commission or the bureau of workers' 1536
compensation under sections 4123.01 to 4123.94 of the Revised Code 1537
with respect to all matters of adjudication, and to the actions of 1538
the industrial commission and bureau of workers' compensation 1539

under division (D) of section 4121.32, sections 4123.29, 4123.34, 1540
4123.341, 4123.342, 4123.40, 4123.411, 4123.44, and 4123.442, and 1541
divisions (B), (C), and (E) of section 4131.14 of the Revised 1542
Code. 1543

(2) "Agency" also means any official or work unit having 1544
authority to promulgate rules or make adjudications in the 1545
department of job and family services, but only with respect to 1546
both of the following: 1547

(a) The adoption, amendment, or rescission of rules that 1548
section 5101.09 of the Revised Code requires be adopted in 1549
accordance with this chapter; 1550

(b) The issuance, suspension, revocation, or cancellation of 1551
licenses. 1552

(B) "License" means any license, permit, certificate, 1553
commission, or charter issued by any agency. "License" does not 1554
include any arrangement whereby a person, institution, or entity 1555
furnishes medicaid services under a provider agreement with the 1556
department of ~~job and family services pursuant to Title XIX of the~~ 1557
~~"Social Security Act," 49 Stat. 620 (1935), 42 U.S.C. 301, as~~ 1558
~~amended~~ health care administration. 1559

(C) "Rule" means any rule, regulation, or standard, having a 1560
general and uniform operation, adopted, promulgated, and enforced 1561
by any agency under the authority of the laws governing such 1562
agency, and includes any appendix to a rule. "Rule" does not 1563
include any internal management rule of an agency unless the 1564
internal management rule affects private rights and does not 1565
include any guideline adopted pursuant to section 3301.0714 of the 1566
Revised Code. 1567

(D) "Adjudication" means the determination by the highest or 1568
ultimate authority of an agency of the rights, duties, privileges, 1569
benefits, or legal relationships of a specified person, but does 1570

not include the issuance of a license in response to an 1571
application with respect to which no question is raised, nor other 1572
acts of a ministerial nature. 1573

(E) "Hearing" means a public hearing by any agency in 1574
compliance with procedural safeguards afforded by sections 119.01 1575
to 119.13 of the Revised Code. 1576

(F) "Person" means a person, firm, corporation, association, 1577
or partnership. 1578

(G) "Party" means the person whose interests are the subject 1579
of an adjudication by an agency. 1580

(H) "Appeal" means the procedure by which a person, aggrieved 1581
by a finding, decision, order, or adjudication of any agency, 1582
invokes the jurisdiction of a court. 1583

(I) "Rule-making agency" means any board, commission, 1584
department, division, or bureau of the government of the state 1585
that is required to file proposed rules, amendments, or 1586
rescissions under division (D) of section 111.15 of the Revised 1587
Code and any agency that is required to file proposed rules, 1588
amendments, or rescissions under divisions (B) and (H) of section 1589
119.03 of the Revised Code. "Rule-making agency" includes the 1590
public utilities commission. "Rule-making agency" does not include 1591
any state-supported college or university. 1592

(J) "Substantive revision" means any addition to, elimination 1593
from, or other change in a rule, an amendment of a rule, or a 1594
rescission of a rule, whether of a substantive or procedural 1595
nature, that changes any of the following: 1596

(1) That which the rule, amendment, or rescission permits, 1597
authorizes, regulates, requires, prohibits, penalizes, rewards, or 1598
otherwise affects; 1599

(2) The scope or application of the rule, amendment, or 1600

rescission. 1601

(K) "Internal management rule" means any rule, regulation, or 1602
standard governing the day-to-day staff procedures and operations 1603
within an agency. 1604

Sec. 121.02. The following administrative departments and 1605
their respective directors are hereby created: 1606

(A) The office of budget and management, which shall be 1607
administered by the director of budget and management; 1608

(B) The department of commerce, which shall be administered 1609
by the director of commerce; 1610

(C) The department of administrative services, which shall be 1611
administered by the director of administrative services; 1612

(D) The department of transportation, which shall be 1613
administered by the director of transportation; 1614

(E) The department of agriculture, which shall be 1615
administered by the director of agriculture; 1616

(F) The department of natural resources, which shall be 1617
administered by the director of natural resources; 1618

(G) The department of health, which shall be administered by 1619
the director of health; 1620

(H) The department of job and family services, which shall be 1621
administered by the director of job and family services; 1622

(I) Until July 1, 1997, the department of liquor control, 1623
which shall be administered by the director of liquor control; 1624

(J) The department of public safety, which shall be 1625
administered by the director of public safety; 1626

(K) The department of mental health, which shall be 1627
administered by the director of mental health; 1628

(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;	1658
(C) The director of transportation;	1659
(D) The director of agriculture;	1660
(E) The director of job and family services;	1661
(F) Until July 1, 1997, the director of liquor control;	1662
(G) The director of public safety;	1663
(H) The superintendent of insurance;	1664
(I) The director of development;	1665
(J) The tax commissioner;	1666
(K) The director of administrative services;	1667
(L) The director of natural resources;	1668
(M) The director of mental health;	1669
(N) The director of mental retardation and developmental disabilities;	1670 1671
(O) The director of health;	1672
(P) The director of youth services;	1673
(Q) The director of rehabilitation and correction;	1674
(R) The director of environmental protection;	1675
(S) The director of aging;	1676
(T) The director of alcohol and drug addiction services;	1677
(U) The administrator of workers' compensation who meets the qualifications required under division (A) of section 4121.121 of the Revised Code.	1678 1679 1680
<u>(V) The director of health care administration.</u>	1681
Sec. 122.15. As used in sections 122.15 to 122.154 of the Revised Code:	1682 1683

(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	1715
or harvesting trees;	1716
(4) Any business involving the production or extraction of	1717
products of a character with respect to which a deduction is	1718
allowable under section 611, 613, or 613A of the "Internal Revenue	1719
Code of 1986," 100 Stat. 2085, 26 U.S.C.A. 611, 613, or 613A;	1720
(5) Any business of operating a hotel, motel, restaurant, or	1721
similar business;	1722
(6) Any trade or business involving a hospital, a private	1723
office of a licensed health care professional, a group practice of	1724
licensed health care professionals, or a nursing home. As used in	1725
division (C)(6) of this section:	1726
(a) "Nursing home" has the same meaning as in section 3721.50	1727
<u>5166.20</u> of the Revised Code.	1728
(b) "Hospital" has the same meaning as in section 3727.01 of	1729
the Revised Code.	1730
(D) "Information technology" means the branch of technology	1731
devoted to the study and application of data and the processing	1732
thereof; the automatic acquisition, storage, manipulation or	1733
transformation, management, movement, control, display, switching,	1734
interchange, transmission or reception of data, and the	1735
development or use of hardware, software, firmware, and procedures	1736
associated with this processing. Information technology includes	1737
matters concerned with the furtherance of computer science and	1738
technology, design, development, installation and implementation	1739
of information systems and applications that in turn will be	1740
licensed or sold to a specific target market. Information	1741
technology does not include the creation of a distribution method	1742
for existing products and services.	1743
(E) "Insider" means an individual who owns, controls, or	1744
holds power to vote five per cent or more of the outstanding	1745

securities of a business. For purposes of determining whether an 1746
investor is an insider, the percentage of voting power in the Ohio 1747
entity held by a person related to the investor shall be added to 1748
the investor's percentage of voting power in the same Ohio entity, 1749
if the investor claimed the person related to the investor as a 1750
dependent or a spouse on the investor's federal income tax return 1751
for the previous tax year. 1752

(F) "Related to" means being the spouse, parent, child, or 1753
sibling of an individual. 1754

(G) "Research and development" means designing, creating, or 1755
formulating new or enhanced products, equipment, or processes, and 1756
conducting scientific or technological inquiry and experimentation 1757
in the physical sciences with the goal of increasing scientific 1758
knowledge that may reveal the bases for new or enhanced products, 1759
equipment, or processes. 1760

(H) "State tax liability" means any tax liability incurred 1761
under division (D) of section 5707.03, section 5727.24, 5727.38, 1762
or 5747.02, or Chapter 5733. of the Revised Code. 1763

(I) "Technology transfer" means the transfer of technology 1764
from one sector of the economy to another, including the transfer 1765
of military technology to civilian applications, civilian 1766
technology to military applications, or technology from public or 1767
private research laboratories to military or civilian 1768
applications. 1769

(J) "Affiliated group" means two or more persons related in 1770
such a way that one of the persons owns or controls the business 1771
operations of another of those persons. In the case of a 1772
corporation issuing capital stock, one corporation owns or 1773
controls the business operations of another corporation if it owns 1774
more than fifty per cent of the other corporation's capital stock 1775
with voting rights. In the case of a limited liability company, 1776

one person owns or controls the business operations of the company 1777
if that person's membership interest, as defined in section 1778
1705.01 of the Revised Code, is greater than fifty per cent of 1779
combined membership interest of all persons owning such interests 1780
in the company. In the case of an unincorporated business 1781
organization, one person owns or controls the business operations 1782
of the organization if, under the articles of organization or 1783
other instrument governing the affairs of the organization, that 1784
person has a beneficial interest in the organization's profits, 1785
surpluses, losses, or other distributions greater than fifty per 1786
cent of the combined beneficial interests of all persons having 1787
such an interest in the organization. 1788

(K) "Money" means United States currency, or a check, draft, 1789
or cashier's check for United States currency, payable on demand 1790
and drawn on a bank. 1791

(L) "EDGE business enterprise" means an Ohio entity certified 1792
by the director of administrative services as a participant in the 1793
encouraging diversity, growth, and equity program established by 1794
the governor's executive order 2002-17T. 1795

(M) "Distressed area" has the same meaning as in section 1796
122.23 of the Revised Code. 1797

Sec. 124.30. (A) Positions in the classified service may be 1798
filled without competition as follows: 1799

(1) Whenever there are urgent reasons for filling a vacancy 1800
in any position in the classified service and the director of 1801
administrative services is unable to certify to the appointing 1802
authority, upon its request, a list of persons eligible for 1803
appointment to the position after a competitive examination, the 1804
appointing authority may fill the position by noncompetitive 1805
examination. 1806

A temporary appointment may be made without regard to the 1807
rules of sections 124.01 to 124.64 of the Revised Code. Except as 1808
otherwise provided in this division, the temporary appointment may 1809
not continue longer than one hundred twenty days, and in no case 1810
shall successive temporary appointments be made. A temporary 1811
appointment longer than one hundred twenty days may be made if 1812
necessary by reason of sickness, disability, or other approved 1813
leave of absence of regular officers or employees, in which case 1814
it may continue during the period of sickness, disability, or 1815
other approved leave of absence, subject to the rules of the 1816
director. 1817

(2) In case of a vacancy in a position in the classified 1818
service where peculiar and exceptional qualifications of a 1819
scientific, managerial, professional, or educational character are 1820
required, and upon satisfactory evidence that for specified 1821
reasons competition in this special case is impracticable and that 1822
the position can best be filled by a selection of some designated 1823
person of high and recognized attainments in those qualities, the 1824
director may suspend the provisions of sections 124.01 to 124.64 1825
of the Revised Code that require competition in this special case, 1826
but no suspension shall be general in its application. All such 1827
cases of suspension shall be reported in the annual report of the 1828
director with the reasons for each suspension. The director shall 1829
suspend the provisions when the director of job and family 1830
services or director of health care administration provides the 1831
certification under section 5101.051 or 5160.05 of the Revised 1832
Code that a position with the department of job and family 1833
services or department of health care administration can best be 1834
filled if the provisions are suspended. 1835

(3) The acceptance or refusal by an eligible person of a 1836
temporary appointment shall not affect the person's standing on 1837
the eligible list for permanent appointment, nor shall the period 1838

of temporary service be counted as a part of the probationary 1839
service in case of subsequent appointment to a permanent position. 1840

(B) Persons who receive temporary or intermittent 1841
appointments are in the unclassified civil service and serve at 1842
the pleasure of their appointing authority. 1843

Sec. 124.301. The director of administrative services shall 1844
waive any residency requirement for the civil service established 1845
by a rule adopted under division (A) of section 124.09 of the 1846
Revised Code if the director of job and family services or 1847
director of health care administration provides the director 1848
certification under section 5101.051 or 5160.05 of the Revised 1849
Code that a position with the department of job and family 1850
services or department of health care administration can best be 1851
filled if the residency requirement is waived. 1852

Sec. 124.821. Each state agency shall pay the monthly 1853
enrollee premium for medical insurance coverage under Part B of 1854
~~"The Social Security Amendments of 1965," 79 Stat. 301, 42 U.S.C.~~ 1855
~~1395j, as amended,~~ the medicare program for state employees and 1856
elected state officials who are employed by or serve in the 1857
agency, are paid directly by warrant of the director of budget and 1858
management, are sixty-five years of age or older, and are 1859
participating in the medicare program ~~of health insurance for the~~ 1860
~~aged under Title XVIII of the "Social Security Act," 79 Stat. 286,~~ 1861
~~42 U.S.C. 1395, as amended.~~ The cost of the premiums shall not be 1862
deducted from any employee's or official's wage or salary. 1863

The director of administrative services shall uniformly 1864
administer this section and shall, by rule, establish procedures 1865
for carrying out such administration. 1866

Sec. 127.16. (A) Upon the request of either a state agency or 1867
the director of budget and management and after the controlling 1868

board determines that an emergency or a sufficient economic reason 1869
exists, the controlling board may approve the making of a purchase 1870
without competitive selection as provided in division (B) of this 1871
section. 1872

(B) Except as otherwise provided in this section, no state 1873
agency, using money that has been appropriated to it directly, 1874
shall: 1875

(1) Make any purchase from a particular supplier, that would 1876
amount to fifty thousand dollars or more when combined with both 1877
the amount of all disbursements to the supplier during the fiscal 1878
year for purchases made by the agency and the amount of all 1879
outstanding encumbrances for purchases made by the agency from the 1880
supplier, unless the purchase is made by competitive selection or 1881
with the approval of the controlling board; 1882

(2) Lease real estate from a particular supplier, if the 1883
lease would amount to seventy-five thousand dollars or more when 1884
combined with both the amount of all disbursements to the supplier 1885
during the fiscal year for real estate leases made by the agency 1886
and the amount of all outstanding encumbrances for real estate 1887
leases made by the agency from the supplier, unless the lease is 1888
made by competitive selection or with the approval of the 1889
controlling board. 1890

(C) Any person who authorizes a purchase in violation of 1891
division (B) of this section shall be liable to the state for any 1892
state funds spent on the purchase, and the attorney general shall 1893
collect the amount from the person. 1894

(D) Nothing in division (B) of this section shall be 1895
construed as: 1896

(1) A limitation upon the authority of the director of 1897
transportation as granted in sections 5501.17, 5517.02, and 1898
5525.14 of the Revised Code; 1899

(2) Applying to medicaid provider agreements under Chapter	1900
5111. <u>5163.</u> or <u>5164.</u> of the Revised Code or payments or provider	1901
agreements under the disability medical assistance program	1902
established under Chapter 5115. <u>5168.</u> of the Revised Code;	1903
(3) Applying to the purchase of examinations from a sole	1904
supplier by a state licensing board under Title XLVII of the	1905
Revised Code;	1906
(4) Applying to entertainment contracts for the Ohio state	1907
fair entered into by the Ohio expositions commission, provided	1908
that the controlling board has given its approval to the	1909
commission to enter into such contracts and has approved a total	1910
budget amount for such contracts as agreed upon by commission	1911
action, and that the commission causes to be kept itemized records	1912
of the amounts of money spent under each contract and annually	1913
files those records with the clerk of the house of representatives	1914
and the clerk of the senate following the close of the fair;	1915
(5) Limiting the authority of the chief of the division of	1916
mineral resources management to contract for reclamation work with	1917
an operator mining adjacent land as provided in section 1513.27 of	1918
the Revised Code;	1919
(6) Applying to investment transactions and procedures of any	1920
state agency, except that the agency shall file with the board the	1921
name of any person with whom the agency contracts to make, broker,	1922
service, or otherwise manage its investments, as well as the	1923
commission, rate, or schedule of charges of such person with	1924
respect to any investment transactions to be undertaken on behalf	1925
of the agency. The filing shall be in a form and at such times as	1926
the board considers appropriate.	1927
(7) Applying to purchases made with money for the per cent	1928
for arts program established by section 3379.10 of the Revised	1929
Code;	1930

- (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; 1931
1932
1933
1934
1935
1936
- (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; 1937
1938
1939
1940
- (10) Applying to any agency of the legislative branch of the state government; 1941
1942
- (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; 1943
1944
1945
- (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; 1946
1947
1948
1949
- (13) Applying to dues or fees paid for membership in an organization or association; 1950
1951
- (14) Applying to purchases of utility services pursuant to section 9.30 of the Revised Code; 1952
1953
- (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; 1954
1955
1956
1957
- (16) Applying to purchases of tickets for passenger air transportation; 1958
1959
- (17) Applying to purchases necessary to provide public 1960

notifications required by law or to provide notifications of job openings;	1961 1962
(18) Applying to the judicial branch of state government;	1963
(19) Applying to purchases of liquor for resale by the division of liquor control;	1964 1965
(20) Applying to purchases of motor courier and freight services made in accordance with department of administrative services rules;	1966 1967 1968
(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;	1969 1970 1971 1972
(22) Applying to purchases of books, periodicals, pamphlets, newspapers, maintenance subscriptions, and other published materials;	1973 1974 1975
(23) Applying to purchases from other state agencies, including state-assisted institutions of higher education;	1976 1977
(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;	1978 1979 1980 1981
(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;	1982 1983 1984
(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;	1985 1986 1987 1988 1989
(27) Applying to contracts entered into by the department of	1990

mental retardation and developmental disabilities under sections 5123.18, 5123.182, and 5123.199 of the Revised Code;	1991 1992
(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;	1993 1994 1995
(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.	1996 1997 1998 1999 2000 2001
(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;	2002 2003 2004 2005 2006
(31) Applying to the department of job and family services <u>health care administration's</u> 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;	2007 2008 2009 2010 2011 2012
(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;	2013 2014 2015 2016
(33) Applying to contracts with a contracting authority or administrative receiver under division (B) of section 5126.056 of the Revised Code;	2017 2018 2019
(34) Applying to reimbursements paid to the United States department of veterans affairs for pharmaceutical and patient	2020 2021

supply purchases made on behalf of the Ohio veterans' home agency; 2022

(35) Applying to agreements entered into with terminal 2023
distributors of dangerous drugs under section ~~173.79~~ 5169.09 of 2024
the Revised Code. 2025

(E) Notwithstanding division (B)(1) of this section, the 2026
cumulative purchase threshold shall be seventy-five thousand 2027
dollars for the departments of mental retardation and 2028
developmental disabilities, mental health, rehabilitation and 2029
correction, and youth services. 2030

(F) When determining whether a state agency has reached the 2031
cumulative purchase thresholds established in divisions (B)(1), 2032
(B)(2), and (E) of this section, all of the following purchases by 2033
such agency shall not be considered: 2034

(1) Purchases made through competitive selection or with 2035
controlling board approval; 2036

(2) Purchases listed in division (D) of this section; 2037

(3) For the purposes of the thresholds of divisions (B)(1) 2038
and (E) of this section only, leases of real estate. 2039

(G) As used in this section, "competitive selection," 2040
"purchase," "supplies," and "services" have the same meanings as 2041
in section 125.01 of the Revised Code. 2042

Sec. 131.23. The various political subdivisions of this state 2043
may issue bonds, and any indebtedness created by that issuance 2044
shall not be subject to the limitations or included in the 2045
calculation of indebtedness prescribed by sections 133.05, 133.06, 2046
133.07, and 133.09 of the Revised Code, but the bonds may be 2047
issued only under the following conditions: 2048

(A) The subdivision desiring to issue the bonds shall obtain 2049
from the county auditor a certificate showing the total amount of 2050
delinquent taxes due and unpayable to the subdivision at the last 2051

semiannual tax settlement. 2052

(B) The fiscal officer of that subdivision shall prepare a 2053
statement, from the books of the subdivision, verified by the 2054
fiscal officer under oath, which shall contain the following facts 2055
of the subdivision: 2056

(1) The total bonded indebtedness; 2057

(2) The aggregate amount of notes payable or outstanding 2058
accounts of the subdivision, incurred prior to the commencement of 2059
the current fiscal year, which shall include all evidences of 2060
indebtedness issued by the subdivision except notes issued in 2061
anticipation of bond issues and the indebtedness of any 2062
nontax-supported public utility; 2063

(3) Except in the case of school districts, the aggregate 2064
current year's requirement for disability financial assistance ~~and~~ 2065
~~disability medical assistance~~ provided under Chapter ~~5115~~. 5168. 2066
of the Revised Code and the disability medical assistance program 2067
that the subdivision is unable to finance except by the issue of 2068
bonds; 2069

(4) The indebtedness outstanding through the issuance of any 2070
bonds or notes pledged or obligated to be paid by any delinquent 2071
taxes; 2072

(5) The total of any other indebtedness; 2073

(6) The net amount of delinquent taxes unpledged to pay any 2074
bonds, notes, or certificates, including delinquent assessments on 2075
improvements on which the bonds have been paid; 2076

(7) The budget requirements for the fiscal year for bond and 2077
note retirement; 2078

(8) The estimated revenue for the fiscal year. 2079

(C) The certificate and statement provided for in divisions 2080
(A) and (B) of this section shall be forwarded to the tax 2081

commissioner together with a request for authority to issue bonds 2082
of the subdivision in an amount not to exceed seventy per cent of 2083
the net unobligated delinquent taxes and assessments due and owing 2084
to the subdivision, as set forth in division (B)(6) of this 2085
section. 2086

(D) No subdivision may issue bonds under this section in 2087
excess of a sufficient amount to pay the indebtedness of the 2088
subdivision as shown by division (B)(2) of this section and, 2089
except in the case of school districts, to provide funds for 2090
disability financial assistance and disability medical assistance, 2091
as shown by division (B)(3) of this section. 2092

(E) The tax commissioner shall grant to the subdivision 2093
authority requested by the subdivision as restricted by divisions 2094
(C) and (D) of this section and shall make a record of the 2095
certificate, statement, and grant in a record book devoted solely 2096
to such recording and which shall be open to inspection by the 2097
public. 2098

(F) The commissioner shall immediately upon issuing the 2099
authority provided in division (E) of this section notify the 2100
proper authority having charge of the retirement of bonds of the 2101
subdivision by forwarding a copy of the grant of authority and of 2102
the statement provided for in division (B) of this section. 2103

(G) Upon receipt of authority, the subdivision shall proceed 2104
according to law to issue the amount of bonds authorized by the 2105
commissioner, and authorized by the taxing authority, provided the 2106
taxing authority of that subdivision may submit, by resolution, to 2107
the electors of that subdivision the question of issuing the 2108
bonds. The resolution shall make the declarations and statements 2109
required by section 133.18 of the Revised Code. The county auditor 2110
and taxing authority shall thereupon proceed as set forth in 2111
divisions (C) and (D) of that section. The election on the 2112
question of issuing the bonds shall be held under divisions (E), 2113

(F), and (G) of that section, except that publication of the 2114
notice of the election shall be made on two separate days prior to 2115
the election in one or more newspapers of general circulation in 2116
the subdivision, and, if the board of elections operates and 2117
maintains a web site, notice of the election also shall be posted 2118
on that web site for thirty days prior to the election. The bonds 2119
may be exchanged at their face value with creditors of the 2120
subdivision in liquidating the indebtedness described and 2121
enumerated in division (B)(2) of this section or may be sold as 2122
provided in Chapter 133. of the Revised Code, and in either event 2123
shall be uncontestable. 2124

(H) The per cent of delinquent taxes and assessments 2125
collected for and to the credit of the subdivision after the 2126
exchange or sale of bonds as certified by the commissioner shall 2127
be paid to the authority having charge of the sinking fund of the 2128
subdivision, which money shall be placed in a separate fund for 2129
the purpose of retiring the bonds so issued. The proper authority 2130
of the subdivisions shall provide for the levying of a tax 2131
sufficient in amount to pay the debt charges on all such bonds 2132
issued under this section. 2133

(I) This section is for the sole purpose of assisting the 2134
various subdivisions in paying their unsecured indebtedness, and 2135
providing funds for disability financial assistance and the 2136
disability medical assistance program. The bonds issued under 2137
authority of this section shall not be used for any other purpose, 2138
and any exchange for other purposes, or the use of the money 2139
derived from the sale of the bonds by the subdivision for any 2140
other purpose, is misapplication of funds. 2141

(J) The bonds authorized by this section shall be redeemable 2142
or payable in not to exceed ten years from date of issue and shall 2143
not be subject to or considered in calculating the net 2144
indebtedness of the subdivision. The budget commission of the 2145

county in which the subdivision is located shall annually allocate 2146
such portion of the then delinquent levy due the subdivision which 2147
is unpledged for other purposes to the payment of debt charges on 2148
the bonds issued under authority of this section. 2149

(K) The issue of bonds under this section shall be governed 2150
by Chapter 133. of the Revised Code, respecting the terms used, 2151
forms, manner of sale, and redemption except as otherwise provided 2152
in this section. 2153

The board of county commissioners of any county may issue 2154
bonds authorized by this section and distribute the proceeds of 2155
the bond issues to any or all of the cities and townships of the 2156
county, according to their relative needs for disability financial 2157
assistance and the disability medical assistance program as 2158
determined by the county. 2159

All sections of the Revised Code inconsistent with or 2160
prohibiting the exercise of the authority conferred by this 2161
section are inoperative respecting bonds issued under this 2162
section. 2163

Sec. 145.27. (A)(1) As used in this division, "personal 2164
history record" means information maintained by the public 2165
employees retirement board on an individual who is a member, 2166
former member, contributor, former contributor, retirant, or 2167
beneficiary that includes the address, telephone number, social 2168
security number, record of contributions, correspondence with the 2169
public employees retirement system, or other information the board 2170
determines to be confidential. 2171

(2) The records of the board shall be open to public 2172
inspection, except that the following shall be excluded, except 2173
with the written authorization of the individual concerned: 2174

(a) The individual's statement of previous service and other 2175

information as provided for in section 145.16 of the Revised Code;	2176
(b) The amount of a monthly allowance or benefit paid to the individual;	2177 2178
(c) The individual's personal history record.	2179
(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.	2180 2181 2182 2183 2184 2185 2186
(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.	2187 2188 2189 2190 2191 2192
(D) Notwithstanding the exceptions to public inspection in division (A)(2) of this section, the board may furnish the following information:	2193 2194 2195
(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.	2196 2197 2198 2199 2200 2201 2202 2203
(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	2204 2205 2206

enforcement agency the information required under that section. 2207

(3) At the written request of any person, the board shall 2208
provide to the person a list of the names and addresses of 2209
members, former members, contributors, former contributors, 2210
retirants, or beneficiaries. The costs of compiling, copying, and 2211
mailing the list shall be paid by such person. 2212

(4) Within fourteen days after receiving ~~from the director of~~ 2213
~~job and family services~~ a list of the names and social security 2214
numbers of recipients of public assistance pursuant to section 2215
5101.181 of the Revised Code or a list of the names and social 2216
security numbers of public medical assistance recipients pursuant 2217
to section 5160.43 of the Revised Code, the board shall inform the 2218
auditor of state of the name, current or most recent employer 2219
address, and social security number of each member whose name and 2220
social security number are the same as that of a person whose name 2221
or social security number ~~was submitted by the director~~ is 2222
included on the list. The board and its employees shall, except 2223
for purposes of furnishing the auditor of state with information 2224
required by this section, preserve the confidentiality of 2225
recipients of public assistance in compliance with ~~division (A) of~~ 2226
section 5101.181 of the Revised Code and preserve the 2227
confidentiality of public medical assistance recipients with 2228
section 5160.43 of the Revised Code. 2229

(5) The system shall comply with orders issued under section 2230
3105.87 of the Revised Code. 2231

On the written request of an alternate payee, as defined in 2232
section 3105.80 of the Revised Code, the system shall furnish to 2233
the alternate payee information on the amount and status of any 2234
amounts payable to the alternate payee under an order issued under 2235
section 3105.171 or 3105.65 of the Revised Code. 2236

(6) At the request of any person, the board shall make 2237

available to the person copies of all documents, including 2238
resumes, in the board's possession regarding filling a vacancy of 2239
an employee member or retirant member of the board. The person who 2240
made the request shall pay the cost of compiling, copying, and 2241
mailing the documents. The information described in this division 2242
is a public record. 2243

(E) A statement that contains information obtained from the 2244
system's records that is signed by the executive director or an 2245
officer of the system and to which the system's official seal is 2246
affixed, or copies of the system's records to which the signature 2247
and seal are attached, shall be received as true copies of the 2248
system's records in any court or before any officer of this state. 2249

Sec. 145.58. (A) As used in this section, "ineligible 2250
individual" means all of the following: 2251

(1) A former member receiving benefits pursuant to section 2252
145.32, 145.33, 145.331, 145.34, or 145.46 of the Revised Code for 2253
whom eligibility is established more than five years after June 2254
13, 1981, and who, at the time of establishing eligibility, has 2255
accrued less than ten years' service credit, exclusive of credit 2256
obtained pursuant to section 145.297 or 145.298 of the Revised 2257
Code, credit obtained after January 29, 1981, pursuant to section 2258
145.293 or 145.301 of the Revised Code, and credit obtained after 2259
May 4, 1992, pursuant to section 145.28 of the Revised Code; 2260

(2) The spouse of the former member; 2261

(3) The beneficiary of the former member receiving benefits 2262
pursuant to section 145.46 of the Revised Code. 2263

(B) The public employees retirement board may enter into 2264
agreements with insurance companies, health insuring corporations, 2265
or government agencies authorized to do business in the state for 2266
issuance of a policy or contract of health, medical, hospital, or 2267

surgical benefits, or any combination thereof, for those 2268
individuals receiving age and service retirement or a disability 2269
or survivor benefit subscribing to the plan, or for PERS retirants 2270
employed under section 145.38 of the Revised Code, for coverage of 2271
benefits in accordance with division (D)(2) of section 145.38 of 2272
the Revised Code. Notwithstanding any other provision of this 2273
chapter, the policy or contract may also include coverage for any 2274
eligible individual's spouse and dependent children and for any of 2275
the individual's sponsored dependents as the board determines 2276
appropriate. If all or any portion of the policy or contract 2277
premium is to be paid by any individual receiving age and service 2278
retirement or a disability or survivor benefit, the individual 2279
shall, by written authorization, instruct the board to deduct the 2280
premium agreed to be paid by the individual to the company, 2281
corporation, or agency. 2282

The board may contract for coverage on the basis of part or 2283
all of the cost of the coverage to be paid from appropriate funds 2284
of the public employees retirement system. The cost paid from the 2285
funds of the system shall be included in the employer's 2286
contribution rate provided by sections 145.48 and 145.51 of the 2287
Revised Code. The board may by rule provide coverage to ineligible 2288
individuals if the coverage is provided at no cost to the 2289
retirement system. The board shall not pay or reimburse the cost 2290
for coverage under this section or section 145.325 of the Revised 2291
Code for any ineligible individual. 2292

The board may provide for self-insurance of risk or level of 2293
risk as set forth in the contract with the companies, 2294
corporations, or agencies, and may provide through the 2295
self-insurance method specific benefits as authorized by rules of 2296
the board. 2297

(C) The board shall, beginning the month following receipt of 2298
satisfactory evidence of the payment for coverage, pay monthly to 2299

each recipient of service retirement, or a disability or survivor 2300
benefit under the public employees retirement system who is 2301
eligible for medical insurance coverage under part B of ~~Title~~ 2302
~~XVIII of "The Social Security Act," 79 Stat. 301 (1965), 42~~ 2303
~~U.S.C.A. 1395j, as amended~~ the medicare program, an amount equal 2304
to the basic premium for such coverage, except that the board 2305
shall make no such payment to any ineligible individual. 2306

(D) The board shall establish by rule requirements for the 2307
coordination of any coverage, payment, or benefit provided under 2308
this section or section 145.325 of the Revised Code with any 2309
similar coverage, payment, or benefit made available to the same 2310
individual by the Ohio police and fire pension fund, state 2311
teachers retirement system, school employees retirement system, or 2312
state highway patrol retirement system. 2313

(E) The board shall make all other necessary rules pursuant 2314
to the purpose and intent of this section. 2315

Sec. 149.431. (A) Any governmental entity or agency and any 2316
nonprofit corporation or association, except a corporation 2317
organized pursuant to Chapter 1719. of the Revised Code prior to 2318
January 1, 1980 or organized pursuant to Chapter 3941. of the 2319
Revised Code, that enters into a contract or other agreement with 2320
the federal government, a unit of state government, or a political 2321
subdivision or taxing unit of this state for the provision of 2322
services shall keep accurate and complete financial records of any 2323
moneys expended in relation to the performance of the services 2324
pursuant to such contract or agreement according to generally 2325
accepted accounting principles. Such contract or agreement and 2326
such financial records shall be deemed to be public records as 2327
defined in division (A)(1) of section 149.43 of the Revised Code 2328
and are subject to the requirements of division (B) of that 2329
section, except that: 2330

(1) Any information directly or indirectly identifying a 2331
present or former individual patient or client or ~~his~~ such an 2332
individual patient's or client's diagnosis, prognosis, or medical 2333
treatment, treatment for a mental or emotional disorder, treatment 2334
for mental retardation or a developmental disability, treatment 2335
for drug abuse or alcoholism, or counseling for personal or social 2336
problems is not a public record; 2337

(2) If disclosure of the contract or agreement or financial 2338
records is requested at a time when confidential professional 2339
services are being provided to a patient or client whose 2340
confidentiality might be violated if disclosure were made at that 2341
time, disclosure may be deferred if reasonable times are 2342
established when the contract or agreement or financial records 2343
will be disclosed. 2344

(3) Any nonprofit corporation or association that receives 2345
both public and private funds in fulfillment of any such contract 2346
or other agreement is not required to keep as public records the 2347
financial records of any private funds expended in relation to the 2348
performance of services pursuant to the contract or agreement. 2349

(B) Any nonprofit corporation or association that receives 2350
more than fifty per cent of its gross receipts excluding moneys 2351
received pursuant to ~~Title XVIII of the "Social Security Act," 49~~ 2352
~~Stat. 620 (1935), 42 U.S.C. 301, as amended~~ medicare program, in a 2353
calendar year in fulfillment of a contract or other agreement for 2354
services with a governmental entity shall maintain information 2355
setting forth the compensation of any individual serving the 2356
nonprofit corporation or association in an executive or 2357
administrative capacity. Such information shall be deemed to be 2358
public records as defined in division (A)(1) of section 149.43 of 2359
the Revised Code and is subject to the requirements of division 2360
(B) of that section. 2361

Nothing in this section shall be construed to otherwise limit 2362

the provisions of section 149.43 of the Revised Code. 2363

Sec. 169.02. Subject to division (B) of section 169.01 of the 2364
Revised Code, the following constitute unclaimed funds: 2365

(A) Except as provided in division (R) of this section, any 2366
demand, savings, or matured time deposit account, or matured 2367
certificate of deposit, together with any interest or dividend on 2368
it, less any lawful claims, that is held or owed by a holder which 2369
is a financial organization, unclaimed for a period of five years; 2370

(B) Any funds paid toward the purchase of withdrawable shares 2371
or other interest in a financial organization, and any interest or 2372
dividends on them, less any lawful claims, that is held or owed by 2373
a holder which is a financial organization, unclaimed for a period 2374
of five years; 2375

(C) Except as provided in division (A) of section 3903.45 of 2376
the Revised Code, moneys held or owed by a holder, including a 2377
fraternal association, providing life insurance, including annuity 2378
or endowment coverage, unclaimed for three years after becoming 2379
payable as established from the records of such holder under any 2380
life or endowment insurance policy or annuity contract that has 2381
matured or terminated. An insurance policy, the proceeds of which 2382
are payable on the death of the insured, not matured by proof of 2383
death of the insured is deemed matured and the proceeds payable if 2384
such policy was in force when the insured attained the limiting 2385
age under the mortality table on which the reserve is based. 2386

Moneys otherwise payable according to the records of such 2387
holder are deemed payable although the policy or contract has not 2388
been surrendered as required. 2389

(D) Any deposit made to secure payment or any sum paid in 2390
advance for utility services of a public utility and any amount 2391
refundable from rates or charges collected by a public utility for 2392

utility services held or owed by a holder, less any lawful claims, 2393
that has remained unclaimed for one year after the termination of 2394
the services for which the deposit or advance payment was made or 2395
one year from the date the refund was payable, whichever is 2396
earlier; 2397

(E) Except as provided in division (R) of this section, any 2398
certificates, securities as defined in section 1707.01 of the 2399
Revised Code, nonwithdrawable shares, other instruments evidencing 2400
ownership, or rights to them or funds paid toward the purchase of 2401
them, or any dividend, capital credit, profit, distribution, 2402
interest, or payment on principal or other sum, held or owed by a 2403
holder, including funds deposited with a fiscal agent or fiduciary 2404
for payment of them, and instruments representing an ownership 2405
interest, unclaimed for five years. Any underlying share or other 2406
intangible instrument representing an ownership interest in a 2407
business association, in which the issuer has recorded on its 2408
books the issuance of the share but has been unable to deliver the 2409
certificate to the shareholder, constitutes unclaimed funds if 2410
such underlying share is unclaimed for five years. In addition, an 2411
underlying share constitutes unclaimed funds if a dividend, 2412
distribution, or other sum payable as a result of the underlying 2413
share has remained unclaimed by the owner for five years. 2414

This division shall not prejudice the rights of fiscal agents 2415
or fiduciaries for payment to return the items described in this 2416
division to their principals, according to the terms of an agency 2417
or fiduciary agreement, but such a return shall constitute the 2418
principal as the holder of the items and shall not interrupt the 2419
period for computing the time for which the items have remained 2420
unclaimed. 2421

In the case of any such funds accruing and held or owed by a 2422
corporation under division (E) of section 1701.24 of the Revised 2423
Code, such corporation shall comply with this chapter, subject to 2424

the limitation contained in section 1701.34 of the Revised Code. 2425
The period of time for which such funds have gone unclaimed 2426
specified in section 1701.34 of the Revised Code shall be 2427
computed, with respect to dividends or distributions, commencing 2428
as of the dates when such dividends or distributions would have 2429
been payable to the shareholder had such shareholder surrendered 2430
the certificates for cancellation and exchange by the date 2431
specified in the order relating to them. 2432

Capital credits of a cooperative which after January 1, 1972, 2433
have been allocated to members and which by agreement are 2434
expressly required to be paid if claimed after death of the owner 2435
are deemed payable, for the purpose of this chapter, fifteen years 2436
after either the termination of service by the cooperative to the 2437
owner or upon the nonactivity as provided in division (B) of 2438
section 169.01 of the Revised Code, whichever occurs later, 2439
provided that this provision does not apply if the payment is not 2440
mandatory. 2441

(F) Any sum payable on certified checks or other written 2442
instruments certified or issued and representing funds held or 2443
owed by a holder, less any lawful claims, that are unclaimed for 2444
five years from the date payable or from the date of issuance if 2445
payable on demand; except that the unclaimed period for money 2446
orders that are not third party bank checks is seven years, and 2447
the unclaimed period for traveler's checks is fifteen years, from 2448
the date payable or from the date of issuance if payable on 2449
demand. 2450

As used in this division, "written instruments" include, but 2451
are not limited to, certified checks, cashier's checks, bills of 2452
exchange, letters of credit, drafts, money orders, and traveler's 2453
checks. 2454

If there is no address of record for the owner or other 2455
person entitled to the funds, such address is presumed to be the 2456

address where the instrument was certified or issued. 2457

(G) Except as provided in division (R) of this section, all 2458
moneys, rights to moneys, or other intangible property, arising 2459
out of the business of engaging in the purchase or sale of 2460
securities, or otherwise dealing in intangibles, less any lawful 2461
claims, that are held or owed by a holder and are unclaimed for 2462
five years from the date of transaction. 2463

(H) Except as provided in division (A) of section 3903.45 of 2464
the Revised Code, all moneys, rights to moneys, and other 2465
intangible property distributable in the course of dissolution or 2466
liquidation of a holder that are unclaimed for one year after the 2467
date set by the holder for distribution; 2468

(I) All moneys, rights to moneys, or other intangible 2469
property removed from a safe-deposit box or other safekeeping 2470
repository located in this state or removed from a safe-deposit 2471
box or other safekeeping repository of a holder, on which the 2472
lease or rental period has expired, or any amount arising from the 2473
sale of such property, less any lawful claims, that are unclaimed 2474
for three years from the date on which the lease or rental period 2475
expired; 2476

(J) Subject to division (M)(2) of this section, all moneys, 2477
rights to moneys, or other intangible property, and any income or 2478
increment on them, held or owed by a holder which is a fiduciary 2479
for the benefit of another, or a fiduciary or custodian of a 2480
qualified retirement plan or individual retirement arrangement 2481
under section 401 or 408 of the Internal Revenue Code, unclaimed 2482
for three years after the final date for distribution; 2483

(K) All moneys, rights to moneys, or other intangible 2484
property held or owed in this state or held for or owed to an 2485
owner whose last known address is within this state, by the United 2486
States government or any state, as those terms are described in 2487

division (E) of section 169.01 of the Revised Code, unclaimed by 2488
the owner for three years, excluding any property in the control 2489
of any court in a proceeding in which a final adjudication has not 2490
been made; 2491

(L) Amounts payable pursuant to the terms of any policy of 2492
insurance, other than life insurance, or any refund available 2493
under such a policy, held or owed by any holder, unclaimed for 2494
three years from the date payable or distributable; 2495

(M)(1) Subject to division (M)(2) of this section, any funds 2496
constituting rents or lease payments due, any deposit made to 2497
secure payment of rents or leases, or any sum paid in advance for 2498
rents, leases, possible damage to property, unused services, 2499
performance requirements, or any other purpose, held or owed by a 2500
holder unclaimed for one year; 2501

(2) Any escrow funds, security deposits, or other moneys that 2502
are received by a licensed broker in a fiduciary capacity and 2503
that, pursuant to division (A)(26) of section 4735.18 of the 2504
Revised Code, are required to be deposited into and maintained in 2505
a special or trust, noninterest-bearing bank account separate and 2506
distinct from any personal or other account of the licensed 2507
broker, held or owed by the licensed broker unclaimed for two 2508
years. 2509

(N) Any sum greater than fifty dollars payable as wages, any 2510
sum payable as salaries or commissions, any sum payable for 2511
services rendered, funds owed or held as royalties, oil and 2512
mineral proceeds, funds held for or owed to suppliers, and moneys 2513
owed under pension and profit-sharing plans, held or owed by any 2514
holder unclaimed for one year from date payable or distributable, 2515
and all other credits held or owed, or to be refunded to a retail 2516
customer, by any holder unclaimed for three years from date 2517
payable or distributable; 2518

(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;	2519 2520 2521
(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;	2522 2523 2524 2525 2526 2527 2528
(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.	2529 2530 2531 2532 2533
(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.	2534 2535 2536 2537 2538 2539 2540 2541
(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.	2542 2543 2544 2545 2546 2547
All moneys in a personal allowance account, as defined by rules adopted by the director of job and family services <u>health</u>	2548 2549

care administration, up to and including the maximum resource 2550
limitation, of a medicaid patient who has died after receiving 2551
care in a long-term care facility, and for whom there is no 2552
identifiable heir or sponsor, are not subject to this chapter. 2553

Sec. 173.14. As used in sections 173.14 to 173.27 of the 2554
Revised Code: 2555

(A)(1) Except as otherwise provided in division (A)(2) of 2556
this section, "long-term care facility" includes any residential 2557
facility that provides personal care services for more than 2558
twenty-four hours for two or more unrelated adults, including all 2559
of the following: 2560

(a) A "nursing home," "residential care facility," or "home 2561
for the aging" as defined in section 3721.01 of the Revised Code; 2562

(b) A facility authorized to provide extended care services 2563
under ~~Title XVIII of the "Social Security Act," 49 Stat. 620~~ 2564
~~(1935), 42 U.S.C. 301, as amended~~ medicare program; 2565

(c) A county home or district home operated pursuant to 2566
Chapter 5155. of the Revised Code; 2567

(d) An "adult care facility" as defined in section 3722.01 of 2568
the Revised Code; 2569

(e) A facility approved by the veterans administration under 2570
section 104(a) of the "Veterans Health Care Amendments of 1983," 2571
97 Stat. 993, 38 U.S.C. 630, as amended, and used exclusively for 2572
the placement and care of veterans; 2573

(f) An adult foster home certified under section 173.36 of 2574
the Revised Code. 2575

(2) "Long-term care facility" does not include a "residential 2576
facility" as defined in section 5119.22 of the Revised Code or a 2577
"residential facility" as defined in section 5123.19 of the 2578
Revised Code. 2579

(B) "Resident" means a resident of a long-term care facility 2580
and, where appropriate, includes a prospective, previous, or 2581
deceased resident of a long-term care facility. 2582

(C) "Community-based long-term care services" means health 2583
and social services provided to persons in their own homes or in 2584
community care settings, and includes any of the following: 2585

(1) Case management; 2586

(2) Home health care; 2587

(3) Homemaker services; 2588

(4) Chore services; 2589

(5) Respite care; 2590

(6) Adult day care; 2591

(7) Home-delivered meals; 2592

(8) Personal care; 2593

(9) Physical, occupational, and speech therapy; 2594

(10) Transportation; 2595

(11) Any other health and social services provided to persons 2596
that allow them to retain their independence in their own homes or 2597
in community care settings. 2598

(D) "Recipient" means a recipient of community-based 2599
long-term care services and, where appropriate, includes a 2600
prospective, previous, or deceased recipient of community-based 2601
long-term care services. 2602

(E) "Sponsor" means an adult relative, friend, or guardian 2603
who has an interest in or responsibility for the welfare of a 2604
resident or a recipient. 2605

(F) "Personal care services" has the same meaning as in 2606
section 3721.01 of the Revised Code. 2607

(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 2669
procedures of a facility required to be maintained under section 2670
~~5111.21~~ 5164.02 of the Revised Code, admission agreements, 2671
staffing schedules, any document depicting the actual staffing 2672
pattern of the provider, any financial records that are matters of 2673
public record, resident council and grievance committee minutes, 2674
and any waiting list maintained by a facility in accordance with 2675
section ~~5111.31~~ 5164.033 of the Revised Code, or any similar 2676
records or lists maintained by a provider of community-based 2677
long-term care services. Pursuant to division (E)(2) of this 2678
section, a representative shall be permitted to make or obtain 2679
copies of any of these records after giving the long-term care 2680
provider twenty-four hours' notice. A long-term care provider may 2681
impose a charge for providing copies of records under this 2682
division that does not exceed the actual and necessary expense of 2683
making the copies. 2684

The state ~~ombudsman~~ ombudsperson shall take whatever action 2685
is necessary to ensure that any copy of a record made or obtained 2686
under this division is returned to the long-term care provider no 2687
later than three years after the date the investigation for which 2688
the copy was made or obtained is completed. 2689

(E)(1) Each long-term care provider shall designate one or 2690
more of its employees to be responsible for witnessing the giving 2691
of oral consent under division (A) of this section. In the event 2692
that a designated employee is not available when a resident or 2693
recipient attempts to give oral consent, the provider shall 2694
designate another employee to witness the consent. 2695

(2) Each long-term care provider shall designate one or more 2696
of its employees to be responsible for releasing records for 2697
copying to representatives of the office of the long-term care 2698
~~ombudsman~~ ombudsperson program who request permission to make or 2699
obtain copies of records specified in division (D) of this 2700

section. In the event that a designated employee is not available 2701
when a representative of the office makes the request, the 2702
long-term care provider shall designate another employee to 2703
release the records for copying. 2704

(F) A long-term care provider or any employee of such a 2705
provider is immune from civil or criminal liability or action 2706
taken pursuant to a professional disciplinary procedure for the 2707
release or disclosure of records to a representative of the office 2708
pursuant to this section. 2709

(G) A state or local government agency or entity with records 2710
relevant to a complaint or investigation being conducted by a 2711
representative of the office shall provide the representative 2712
access to the records. 2713

(H) The state ~~ombudsman~~ ombudsperson, with the approval of 2714
the director of aging, may issue a subpoena to compel any person 2715
~~he~~ the ombudsperson reasonably believes may be able to provide 2716
information to appear before ~~him~~ the ombudsperson or ~~his~~ the 2717
ombudsperson's designee and give sworn testimony and to produce 2718
documents, books, records, papers, or other evidence the state 2719
~~ombudsman~~ ombudsperson believes is relevant to the investigation. 2720
On the refusal of a witness to be sworn or to answer any question 2721
put to ~~him~~ the witness, or if a person disobeys a subpoena, the 2722
~~ombudsman~~ ombudsperson shall apply to the Franklin county court of 2723
common pleas for a contempt order, as in the case of disobedience 2724
of the requirements of a subpoena issued from the court, or a 2725
refusal to testify in the court. 2726

(I) The state ~~ombudsman~~ ombudsperson may petition the court 2727
of common pleas in the county in which a long-term care facility 2728
is located to issue an injunction against any long-term care 2729
facility in violation of sections 3721.10 to 3721.17 of the 2730
Revised Code. 2731

(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 2763
consist of the following: 2764

(1) A minimum of forty clock hours of basic instruction, 2765
which shall be completed before the trainee is permitted to handle 2766
complaints without the supervision of a representative of the 2767
office certified under this section; 2768

(2) An additional sixty clock hours of instruction, which 2769
shall be completed within the first fifteen months of employment; 2770

(3) An internship of twenty clock hours, which shall be 2771
completed within the first twenty-four months of employment, 2772
including instruction in, and observation of, basic nursing care 2773
and long-term care provider operations and procedures. The 2774
internship shall be performed at a site that has been approved as 2775
an internship site by the state long-term care ~~ombudsman~~ 2776
ombudsperson. 2777

(4) One of the following, which shall be completed within the 2778
first twenty-four months of employment: 2779

(a) Observation of a survey conducted by the director of 2780
health to certify a facility to receive funds under sections 2781
~~5111.20~~ 5164.01 to ~~5111.32~~ 5164.35 of the Revised Code; 2782

(b) Observation of an inspection conducted by the director of 2783
health to license an adult care facility under section 3722.04 of 2784
the Revised Code. 2785

(5) Any other training considered appropriate by the 2786
department. 2787

(C) Persons who for a period of at least six months prior to 2788
June 11, 1990, served as ombudsmen through the long-term care 2789
~~ombudsman~~ ombudsperson program established by the department of 2790
aging under division (M) of section 173.01 of the Revised Code 2791
shall not be required to complete a training program. These 2792

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. 2855

(B) All money collected under this section shall be deposited 2856
in the state treasury to the credit of the office of the state 2857
long-term care ombudsperson program fund, which is hereby created. 2858
Money credited to the fund shall be used solely to pay the costs 2859
of operating the regional long-term care ombudsperson programs. 2860

(C) The state long-term care ombudsperson and the regional 2861
programs may solicit and receive contributions to support the 2862
operation of the office or a regional program, except that no 2863
contribution shall be solicited or accepted that would interfere 2864
with the independence or objectivity of the office or program. 2865

Sec. 173.394. (A) As used in this section: 2866

(1) "Applicant" means a person who is under final 2867
consideration for employment with a community-based long-term care 2868
agency in a full-time, part-time, or temporary position that 2869
involves providing direct care to an individual. "Applicant" does 2870
not include a person who provides direct care as a volunteer 2871
without receiving or expecting to receive any form of remuneration 2872
other than reimbursement for actual expenses. 2873

(2) "Criminal records check" has the same meaning as in 2874
section 109.572 of the Revised Code. 2875

(B)(1) Except as provided in division (I) of this section, 2876
the chief administrator of a community-based long-term care agency 2877
shall request that the superintendent of the bureau of criminal 2878
identification and investigation conduct a criminal records check 2879
with respect to each applicant. If an applicant for whom a 2880
criminal records check request is required under this division 2881
does not present proof of having been a resident of this state for 2882
the five-year period immediately prior to the date the criminal 2883
records check is requested or provide evidence that within that 2884

five-year period the superintendent has requested information 2885
about the applicant from the federal bureau of investigation in a 2886
criminal records check, the chief administrator shall request that 2887
the superintendent obtain information from the federal bureau of 2888
investigation as part of the criminal records check of the 2889
applicant. Even if an applicant for whom a criminal records check 2890
request is required under this division presents proof of having 2891
been a resident of this state for the five-year period, the chief 2892
administrator may request that the superintendent include 2893
information from the federal bureau of investigation in the 2894
criminal records check. 2895

(2) A person required by division (B)(1) of this section to 2896
request a criminal records check shall do both of the following: 2897

(a) Provide to each applicant for whom a criminal records 2898
check request is required under that division a copy of the form 2899
prescribed pursuant to division (C)(1) of section 109.572 of the 2900
Revised Code and a standard fingerprint impression sheet 2901
prescribed pursuant to division (C)(2) of that section, and obtain 2902
the completed form and impression sheet from the applicant; 2903

(b) Forward the completed form and impression sheet to the 2904
superintendent of the bureau of criminal identification and 2905
investigation. 2906

(3) An applicant provided the form and fingerprint impression 2907
sheet under division (B)(2)(a) of this section who fails to 2908
complete the form or provide fingerprint impressions shall not be 2909
employed in any position for which a criminal records check is 2910
required by this section. 2911

(C)(1) Except as provided in rules adopted by the department 2912
of aging in accordance with division (F) of this section and 2913
subject to division (C)(2) of this section, no community-based 2914
long-term care agency shall employ a person in a position that 2915

involves providing direct care to an individual if the person has 2916
been convicted of or pleaded guilty to any of the following: 2917

(a) A violation of section 2903.01, 2903.02, 2903.03, 2918
2903.04, 2903.11, 2903.12, 2903.13, 2903.16, 2903.21, 2903.34, 2919
2905.01, 2905.02, 2905.11, 2905.12, 2907.02, 2907.03, 2907.05, 2920
2907.06, 2907.07, 2907.08, 2907.09, 2907.12, 2907.25, 2907.31, 2921
2907.32, 2907.321, 2907.322, 2907.323, 2911.01, 2911.02, 2911.11, 2922
2911.12, 2911.13, 2913.02, 2913.03, 2913.04, 2913.11, 2913.21, 2923
2913.31, 2913.40, 2913.43, 2913.47, 2913.51, 2919.25, 2921.36, 2924
2923.12, 2923.13, 2923.161, 2925.02, 2925.03, 2925.11, 2925.13, 2925
2925.22, 2925.23, or 3716.11 of the Revised Code. 2926

(b) A violation of an existing or former law of this state, 2927
any other state, or the United States that is substantially 2928
equivalent to any of the offenses listed in division (C)(1)(a) of 2929
this section. 2930

(2)(a) A community-based long-term care agency may employ 2931
conditionally an applicant for whom a criminal records check 2932
request is required under division (B) of this section prior to 2933
obtaining the results of a criminal records check regarding the 2934
individual, provided that the agency shall request a criminal 2935
records check regarding the individual in accordance with division 2936
(B)(1) of this section not later than five business days after the 2937
individual begins conditional employment. In the circumstances 2938
described in division (I)(2) of this section, a community-based 2939
long-term care agency may employ conditionally an applicant who 2940
has been referred to the agency by an employment service that 2941
supplies full-time, part-time, or temporary staff for positions 2942
involving the direct care of individuals and for whom, pursuant to 2943
that division, a criminal records check is not required under 2944
division (B) of this section. 2945

(b) A community-based long-term care agency that employs an 2946
individual conditionally under authority of division (C)(2)(a) of 2947

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. 2980

(E) The report of any criminal records check conducted 2981
pursuant to a request made under this section is not a public 2982
record for the purposes of section 149.43 of the Revised Code and 2983
shall not be made available to any person other than the 2984
following: 2985

(1) The individual who is the subject of the criminal records 2986
check or the individual's representative; 2987

(2) The chief administrator of the agency requesting the 2988
criminal records check or the administrator's representative; 2989

(3) The administrator of any other facility, agency, or 2990
program that provides direct care to individuals that is owned or 2991
operated by the same entity that owns or operates the 2992
community-based long-term care agency; 2993

(4) The director of aging or a person authorized by the 2994
director to monitor a community-based long-term care agency's 2995
compliance with this section; 2996

(5) A court, hearing officer, or other necessary individual 2997
involved in a case dealing with a denial of employment of the 2998
applicant or dealing with employment or unemployment benefits of 2999
the applicant; 3000

(6) Any person to whom the report is provided pursuant to, 3001
and in accordance with, division (I)(1) or (2) of this section. 3002

(F) The department of aging shall adopt rules in accordance 3003
with Chapter 119. of the Revised Code to implement this section. 3004
The rules shall specify circumstances under which a 3005
community-based long-term care agency may employ a person who has 3006
been convicted of or pleaded guilty to an offense listed or 3007
described in division (C)(1) of this section but meets personal 3008
character standards set by the department. 3009

(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 3041
criminal records check of an applicant if the applicant has been 3042
referred to the agency by an employment service that supplies 3043
full-time, part-time, or temporary staff for positions involving 3044
the direct care of individuals and both of the following apply: 3045
3046

(a) The chief administrator receives from the employment 3047
service or the applicant a report of the results of a criminal 3048
records check regarding the applicant that has been conducted by 3049
the superintendent within the one-year period immediately 3050
preceding the applicant's referral; 3051

(b) The report of the criminal records check demonstrates 3052
that the person has not been convicted of or pleaded guilty to an 3053
offense listed or described in division (C)(1) of this section, or 3054
the report demonstrates that the person has been convicted of or 3055
pleaded guilty to one or more of those offenses, but the 3056
community-based long-term care agency chooses to employ the 3057
individual pursuant to division (F) of this section. 3058

(2) The chief administrator of a community-based long-term 3059
care agency is not required to request that the superintendent of 3060
the bureau of criminal identification and investigation conduct a 3061
criminal records check of an applicant and may employ the 3062
applicant conditionally as described in this division, if the 3063
applicant has been referred to the agency by an employment service 3064
that supplies full-time, part-time, or temporary staff for 3065
positions involving the direct care of individuals and if the 3066
chief administrator receives from the employment service or the 3067
applicant a letter from the employment service that is on the 3068
letterhead of the employment service, dated, and signed by a 3069
supervisor or another designated official of the employment 3070
service and that states that the employment service has requested 3071
the superintendent to conduct a criminal records check regarding 3072

the applicant, that the requested criminal records check will 3073
include a determination of whether the applicant has been 3074
convicted of or pleaded guilty to any offense listed or described 3075
in division (C)(1) of this section, that, as of the date set forth 3076
on the letter, the employment service had not received the results 3077
of the criminal records check, and that, when the employment 3078
service receives the results of the criminal records check, it 3079
promptly will send a copy of the results to the community-based 3080
long-term care agency. If a community-based long-term care agency 3081
employs an applicant conditionally in accordance with this 3082
division, the employment service, upon its receipt of the results 3083
of the criminal records check, promptly shall send a copy of the 3084
results to the community-based long-term care agency, and division 3085
(C)(2)(b) of this section applies regarding the conditional 3086
employment. 3087

Sec. 173.40. There is hereby created a medicaid waiver 3088
component, as defined in section ~~5111.85~~ 5163.50 of the Revised 3089
Code, to be known as the preadmission screening system providing 3090
options and resources today program, or PASSPORT. The PASSPORT 3091
program shall provide home and community-based services as an 3092
alternative to nursing facility placement for aged and disabled 3093
medicaid recipients. The program shall be operated pursuant to a 3094
home and community-based waiver granted by the United States 3095
secretary of health and human services under ~~section 1915 of the~~ 3096
~~"Social Security Act," 49 Stat. 620 (1935),~~ 42 U.S.C. 1396n, ~~as~~ 3097
~~amended.~~ The department of aging shall administer the program 3098
through a contract entered into with the department of ~~job and~~ 3099
~~family services~~ health care administration under section ~~5111.91~~ 3100
5161.05 of the Revised Code. The director of ~~job and family~~ 3101
~~services~~ health care administration shall adopt rules under 3102
section ~~5111.85~~ 5163.50 of the Revised Code and the director of 3103
aging shall adopt rules in accordance with Chapter 119. of the 3104

Revised Code to implement the program. 3105

Sec. 173.42. (A) As used in this section: 3106

(1) "Area agency on aging" means a public or private 3107
nonprofit entity designated under section 173.011 of the Revised 3108
Code to administer programs on behalf of the department of aging. 3109

(2) "Long-term care consultation" means the process used to 3110
provide services under the long-term care consultation program 3111
established pursuant to this section, including, but not limited 3112
to, such services as the provision of information about long-term 3113
care options and costs, the assessment of an individual's 3114
functional capabilities, and the conduct of all or part of the 3115
reviews, assessments, and determinations specified in sections 3116
~~5111.202, 5111.204,~~ 5119.061, ~~and 5123.021, 5164.45, and 5164.47~~ 3117
of the Revised Code and the rules adopted under those sections. 3118

(3) ~~"Medicaid" means the medical assistance program 3119
established under Chapter 5111. of the Revised Code. 3120~~

~~(4)~~ "Nursing facility" has the same meaning as in section 3121
~~5111.20~~ 5164.01 of the Revised Code. 3122

~~(5)~~(4) "Representative" means a person acting on behalf of an 3123
individual seeking a long-term care consultation, applying for 3124
admission to a nursing facility, or residing in a nursing 3125
facility. A representative may be a family member, attorney, 3126
hospital social worker, or any other person chosen to act on 3127
behalf of the individual. 3128

(B) The department of aging shall develop a long-term care 3129
consultation program whereby individuals or their representatives 3130
are provided with long-term care consultations and receive through 3131
these professional consultations information about options 3132
available to meet long-term care needs and information about 3133
factors to consider in making long-term care decisions. The 3134

long-term care consultations provided under the program may be 3135
provided at any appropriate time, as permitted or required under 3136
this section and the rules adopted under it, including either 3137
prior to or after the individual who is the subject of a 3138
consultation has been admitted to a nursing facility. 3139

(C) The long-term care consultation program shall be 3140
administered by the department of aging, except that the 3141
department may enter into a contract with an area agency on aging 3142
or other entity selected by the department under which the program 3143
for a particular area is administered by the area agency on aging 3144
or other entity pursuant to the contract. 3145

(D) The long-term care consultations provided for purposes of 3146
the program shall be provided by individuals certified by the 3147
department under section 173.43 of the Revised Code. 3148

(E) The information provided through a long-term care 3149
consultation shall be appropriate to the individual's needs and 3150
situation and shall address all of the following: 3151

(1) The availability of any long-term care options open to 3152
the individual; 3153

(2) Sources and methods of both public and private payment 3154
for long-term care services; 3155

(3) Factors to consider when choosing among the available 3156
programs, services, and benefits; 3157

(4) Opportunities and methods for maximizing independence and 3158
self-reliance, including support services provided by the 3159
individual's family, friends, and community. 3160

(F) An individual's long-term care consultation may include 3161
an assessment of the individual's functional capabilities. The 3162
consultation may incorporate portions of the determinations 3163
required under sections ~~5111.202~~, 5119.061, ~~and~~ 5123.021, and 3164

5164.45 of the Revised Code and may be provided concurrently with 3165
the assessment required under section ~~5111.204~~ 5164.47 of the 3166
Revised Code. 3167

(G)(1) Unless an exemption specified in division (I) of this 3168
section is applicable, each individual in the following categories 3169
shall be provided with a long-term care consultation: 3170

(a) Individuals who apply or indicate an intention to apply 3171
for admission to a nursing facility, regardless of the source of 3172
payment to be used for their care in a nursing facility; 3173

(b) Nursing facility residents who apply or indicate an 3174
intention to apply for medicaid; 3175

(c) Nursing facility residents who are likely to spend down 3176
their resources within six months after admission to a nursing 3177
facility to a level at which they are financially eligible for 3178
medicaid; 3179

(d) Individuals who request a long-term care consultation. 3180

(2) In addition to the individuals included in the categories 3181
specified in division (G)(1) of this section, long-term care 3182
consultations may be provided to nursing facility residents who 3183
have not applied and have not indicated an intention to apply for 3184
medicaid. The purpose of the consultations provided to these 3185
individuals shall be to determine continued need for nursing 3186
facility services, to provide information on alternative services, 3187
and to make referrals to alternative services. 3188

(H)(1) When a long-term care consultation is required to be 3189
provided pursuant to division (G)(1) of this section, the 3190
consultation shall be provided as follows or pursuant to division 3191
(H)(2) or (3) of this section: 3192

(a) If the individual for whom the consultation is being 3193
provided has applied for medicaid and the consultation is being 3194

provided concurrently with the assessment required under section 3195
5111.204 of the Revised Code, the consultation shall be completed 3196
in accordance with the applicable time frames specified in that 3197
section for providing a level of care determination based on the 3198
assessment. 3199

(b) In all other cases, the consultation shall be provided 3200
not later than five calendar days after the department or the 3201
program administrator under contract with the department receives 3202
notice of the reason for which the consultation is required to be 3203
provided pursuant to division (G)(1) of this section. 3204

(2) An individual or the individual's representative may 3205
request that a long-term care consultation be provided on a date 3206
that is later than the date required under division (H)(1)(a) or 3207
(b) of this section. 3208

(3) If a long-term care consultation cannot be completed 3209
within the number of days required by division (H)(1) or (2) of 3210
this section, the department or the program administrator under 3211
contract with the department may do any of the following: 3212

(a) Exempt the individual from the consultation pursuant to 3213
rules that may be adopted under division (L) of this section; 3214

(b) In the case of an applicant for admission to a nursing 3215
facility, provide the consultation after the individual is 3216
admitted to the nursing facility; 3217

(c) In the case of a resident of a nursing facility, provide 3218
the consultation as soon as practicable. 3219

(I) An individual is not required to be provided a long-term 3220
care consultation under this section if any of the following 3221
apply: 3222

(1) The individual or the individual's representative chooses 3223
to forego participation in the consultation pursuant to criteria 3224

specified in rules adopted under division (L) of this section;	3225
(2) The individual is to receive care in a nursing facility	3226
under a contract for continuing care as defined in section 173.13	3227
of the Revised Code;	3228
(3) The individual has a contractual right to admission to a	3229
nursing facility operated as part of a system of continuing care	3230
in conjunction with one or more facilities that provide a less	3231
intensive level of services, including a residential care facility	3232
licensed under Chapter 3721. of the Revised Code, an adult care	3233
facility licensed under Chapter 3722. of the Revised Code, or an	3234
independent living arrangement;	3235
(4) The individual is to receive continual care in a home for	3236
the aged exempt from taxation under section 5701.13 of the Revised	3237
Code;	3238
(5) The individual is seeking admission to a facility that is	3239
not a nursing facility with a provider agreement under section	3240
5111.22 <u>5164.03</u> of the Revised Code;	3241
(6) The individual is to be transferred from another nursing	3242
facility;	3243
(7) The individual is to be readmitted to a nursing facility	3244
following a period of hospitalization;	3245
(8) The individual is exempted from the long-term care	3246
consultation requirement by the department or the program	3247
administrator pursuant to rules that may be adopted under division	3248
(L) of this section.	3249
(J) At the conclusion of an individual's long-term care	3250
consultation, the department or the program administrator under	3251
contract with the department shall provide the individual or	3252
individual's representative with a written summary of options and	3253
resources available to meet the individual's needs. Even though	3254

the summary may specify that a source of long-term care other than 3255
care in a nursing facility is appropriate and available, the 3256
individual is not required to seek an alternative source of 3257
long-term care and may be admitted to or continue to reside in a 3258
nursing facility. 3259

(K) No nursing facility for which an operator has a provider 3260
agreement under section ~~5111.22~~ 5164.03 of the Revised Code shall 3261
admit or retain any individual as a resident, unless the nursing 3262
facility has received evidence that a long-term care consultation 3263
has been completed for the individual or division (I) of this 3264
section is applicable to the individual. 3265

(L) The director of aging may adopt any rules the director 3266
considers necessary for the implementation and administration of 3267
this section. The rules shall be adopted in accordance with 3268
Chapter 119. of the Revised Code and may specify any or all of the 3269
following: 3270

(1) Procedures for providing long-term care consultations 3271
pursuant to this section; 3272

(2) Information to be provided through long-term care 3273
consultations regarding long-term care services that are 3274
available; 3275

(3) Criteria under which an individual or the individual's 3276
representative may choose to forego participation in a long-term 3277
care consultation; 3278

(4) Criteria for exempting individuals from the long-term 3279
care consultation requirement; 3280

(5) Circumstances under which it may be appropriate to 3281
provide an individual's long-term care consultation after the 3282
individual's admission to a nursing facility rather than before 3283
admission; 3284

(6) Criteria for identifying nursing facility residents who would benefit from the provision of a long-term care consultation. 3285
3286

(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. 3287
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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. 3292
3293
3294
3295

Sec. 173.45. As used in this section and in sections 173.46 to 173.49 of the Revised Code: 3296
3297

(A) "Long-term care facility" means a nursing home or residential care facility. 3298
3299

(B) "Nursing home" and "residential care facility" have the same meanings as in section 3721.01 of the Revised Code. 3300
3301

(C) "Nursing facility" has the same meaning as in section ~~5111.20~~ 5164.01 of the Revised Code. 3302
3303

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. 3304
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(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 3310
3311
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3313

in accordance with section 173.48 of the Revised Code. 3314

(2) The fees charged under this section shall not exceed the 3315
following amounts: 3316

(a) Four hundred dollars for the customer satisfaction survey 3317
of a long-term care facility that is a nursing home; 3318

(b) Three hundred dollars for the customer satisfaction 3319
survey pertaining to a long-term care facility that is a 3320
residential care facility. 3321

(3) Fees paid by a long-term care facility that is a nursing 3322
facility shall be reimbursed through the medicaid program ~~operated~~ 3323
~~under Chapter 5111. of the Revised Code.~~ 3324

(C) Each long-term care facility shall cooperate in the 3325
conduct of its annual customer satisfaction survey. 3326

Sec. 173.50. (A) Pursuant to a contract entered into with the 3327
department of ~~job and family services~~ health care administration 3328
as an interagency agreement under section ~~5111.91~~ 5161.05 of the 3329
Revised Code, the department of aging shall carry out the 3330
day-to-day administration of the component of the medicaid program 3331
~~established under Chapter 5111. of the Revised Code~~ known as the 3332
program of all-inclusive care for the elderly or PACE. The 3333
department of aging shall carry out its PACE administrative duties 3334
in accordance with the provisions of the interagency agreement and 3335
all applicable federal laws, including the "Social Security Act," 3336
79 Stat. 286 (1965), 42 U.S.C. 1396u-4, as amended. 3337

(B) The department of aging may adopt rules in accordance 3338
with Chapter 119. of the Revised Code regarding the PACE program, 3339
subject to both of the following: 3340

(1) The rules shall be authorized by rules adopted by the 3341
department of job and family services. 3342

(2) The rules shall address only those issues that are not 3343

addressed in rules adopted by the department of job and family 3344
services for the PACE program. 3345

Sec. 173.99. (A) A long-term care provider, person employed 3346
by a long-term care provider, other entity, or employee of such 3347
other entity that violates division (C) of section 173.24 of the 3348
Revised Code is subject to a fine not to exceed one thousand 3349
dollars for each violation. 3350

(B) Whoever violates division (C) of section 173.23 of the 3351
Revised Code is guilty of registering a false complaint, a 3352
misdemeanor of the first degree. 3353

(C) A long-term care provider, other entity, or person 3354
employed by a long-term care provider or other entity that 3355
violates division (E) of section 173.19 of the Revised Code by 3356
denying a representative of the office of the state long-term care 3357
ombudsperson program the access required by that division is 3358
subject to a fine not to exceed five hundred dollars for each 3359
violation. 3360

(D) Whoever violates division (C) of section 173.44 of the 3361
Revised Code is subject to a fine of one hundred dollars. 3362

~~(E) Whoever violates division (B) of section 173.90 of the 3363
Revised Code is guilty of a misdemeanor of the first degree. 3364~~

Sec. 317.08. (A) Except as provided in divisions (C) and (D) 3365
of this section, the county recorder shall keep six separate sets 3366
of records as follows: 3367

(1) A record of deeds, in which shall be recorded all deeds 3368
and other instruments of writing for the absolute and 3369
unconditional sale or conveyance of lands, tenements, and 3370
hereditaments; all notices as provided in sections 5301.47 to 3371
5301.56 of the Revised Code; all judgments or decrees in actions 3372
brought under section 5303.01 of the Revised Code; all 3373

declarations and bylaws, and all amendments to declarations and 3374
bylaws, as provided in Chapter 5311. of the Revised Code; 3375
affidavits as provided in sections 5301.252 and 5301.56 of the 3376
Revised Code; all certificates as provided in section 5311.17 of 3377
the Revised Code; all articles dedicating archaeological preserves 3378
accepted by the director of the Ohio historical society under 3379
section 149.52 of the Revised Code; all articles dedicating nature 3380
preserves accepted by the director of natural resources under 3381
section 1517.05 of the Revised Code; all agreements for the 3382
registration of lands as archaeological or historic landmarks 3383
under section 149.51 or 149.55 of the Revised Code; all 3384
conveyances of conservation easements and agricultural easements 3385
under section 5301.68 of the Revised Code; all instruments 3386
extinguishing agricultural easements under section 901.21 or 3387
5301.691 of the Revised Code or pursuant to terms of such an 3388
easement granted to a charitable organization under section 3389
5301.68 of the Revised Code; all instruments or orders described 3390
in division (B)(2)(b) of section 5301.56 of the Revised Code; all 3391
no further action letters issued under section 122.654 or 3746.11 3392
of the Revised Code; all covenants not to sue issued under section 3393
3746.12 of the Revised Code, including all covenants not to sue 3394
issued pursuant to section 122.654 of the Revised Code; any 3395
restrictions on the use of property contained in a no further 3396
action letter issued under section 122.654 of the Revised Code, 3397
any restrictions on the use of property identified pursuant to 3398
division (C)(3)(a) of section 3746.10 of the Revised Code, and any 3399
restrictions on the use of property contained in a deed or other 3400
instrument as provided in division (E) or (F) of section 3737.882 3401
of the Revised Code; any easement executed or granted under 3402
section 3734.22, 3734.24, 3734.25, or 3734.26 of the Revised Code; 3403
any environmental covenant entered into in accordance with 3404
sections 5301.80 to 5301.92 of the Revised Code; all memoranda of 3405
trust, as described in division (A) of section 5301.255 of the 3406

Revised Code, that describe specific real property; and all 3407
agreements entered into under division (A) of section 1521.26 of 3408
the Revised Code; 3409

(2) A record of mortgages, in which shall be recorded all of 3410
the following: 3411

(a) All mortgages, including amendments, supplements, 3412
modifications, and extensions of mortgages, or other instruments 3413
of writing by which lands, tenements, or hereditaments are or may 3414
be mortgaged or otherwise conditionally sold, conveyed, affected, 3415
or encumbered; 3416

(b) All executory installment contracts for the sale of land 3417
executed after September 29, 1961, that by their terms are not 3418
required to be fully performed by one or more of the parties to 3419
them within one year of the date of the contracts; 3420

(c) All options to purchase real estate, including 3421
supplements, modifications, and amendments of the options, but no 3422
option of that nature shall be recorded if it does not state a 3423
specific day and year of expiration of its validity; 3424

(d) Any tax certificate sold under section 5721.33 of the 3425
Revised Code, or memorandum of it, that is presented for filing of 3426
record. 3427

(3) A record of powers of attorney, including all memoranda 3428
of trust, as described in division (A) of section 5301.255 of the 3429
Revised Code, that do not describe specific real property; 3430

(4) A record of plats, in which shall be recorded all plats 3431
and maps of town lots, of the subdivision of town lots, and of 3432
other divisions or surveys of lands, any center line survey of a 3433
highway located within the county, the plat of which shall be 3434
furnished by the director of transportation or county engineer, 3435
and all drawings and amendments to drawings, as provided in 3436
Chapter 5311. of the Revised Code; 3437

(5) A record of leases, in which shall be recorded all 3438
leases, memoranda of leases, and supplements, modifications, and 3439
amendments of leases and memoranda of leases; 3440

(6) A record of declarations executed pursuant to section 3441
2133.02 of the Revised Code and durable powers of attorney for 3442
health care executed pursuant to section 1337.12 of the Revised 3443
Code. 3444

(B) All instruments or memoranda of instruments entitled to 3445
record shall be recorded in the proper record in the order in 3446
which they are presented for record. The recorder may index, keep, 3447
and record in one volume unemployment compensation liens, internal 3448
revenue tax liens and other liens in favor of the United States as 3449
described in division (A) of section 317.09 of the Revised Code, 3450
personal tax liens, mechanic's liens, agricultural product liens, 3451
notices of liens, certificates of satisfaction or partial release 3452
of estate tax liens, discharges of recognizances, excise and 3453
franchise tax liens on corporations, broker's liens, and liens 3454
provided for in sections 1513.33, 1513.37, 3752.13, ~~5111.022~~ 3455
5163.08, and 5311.18 of the Revised Code. 3456

The recording of an option to purchase real estate, including 3457
any supplement, modification, and amendment of the option, under 3458
this section shall serve as notice to any purchaser of an interest 3459
in the real estate covered by the option only during the period of 3460
the validity of the option as stated in the option. 3461

(C) In lieu of keeping the six separate sets of records 3462
required in divisions (A)(1) to (6) of this section and the 3463
records required in division (D) of this section, a county 3464
recorder may record all the instruments required to be recorded by 3465
this section in two separate sets of record books. One set shall 3466
be called the "official records" and shall contain the instruments 3467
listed in divisions (A)(1), (2), (3), (5), and (6) and (D) of this 3468
section. The second set of records shall contain the instruments 3469

listed in division (A)(4) of this section. 3470

(D) Except as provided in division (C) of this section, the 3471
county recorder shall keep a separate set of records containing 3472
all corrupt activity lien notices filed with the recorder pursuant 3473
to section 2923.36 of the Revised Code and a separate set of 3474
records containing all medicaid fraud lien notices filed with the 3475
recorder pursuant to section 2933.75 of the Revised Code. 3476

Sec. 317.36. (A) The county recorder shall collect the low- 3477
and moderate-income housing trust fund fee as specified in 3478
sections 317.32, 1563.42, 1702.59, 2505.13, 4141.23, 4509.60, 3479
~~5111.022~~ 5163.08, 5310.15, 5719.07, 5727.56, 5733.18, 5733.22, 3480
6101.09, and 6115.09 of the Revised Code. The amount of any 3481
housing trust fund fee the recorder is authorized to collect is 3482
equal to the amount of any base fee the recorder is authorized to 3483
collect for services. The housing trust fund fee shall be 3484
collected in addition to the base fee. 3485

(B) The recorder shall certify the amounts collected as 3486
housing trust fund fees pursuant to division (A) of this section 3487
into the county treasury as housing trust fund fees to be paid to 3488
the treasurer of state pursuant to section 319.63 of the Revised 3489
Code. 3490

Sec. 323.01. Except as otherwise provided, as used in Chapter 3491
323. of the Revised Code: 3492

(A) "Subdivision" means any county, township, school 3493
district, or municipal corporation. 3494

(B) "Municipal corporation" includes charter municipalities. 3495

(C) "Taxes" means the total amount of all charges against an 3496
entry appearing on a tax list and the duplicate thereof that was 3497
prepared and certified in accordance with section 319.28 of the 3498
Revised Code, including taxes levied against real estate; taxes on 3499

property whose value is certified pursuant to section 5727.23 of 3500
the Revised Code; recoupment charges applied pursuant to section 3501
5713.35 of the Revised Code; all assessments; penalties and 3502
interest charged pursuant to section 323.121 of the Revised Code; 3503
charges added pursuant to section 319.35 of the Revised Code; and 3504
all of such charges which remain unpaid from any previous tax 3505
year. 3506

(D) "Current taxes" means all taxes charged against an entry 3507
on the general tax list and duplicate of real and public utility 3508
property that have not appeared on such list and duplicate for any 3509
prior tax year and any penalty thereon charged by division (A) of 3510
section 323.121 of the Revised Code. Current taxes, whether or not 3511
they have been certified delinquent, become delinquent taxes if 3512
they remain unpaid after the last day prescribed for payment of 3513
the second installment of current taxes without penalty. 3514

(E) "Delinquent taxes" means: 3515

(1) Any taxes charged against an entry on the general tax 3516
list and duplicate of real and public utility property that were 3517
charged against an entry on such list and duplicate for a prior 3518
tax year and any penalties and interest charged against such 3519
taxes. 3520

(2) Any current taxes charged on the general tax list and 3521
duplicate of real and public utility property that remain unpaid 3522
after the last day prescribed for payment of the second 3523
installment of such taxes without penalty, whether or not they 3524
have been certified delinquent, and any penalties and interest 3525
charged against such taxes. 3526

(F) "Current tax year" means, with respect to particular 3527
taxes, the calendar year in which the first installment of taxes 3528
is due prior to any extension granted under section 323.17 of the 3529
Revised Code. 3530

(G) "Liquidated claim" means: 3531

(1) Any sum of money due and payable, upon a written 3532
contractual obligation executed between the subdivision and the 3533
taxpayer, but excluding any amount due on general and special 3534
assessment bonds and notes; 3535

(2) Any sum of money due and payable, for disability 3536
financial assistance ~~or disability medical assistance~~ provided 3537
under Chapter 5115. of the Revised Code or the disability medical 3538
assistance program that is furnished to or in behalf of a 3539
subdivision, provided that such claim is recognized by a 3540
resolution or ordinance of the legislative body of such 3541
subdivision; 3542

(3) Any sum of money advanced and paid to or received and 3543
used by a subdivision, pursuant to a resolution or ordinance of 3544
such subdivision or its predecessor in interest, and the moral 3545
obligation to repay which sum, when in funds, shall be recognized 3546
by resolution or ordinance by the subdivision. 3547

Sec. 329.04. (A) The county department of job and family 3548
services shall have, exercise, and perform the following powers 3549
and duties: 3550

(1) Perform any duties assigned by the state department of 3551
job and family services regarding the provision of public family 3552
services, including the provision of the following services to 3553
prevent or reduce economic or personal dependency and to 3554
strengthen family life: 3555

(a) Services authorized by a Title IV-A program, as defined 3556
in section 5101.80 of the Revised Code; 3557

(b) Social services authorized by Title XX of the "Social 3558
Security Act" and provided for by section 5101.46 or 5101.461 of 3559
the Revised Code; 3560

(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 3592
~~assistance of recipients of aid under Title XVI of the "Social~~ 3593
~~Security Act" the medicaid program in accordance with rules~~ 3594
adopted by the director of health care administration under 3595
section 5162.20 of the Revised Code; 3596

(9) If assigned by the ~~state~~ director of ~~job and family~~ 3597
~~services~~ health care administration under section ~~5101.515~~ 5167.15 3598
of the Revised Code, determine applicants' eligibility for health 3599
assistance under the children's health insurance program part II; 3600

(10) Enter into a plan of cooperation with the board of 3601
county commissioners under section 307.983, consult with the board 3602
in the development of the transportation work plan developed under 3603
section 307.985, establish with the board procedures under section 3604
307.986 for providing services to children whose families relocate 3605
frequently, and comply with the contracts the board enters into 3606
under sections 307.981 and 307.982 of the Revised Code that affect 3607
the county department; 3608

(11) For the purpose of complying with a fiscal agreement the 3609
board of county commissioners enters into under section 307.98 of 3610
the Revised Code, exercise the powers and perform the duties the 3611
fiscal agreement assigns to the county department; 3612

(12) If the county department is designated as the workforce 3613
development agency, provide the workforce development activities 3614
specified in the contract required by section 330.05 of the 3615
Revised Code. 3616

(B) The powers and duties of a county department of job and 3617
family services are, and shall be exercised and performed, under 3618
the control and direction of the board of county commissioners. 3619
The board may assign to the county department any power or duty of 3620
the board regarding family services duties and workforce 3621
development activities. If the new power or duty necessitates the 3622

state department of job and family services changing its federal 3623
cost allocation plan, the county department may not implement the 3624
power or duty unless the United States department of health and 3625
human services approves the changes. 3626

Sec. 329.043. With regard to applicants for and recipients of 3627
disability financial assistance or disability medical assistance, 3628
each county department of job and family services shall do all of 3629
the following: 3630

(A) Identify applicants and recipients who might be eligible 3631
for benefits under the supplemental security income program; 3632

(B) Assist applicants and recipients in securing 3633
documentation of disabling conditions or refer them for such 3634
assistance to a person or government entity with which the 3635
department of job and family services or county department has 3636
contracted under section 5115.20 of the Revised Code; 3637

(C) Inform applicants and recipients of available sources of 3638
representation, which may include a person or government entity 3639
with which the department of job and family services or county 3640
department has contracted under section 5115.20 of the Revised 3641
Code, and of their right to represent themselves in 3642
reconsiderations and appeals of social security administration 3643
decisions that deny them supplemental security income benefits. 3644
The county department may require the applicants and recipients, 3645
as a condition of eligibility for disability financial assistance 3646
or disability medical assistance, to pursue reconsiderations and 3647
appeals of social security administration decisions that deny them 3648
supplemental security income benefits, and shall assist applicants 3649
and recipients as necessary to obtain such benefits or refer them 3650
to a person or government entity with which the department or 3651
county department has contracted under section 5115.20 of the 3652
Revised Code. 3653

(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; 3654
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(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." 3661
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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: 3674
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(A) The disability financial assistance program established under Chapter 5115. of the Revised Code; 3679
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(B) The disability medical assistance program ~~established under Chapter 5115. of the Revised Code;~~ 3681
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(C) The ~~medical assistance~~ medicaid program ~~established under Chapter 5111. of the Revised Code;~~ 3683
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(D) The Ohio works first program established under Chapter 3685
5107. of the Revised Code; 3686

(E) The prevention, retention, and contingency program 3687
established under Chapter 5108. of the Revised Code. 3688

Sec. 329.06. (A) Except as provided in division (C) of this 3689
section and section 6301.08 of the Revised Code, the board of 3690
county commissioners shall establish a county family services 3691
planning committee. The board shall appoint a member to represent 3692
the county department of job and family services; an employee in 3693
the classified civil service of the county department of job and 3694
family services, if there are any such employees; and a member to 3695
represent the public. The board shall appoint other individuals to 3696
the committee in such a manner that the committee's membership is 3697
broadly representative of the groups of individuals and the public 3698
and private entities that have an interest in the family services 3699
provided in the county. The board shall make appointments in a 3700
manner that reflects the ethnic and racial composition of the 3701
county. The following groups and entities may be represented on 3702
the committee: 3703

(1) Consumers of family services; 3704

(2) The public children services agency; 3705

(3) The child support enforcement agency; 3706

(4) The county family and children first council; 3707

(5) Public and private colleges and universities; 3708

(6) Public entities that provide family services, including 3709
boards of health, boards of education, the county board of mental 3710
retardation and developmental disabilities, and the board of 3711
alcohol, drug addiction, and mental health services that serves 3712
the county; 3713

(7) Private nonprofit and for-profit entities that provide 3714

family services in the county or that advocate for consumers of 3715
family services in the county, including entities that provide 3716
services to or advocate for victims of domestic violence; 3717

(8) Labor organizations; 3718

(9) Any other group or entity that has an interest in the 3719
family services provided in the county, including groups or 3720
entities that represent any of the county's business, urban, and 3721
rural sectors. 3722

(B) The county family services planning committee shall do 3723
all of the following: 3724

(1) Serve as an advisory body to the board of county 3725
commissioners with regard to the family services provided in the 3726
county, including assistance under Chapters 5107. and 5108. of the 3727
Revised Code, publicly funded child care under Chapter 5104. of 3728
the Revised Code, and social services provided under section 3729
5101.46 of the Revised Code; 3730

(2) At least once a year, review and analyze the county 3731
department of job and family services' implementation of the 3732
programs established under Chapters 5107. and 5108. of the Revised 3733
Code. In its review, the committee shall use information available 3734
to it to examine all of the following: 3735

(a) Return of assistance groups to participation in either 3736
program after ceasing to participate; 3737

(b) Teen pregnancy rates among the programs' participants; 3738

(c) The other types of assistance the programs' participants 3739
receive, including ~~medical assistance under Chapter 5111. of the~~ 3740
~~Revised Code~~ medicaid, publicly funded child care under Chapter 3741
5104. of the Revised Code, food stamp benefits under section 3742
5101.54 of the Revised Code, and energy assistance under Chapter 3743
5117. of the Revised Code; 3744

(d) Other issues the committee considers appropriate. 3745

The committee shall make recommendations to the board of 3746
county commissioners and county department of job and family 3747
services regarding the committee's findings. 3748

(3) Conduct public hearings on proposed county profiles for 3749
the provision of social services under section 5101.46 of the 3750
Revised Code; 3751

(4) At the request of the board, make recommendations and 3752
provide assistance regarding the family services provided in the 3753
county; 3754

(5) At any other time the committee considers appropriate, 3755
consult with the board and make recommendations regarding the 3756
family services provided in the county. The committee's 3757
recommendations may address the following: 3758

(a) Implementation and administration of family service 3759
programs; 3760

(b) Use of federal, state, and local funds available for 3761
family service programs; 3762

(c) Establishment of goals to be achieved by family service 3763
programs; 3764

(d) Evaluation of the outcomes of family service programs; 3765

(e) Any other matter the board considers relevant to the 3766
provision of family services. 3767

(C) If there is a committee in existence in a county on 3768
October 1, 1997, that the board of county commissioners determines 3769
is capable of fulfilling the responsibilities of a county family 3770
services planning committee, the board may designate the committee 3771
as the county's family services planning committee and the 3772
committee shall serve in that capacity. 3773

Sec. 329.14. (A) An individual whose household income does 3774
not exceed one hundred fifty per cent of the federal poverty line 3775
is eligible to participate in an individual development account 3776
program established by the county department of job and family 3777
services of the county in which the individual resides. An 3778
eligible individual seeking to be a participant in the program 3779
shall enter into an agreement with the fiduciary organization 3780
administering the program. The agreement shall specify the terms 3781
and conditions of uses of funds deposited, financial documentation 3782
required to be maintained by the participant, expectations and 3783
responsibilities of the participant, and services to be provided 3784
by the fiduciary organization. 3785

(B) A participant may deposit earned income, as defined in 26 3786
U.S.C. 911(d)(2), as amended, into the account. The fiduciary 3787
organization may deposit into the account an amount not exceeding 3788
twice the amount deposited by the participant except that a 3789
fiduciary organization may not, pursuant to an agreement with an 3790
employer, deposit an amount into an account held by a participant 3791
who is employed by the employer. An account may have no more than 3792
ten thousand dollars in it at any time. 3793

(C) Notwithstanding eligibility requirements established in 3794
or pursuant to Chapter 5107.7 or 5108.7 ~~or 5111.~~ of the Revised 3795
Code or for the medicaid program, to the extent permitted by 3796
federal statutes and regulations, money in an individual 3797
development account, including interest, is exempt from 3798
consideration in determining whether the participant or a member 3799
of the participant's assistance group is eligible for assistance 3800
under Chapter 5107.7 or 5108.7 ~~or 5111.~~ of the Revised Code or the 3801
medicaid program and the amount of assistance the participant or 3802
assistance group is eligible to receive. 3803

(D)(1) Except as provided in division (D)(2) of this section, 3804

an individual development account program participant may use 3805
money in the account only for the following purposes: 3806

(a) Postsecondary educational expenses paid directly from the 3807
account to an eligible education institution or vendor; 3808

(b) Qualified acquisition expenses of a principal residence, 3809
as defined in 26 U.S.C. 1034, as amended, paid directly from the 3810
account to the person or government entity to which the expenses 3811
are due; 3812

(c) Qualified business capitalization expenses made in 3813
accordance with a qualified business plan that has been approved 3814
by a financial institution or by a nonprofit microenterprise 3815
program having demonstrated business expertise and paid directly 3816
from the account to the person to whom the expenses are due. 3817

(2) A fiduciary organization shall permit a participant to 3818
withdraw money deposited by the participant if it is needed to 3819
deal with a personal emergency of the participant or a member of 3820
the participant's family or household. Withdrawal shall result in 3821
the loss of any matching funds in an amount equal to the amount of 3822
the withdrawal. 3823

(3) Regardless of the reason for the withdrawal, a withdrawal 3824
from an individual development account may be made only with the 3825
approval of the fiduciary organization. 3826

Sec. 340.03. (A) Subject to rules issued by the director of 3827
mental health after consultation with relevant constituencies as 3828
required by division (A)(11) of section 5119.06 of the Revised 3829
Code, with regard to mental health services, the board of alcohol, 3830
drug addiction, and mental health services shall: 3831

(1) Serve as the community mental health planning agency for 3832
the county or counties under its jurisdiction, and in so doing it 3833
shall: 3834

(a) Evaluate the need for facilities and community mental health services; 3835
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(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; 3837
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(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. 3842
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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 3856
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department requests, and a budget for moneys the board expects to 3867
receive. The board shall also submit an allocation request for 3868
state and federal funds. Within sixty days after the department's 3869
determination that the plan and allocation request are complete, 3870
the department shall approve or disapprove the plan and request, 3871
in whole or in part, according to the criteria developed pursuant 3872
to section 5119.61 of the Revised Code. The department's statement 3873
of approval or disapproval shall specify the inpatient and the 3874
community-based services that the department will operate for the 3875
board. 3876

Eligibility for state and federal funding shall be contingent 3877
upon an approved plan or relevant part of a plan. The department 3878
may provide state and federal funding for services included in a 3879
plan only if the services are for individuals whose focus of 3880
treatment or prevention is a mental disorder according to the 3881
edition of the American psychiatric association's diagnostic and 3882
statistical manual of mental disorders that is current at the time 3883
the funding is provided. This shall include such services for 3884
individuals who have a mental disorder and a co-occurring 3885
substance use disorder, substance-induced disorder, chronic 3886
dementing organic mental disorder, mental retardation, or 3887
developmental disability. The department may not provide state or 3888
federal funding under a plan for a service for individuals whose 3889
focus of treatment or prevention is solely a substance use 3890
disorder, substance-induced disorder, chronic dementing organic 3891
mental disorder, mental retardation, or developmental disability. 3892

If the director disapproves all or part of any plan, the 3893
director shall inform the board of the reasons for the disapproval 3894
and of the criteria that must be met before the plan may be 3895
approved. The director shall provide the board an opportunity to 3896
present its case on behalf of the plan. The director shall give 3897
the board a reasonable time in which to meet the criteria, and 3898

shall offer the board technical assistance to help it meet the 3899
criteria. 3900

If the approval of a plan remains in dispute thirty days 3901
prior to the conclusion of the fiscal year in which the board's 3902
current plan is scheduled to expire, the board or the director may 3903
request that the dispute be submitted to a mutually agreed upon 3904
third-party mediator with the cost to be shared by the board and 3905
the department. The mediator shall issue to the board and the 3906
department recommendations for resolution of the dispute. Prior to 3907
the conclusion of the fiscal year in which the current plan is 3908
scheduled to expire, the director, taking into consideration the 3909
recommendations of the mediator, shall make a final determination 3910
and approve or disapprove the plan, in whole or in part. 3911

If a board determines that it is necessary to amend a plan or 3912
an allocation request that has been approved under division 3913
(A)(1)(c) of this section, the board shall submit a proposed 3914
amendment to the director. The director may approve or disapprove 3915
all or part of the amendment. If the director does not approve all 3916
or part of the amendment within thirty days after it is submitted, 3917
the amendment or part of it shall be considered to have been 3918
approved. The director shall inform the board of the reasons for 3919
disapproval of all or part of an amendment and of the criteria 3920
that must be met before the amendment may be approved. The 3921
director shall provide the board an opportunity to present its 3922
case on behalf of the amendment. The director shall give the board 3923
a reasonable time in which to meet the criteria, and shall offer 3924
the board technical assistance to help it meet the criteria. 3925

The board shall implement the plan approved by the 3926
department. 3927

(d) Receive, compile, and transmit to the department of 3928
mental health applications for state reimbursement; 3929

(e) Promote, arrange, and implement working agreements with social agencies, both public and private, and with judicial agencies. 3930
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(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. 3933
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(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; 3943
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(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; 3948
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(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; 3953
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(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 3957
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services of private auditors. A copy of the fiscal audit report 3961
shall be provided to the director of mental health, the auditor of 3962
state, and the county auditor of each county in the board's 3963
district. 3964

(7) Recruit and promote local financial support for mental 3965
health programs from private and public sources; 3966

(8)(a) Enter into contracts with public and private 3967
facilities for the operation of facility services included in the 3968
board's community mental health plan and enter into contracts with 3969
public and private community mental health agencies for the 3970
provision of community mental health services that are listed in 3971
section 340.09 of the Revised Code and included in the board's 3972
community mental health plan. The board may not contract with a 3973
community mental health agency to provide community mental health 3974
services included in the board's community mental health plan 3975
unless the services are certified by the director of mental health 3976
under section 5119.611 of the Revised Code. Section 307.86 of the 3977
Revised Code does not apply to contracts entered into under this 3978
division. In contracting with a community mental health agency, a 3979
board shall consider the cost effectiveness of services provided 3980
by that agency and the quality and continuity of care, and may 3981
review cost elements, including salary costs, of the services to 3982
be provided. A utilization review process shall be established as 3983
part of the contract for services entered into between a board and 3984
a community mental health agency. The board may establish this 3985
process in a way that is most effective and efficient in meeting 3986
local needs. In the case of a contract with a community mental 3987
health facility, as defined in section ~~5111.023~~ 5163.20 of the 3988
Revised Code, to provide services listed in division (B) of that 3989
section, the contract shall provide for the facility to be paid in 3990
accordance with the contract entered into between the departments 3991
of ~~job and family services~~ health care administration and mental 3992

health under section ~~5111.91~~ 5161.05 of the Revised Code and any 3993
rules adopted under division (A) of section 5119.61 of the Revised 3994
Code. 3995

If either the board or a facility or community mental health 3996
agency with which the board contracts under division (A)(8)(a) of 3997
this section proposes not to renew the contract or proposes 3998
substantial changes in contract terms, the other party shall be 3999
given written notice at least one hundred twenty days before the 4000
expiration date of the contract. During the first sixty days of 4001
this one hundred twenty-day period, both parties shall attempt to 4002
resolve any dispute through good faith collaboration and 4003
negotiation in order to continue to provide services to persons in 4004
need. If the dispute has not been resolved sixty days before the 4005
expiration date of the contract, either party may notify the 4006
department of mental health of the unresolved dispute. The 4007
director may require both parties to submit the dispute to a third 4008
party with the cost to be shared by the board and the facility or 4009
community mental health agency. The third party shall issue to the 4010
board, the facility or agency, and the department recommendations 4011
on how the dispute may be resolved twenty days prior to the 4012
expiration date of the contract, unless both parties agree to a 4013
time extension. The director shall adopt rules establishing the 4014
procedures of this dispute resolution process. 4015

(b) With the prior approval of the director of mental health, 4016
a board may operate a facility or provide a community mental 4017
health service as follows, if there is no other qualified private 4018
or public facility or community mental health agency that is 4019
immediately available and willing to operate such a facility or 4020
provide the service: 4021

(i) In an emergency situation, any board may operate a 4022
facility or provide a community mental health service in order to 4023
provide essential services for the duration of the emergency; 4024

(ii) In a service district with a population of at least one 4025
hundred thousand but less than five hundred thousand, a board may 4026
operate a facility or provide a community mental health service 4027
for no longer than one year; 4028

(iii) In a service district with a population of less than 4029
one hundred thousand, a board may operate a facility or provide a 4030
community mental health service for no longer than one year, 4031
except that such a board may operate a facility or provide a 4032
community mental health service for more than one year with the 4033
prior approval of the director and the prior approval of the board 4034
of county commissioners, or of a majority of the boards of county 4035
commissioners if the district is a joint-county district. 4036

The director shall not give a board approval to operate a 4037
facility or provide a community mental health service under 4038
division (A)(8)(b)(ii) or (iii) of this section unless the 4039
director determines that it is not feasible to have the department 4040
operate the facility or provide the service. 4041

The director shall not give a board approval to operate a 4042
facility or provide a community mental health service under 4043
division (A)(8)(b)(iii) of this section unless the director 4044
determines that the board will provide greater administrative 4045
efficiency and more or better services than would be available if 4046
the board contracted with a private or public facility or 4047
community mental health agency. 4048

The director shall not give a board approval to operate a 4049
facility previously operated by a person or other government 4050
entity unless the board has established to the director's 4051
satisfaction that the person or other government entity cannot 4052
effectively operate the facility or that the person or other 4053
government entity has requested the board to take over operation 4054
of the facility. The director shall not give a board approval to 4055
provide a community mental health service previously provided by a 4056

community mental health agency unless the board has established to 4057
the director's satisfaction that the agency cannot effectively 4058
provide the service or that the agency has requested the board 4059
take over providing the service. 4060

The director shall review and evaluate a board's operation of 4061
a facility and provision of community mental health service under 4062
division (A)(8)(b) of this section. 4063

Nothing in division (A)(8)(b) of this section authorizes a 4064
board to administer or direct the daily operation of any facility 4065
or community mental health agency, but a facility or agency may 4066
contract with a board to receive administrative services or staff 4067
direction from the board under the direction of the governing body 4068
of the facility or agency. 4069

(9) Approve fee schedules and related charges or adopt a unit 4070
cost schedule or other methods of payment for contract services 4071
provided by community mental health agencies in accordance with 4072
guidelines issued by the department as necessary to comply with 4073
state and federal laws pertaining to financial assistance; 4074

(10) Submit to the director and the county commissioners of 4075
the county or counties served by the board, and make available to 4076
the public, an annual report of the programs under the 4077
jurisdiction of the board, including a fiscal accounting; 4078

(11) Establish, to the extent resources are available, a 4079
community support system, which provides for treatment, support, 4080
and rehabilitation services and opportunities. The essential 4081
elements of the system include, but are not limited to, the 4082
following components in accordance with section 5119.06 of the 4083
Revised Code: 4084

(a) To locate persons in need of mental health services to 4085
inform them of available services and benefits mechanisms; 4086

(b) Assistance for clients to obtain services necessary to 4087

meet basic human needs for food, clothing, shelter, medical care, 4088
personal safety, and income; 4089

(c) Mental health care, including, but not limited to, 4090
outpatient, partial hospitalization, and, where appropriate, 4091
inpatient care; 4092

(d) Emergency services and crisis intervention; 4093

(e) Assistance for clients to obtain vocational services and 4094
opportunities for jobs; 4095

(f) The provision of services designed to develop social, 4096
community, and personal living skills; 4097

(g) Access to a wide range of housing and the provision of 4098
residential treatment and support; 4099

(h) Support, assistance, consultation, and education for 4100
families, friends, consumers of mental health services, and 4101
others; 4102

(i) Recognition and encouragement of families, friends, 4103
neighborhood networks, especially networks that include racial and 4104
ethnic minorities, churches, community organizations, and 4105
meaningful employment as natural supports for consumers of mental 4106
health services; 4107

(j) Grievance procedures and protection of the rights of 4108
consumers of mental health services; 4109

(k) Case management, which includes continual individualized 4110
assistance and advocacy to ensure that needed services are offered 4111
and procured. 4112

(12) Designate the treatment program, agency, or facility for 4113
each person involuntarily committed to the board pursuant to 4114
Chapter 5122. of the Revised Code and authorize payment for such 4115
treatment. The board shall provide the least restrictive and most 4116
appropriate alternative that is available for any person 4117

involuntarily committed to it and shall assure that the services 4118
listed in section 340.09 of the Revised Code are available to 4119
severely mentally disabled persons residing within its service 4120
district. The board shall establish the procedure for authorizing 4121
payment for services, which may include prior authorization in 4122
appropriate circumstances. The board may provide for services 4123
directly to a severely mentally disabled person when life or 4124
safety is endangered and when no community mental health agency is 4125
available to provide the service. 4126

(13) Establish a method for evaluating referrals for 4127
involuntary commitment and affidavits filed pursuant to section 4128
5122.11 of the Revised Code in order to assist the probate 4129
division of the court of common pleas in determining whether there 4130
is probable cause that a respondent is subject to involuntary 4131
hospitalization and what alternative treatment is available and 4132
appropriate, if any; 4133

(14) Ensure that apartments or rooms built, subsidized, 4134
renovated, rented, owned, or leased by the board or a community 4135
mental health agency have been approved as meeting minimum fire 4136
safety standards and that persons residing in the rooms or 4137
apartments are receiving appropriate and necessary services, 4138
including culturally relevant services, from a community mental 4139
health agency. This division does not apply to residential 4140
facilities licensed pursuant to section 5119.22 of the Revised 4141
Code. 4142

(15) Establish a mechanism for involvement of consumer 4143
recommendation and advice on matters pertaining to mental health 4144
services in the alcohol, drug addiction, and mental health service 4145
district; 4146

(16) Perform the duties under section 3722.18 of the Revised 4147
Code required by rules adopted under section 5119.61 of the 4148
Revised Code regarding referrals by the board or mental health 4149

agencies under contract with the board of individuals with mental 4150
illness or severe mental disability to adult care facilities and 4151
effective arrangements for ongoing mental health services for the 4152
individuals. The board is accountable in the manner specified in 4153
the rules for ensuring that the ongoing mental health services are 4154
effectively arranged for the individuals. 4155

(B) The board shall establish such rules, operating 4156
procedures, standards, and bylaws, and perform such other duties 4157
as may be necessary or proper to carry out the purposes of this 4158
chapter. 4159

(C) A board of alcohol, drug addiction, and mental health 4160
services may receive by gift, grant, devise, or bequest any 4161
moneys, lands, or property for the benefit of the purposes for 4162
which the board is established, and may hold and apply it 4163
according to the terms of the gift, grant, or bequest. All money 4164
received, including accrued interest, by gift, grant, or bequest 4165
shall be deposited in the treasury of the county, the treasurer of 4166
which is custodian of the alcohol, drug addiction, and mental 4167
health services funds to the credit of the board and shall be 4168
available for use by the board for purposes stated by the donor or 4169
grantor. 4170

(D) No board member or employee of a board of alcohol, drug 4171
addiction, and mental health services shall be liable for injury 4172
or damages caused by any action or inaction taken within the scope 4173
of the board member's official duties or the employee's 4174
employment, whether or not such action or inaction is expressly 4175
authorized by this section, section 340.033, or any other section 4176
of the Revised Code, unless such action or inaction constitutes 4177
willful or wanton misconduct. Chapter 2744. of the Revised Code 4178
applies to any action or inaction by a board member or employee of 4179
a board taken within the scope of the board member's official 4180
duties or employee's employment. For the purposes of this 4181

division, the conduct of a board member or employee shall not be 4182
considered willful or wanton misconduct if the board member or 4183
employee acted in good faith and in a manner that the board member 4184
or employee reasonably believed was in or was not opposed to the 4185
best interests of the board and, with respect to any criminal 4186
action or proceeding, had no reasonable cause to believe the 4187
conduct was unlawful. 4188

(E) The meetings held by any committee established by a board 4189
of alcohol, drug addiction, and mental health services shall be 4190
considered to be meetings of a public body subject to section 4191
121.22 of the Revised Code. 4192

Sec. 340.091. Each board of alcohol, drug addiction, and 4193
mental health services shall contract with a community mental 4194
health agency under division (A)(8)(a) of section 340.03 of the 4195
Revised Code for the agency to do all of the following in 4196
accordance with rules adopted under section 5119.61 of the Revised 4197
Code for an individual referred to the agency under division 4198
(C)(2) of section ~~173.35~~ 5160.80 of the Revised Code: 4199

(A) Assess the individual to determine whether to recommend 4200
that a PASSPORT administrative agency determine that the 4201
environment in which the individual will be living while receiving 4202
residential state supplement payments is appropriate for the 4203
individual's needs and, if it determines the environment is 4204
appropriate, issue the recommendation to the PASSPORT 4205
administrative agency; 4206

(B) Provide ongoing monitoring to ensure that services 4207
provided under section 340.09 of the Revised Code are available to 4208
the individual; 4209

(C) Provide discharge planning to ensure the individual's 4210
earliest possible transition to a less restrictive environment. 4211

Sec. 340.16. Not later than ninety days after September 5, 4212
2001, the department of mental health and the department of job 4213
and family services shall adopt rules that establish requirements 4214
and procedures for prior notification and service coordination 4215
between public children services agencies and boards of alcohol, 4216
drug addiction, and mental health services when a public children 4217
services agency refers a child in its custody to a board for 4218
services funded by the board. The rules shall be adopted in 4219
accordance with Chapter 119. of the Revised Code. 4220

The department of mental health and department of ~~job and~~ 4221
~~family services~~ health care administration shall collaborate in 4222
formulating a plan that delineates the funding responsibilities of 4223
public children services agencies and boards of alcohol, drug 4224
addiction, and mental health services for services provided under 4225
section ~~5111.023~~ 5163.20 of the Revised Code to children in the 4226
custody of public children services agencies. ~~The departments~~ 4227
~~shall complete the plan not later than ninety days after September~~ 4228
~~5, 2001.~~ 4229

Sec. 341.192. (A) As used in this section: 4230

(1) ~~"Medical assistance program" has the same meaning as in~~ 4231
~~section 2913.40 of the Revised Code.~~ 4232

~~(2)~~ "Medical provider" means a physician, hospital, 4233
laboratory, pharmacy, or other health care provider that is not 4234
employed by or under contract to a county or the department of 4235
rehabilitation and correction to provide medical services to 4236
persons confined in the county jail or a state correctional 4237
institution. 4238

~~(3)~~(2) "Necessary care" means medical care of a nonelective 4239
nature that cannot be postponed until after the period of 4240
confinement of a person who is confined in a county jail or a 4241

state correctional institution or is in the custody of a law 4242
enforcement officer without endangering the life or health of the 4243
person. 4244

(B) If a physician employed by or under contract to a county 4245
or the department of rehabilitation and correction to provide 4246
medical services to persons confined in the county jail or state 4247
correctional institution determines that a person who is confined 4248
in the county jail or a state correctional institution or who is 4249
in the custody of a law enforcement officer prior to the person's 4250
confinement in the county jail or a state correctional institution 4251
requires necessary care that the physician cannot provide, the 4252
necessary care shall be provided by a medical provider. The county 4253
or the department of rehabilitation and correction shall pay a 4254
medical provider for necessary care an amount not exceeding the 4255
authorized reimbursement rate for the same service established by 4256
the department of ~~job and family services~~ health care 4257
administration under the ~~medical assistance~~ medicaid program. 4258

Sec. 505.84. As used in this section, "authorized medicare 4259
reimbursement rate" means such rate established for the locality 4260
under ~~Title XVIII of the "Social Security Act," 49 Stat. 620~~ 4261
~~(1935), 42 U.S.C.A. 301, as amended~~ medicare program. 4262

A board of township trustees may establish reasonable charges 4263
for the use of fire and rescue services, ambulance services, or 4264
emergency medical services. The board may establish different 4265
charges for township residents and nonresidents, and may, in its 4266
discretion, waive all or part of the charge for any resident. The 4267
charge for ambulance transportation for nonresidents shall be an 4268
amount not less than the authorized medicare reimbursement rate, 4269
except that, if prior to September 9, 1988, the board had 4270
different charges for residents and nonresidents and the charge 4271
for nonresidents was less than the authorized medicare 4272

reimbursement rate, the board may charge nonresidents less than 4273
the authorized medicare reimbursement rate. 4274

Charges collected under this section shall be kept in a 4275
separate fund designated as "the fire and rescue services, 4276
ambulance services, and emergency medical services fund," and 4277
shall be appropriated and administered by the board. The fund 4278
shall be used for the payment of the costs of the management, 4279
maintenance, and operation of fire and rescue services, ambulance 4280
services, and emergency medical services in the township. If the 4281
fire and rescue services, ambulance services, and emergency 4282
medical services are discontinued in the township, any balance 4283
remaining in the fund shall be paid into the general fund of the 4284
township. 4285

Sec. 742.41. (A) As used in this section: 4286

(1) "Other system retirant" has the same meaning as in 4287
section 742.26 of the Revised Code. 4288

(2) "Personal history record" includes a member's, former 4289
member's, or other system retirant's name, address, telephone 4290
number, social security number, record of contributions, 4291
correspondence with the Ohio police and fire pension fund, status 4292
of any application for benefits, and any other information deemed 4293
confidential by the trustees of the fund. 4294

(B) The treasurer of state shall furnish annually to the 4295
board of trustees of the fund a sworn statement of the amount of 4296
the funds in the treasurer of state's custody belonging to the 4297
Ohio police and fire pension fund. The records of the fund shall 4298
be open for public inspection except for the following, which 4299
shall be excluded, except with the written authorization of the 4300
individual concerned: 4301

(1) The individual's personal history record; 4302

(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 4334
association at least once a year and may impose a reasonable 4335
charge for the list. 4336

(4) Within fourteen days after receiving ~~from the director of~~ 4337
~~job and family services~~ a list of the names and social security 4338
numbers of recipients of public assistance pursuant to section 4339
5101.181 of the Revised Code or a list of the names and social 4340
security numbers of public medical assistance program recipients 4341
pursuant to section 5160.43 of the Revised Code, the fund shall 4342
inform the auditor of state of the name, current or most recent 4343
employer address, and social security number of each member or 4344
other system retirant whose name and social security number are 4345
the same as that of a person whose name or social security number 4346
~~was submitted by the director~~ is included on the list. The fund 4347
and its employees shall, except for purposes of furnishing the 4348
auditor of state with information required by this section, 4349
preserve the confidentiality of recipients of public assistance in 4350
compliance with ~~division (A) of~~ section 5101.181 of the Revised 4351
Code and preserve the confidentiality of public medical assistance 4352
program recipients in compliance with section 5160.43 of the 4353
Revised Code. 4354

(5) The fund shall comply with orders issued under section 4355
3105.87 of the Revised Code. 4356

On the written request of an alternate payee, as defined in 4357
section 3105.80 of the Revised Code, the fund shall furnish to the 4358
alternate payee information on the amount and status of any 4359
amounts payable to the alternate payee under an order issued under 4360
section 3105.171 or 3105.65 of the Revised Code. 4361

(6) At the request of any person, the fund shall make 4362
available to the person copies of all documents, including 4363
resumes, in the fund's possession regarding filling a vacancy of a 4364
police officer employee member, firefighter employee member, 4365

police retirant member, or firefighter retirant member of the 4366
board of trustees. The person who made the request shall pay the 4367
cost of compiling, copying, and mailing the documents. The 4368
information described in this division is a public record. 4369

(F) A statement that contains information obtained from the 4370
fund's records that is signed by the secretary of the board of 4371
trustees of the Ohio police and fire pension fund and to which the 4372
board's official seal is affixed, or copies of the fund's records 4373
to which the signature and seal are attached, shall be received as 4374
true copies of the fund's records in any court or before any 4375
officer of this state. 4376

Sec. 955.201. (A) As used in this section and in section 4377
955.202 of the Revised Code, "Ohio pet fund" means a nonprofit 4378
corporation organized by that name under Chapter 1702. of the 4379
Revised Code that consists of humane societies, veterinarians, 4380
animal shelters, companion animal breeders, dog wardens, and 4381
similar individuals and entities. 4382

(B) The Ohio pet fund shall do all of the following: 4383

(1) Establish eligibility criteria for organizations that may 4384
receive financial assistance from the pets program funding board 4385
created in section 955.202 of the Revised Code. Those 4386
organizations may include any of the following: 4387

(a) An animal shelter as defined in section 4729.01 of the 4388
Revised Code; 4389

(b) A local nonprofit veterinary association that operates a 4390
program for the sterilization of dogs and cats; 4391

(c) A charitable organization that is exempt from federal 4392
income taxation under subsection 501(c)(3) of the Internal Revenue 4393
Code and the primary purpose of which is to support programs for 4394
the sterilization of dogs and cats and educational programs 4395

concerning the proper veterinary care of those animals. 4396

(2) Establish procedures for applying for financial 4397
assistance from the pets program funding board. Application 4398
procedures shall require eligible organizations to submit detailed 4399
proposals that outline the intended uses of the moneys sought. 4400

(3) Establish eligibility criteria for sterilization and 4401
educational programs for which moneys from the pets program 4402
funding board may be used and, consistent with division (C) of 4403
this section, establish eligibility criteria for individuals who 4404
seek sterilization for their dogs and cats from eligible 4405
organizations; 4406

(4) Establish procedures for the disbursement of moneys the 4407
pets program funding board receives from license plate 4408
contributions pursuant to division (C) of section 4503.551 of the 4409
Revised Code; 4410

(5) Advertise or otherwise provide notification of the 4411
availability of financial assistance from the pets program funding 4412
board for eligible organizations; 4413

(6) Design markings to be inscribed on "pets" license plates 4414
under section 4503.551 of the Revised Code. 4415

(C)(1) The owner of a dog or cat is eligible for dog or cat 4416
sterilization services from an eligible organization when those 4417
services are subsidized in whole or in part by money from the pets 4418
program funding board if any of the following applies: 4419

(a) The income of the owner's family does not exceed one 4420
hundred fifty per cent of the federal poverty guideline. 4421

(b) The owner, or any member of the owner's family who 4422
resides with the owner, is a recipient or beneficiary of one of 4423
the following government assistance programs: 4424

(i) Low-income housing assistance under the "United States 4425

Housing Act of 1937," 42 U.S.C.A. 1437f, as amended, known as the 4426
federal section 8 housing program; 4427

(ii) The Ohio works first program established by Chapter 4428
5107. of the Revised Code; 4429

(iii) ~~Title XIX of the "Social Security Act," 49 Stat. 620~~ 4430
~~(1935), 42 U.S.C.A. 301, as amended, known as the medical~~ 4431
~~assistance program or The medicaid, provided by the department of~~ 4432
~~job and family services under Chapter 5111. of the Revised Code~~ 4433
~~program;~~ 4434

(iv) A program or law administered by the United States 4435
department of veterans' affairs or veterans' administration for 4436
any service-connected disability; 4437

(v) The food stamp program established under the "Food Stamp 4438
Act of 1977," 91 Stat. 958, 7 U.S.C.A. 2011, as amended, 4439
administered by the department of job and family services under 4440
section 5101.54 of the Revised Code; 4441

(vi) The "special supplemental nutrition program for women, 4442
infants, and children" established under the "Child Nutrition Act 4443
of 1966," 80 Stat. 885, 42 U.S.C. 1786, as amended, administered 4444
by the department of health under section 3701.132 of the Revised 4445
Code; 4446

(vii) Supplemental security income ~~under Title XVI of the~~ 4447
~~"Social Security Act," 86 Stat. 1475 (1972), 42 U.S.C.A. 1383, as~~ 4448
~~amended;~~ 4449

(viii) Social security disability insurance benefits provided 4450
under Title II of the "Social Security Act," 49 Stat. 620 (1935), 4451
42 U.S.C.A. 401, as amended. 4452

(c) The owner of the dog or cat submits to the eligible 4453
organization operating the sterilization program either of the 4454
following: 4455

(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;	4486 4487
(2) Hydration when administered to diminish the pain or discomfort of a principal, but not to postpone death;	4488 4489
(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.	4490 4491 4492
(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.	4493 4494 4495 4496 4497 4498 4499 4500
(E) "Declaration for mental health treatment" has the same meaning as in section 2135.01 of the Revised Code.	4501 4502
(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.	4503 4504 4505
(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.	4506 4507 4508
(H) "Health care decision" means informed consent, refusal to give informed consent, or withdrawal of informed consent to health care.	4509 4510 4511
(I) "Health care facility" means any of the following:	4512
(1) A hospital;	4513
(2) A hospice care program or other institution that specializes in comfort care of patients in a terminal condition or	4514 4515

in a permanently unconscious state;	4516
(3) A nursing home;	4517
(4) A home health agency;	4518
(5) An intermediate care facility for the mentally retarded;	4519
(6) A regulated community mental health organization.	4520
(J) "Health care personnel" means physicians, nurses,	4521
physician assistants, emergency medical technicians-basic,	4522
emergency medical technicians-intermediate, emergency medical	4523
technicians-paramedic, medical technicians, dietitians, other	4524
authorized persons acting under the direction of an attending	4525
physician, and administrators of health care facilities.	4526
(K) "Home health agency" has the same meaning as in section	4527
5101.61 <u>3701.881</u> of the Revised Code.	4528
(L) "Hospice care program" has the same meaning as in section	4529
3712.01 of the Revised Code.	4530
(M) "Hospital" has the same meanings as in sections 2108.01,	4531
3701.01, and 5122.01 of the Revised Code.	4532
(N) "Hydration" means fluids that are artificially or	4533
technologically administered.	4534
(O) "Incompetent" has the same meaning as in section 2111.01	4535
of the Revised Code.	4536
(P) "Intermediate care facility for the mentally retarded"	4537
has the same meaning as in section 5111.20 <u>5164.01</u> of the Revised	4538
Code.	4539
(Q) "Life-sustaining treatment" means any medical procedure,	4540
treatment, intervention, or other measure that, when administered	4541
to a principal, will serve principally to prolong the process of	4542
dying.	4543
(R) "Medical claim" has the same meaning as in section	4544

2305.113 of the Revised Code.	4545
(S) "Mental health treatment" has the same meaning as in section 2135.01 of the Revised Code.	4546 4547
(T) "Nursing home" has the same meaning as in section 3721.01 of the Revised Code.	4548 4549
(U) "Nutrition" means sustenance that is artificially or technologically administered.	4550 4551
(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:	4552 4553 4554 4555 4556 4557
(1) Irreversible unawareness of one's being and environment.	4558
(2) Total loss of cerebral cortical functioning, resulting in the principal having no capacity to experience pain or suffering.	4559 4560
(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.	4561 4562 4563 4564
(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.	4565 4566 4567
(Y) "Political subdivision" and "state" have the same meanings as in section 2744.01 of the Revised Code.	4568 4569
(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.	4570 4571 4572 4573
(AA) "Regulated community mental health organization" means a	4574

residential facility as defined and licensed under section 5119.22 4575
of the Revised Code or a community mental health agency as defined 4576
in section 5122.01 of the Revised Code. 4577

(BB) "Terminal condition" means an irreversible, incurable, 4578
and untreatable condition caused by disease, illness, or injury 4579
from which, to a reasonable degree of medical certainty as 4580
determined in accordance with reasonable medical standards by a 4581
principal's attending physician and one other physician who has 4582
examined the principal, both of the following apply: 4583

(1) There can be no recovery. 4584

(2) Death is likely to occur within a relatively short time 4585
if life-sustaining treatment is not administered. 4586

(CC) "Tort action" means a civil action for damages for 4587
injury, death, or loss to person or property, other than a civil 4588
action for damages for a breach of contract or another agreement 4589
between persons. 4590

Sec. 1347.08. (A) Every state or local agency that maintains 4591
a personal information system, upon the request and the proper 4592
identification of any person who is the subject of personal 4593
information in the system, shall: 4594

(1) Inform the person of the existence of any personal 4595
information in the system of which the person is the subject; 4596

(2) Except as provided in divisions (C) and (E)(2) of this 4597
section, permit the person, the person's legal guardian, or an 4598
attorney who presents a signed written authorization made by the 4599
person, to inspect all personal information in the system of which 4600
the person is the subject; 4601

(3) Inform the person about the types of uses made of the 4602
personal information, including the identity of any users usually 4603
granted access to the system. 4604

(B) Any person who wishes to exercise a right provided by 4605
this section may be accompanied by another individual of the 4606
person's choice. 4607

(C)(1) A state or local agency, upon request, shall disclose 4608
medical, psychiatric, or psychological information to a person who 4609
is the subject of the information or to the person's legal 4610
guardian, unless a physician, psychiatrist, or psychologist 4611
determines for the agency that the disclosure of the information 4612
is likely to have an adverse effect on the person, in which case 4613
the information shall be released to a physician, psychiatrist, or 4614
psychologist who is designated by the person or by the person's 4615
legal guardian. 4616

(2) Upon the signed written request of either a licensed 4617
attorney at law or a licensed physician designated by the inmate, 4618
together with the signed written request of an inmate of a 4619
correctional institution under the administration of the 4620
department of rehabilitation and correction, the department shall 4621
disclose medical information to the designated attorney or 4622
physician as provided in division (C) of section 5120.21 of the 4623
Revised Code. 4624

(D) If an individual who is authorized to inspect personal 4625
information that is maintained in a personal information system 4626
requests the state or local agency that maintains the system to 4627
provide a copy of any personal information that the individual is 4628
authorized to inspect, the agency shall provide a copy of the 4629
personal information to the individual. Each state and local 4630
agency may establish reasonable fees for the service of copying, 4631
upon request, personal information that is maintained by the 4632
agency. 4633

(E)(1) This section regulates access to personal information 4634
that is maintained in a personal information system by persons who 4635
are the subject of the information, but does not limit the 4636

authority of any person, including a person who is the subject of 4637
personal information maintained in a personal information system, 4638
to inspect or have copied, pursuant to section 149.43 of the 4639
Revised Code, a public record as defined in that section. 4640

(2) This section does not provide a person who is the subject 4641
of personal information maintained in a personal information 4642
system, the person's legal guardian, or an attorney authorized by 4643
the person, with a right to inspect or have copied, or require an 4644
agency that maintains a personal information system to permit the 4645
inspection of or to copy, a confidential law enforcement 4646
investigatory record or trial preparation record, as defined in 4647
divisions (A)(2) and (4) of section 149.43 of the Revised Code. 4648

(F) This section does not apply to any of the following: 4649

(1) The contents of an adoption file maintained by the 4650
department of health under section 3705.12 of the Revised Code; 4651

(2) Information contained in the putative father registry 4652
established by section 3107.062 of the Revised Code, regardless of 4653
whether the information is held by the department of job and 4654
family services or, pursuant to section 3111.69 of the Revised 4655
Code, the office of child support in the department or a child 4656
support enforcement agency; 4657

(3) Papers, records, and books that pertain to an adoption 4658
and that are subject to inspection in accordance with section 4659
3107.17 of the Revised Code; 4660

(4) Records listed in division (A) of section 3107.42 of the 4661
Revised Code or specified in division (A) of section 3107.52 of 4662
the Revised Code; 4663

(5) Records that identify an individual described in division 4664
(A)(1) of section 3721.031 of the Revised Code, or that would tend 4665
to identify such an individual; 4666

(6) Files and records that have been expunged under division	4667
(D)(1) of section 3721.23 of the Revised Code;	4668
(7) Records that identify an individual described in division	4669
(A)(1) of section 3721.25 of the Revised Code, or that would tend	4670
to identify such an individual;	4671
(8) Records that identify an individual described in division	4672
(A)(1) of section 5111.61 <u>5164.77</u> of the Revised Code, or that	4673
would tend to identify such an individual;	4674
(9) Test materials, examinations, or evaluation tools used in	4675
an examination for licensure as a nursing home administrator that	4676
the board of examiners of nursing home administrators administers	4677
under section 4751.04 of the Revised Code or contracts under that	4678
section with a private or government entity to administer;	4679
(10) Information contained in a database established and	4680
maintained pursuant to section 5101.13 of the Revised Code.	4681
Sec. 1731.04. (A) An agreement between an alliance and an	4682
insurer referred to in division (B) of section 1731.01 of the	4683
Revised Code shall contain at least the following:	4684
(1) A provision requiring the insurer to offer and sell to	4685
small employers served or to be served by an alliance one or more	4686
health benefit plan options for coverage of their eligible	4687
employees and the eligible dependents and members of the families	4688
of the eligible employees and, if applicable, such members'	4689
eligible retirees and the eligible dependents and members of the	4690
families of the retirees, subject to such conditions and	4691
restrictions as may be set forth or incorporated into the	4692
agreement;	4693
(2) A brief description of each type of health benefit plan	4694
option that is to be so offered and the conditions for the	4695
modification, continuation, and termination of the coverage and	4696

benefits thereunder; 4697

(3) A statement of the eligibility requirements that an 4698
employee or retiree must meet in order for the employee or retiree 4699
to be eligible to obtain and retain coverage under any health 4700
benefit plan option so offered and, if one of such requirements is 4701
that an employee must regularly work for a minimum number of hours 4702
per week, a statement of such minimum number of hours, which 4703
minimum shall not exceed twenty-five hours per week; 4704

(4) A description of any pre-existing condition and waiting 4705
period rules; 4706

(5) A statement of the premium rates or other charges that 4707
apply to each health benefit plan option or a formula or method of 4708
determining the rates or charges; 4709

(6) A provision prescribing the minimum employer contribution 4710
toward premiums or other charges required in order to permit a 4711
small employer to obtain coverage under a health benefit plan 4712
option offered under an alliance program; 4713

(7) A provision requiring that each health benefit plan under 4714
the alliance program must provide for the continuation of coverage 4715
of participants of an enrolled small employer so long as the small 4716
employer determines that such person is a qualified beneficiary 4717
entitled to such coverage pursuant to Part 6 of Title I of the 4718
"Federal Employee Retirement Income Security Act of 1974," 88 4719
Stat. 832, 29 U.S.C.A. 1001, and the laws of this state, and 4720
regulations or rulings interpreting such provisions. Such coverage 4721
provided by the insurer under the plan to participants shall 4722
comply with the "Federal Employee Retirement Income Security Act 4723
of 1974" and the relevant statutes, regulations, and rulings 4724
interpreting that act, including provisions regarding types of 4725
coverage to be provided, apportionments of limitations on 4726
coverage, apportionments of deductibles, and the rights of 4727

qualified beneficiaries to elect coverage options relating to 4728
types of coverage and otherwise. 4729

(B) An agreement between an alliance and an insurer referred 4730
to in division (B) of section 1731.01 of the Revised Code may 4731
contain provisions relating to, but not limited to, any of the 4732
following: 4733

(1) The application and enrollment process for a small 4734
employer and related provisions pertaining to historical 4735
experience, health statements, and underwriting standards; 4736

(2) The minimum number of those employees eligible to be 4737
participants that are required to participate in order to permit a 4738
small employer to obtain coverage under a health benefit plan 4739
option offered under the alliance program, which may vary with the 4740
number of employees or those eligible to be participants in 4741
respect of the small employer; 4742

(3) A procedure for allowing an enrolled small employer to 4743
change from one plan option to another under the alliance program, 4744
subject to qualifying by size or otherwise under the alliance 4745
program; 4746

(4) The application of any risk-related pooling or grouping 4747
programs and related premiums, conditions, reviews, and 4748
alternatives offered by the insurer; 4749

(5) The availability of a medicare supplement coverage option 4750
for eligible participants who are covered by Parts A and B of the 4751
~~medicare, Title XVIII of the "Social Security Act," 49 Stat. 620~~ 4752
~~(1935), 42 U.S.C.A. 301~~ program; 4753

(6) Relevant experience periods, enrollment periods, and 4754
contract periods; 4755

(7) Effective dates for coverage of eligible participants; 4756

(8) Conditions under which denial or withdrawal of coverage 4757

of participants or small employers and their employees may occur 4758
by reason of falsification or misrepresentation of material facts 4759
or criminal conduct toward the insurer, small employer, or 4760
alliance under the program; 4761

(9) Premium rate structures, which may be uniform or make 4762
provision for age-specific rates, differentials based on number of 4763
participants of an enrolled small employer, products and plan 4764
options selected, and other factors, rate adjustments based on 4765
consumer price indices, utilization, or other relevant factors, 4766
notification of rate adjustments, and arbitration; 4767

(10) Any responsibilities of the alliance for billing, 4768
collection, and transmittal of premiums; 4769

(11) Inclusion under the alliance program of small employers 4770
that are members of other organizations described in division 4771
(A)(1) of section 1731.01 of the Revised Code that contract with 4772
the alliance for this purpose, and conditions pertaining to those 4773
small employer members and to their employees and retirees, and 4774
dependents and family members of those employees or retirees, as 4775
applicable under the alliance program; 4776

(12) The agreement of the insurer to offer and sell one or 4777
more health benefit plans to small employer members of another 4778
small employer health care alliance that contracts with the 4779
alliance for this purpose; 4780

(13) Use of the health benefit plan options of the insurer in 4781
the alliance program and use of the names of the alliance and the 4782
insurer; 4783

(14) Indemnification from claims and liability by reason of 4784
acts or omissions of others; 4785

(15) Ownership, use, availability, and maintenance of 4786
confidentiality of data and records relating to the alliance 4787
program; 4788

(16) Utilization reports to be provided to the alliance by 4789
the insurer; 4790

(17) Such other provisions as may be agreed upon by the 4791
alliance and the insurer to better provide for the articulation, 4792
promotion, financing, and operation of the alliance program or a 4793
health benefit plan under the program in furtherance of the public 4794
purposes stated in section 1731.02 of the Revised Code. 4795

(C) Neither an alliance program nor an agreement between an 4796
alliance and an insurer is itself a policy or contract of 4797
insurance, or a certificate, indorsement, rider, or application 4798
forming any part of a policy, contract, or certificate of 4799
insurance. Chapters 3905., 3933., and 3959. of the Revised Code do 4800
not apply to an alliance program or to an agreement between an 4801
alliance and an insurer thereunder, as such, or to the functions 4802
of the alliance under an alliance program. 4803

Sec. 1739.061. (A)(1) This section applies to both of the 4804
following: 4805

(a) A multiple employer welfare arrangement that issues or 4806
requires the use of a standardized identification card or an 4807
electronic technology for submission and routing of prescription 4808
drug claims; 4809

(b) A person or entity that a multiple employer welfare 4810
arrangement contracts with to issue a standardized identification 4811
card or an electronic technology described in division (A)(1)(a) 4812
of this section. 4813

(2) Notwithstanding division (A)(1) of this section, this 4814
section does not apply to the issuance or required use of a 4815
standardized identification card or an electronic technology for 4816
the submission and routing of prescription drug claims in 4817
connection with any of the following: 4818

(a) Any program or arrangement covering only accident, 4819
credit, dental, disability income, long-term care, hospital 4820
indemnity, medicare supplement, medicare, tricare, specified 4821
disease, or vision care; coverage under a 4822
one-time-limited-duration policy of not longer than six months; 4823
coverage issued as a supplement to liability insurance; insurance 4824
arising out of workers' compensation or similar law; automobile 4825
medical payment insurance; or insurance under which benefits are 4826
payable with or without regard to fault and which is statutorily 4827
required to be contained in any liability insurance policy or 4828
equivalent self-insurance. 4829

(b) Coverage provided under the medicaid, ~~as defined in~~ 4830
~~section 5111.01 of the Revised Code~~ program. 4831

(c) Coverage provided under an employer's self-insurance plan 4832
or by any of its administrators, as defined in section 3959.01 of 4833
the Revised Code, to the extent that federal law supersedes, 4834
preempts, prohibits, or otherwise precludes the application of 4835
this section to the plan and its administrators. 4836

(B) A standardized identification card or an electronic 4837
technology issued or required to be used as provided in division 4838
(A)(1) of this section shall contain uniform prescription drug 4839
information in accordance with either division (B)(1) or (2) of 4840
this section. 4841

(1) The standardized identification card or the electronic 4842
technology shall be in a format and contain information fields 4843
approved by the national council for prescription drug programs or 4844
a successor organization, as specified in the council's or 4845
successor organization's pharmacy identification card 4846
implementation guide in effect on the first day of October most 4847
immediately preceding the issuance or required use of the 4848
standardized identification card or the electronic technology. 4849

(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. 4880

(E)(1) Except as provided in division (E)(2) of this section, 4881
if there is a change in the information contained in the 4882
standardized identification card or the electronic technology 4883
issued to an individual, the multiple employer welfare arrangement 4884
or person under contract with it to issue a standardized 4885
identification card or an electronic technology shall issue a new 4886
card or electronic technology to the individual. 4887

(2) A multiple employer welfare arrangement or person under 4888
contract with it is not required under division (E)(1) of this 4889
section to issue a new card or electronic technology to an 4890
individual more than once during a twelve-month period. 4891

(F) Nothing in this section shall be construed as requiring a 4892
multiple employer welfare arrangement to produce more than one 4893
standardized identification card or one electronic technology for 4894
use by individuals accessing health care benefits provided under a 4895
multiple employer welfare arrangement. 4896

Sec. 1751.01. As used in this chapter: 4897

(A)(1) "Basic health care services" means the following 4898
services when medically necessary: 4899

(a) Physician's services, except when such services are 4900
supplemental under division (B) of this section; 4901

(b) Inpatient hospital services; 4902

(c) Outpatient medical services; 4903

(d) Emergency health services; 4904

(e) Urgent care services; 4905

(f) Diagnostic laboratory services and diagnostic and 4906
therapeutic radiologic services; 4907

(g) Diagnostic and treatment services, other than 4908

prescription drug services, for biologically based mental 4909
illnesses; 4910

(h) Preventive health care services, including, but not 4911
limited to, voluntary family planning services, infertility 4912
services, periodic physical examinations, prenatal obstetrical 4913
care, and well-child care. 4914

"Basic health care services" does not include experimental 4915
procedures. 4916

Except as provided by divisions (A)(2) and (3) of this 4917
section in connection with the offering of coverage for diagnostic 4918
and treatment services for biologically based mental illnesses, a 4919
health insuring corporation shall not offer coverage for a health 4920
care service, defined as a basic health care service by this 4921
division, unless it offers coverage for all listed basic health 4922
care services. However, this requirement does not apply to the 4923
coverage of beneficiaries enrolled in ~~Title XVIII of the "Social~~ 4924
~~Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended,~~ 4925
the medicare program pursuant to a medicare contract, or to the 4926
coverage of beneficiaries enrolled in the federal employee health 4927
benefits program pursuant to 5 U.S.C.A. 8905, or to the coverage 4928
of ~~beneficiaries enrolled in Title XIX~~ recipients of the "~~Social~~ 4929
~~Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended,~~ 4930
~~known as the medical assistance program or medicaid, provided by~~ 4931
~~the department of job and family services under Chapter 5111. of~~ 4932
~~the Revised Code~~ program, or to the coverage of beneficiaries 4933
under any federal health care program regulated by a federal 4934
regulatory body, or to the coverage of beneficiaries under any 4935
contract covering officers or employees of the state that has been 4936
entered into by the department of administrative services. 4937

(2) A health insuring corporation may offer coverage for 4938
diagnostic and treatment services for biologically based mental 4939
illnesses without offering coverage for all other basic health 4940

care services. A health insuring corporation may offer coverage 4941
for diagnostic and treatment services for biologically based 4942
mental illnesses alone or in combination with one or more 4943
supplemental health care services. However, a health insuring 4944
corporation that offers coverage for any other basic health care 4945
service shall offer coverage for diagnostic and treatment services 4946
for biologically based mental illnesses in combination with the 4947
offer of coverage for all other listed basic health care services. 4948

(3) A health insuring corporation that offers coverage for 4949
basic health care services is not required to offer coverage for 4950
diagnostic and treatment services for biologically based mental 4951
illnesses in combination with the offer of coverage for all other 4952
listed basic health care services if all of the following apply: 4953

(a) The health insuring corporation submits documentation 4954
certified by an independent member of the American academy of 4955
actuaries to the superintendent of insurance showing that incurred 4956
claims for diagnostic and treatment services for biologically 4957
based mental illnesses for a period of at least six months 4958
independently caused the health insuring corporation's costs for 4959
claims and administrative expenses for the coverage of basic 4960
health care services to increase by more than one per cent per 4961
year. 4962

(b) The health insuring corporation submits a signed letter 4963
from an independent member of the American academy of actuaries to 4964
the superintendent of insurance opining that the increase in costs 4965
described in division (A)(3)(a) of this section could reasonably 4966
justify an increase of more than one per cent in the annual 4967
premiums or rates charged by the health insuring corporation for 4968
the coverage of basic health care services. 4969

(c) The superintendent of insurance makes the following 4970
determinations from the documentation and opinion submitted 4971
pursuant to divisions (A)(3)(a) and (b) of this section: 4972

(i) Incurred claims for diagnostic and treatment services for 4973
biologically based mental illnesses for a period of at least six 4974
months independently caused the health insuring corporation's 4975
costs for claims and administrative expenses for the coverage of 4976
basic health care services to increase by more than one per cent 4977
per year. 4978

(ii) The increase in costs reasonably justifies an increase 4979
of more than one per cent in the annual premiums or rates charged 4980
by the health insuring corporation for the coverage of basic 4981
health care services. 4982

Any determination made by the superintendent under this 4983
division is subject to Chapter 119. of the Revised Code. 4984

(B)(1) "Supplemental health care services" means any health 4985
care services other than basic health care services that a health 4986
insuring corporation may offer, alone or in combination with 4987
either basic health care services or other supplemental health 4988
care services, and includes: 4989

(a) Services of facilities for intermediate or long-term 4990
care, or both; 4991

(b) Dental care services; 4992

(c) Vision care and optometric services including lenses and 4993
frames; 4994

(d) Podiatric care or foot care services; 4995

(e) Mental health services, excluding diagnostic and 4996
treatment services for biologically based mental illnesses; 4997

(f) Short-term outpatient evaluative and crisis-intervention 4998
mental health services; 4999

(g) Medical or psychological treatment and referral services 5000
for alcohol and drug abuse or addiction; 5001

(h) Home health services; 5002

(i) Prescription drug services;	5003
(j) Nursing services;	5004
(k) Services of a dietitian licensed under Chapter 4759. of the Revised Code;	5005 5006
(l) Physical therapy services;	5007
(m) Chiropractic services;	5008
(n) Any other category of services approved by the superintendent of insurance.	5009 5010
(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.	5011 5012 5013 5014 5015
(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.	5016 5017 5018 5019 5020
(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.	5021 5022 5023 5024 5025 5026 5027
(E) "Closed panel plan" means a health care plan that requires enrollees to use participating providers.	5028 5029
(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.	5030 5031 5032

(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 5064
defined in division (H) of this section, that, pursuant to a 5065
policy, contract, certificate, or agreement, pays for, reimburses, 5066
or provides, delivers, arranges for, or otherwise makes available, 5067
basic health care services, supplemental health care services, or 5068
specialty health care services, or a combination of basic health 5069
care services and either supplemental health care services or 5070
specialty health care services, through either an open panel plan 5071
or a closed panel plan. 5072

"Health insuring corporation" does not include a limited 5073
liability company formed pursuant to Chapter 1705. of the Revised 5074
Code, an insurer licensed under Title XXXIX of the Revised Code if 5075
that insurer offers only open panel plans under which all 5076
providers and health care facilities participating receive their 5077
compensation directly from the insurer, a corporation formed by or 5078
on behalf of a political subdivision or a department, office, or 5079
institution of the state, or a public entity formed by or on 5080
behalf of a board of county commissioners, a county board of 5081
mental retardation and developmental disabilities, an alcohol and 5082
drug addiction services board, a board of alcohol, drug addiction, 5083
and mental health services, or a community mental health board, as 5084
those terms are used in Chapters 340. and 5126. of the Revised 5085
Code. Except as provided by division (D) of section 1751.02 of the 5086
Revised Code, or as otherwise provided by law, no board, 5087
commission, agency, or other entity under the control of a 5088
political subdivision may accept insurance risk in providing for 5089
health care services. However, nothing in this division shall be 5090
construed as prohibiting such entities from purchasing the 5091
services of a health insuring corporation or a third-party 5092
administrator licensed under Chapter 3959. of the Revised Code. 5093

(P) "Intermediary organization" means a health delivery 5094
network or other entity that contracts with licensed health 5095

insuring corporations or self-insured employers, or both, to 5096
provide health care services, and that enters into contractual 5097
arrangements with other entities for the provision of health care 5098
services for the purpose of fulfilling the terms of its contracts 5099
with the health insuring corporations and self-insured employers. 5100

(Q) "Intermediate care" means residential care above the 5101
level of room and board for patients who require personal 5102
assistance and health-related services, but who do not require 5103
skilled nursing care. 5104

(R) "Medical record" means the personal information that 5105
relates to an individual's physical or mental condition, medical 5106
history, or medical treatment. 5107

(S)(1) "Open panel plan" means a health care plan that 5108
provides incentives for enrollees to use participating providers 5109
and that also allows enrollees to use providers that are not 5110
participating providers. 5111

(2) No health insuring corporation may offer an open panel 5112
plan, unless the health insuring corporation is also licensed as 5113
an insurer under Title XXXIX of the Revised Code, the health 5114
insuring corporation, on June 4, 1997, holds a certificate of 5115
authority or license to operate under Chapter 1736. or 1740. of 5116
the Revised Code, or an insurer licensed under Title XXXIX of the 5117
Revised Code is responsible for the out-of-network risk as 5118
evidenced by both an evidence of coverage filing under section 5119
1751.11 of the Revised Code and a policy and certificate filing 5120
under section 3923.02 of the Revised Code. 5121

(T) "Panel" means a group of providers or health care 5122
facilities that have joined together to deliver health care 5123
services through a contractual arrangement with a health insuring 5124
corporation, employer group, or other payor. 5125

(U) "Person" has the same meaning as in section 1.59 of the 5126

Revised Code, and, unless the context otherwise requires, includes 5127
any insurance company holding a certificate of authority under 5128
Title XXXIX of the Revised Code, any subsidiary and affiliate of 5129
an insurance company, and any government agency. 5130

(V) "Premium rate" means any set fee regularly paid by a 5131
subscriber to a health insuring corporation. A "premium rate" does 5132
not include a one-time membership fee, an annual administrative 5133
fee, or a nominal access fee, paid to a managed health care system 5134
under which the recipient of health care services remains solely 5135
responsible for any charges assessed for those services by the 5136
provider or health care facility. 5137

(W) "Primary care provider" means a provider that is 5138
designated by a health insuring corporation to supervise, 5139
coordinate, or provide initial care or continuing care to an 5140
enrollee, and that may be required by the health insuring 5141
corporation to initiate a referral for specialty care and to 5142
maintain supervision of the health care services rendered to the 5143
enrollee. 5144

(X) "Provider" means any natural person or partnership of 5145
natural persons who are licensed, certified, accredited, or 5146
otherwise authorized in this state to furnish health care 5147
services, or any professional association organized under Chapter 5148
1785. of the Revised Code, provided that nothing in this chapter 5149
or other provisions of law shall be construed to preclude a health 5150
insuring corporation, health care practitioner, or organized 5151
health care group associated with a health insuring corporation 5152
from employing certified nurse practitioners, certified nurse 5153
anesthetists, clinical nurse specialists, certified nurse 5154
midwives, dietitians, physician assistants, dental assistants, 5155
dental hygienists, optometric technicians, or other allied health 5156
personnel who are licensed, certified, accredited, or otherwise 5157
authorized in this state to furnish health care services. 5158

(Y) "Provider sponsored organization" means a corporation, as 5159
defined in division (H) of this section, that is at least eighty 5160
per cent owned or controlled by one or more hospitals, as defined 5161
in section 3727.01 of the Revised Code, or one or more physicians 5162
licensed to practice medicine or surgery or osteopathic medicine 5163
and surgery under Chapter 4731. of the Revised Code, or any 5164
combination of such physicians and hospitals. Such control is 5165
presumed to exist if at least eighty per cent of the voting rights 5166
or governance rights of a provider sponsored organization are 5167
directly or indirectly owned, controlled, or otherwise held by any 5168
combination of the physicians and hospitals described in this 5169
division. 5170

(Z) "Solicitation document" means the written materials 5171
provided to prospective subscribers or enrollees, or both, and 5172
used for advertising and marketing to induce enrollment in the 5173
health care plans of a health insuring corporation. 5174

(AA) "Subscriber" means a person who is responsible for 5175
making payments to a health insuring corporation for participation 5176
in a health care plan, or an enrollee whose employment or other 5177
status is the basis of eligibility for enrollment in a health 5178
insuring corporation. 5179

(BB) "Urgent care services" means those health care services 5180
that are appropriately provided for an unforeseen condition of a 5181
kind that usually requires medical attention without delay but 5182
that does not pose a threat to the life, limb, or permanent health 5183
of the injured or ill person, and may include such health care 5184
services provided out of the health insuring corporation's 5185
approved service area pursuant to indemnity payments or service 5186
agreements. 5187

Sec. 1751.04. (A) Except as provided by division (F) of this 5188
section, upon the receipt by the superintendent of insurance of a 5189

complete application for a certificate of authority to establish 5190
or operate a health insuring corporation, which application sets 5191
forth or is accompanied by the information and documents required 5192
by division (A) of section 1751.03 of the Revised Code, the 5193
superintendent shall transmit copies of the application and 5194
accompanying documents to the director of health. 5195

(B) The director shall review the application and 5196
accompanying documents and make findings as to whether the 5197
applicant for a certificate of authority has done all of the 5198
following with respect to any basic health care services and 5199
supplemental health care services to be furnished: 5200

(1) Demonstrated the willingness and potential ability to 5201
ensure that all basic health care services and supplemental health 5202
care services described in the evidence of coverage will be 5203
provided to all its enrollees as promptly as is appropriate and in 5204
a manner that assures continuity; 5205

(2) Made effective arrangements to ensure that its enrollees 5206
have reliable access to qualified providers in those specialties 5207
that are generally available in the geographic area or areas to be 5208
served by the applicant and that are necessary to provide all 5209
basic health care services and supplemental health care services 5210
described in the evidence of coverage; 5211

(3) Made appropriate arrangements for the availability of 5212
short-term health care services in emergencies within the 5213
geographic area or areas to be served by the applicant, 5214
twenty-four hours per day, seven days per week, and for the 5215
provision of adequate coverage whenever an out-of-area emergency 5216
arises; 5217

(4) Made appropriate arrangements for an ongoing evaluation 5218
and assurance of the quality of health care services provided to 5219
enrollees, including, if applicable, the development of a quality 5220

assurance program complying with the requirements of sections 5221
1751.73 to 1751.75 of the Revised Code, and the adequacy of the 5222
personnel, facilities, and equipment by or through which the 5223
services are rendered; 5224

(5) Developed a procedure to gather and report statistics 5225
relating to the cost and effectiveness of its operations, the 5226
pattern of utilization of its services, and the quality, 5227
availability, and accessibility of its services. 5228

(C) Within ninety days of the director's receipt of the 5229
application for issuance of a certificate of authority, the 5230
director shall certify to the superintendent whether or not the 5231
applicant meets the requirements of division (B) of this section 5232
and sections 3702.51 to 3702.62 of the Revised Code. If the 5233
director certifies that the applicant does not meet these 5234
requirements, the director shall specify in what respects it is 5235
deficient. However, the director shall not certify that the 5236
requirements of this section are not met unless the applicant has 5237
been given an opportunity for a hearing. 5238

(D) If the applicant requests a hearing, the director shall 5239
hold a hearing before certifying that the applicant does not meet 5240
the requirements of this section. The hearing shall be held in 5241
accordance with Chapter 119. of the Revised Code. 5242

(E) The ninety-day review period provided for under division 5243
(C) of this section shall cease to run as of the date on which the 5244
notice of the applicant's right to request a hearing is mailed and 5245
shall remain suspended until the director issues a final 5246
certification order. 5247

(F) Nothing in this section requires the director to review 5248
or make findings with regard to an application and accompanying 5249
documents to establish or operate a health insuring corporation to 5250
cover solely recipients of assistance under the medicaid program 5251

~~operated pursuant to Chapter 5111. of the Revised Code, a health 5252~~
insuring corporation to cover solely recipients of assistance 5253
under the ~~federal~~ medicare program ~~under Title XVIII of the 5254~~
~~"Social Security Act," 49 Stat. 62 (1935), 42 U.S.C. 301, as 5255~~
~~amended, or a health insuring corporation to cover solely 5256~~
recipients of assistance under both the medicaid and medicare 5257
programs. 5258

Sec. 1751.05. (A) The superintendent of insurance shall issue 5259
or deny a certificate of authority to health insuring corporations 5260
within the deadlines specified as follows: 5261

(1) For a health insuring corporation filing an application 5262
pursuant to section 1751.03 of the Revised Code, forty-five days 5263
from the superintendent's receipt of the certification from the 5264
director of health under division (C) of section 1751.04 of the 5265
Revised Code; 5266

(2) For a health insuring corporation that covers solely 5267
recipients of ~~assistance under~~ the medicaid program ~~operated 5268~~
~~pursuant to Chapter 5111. of the Revised Code, one hundred 5269~~
thirty-five days from the superintendent's receipt of a complete 5270
application and accompanying documents. 5271

(B) A certificate of authority shall be issued upon payment 5272
of the application fee prescribed in section 1751.44 of the 5273
Revised Code if the superintendent is satisfied that the following 5274
conditions are met: 5275

(1) The persons responsible for the conduct of the affairs of 5276
the applicant are competent, trustworthy, and possess good 5277
reputations. 5278

(2) The director certifies, in accordance with division (C) 5279
of section 1751.04 of the Revised Code, that the organization's 5280
proposed plan of operation meets the requirements of division (B) 5281

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;	5313 5314
(d) Any agreement with providers or health care facilities for the provision of health care services;	5315 5316
(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.	5317 5318 5319
(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:	5320 5321 5322 5323 5324 5325 5326 5327
(a) The maintenance of insolvency insurance;	5328
(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;	5329 5330 5331
(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;	5332 5333 5334 5335
(d) Such other methods as approved by the superintendent.	5336
(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.	5337 5338 5339 5340 5341
(7) Any deficiencies certified by the director have been	5342

corrected. 5343

(8) The applicant has deposited securities as set forth in 5344
section 1751.27 of the Revised Code. 5345

(C) If an applicant elects to fulfill the requirements of 5346
division (A)(5) of this section through an agreement with other 5347
health insuring corporations or insurers, the agreement shall 5348
require those health insuring corporations or insurers to give 5349
thirty days' notice to the superintendent prior to cancellation or 5350
discontinuation of the agreement for any reason. 5351

(D) A certificate of authority shall be denied only after 5352
compliance with the requirements of section 1751.36 of the Revised 5353
Code. 5354

Sec. 1751.11. (A) Every subscriber of a health insuring 5355
corporation is entitled to an evidence of coverage for the health 5356
care plan under which health care benefits are provided. 5357

(B) Every subscriber of a health insuring corporation that 5358
offers basic health care services is entitled to an identification 5359
card or similar document that specifies the health insuring 5360
corporation's name as stated in its articles of incorporation, and 5361
any trade or fictitious names used by the health insuring 5362
corporation. The identification card or document shall list at 5363
least one toll-free telephone number that provides the subscriber 5364
with access, to information on a twenty-four-hours-per-day, 5365
seven-days-per-week basis, as to how health care services may be 5366
obtained. The identification card or document shall also list at 5367
least one toll-free number that, during normal business hours, 5368
provides the subscriber with access to information on the coverage 5369
available under the subscriber's health care plan and information 5370
on the health care plan's internal and external review processes. 5371

(C) No evidence of coverage, or amendment to the evidence of 5372

coverage, shall be delivered, issued for delivery, renewed, or 5373
used, until the form of the evidence of coverage or amendment has 5374
been filed by the health insuring corporation with the 5375
superintendent of insurance. If the superintendent does not 5376
disapprove the evidence of coverage or amendment within sixty days 5377
after it is filed it shall be deemed approved, unless the 5378
superintendent sooner gives approval for the evidence of coverage 5379
or amendment. With respect to an amendment to an approved evidence 5380
of coverage, the superintendent only may disapprove provisions 5381
amended or added to the evidence of coverage. If the 5382
superintendent determines within the sixty-day period that any 5383
evidence of coverage or amendment fails to meet the requirements 5384
of this section, the superintendent shall so notify the health 5385
insuring corporation and it shall be unlawful for the health 5386
insuring corporation to use such evidence of coverage or 5387
amendment. At any time, the superintendent, upon at least thirty 5388
days' written notice to a health insuring corporation, may 5389
withdraw an approval, deemed or actual, of any evidence of 5390
coverage or amendment on any of the grounds stated in this 5391
section. Such disapproval shall be effected by a written order, 5392
which shall state the grounds for disapproval and shall be issued 5393
in accordance with Chapter 119. of the Revised Code. 5394

(D) No evidence of coverage or amendment shall be delivered, 5395
issued for delivery, renewed, or used: 5396

(1) If it contains provisions or statements that are 5397
inequitable, untrue, misleading, or deceptive; 5398

(2) Unless it contains a clear, concise, and complete 5399
statement of the following: 5400

(a) The health care services and insurance or other benefits, 5401
if any, to which an enrollee is entitled under the health care 5402
plan; 5403

(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;	5404 5405 5406
(c) An enrollee's personal financial obligation for noncovered services;	5407 5408
(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;	5409 5410 5411
(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.	5412 5413 5414 5415
(f) The method utilized by the health insuring corporation for resolving enrollee complaints;	5416 5417
(g) The utilization review, internal review, and external review procedures established under sections 1751.77 to 1751.85 of the Revised Code.	5418 5419 5420
(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:	5421 5422 5423 5424 5425 5426
(a) The enrollee's discharge from the hospital;	5427
(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.	5428 5429 5430 5431 5432
(c) The enrollee's reaching the limit for contractual	5433

benefits; 5434

(d) The effective date of any new coverage. 5435

(4) Unless it contains a provision that states, in substance, 5436
that the health insuring corporation is not a member of any 5437
guaranty fund, and that in the event of the health insuring 5438
corporation's insolvency, an enrollee is protected only to the 5439
extent that the hold harmless provision required by section 5440
1751.13 of the Revised Code applies to the health care services 5441
rendered; 5442

(5) Unless it contains a provision that states, in substance, 5443
that in the event of the insolvency of the health insuring 5444
corporation, an enrollee may be financially responsible for health 5445
care services rendered by a provider or health care facility that 5446
is not under contract to the health insuring corporation, whether 5447
or not the health insuring corporation authorized the use of the 5448
provider or health care facility. 5449

(E) Notwithstanding divisions (C) and (D) of this section, a 5450
health insuring corporation may use an evidence of coverage that 5451
provides for the coverage of beneficiaries enrolled in ~~Title XVIII~~ 5452
~~of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A.~~ 5453
~~301, as amended~~ medicare program, pursuant to a medicare contract, 5454
or an evidence of coverage that provides for the coverage of 5455
beneficiaries enrolled in the federal employees health benefits 5456
program pursuant to 5 U.S.C.A. 8905, or an evidence of coverage 5457
that provides for the coverage of ~~beneficiaries enrolled in Title~~ 5458
~~XIX recipients~~ of the ~~"Social Security Act," 49 Stat. 620 (1935),~~ 5459
~~42 U.S.C.A. 301, as amended, known as the medical assistance~~ 5460
~~program or medicaid, provided by the Ohio department of job and~~ 5461
~~family services under Chapter 5111. of the Revised Code~~ program, 5462
or an evidence of coverage that provides for the coverage of 5463
beneficiaries under any other federal health care program 5464
regulated by a federal regulatory body, or an evidence of coverage 5465

that provides for the coverage of beneficiaries under any contract 5466
covering officers or employees of the state that has been entered 5467
into by the department of administrative services, if both of the 5468
following apply: 5469

(1) The evidence of coverage has been approved by the United 5470
States department of health and human services, the United States 5471
office of personnel management, the ~~Ohio~~ department of ~~job and~~ 5472
~~family services~~ health care administration, or the department of 5473
administrative services. 5474

(2) The evidence of coverage is filed with the superintendent 5475
of insurance prior to use and is accompanied by documentation of 5476
approval from the United States department of health and human 5477
services, the United States office of personnel management, the 5478
~~Ohio~~ department of ~~job and family services~~ health care 5479
administration, or the department of administrative services. 5480

Sec. 1751.111. (A)(1) This section applies to both of the 5481
following: 5482

(a) A health insuring corporation that issues or requires the 5483
use of a standardized identification card or an electronic 5484
technology for submission and routing of prescription drug claims 5485
pursuant to a policy, contract, or agreement for health care 5486
services; 5487

(b) A person or entity that a health insuring corporation 5488
contracts with to issue a standardized identification card or an 5489
electronic technology described in division (A)(1)(a) of this 5490
section. 5491

(2) Notwithstanding division (A)(1) of this section, this 5492
section does not apply to the issuance or required use of a 5493
standardized identification card or an electronic technology for 5494
submission and routing of prescription drug claims in connection 5495

with any of the following: 5496

(a) Coverage provided under the medicare advantage program 5497
operated pursuant to Part C of ~~Title XVIII of the "Social Security~~ 5498
~~Act," 49 Stat. 62 (1935), 42 U.S.C. 301, as amended~~ medicare 5499
program. 5500

(b) Coverage provided under the ~~medicaid, as defined in~~ 5501
~~section 5111.01 of the Revised Code~~ program. 5502

(c) Coverage provided under an employer's self-insurance plan 5503
or by any of its administrators, as defined in section 3959.01 of 5504
the Revised Code, to the extent that federal law supersedes, 5505
preempts, prohibits, or otherwise precludes the application of 5506
this section to the plan and its administrators. 5507

(B) A standardized identification card or an electronic 5508
technology issued or required to be used as provided in division 5509
(A)(1) of this section shall contain uniform prescription drug 5510
information in accordance with either division (B)(1) or (2) of 5511
this section. 5512

(1) The standardized identification card or the electronic 5513
technology shall be in a format and contain information fields 5514
approved by the national council for prescription drug programs or 5515
a successor organization, as specified in the council's or 5516
successor organization's pharmacy identification card 5517
implementation guide in effect on the first day of October most 5518
immediately preceding the issuance or required use of the 5519
standardized identification card or the electronic technology. 5520

(2) If the health insuring corporation or the person under 5521
contract with the corporation to issue a standardized 5522
identification card or an electronic technology requires the 5523
information for the submission and routing of a claim, the 5524
standardized identification card or the electronic technology 5525
shall contain any of the following information: 5526

(a) The health insuring corporation's name;	5527
(b) The subscriber's name, group number, and identification number;	5528 5529
(c) A telephone number to inquire about pharmacy-related issues;	5530 5531
(d) The issuer's international identification number, labeled as "ANSI BIN" or "RxBIN";	5532 5533
(e) The processor's control number, labeled as "RxPCN";	5534
(f) The subscriber's pharmacy benefits group number if different from the subscriber's medical group number, labeled as "RxGrp. "	5535 5536 5537
(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.	5538 5539 5540 5541 5542 5543 5544 5545
(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.	5546 5547 5548 5549 5550 5551
(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	5552 5553 5554 5555 5556

identification card or an electronic technology shall issue a new 5557
card or electronic technology to the subscriber. 5558

(2) A health insuring corporation or person under contract 5559
with the corporation is not required under division (E)(1) of this 5560
section to issue a new card or electronic technology to a 5561
subscriber more than once during a twelve-month period. 5562

(F) Nothing in this section shall be construed as requiring a 5563
health insuring corporation to produce more than one standardized 5564
identification card or one electronic technology for use by 5565
subscribers accessing health care benefits provided under a 5566
policy, contract, or agreement for health care services. 5567

Sec. 1751.12. (A)(1) No contractual periodic prepayment and 5568
no premium rate for nongroup and conversion policies for health 5569
care services, or any amendment to them, may be used by any health 5570
insuring corporation at any time until the contractual periodic 5571
prepayment and premium rate, or amendment, have been filed with 5572
the superintendent of insurance, and shall not be effective until 5573
the expiration of sixty days after their filing unless the 5574
superintendent sooner gives approval. The filing shall be 5575
accompanied by an actuarial certification in the form prescribed 5576
by the superintendent. The superintendent shall disapprove the 5577
filing, if the superintendent determines within the sixty-day 5578
period that the contractual periodic prepayment or premium rate, 5579
or amendment, is not in accordance with sound actuarial principles 5580
or is not reasonably related to the applicable coverage and 5581
characteristics of the applicable class of enrollees. The 5582
superintendent shall notify the health insuring corporation of the 5583
disapproval, and it shall thereafter be unlawful for the health 5584
insuring corporation to use the contractual periodic prepayment or 5585
premium rate, or amendment. 5586

(2) No contractual periodic prepayment for group policies for 5587

health care services shall be used until the contractual periodic 5588
prepayment has been filed with the superintendent. The filing 5589
shall be accompanied by an actuarial certification in the form 5590
prescribed by the superintendent. The superintendent may reject a 5591
filing made under division (A)(2) of this section at any time, 5592
with at least thirty days' written notice to a health insuring 5593
corporation, if the contractual periodic prepayment is not in 5594
accordance with sound actuarial principles or is not reasonably 5595
related to the applicable coverage and characteristics of the 5596
applicable class of enrollees. 5597

(3) At any time, the superintendent, upon at least thirty 5598
days' written notice to a health insuring corporation, may 5599
withdraw the approval given under division (A)(1) of this section, 5600
deemed or actual, of any contractual periodic prepayment or 5601
premium rate, or amendment, based on information that either of 5602
the following applies: 5603

(a) The contractual periodic prepayment or premium rate, or 5604
amendment, is not in accordance with sound actuarial principles. 5605

(b) The contractual periodic prepayment or premium rate, or 5606
amendment, is not reasonably related to the applicable coverage 5607
and characteristics of the applicable class of enrollees. 5608

(4) Any disapproval under division (A)(1) of this section, 5609
any rejection of a filing made under division (A)(2) of this 5610
section, or any withdrawal of approval under division (A)(3) of 5611
this section, shall be effected by a written notice, which shall 5612
state the specific basis for the disapproval, rejection, or 5613
withdrawal and shall be issued in accordance with Chapter 119. of 5614
the Revised Code. 5615

(B) Notwithstanding division (A) of this section, a health 5616
insuring corporation may use a contractual periodic prepayment or 5617
premium rate for policies used for the coverage of beneficiaries 5618

enrolled in ~~Title XVIII of the "Social Security Act," 49 Stat. 620~~ 5619
~~(1935), 42 U.S.C.A. 301, as amended, the medicare program~~ pursuant 5620
to a medicare risk contract or medicare cost contract, or for 5621
policies used for the coverage of beneficiaries enrolled in the 5622
federal employees health benefits program pursuant to 5 U.S.C.A. 5623
8905, or for policies used for the coverage of ~~beneficiaries~~ 5624
~~enrolled in Title XIX recipients of the "Social Security Act," 49~~ 5625
~~Stat. 620 (1935), 42 U.S.C.A. 301, as amended, known as the~~ 5626
~~medical assistance program or medicaid, provided by the department~~ 5627
~~of job and family services under Chapter 5111. of the Revised Code~~ 5628
~~program,~~ or for policies used for the coverage of beneficiaries 5629
under any other federal health care program regulated by a federal 5630
regulatory body, or for policies used for the coverage of 5631
beneficiaries under any contract covering officers or employees of 5632
the state that has been entered into by the department of 5633
administrative services, if both of the following apply: 5634

(1) The contractual periodic prepayment or premium rate has 5635
been approved by the United States department of health and human 5636
services, the United States office of personnel management, the 5637
department of ~~job and family services~~ health care administration, 5638
or the department of administrative services. 5639

(2) The contractual periodic prepayment or premium rate is 5640
filed with the superintendent prior to use and is accompanied by 5641
documentation of approval from the United States department of 5642
health and human services, the United States office of personnel 5643
management, the department of ~~job and family services~~ health care 5644
administration, or the department of administrative services. 5645

(C) The administrative expense portion of all contractual 5646
periodic prepayment or premium rate filings submitted to the 5647
superintendent for review must reflect the actual cost of 5648
administering the product. The superintendent may require that the 5649
administrative expense portion of the filings be itemized and 5650

supported. 5651

(D)(1) Copayments must be reasonable and must not be a 5652
barrier to the necessary utilization of services by enrollees. 5653

(2) A health insuring corporation, in order to ensure that 5654
copayments are reasonable and not a barrier to the necessary 5655
utilization of basic health care services by enrollees, may do one 5656
of the following: 5657

(a) Impose copayment charges on any single covered basic 5658
health care service that does not exceed forty per cent of the 5659
average cost to the health insuring corporation of providing the 5660
service; 5661

(b) Impose copayment charges that annually do not exceed 5662
twenty per cent of the total annual cost to the health insuring 5663
corporation of providing all covered basic health care services, 5664
including physician office visits, urgent care services, and 5665
emergency health services, when aggregated as to all persons 5666
covered under the filed product in question. In addition, annual 5667
copayment charges as to each enrollee shall not exceed twenty per 5668
cent of the total annual cost to the health insuring corporation 5669
of providing all covered basic health care services, including 5670
physician office visits, urgent care services, and emergency 5671
health services, as to such enrollee. The total annual cost of 5672
providing a health care service is the cost to the health insuring 5673
corporation of providing the health care service to its enrollees 5674
as reduced by any applicable provider discount. 5675

(3) To ensure that copayments are reasonable and not a 5676
barrier to the utilization of basic health care services, a health 5677
insuring corporation may not impose, in any contract year, on any 5678
subscriber or enrollee, copayments that exceed two hundred per 5679
cent of the average annual premium rate to subscribers or 5680
enrollees. 5681

(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 5713
"high deductible health plan" have the same meanings as in the 5714
"Internal Revenue Code of 1986," 100 Stat. 2085, 26 U.S.C. 223, as 5715
amended. 5716

Sec. 1751.13. (A)(1)(a) A health insuring corporation shall, 5717
either directly or indirectly, enter into contracts for the 5718
provision of health care services with a sufficient number and 5719
types of providers and health care facilities to ensure that all 5720
covered health care services will be accessible to enrollees from 5721
a contracted provider or health care facility. 5722

(b) A health insuring corporation shall not refuse to 5723
contract with a physician for the provision of health care 5724
services or refuse to recognize a physician as a specialist on the 5725
basis that the physician attended an educational program or a 5726
residency program approved or certified by the American 5727
osteopathic association. A health insuring corporation shall not 5728
refuse to contract with a health care facility for the provision 5729
of health care services on the basis that the health care facility 5730
is certified or accredited by the American osteopathic association 5731
or that the health care facility is an osteopathic hospital as 5732
defined in section 3702.51 of the Revised Code. 5733

(c) Nothing in division (A)(1)(b) of this section shall be 5734
construed to require a health insuring corporation to make a 5735
benefit payment under a closed panel plan to a physician or health 5736
care facility with which the health insuring corporation does not 5737
have a contract, provided that none of the bases set forth in that 5738
division are used as a reason for failing to make a benefit 5739
payment. 5740

(2) When a health insuring corporation is unable to provide a 5741
covered health care service from a contracted provider or health 5742
care facility, the health insuring corporation must provide that 5743

health care service from a noncontracted provider or health care 5744
facility consistent with the terms of the enrollee's policy, 5745
contract, certificate, or agreement. The health insuring 5746
corporation shall either ensure that the health care service be 5747
provided at no greater cost to the enrollee than if the enrollee 5748
had obtained the health care service from a contracted provider or 5749
health care facility, or make other arrangements acceptable to the 5750
superintendent of insurance. 5751

(3) Nothing in this section shall prohibit a health insuring 5752
corporation from entering into contracts with out-of-state 5753
providers or health care facilities that are licensed, certified, 5754
accredited, or otherwise authorized in that state. 5755

(B)(1) A health insuring corporation shall, either directly 5756
or indirectly, enter into contracts with all providers and health 5757
care facilities through which health care services are provided to 5758
its enrollees. 5759

(2) A health insuring corporation, upon written request, 5760
shall assist its contracted providers in finding stop-loss or 5761
reinsurance carriers. 5762

(C) A health insuring corporation shall file an annual 5763
certificate with the superintendent certifying that all provider 5764
contracts and contracts with health care facilities through which 5765
health care services are being provided contain the following: 5766

(1) A description of the method by which the provider or 5767
health care facility will be notified of the specific health care 5768
services for which the provider or health care facility will be 5769
responsible, including any limitations or conditions on such 5770
services; 5771

(2) The specific hold harmless provision specifying 5772
protection of enrollees set forth as follows: 5773

"[Provider/Health Care Facility] agrees that in no event, 5774

including but not limited to nonpayment by the health insuring 5775
corporation, insolvency of the health insuring corporation, or 5776
breach of this agreement, shall [Provider/Health Care Facility] 5777
bill, charge, collect a deposit from, seek remuneration or 5778
reimbursement from, or have any recourse against, a subscriber, 5779
enrollee, person to whom health care services have been provided, 5780
or person acting on behalf of the covered enrollee, for health 5781
care services provided pursuant to this agreement. This does not 5782
prohibit [Provider/Health Care Facility] from collecting 5783
co-insurance, deductibles, or copayments as specifically provided 5784
in the evidence of coverage, or fees for uncovered health care 5785
services delivered on a fee-for-service basis to persons 5786
referenced above, nor from any recourse against the health 5787
insuring corporation or its successor." 5788

(3) Provisions requiring the provider or health care facility 5789
to continue to provide covered health care services to enrollees 5790
in the event of the health insuring corporation's insolvency or 5791
discontinuance of operations. The provisions shall require the 5792
provider or health care facility to continue to provide covered 5793
health care services to enrollees as needed to complete any 5794
medically necessary procedures commenced but unfinished at the 5795
time of the health insuring corporation's insolvency or 5796
discontinuance of operations. The completion of a medically 5797
necessary procedure shall include the rendering of all covered 5798
health care services that constitute medically necessary follow-up 5799
care for that procedure. If an enrollee is receiving necessary 5800
inpatient care at a hospital, the provisions may limit the 5801
required provision of covered health care services relating to 5802
that inpatient care in accordance with division (D)(3) of section 5803
1751.11 of the Revised Code, and may also limit such required 5804
provision of covered health care services to the period ending 5805
thirty days after the health insuring corporation's insolvency or 5806
discontinuance of operations. 5807

The provisions required by division (C)(3) of this section 5808
shall not require any provider or health care facility to continue 5809
to provide any covered health care service after the occurrence of 5810
any of the following: 5811

(a) The end of the thirty-day period following the entry of a 5812
liquidation order under Chapter 3903. of the Revised Code; 5813

(b) The end of the enrollee's period of coverage for a 5814
contractual prepayment or premium; 5815

(c) The enrollee obtains equivalent coverage with another 5816
health insuring corporation or insurer, or the enrollee's employer 5817
obtains such coverage for the enrollee; 5818

(d) The enrollee or the enrollee's employer terminates 5819
coverage under the contract; 5820

(e) A liquidator effects a transfer of the health insuring 5821
corporation's obligations under the contract under division (A)(8) 5822
of section 3903.21 of the Revised Code. 5823

(4) A provision clearly stating the rights and 5824
responsibilities of the health insuring corporation, and of the 5825
contracted providers and health care facilities, with respect to 5826
administrative policies and programs, including, but not limited 5827
to, payments systems, utilization review, quality assurance, 5828
assessment, and improvement programs, credentialing, 5829
confidentiality requirements, and any applicable federal or state 5830
programs; 5831

(5) A provision regarding the availability and 5832
confidentiality of those health records maintained by providers 5833
and health care facilities to monitor and evaluate the quality of 5834
care, to conduct evaluations and audits, and to determine on a 5835
concurrent or retrospective basis the necessity of and 5836
appropriateness of health care services provided to enrollees. The 5837
provision shall include terms requiring the provider or health 5838

care facility to make these health records available to 5839
appropriate state and federal authorities involved in assessing 5840
the quality of care or in investigating the grievances or 5841
complaints of enrollees, and requiring the provider or health care 5842
facility to comply with applicable state and federal laws related 5843
to the confidentiality of medical or health records. 5844

(6) A provision that states that contractual rights and 5845
responsibilities may not be assigned or delegated by the provider 5846
or health care facility without the prior written consent of the 5847
health insuring corporation; 5848

(7) A provision requiring the provider or health care 5849
facility to maintain adequate professional liability and 5850
malpractice insurance. The provision shall also require the 5851
provider or health care facility to notify the health insuring 5852
corporation not more than ten days after the provider's or health 5853
care facility's receipt of notice of any reduction or cancellation 5854
of such coverage. 5855

(8) A provision requiring the provider or health care 5856
facility to observe, protect, and promote the rights of enrollees 5857
as patients; 5858

(9) A provision requiring the provider or health care 5859
facility to provide health care services without discrimination on 5860
the basis of a patient's participation in the health care plan, 5861
age, sex, ethnicity, religion, sexual preference, health status, 5862
or disability, and without regard to the source of payments made 5863
for health care services rendered to a patient. This requirement 5864
shall not apply to circumstances when the provider or health care 5865
facility appropriately does not render services due to limitations 5866
arising from the provider's or health care facility's lack of 5867
training, experience, or skill, or due to licensing restrictions. 5868

(10) A provision containing the specifics of any obligation 5869

on the primary care provider to provide, or to arrange for the 5870
provision of, covered health care services twenty-four hours per 5871
day, seven days per week; 5872

(11) A provision setting forth procedures for the resolution 5873
of disputes arising out of the contract; 5874

(12) A provision stating that the hold harmless provision 5875
required by division (C)(2) of this section shall survive the 5876
termination of the contract with respect to services covered and 5877
provided under the contract during the time the contract was in 5878
effect, regardless of the reason for the termination, including 5879
the insolvency of the health insuring corporation; 5880

(13) A provision requiring those terms that are used in the 5881
contract and that are defined by this chapter, be used in the 5882
contract in a manner consistent with those definitions. 5883

This division does not apply to the coverage of beneficiaries 5884
enrolled in ~~Title XVIII of the "Social Security Act," 49 Stat. 620~~ 5885
~~(1935), 42 U.S.C.A. 301, as amended~~ medicare program, pursuant to 5886
a medicare risk contract or medicare cost contract, or to the 5887
coverage of beneficiaries enrolled in the federal employee health 5888
benefits program pursuant to 5 U.S.C.A. 8905, or to the coverage 5889
of ~~beneficiaries enrolled in Title XIX~~ recipients of the "Social 5890
Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended, 5891
~~known as the medical assistance program or medicaid, provided by~~ 5892
~~the department of job and family services under Chapter 5111. of~~ 5893
~~the Revised Code~~ program, or to the coverage of beneficiaries 5894
under any federal health care program regulated by a federal 5895
regulatory body, or to the coverage of beneficiaries under any 5896
contract covering officers or employees of the state that has been 5897
entered into by the department of administrative services. 5898

(D)(1) No health insuring corporation contract with a 5899
provider or health care facility shall contain any of the 5900

following: 5901

(a) A provision that directly or indirectly offers an 5902
inducement to the provider or health care facility to reduce or 5903
limit medically necessary health care services to a covered 5904
enrollee; 5905

(b) A provision that penalizes a provider or health care 5906
facility that assists an enrollee to seek a reconsideration of the 5907
health insuring corporation's decision to deny or limit benefits 5908
to the enrollee; 5909

(c) A provision that limits or otherwise restricts the 5910
provider's or health care facility's ethical and legal 5911
responsibility to fully advise enrollees about their medical 5912
condition and about medically appropriate treatment options; 5913

(d) A provision that penalizes a provider or health care 5914
facility for principally advocating for medically necessary health 5915
care services; 5916

(e) A provision that penalizes a provider or health care 5917
facility for providing information or testimony to a legislative 5918
or regulatory body or agency. This shall not be construed to 5919
prohibit a health insuring corporation from penalizing a provider 5920
or health care facility that provides information or testimony 5921
that is libelous or slanderous or that discloses trade secrets 5922
which the provider or health care facility has no privilege or 5923
permission to disclose. 5924

(2) Nothing in this division shall be construed to prohibit a 5925
health insuring corporation from doing either of the following: 5926

(a) Making a determination not to reimburse or pay for a 5927
particular medical treatment or other health care service; 5928

(b) Enforcing reasonable peer review or utilization review 5929
protocols, or determining whether a particular provider or health 5930

care facility has complied with these protocols. 5931

(E) Any contract between a health insuring corporation and an 5932
intermediary organization shall clearly specify that the health 5933
insuring corporation must approve or disapprove the participation 5934
of any provider or health care facility with which the 5935
intermediary organization contracts. 5936

(F) If an intermediary organization that is not a health 5937
delivery network contracting solely with self-insured employers 5938
subcontracts with a provider or health care facility, the 5939
subcontract with the provider or health care facility shall do all 5940
of the following: 5941

(1) Contain the provisions required by divisions (C) and (G) 5942
of this section, as made applicable to an intermediary 5943
organization, without the inclusion of inducements or penalties 5944
described in division (D) of this section; 5945

(2) Acknowledge that the health insuring corporation is a 5946
third-party beneficiary to the agreement; 5947

(3) Acknowledge the health insuring corporation's role in 5948
approving the participation of the provider or health care 5949
facility, pursuant to division (E) of this section. 5950

(G) Any provider contract or contract with a health care 5951
facility shall clearly specify the health insuring corporation's 5952
statutory responsibility to monitor and oversee the offering of 5953
covered health care services to its enrollees. 5954

(H)(1) A health insuring corporation shall maintain its 5955
provider contracts and its contracts with health care facilities 5956
at one or more of its places of business in this state, and shall 5957
provide copies of these contracts to facilitate regulatory review 5958
upon written notice by the superintendent of insurance. 5959

(2) Any contract with an intermediary organization that 5960

accepts compensation shall include provisions requiring the 5961
intermediary organization to provide the superintendent with 5962
regulatory access to all books, records, financial information, 5963
and documents related to the provision of health care services to 5964
subscribers and enrollees under the contract. The contract shall 5965
require the intermediary organization to maintain such books, 5966
records, financial information, and documents at its principal 5967
place of business in this state and to preserve them for at least 5968
three years in a manner that facilitates regulatory review. 5969

(I)(1) A health insuring corporation shall notify its 5970
affected enrollees of the termination of a contract for the 5971
provision of health care services between the health insuring 5972
corporation and a primary care physician or hospital, by mail, 5973
within thirty days after the termination of the contract. 5974

(a) Notice shall be given to subscribers of the termination 5975
of a contract with a primary care physician if the subscriber, or 5976
a dependent covered under the subscriber's health care coverage, 5977
has received health care services from the primary care physician 5978
within the previous twelve months or if the subscriber or 5979
dependent has selected the physician as the subscriber's or 5980
dependent's primary care physician within the previous twelve 5981
months. 5982

(b) Notice shall be given to subscribers of the termination 5983
of a contract with a hospital if the subscriber, or a dependent 5984
covered under the subscriber's health care coverage, has received 5985
health care services from that hospital within the previous twelve 5986
months. 5987

(2) The health insuring corporation shall pay, in accordance 5988
with the terms of the contract, for all covered health care 5989
services rendered to an enrollee by a primary care physician or 5990
hospital between the date of the termination of the contract and 5991
five days after the notification of the contract termination is 5992

mailed to a subscriber at the subscriber's last known address. 5993

(J) Divisions (A) and (B) of this section do not apply to any 5994
health insuring corporation that, on June 4, 1997, holds a 5995
certificate of authority or license to operate under Chapter 1740. 5996
of the Revised Code. 5997

(K) Nothing in this section shall restrict the governing body 5998
of a hospital from exercising the authority granted it pursuant to 5999
section 3701.351 of the Revised Code. 6000

Sec. 1751.15. (A) After a health insuring corporation has 6001
furnished, directly or indirectly, basic health care services for 6002
a period of twenty-four months, and if it currently meets the 6003
financial requirements set forth in section 1751.28 of the Revised 6004
Code and had net income as reported to the superintendent of 6005
insurance for at least one of the preceding four calendar 6006
quarters, it shall hold an annual open enrollment period of not 6007
less than thirty days during its month of licensure for 6008
individuals who are not federally eligible individuals at the time 6009
they apply for enrollment. 6010

(B) During the open enrollment period described in division 6011
(A) of this section, the health insuring corporation shall accept 6012
applicants and their dependents in the order in which they apply 6013
for enrollment and in accordance with any of the following: 6014

(1) Up to its capacity, as determined by the health insuring 6015
corporation subject to review by the superintendent; 6016

(2) If less than its capacity, one per cent of the health 6017
insuring corporation's total number of subscribers residing in 6018
this state as of the immediately preceding thirty-first day of 6019
December. 6020

(C) Where a health insuring corporation demonstrates to the 6021
satisfaction of the superintendent that such open enrollment would 6022

jeopardize its economic viability, the superintendent may do any 6023
of the following: 6024

(1) Waive the requirement for open enrollment; 6025

(2) Impose a limit on the number of applicants and their 6026
dependents that must be enrolled; 6027

(3) Authorize such underwriting restrictions upon open 6028
enrollment as are necessary to do any of the following: 6029

(a) Preserve its financial stability; 6030

(b) Prevent excessive adverse selection; 6031

(c) Avoid unreasonably high or unmarketable charges for 6032
coverage of health care services. 6033

(D)(1) A request to the superintendent under division (C) of 6034
this section for any restriction, limit, or waiver during an open 6035
enrollment period must be accompanied by supporting documentation, 6036
including financial data. In reviewing the request, the 6037
superintendent may consider various factors, including the size of 6038
the health insuring corporation, the health insuring corporation's 6039
net worth and profitability, the health insuring corporation's 6040
delivery system structure, and the effect on profitability of 6041
prior open enrollments. 6042

(2) Any action taken by the superintendent under division (C) 6043
of this section shall be effective for a period of not more than 6044
one year. At the expiration of such time, a new demonstration of 6045
the health insuring corporation's need for the restriction, limit, 6046
or waiver shall be made before a new restriction, limit, or waiver 6047
is granted by the superintendent. 6048

(3) Irrespective of the granting of any restriction, limit, 6049
or waiver by the superintendent, a health insuring corporation may 6050
reject an applicant or a dependent of the applicant during its 6051
open enrollment period if the applicant or dependent: 6052

(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; 6084
6085

(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; 6086
6087
6088

(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; 6089
6090
6091

(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; 6092
6093
6094

(6) Any request for a restriction, limit, or waiver with respect to the open enrollment period, along with any supporting documentation. 6095
6096
6097

(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. 6098
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(2) A public notice pursuant to division (H)(1) of this 6114

section shall be published in at least one newspaper of general 6115
circulation in each county in the health insuring corporation's 6116
service area, at least once in each of the two weeks immediately 6117
preceding the month in which the open enrollment is to occur and 6118
in each week of that month, or until the enrollment limitation is 6119
reached, whichever occurs first. The notice published during the 6120
last week of open enrollment shall appear not less than five days 6121
before the end of the open enrollment period. It shall be at least 6122
two newspaper columns wide or two and one-half inches wide, 6123
whichever is larger. The first two lines of the text shall be 6124
published in not less than twelve-point, boldface type. The 6125
remainder of the text of the notice shall be published in not less 6126
than eight-point type. The entire public notice shall be 6127
surrounded by a continuous black line not less than one-eighth of 6128
an inch wide. 6129

(3) The following information shall be included in the public 6130
notice provided under division (H)(2) of this section: 6131

(a) The dates that open enrollment will be held and the date 6132
coverage obtained under the open enrollment will become effective; 6133

(b) Notice that an applicant or the applicant's dependents 6134
will not be denied coverage during open enrollment because of a 6135
preexisting health condition, but that some limitations and 6136
restrictions may apply; 6137

(c) The address where a person may obtain an application; 6138

(d) The telephone number that a person may call to request an 6139
application or to ask questions; 6140

(e) The date the first payment will be due; 6141

(f) The actual rates or range of rates that will be 6142
applicable for applicants; 6143

(g) Any limitation granted by the superintendent on the 6144

number of applications that will be accepted by the health 6145
insuring corporation. 6146

(4) Within thirty days after the end of an open enrollment 6147
period, the health insuring corporation shall submit to the 6148
superintendent proof of publication for the public notices, and 6149
shall report the total number of applicants and their dependents 6150
enrolled during the open enrollment period. 6151

(I)(1) No health insuring corporation may employ any scheme, 6152
plan, or device that restricts the ability of any person to enroll 6153
during open enrollment. 6154

(2) No health insuring corporation may require enrollment to 6155
be made in person. Every health insuring corporation shall permit 6156
application for coverage by mail. A representative of the health 6157
insuring corporation may visit an applicant who has submitted an 6158
application by mail, in order to explain the operations of the 6159
health insuring corporation and to answer any questions the 6160
applicant may have. Every health insuring corporation shall make 6161
open enrollment applications and solicitation documents readily 6162
available to any potential applicant who requests such material. 6163

(J) An application postmarked on the last day of an open 6164
enrollment period shall qualify as a valid application, regardless 6165
of the date on which it is received by the health insuring 6166
corporation. 6167

(K) This section does not apply to any health insuring 6168
corporation that offers only supplemental health care services or 6169
specialty health care services, or to any health insuring 6170
corporation that offers plans only through ~~Title XVIII or Title~~ 6171
~~XIX of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A.~~ 6172
~~301, as amended~~ medicare program or medicaid program, and that has 6173
no other commercial enrollment, or to any health insuring 6174
corporation that offers plans only through other federal health 6175

care programs regulated by federal regulatory bodies and that has 6176
no other commercial enrollment, or to any health insuring 6177
corporation that offers plans only through contracts covering 6178
officers or employees of the state that have been entered into by 6179
the department of administrative services and that has no other 6180
commercial enrollment. 6181

(L) Each health insuring corporation shall accept federally 6182
eligible individuals for open enrollment coverage as provided in 6183
section 3923.581 of the Revised Code. A health insuring 6184
corporation may reinsure coverage of any federally eligible 6185
individual acquired under that section with the open enrollment 6186
reinsurance program in accordance with division (G) of section 6187
3924.11 of the Revised Code. Fixed periodic prepayment rates 6188
charged for coverage reinsured by the program shall be established 6189
in accordance with section 3924.12 of the Revised Code. 6190

(M) As used in this section, "federally eligible individual" 6191
means an eligible individual as defined in 45 C.F.R. 148.103. 6192

Sec. 1751.16. (A) Except as provided in division (F) of this 6193
section, every group contract issued by a health insuring 6194
corporation shall provide an option for conversion to an 6195
individual contract issued on a direct-payment basis to any 6196
subscriber covered by the group contract who terminates employment 6197
or membership in the group, unless: 6198

(1) Termination of the conversion option or contract is based 6199
upon nonpayment of premium after reasonable notice in writing has 6200
been given by the health insuring corporation to the subscriber. 6201

(2) The subscriber is, or is eligible to be, covered for 6202
benefits at least comparable to the group contract under any of 6203
the following: 6204

(a) ~~Title XVIII of the "Social Security Act," 49 Stat. 620~~ 6205

~~(1935), 42 U.S.C.A. 301, as amended~~ The medicare program; 6206

(b) Any act of congress or law under this or any other state 6207
of the United States providing coverage at least comparable to the 6208
benefits under division (A)(2)(a) of this section; 6209

(c) Any policy of insurance or health care plan providing 6210
coverage at least comparable to the benefits under division 6211
(A)(2)(a) of this section. 6212

(B)(1) The direct-payment contract offered by the health 6213
insuring corporation pursuant to division (A) of this section 6214
shall provide the following: 6215

(a) In the case of an individual who is not a federally 6216
eligible individual, benefits comparable to benefits in any of the 6217
individual contracts then being issued to individual subscribers 6218
by the health insuring corporation; 6219

(b) In the case of a federally eligible individual, a basic 6220
and standard plan established by the board of directors of the 6221
Ohio health reinsurance program or plans substantially similar to 6222
the basic and standard plan in benefit design and scope of covered 6223
services. For purposes of division (B)(1)(b) of this section, the 6224
superintendent of insurance shall determine whether a plan is 6225
substantially similar to the basic or standard plan in benefit 6226
design and scope of covered services. The contractual periodic 6227
prepayments charged for such plans may not exceed an amount that 6228
is two times the midpoint of the standard rate charged any other 6229
individual of a group to which the organization is currently 6230
accepting new business and for which similar copayments and 6231
deductibles are applied. 6232

(2) The direct payment contract offered pursuant to division 6233
(A) of this section may include a coordination of benefits 6234
provision as approved by the superintendent. 6235

(3) For purposes of division (B) of this section "federally 6236

eligible individual" means an eligible individual as defined in 45 C.F.R. 148.103. 6237
6238

(C) The option for conversion shall be available: 6239

(1) Upon the death of the subscriber, to the surviving spouse 6240
with respect to such of the spouse and dependents as are then 6241
covered by the group contract; 6242

(2) To a child solely with respect to the child upon the 6243
child's attaining the limiting age of coverage under the group 6244
contract while covered as a dependent under the contract; 6245

(3) Upon the divorce, dissolution, or annulment of the 6246
marriage of the subscriber, to the divorced spouse, or, in the 6247
event of annulment, to the former spouse of the subscriber. 6248

(D) No health insuring corporation shall use age as the basis 6249
for refusing to renew a converted contract. 6250

(E) Written notice of the conversion option provided by this 6251
section shall be given to the subscriber by the health insuring 6252
corporation by mail. The notice shall be sent to the subscriber's 6253
address in the records of the employer upon receipt of notice from 6254
the employer of the event giving rise to the conversion option. If 6255
the subscriber has not received notice of the conversion privilege 6256
at least fifteen days prior to the expiration of the thirty-day 6257
conversion period, then the subscriber shall have an additional 6258
period within which to exercise the privilege. This additional 6259
period shall expire fifteen days after the subscriber receives 6260
notice, but in no event shall the period extend beyond sixty days 6261
after the expiration of the thirty-day conversion period. 6262

(F) This section does not apply to any group contract 6263
offering only supplemental health care services or specialty 6264
health care services. 6265

Sec. 1751.17. (A) As used in this section, "nongroup 6266

contract" means a contract issued by a health insuring corporation 6267
to an individual who makes direct application for coverage under 6268
the contract and who, if required by the health insuring 6269
corporation, submits to medical underwriting. "Nongroup contract" 6270
does not include group conversion coverage, coverage obtained 6271
through open enrollment, or coverage issued on the basis of 6272
membership in a group. 6273

(B) Except as provided in division (C) of this section, every 6274
nongroup contract that is issued by a health insuring corporation 6275
and that makes available basic health care services shall provide 6276
an option for conversion to a contract issued on a direct-payment 6277
basis to an enrollee covered by the nongroup contract. The option 6278
for conversion shall be available: 6279

(1) Upon the death of the subscriber, to the surviving spouse 6280
with respect to the spouse or dependents who were then covered by 6281
the nongroup contract; 6282

(2) Upon the divorce, dissolution, or annulment of the 6283
marriage of the subscriber, to the divorced spouse, or, in the 6284
event of annulment, to the former spouse of the subscriber; 6285

(3) To a child solely with respect to the child, upon the 6286
child's attaining the limiting age of coverage under the nongroup 6287
contract while covered as a dependent under the contract. 6288

(C) The direct payment contract offered pursuant to division 6289
(B) of this section shall not be made available to an enrollee if 6290
any of the following applies: 6291

(1) The enrollee is, or is eligible to be, covered for 6292
benefits at least comparable to the nongroup contract under any of 6293
the following: 6294

(a) The ~~medical assistance~~ medicaid program under Chapter 6295
~~5111. of the Revised Code;~~ 6296

(b) ~~Title XVIII of the "Social Security Act," 49 Stat. 620~~ 6297
~~(1935), 42 U.S.C.A. 301, as amended~~ The medicare program; 6298

(c) Any act of congress or law under this or any other state 6299
of the United States providing coverage at least comparable to the 6300
benefits offered under division (C)(1)(a) or (b) of this section. 6301

(2) The nongroup contract under which the enrollee was 6302
covered was terminated due to nonpayment of a premium rate. 6303

(3) The enrollee is eligible for group coverage provided by, 6304
or available through, an employer or association and the group 6305
coverage provides benefits comparable to the benefits provided 6306
under a direct payment contract. 6307

(D) The direct payment contract offered pursuant to division 6308
(B) of this section shall provide benefits that are at least 6309
comparable to the benefits provided by the nongroup contract under 6310
which the enrollee was covered at the time of the occurrence of 6311
any of the events set forth in division (B) of this section. The 6312
coverage provided under the direct payment contract shall be 6313
continuous, provided that the enrollee makes the required premium 6314
rate payment within the thirty-day period immediately following 6315
the occurrence of the event, and may be terminated for nonpayment 6316
of any required premium rate payment. 6317

(E) The evidence of coverage of every nongroup contract shall 6318
contain notice that an option for conversion to a contract issued 6319
on a direct-payment basis is available, in accordance with this 6320
section, to any enrollee covered by the contract. 6321

(F) Benefits otherwise payable to an enrollee under a direct 6322
payment contract shall be reduced by the amount of any benefits 6323
available to the enrollee under any applicable group health 6324
insuring corporation contract or group sickness and accident 6325
insurance policy. 6326

(G) Nothing in this section shall be construed as requiring a 6327

health insuring corporation to offer nongroup contracts. 6328

(H) This section does not apply to any nongroup contract 6329
offering only supplemental health care services or specialty 6330
health care services. 6331

Sec. 1751.18. (A)(1) No health insuring corporation shall 6332
cancel or fail to renew the coverage of a subscriber or enrollee 6333
because of any health status-related factor in relation to the 6334
subscriber or enrollee, the subscriber's or enrollee's 6335
requirements for health care services, or for any other reason 6336
designated under rules adopted by the superintendent of insurance. 6337

(2) Unless otherwise required by state or federal law, no 6338
health insuring corporation, or health care facility or provider 6339
through which the health insuring corporation has made 6340
arrangements to provide health care services, shall discriminate 6341
against any individual with regard to enrollment, disenrollment, 6342
or the quality of health care services rendered, on the basis of 6343
the individual's race, color, sex, age, religion, or status as a 6344
recipient of medicare or ~~medical assistance under Title XVIII or~~ 6345
~~XIX of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A.~~ 6346
~~301, as amended~~ medicaid, or any health status-related factor in 6347
relation to the individual. However, a health insuring corporation 6348
shall not be required to accept a recipient of medicare or ~~medical~~ 6349
~~assistance~~ medicaid, if an agreement has not been reached on 6350
appropriate payment mechanisms between the health insuring 6351
corporation and the governmental agency administering these 6352
programs. Further, except during a period of open enrollment under 6353
section 1751.15 of the Revised Code, a health insuring corporation 6354
may reject an applicant for nongroup enrollment on the basis of 6355
any health status-related factor in relation to the applicant. 6356

(B) A health insuring corporation may cancel or decide not to 6357
renew the coverage of an enrollee if the enrollee has performed an 6358

act or practice that constitutes fraud or intentional 6359
misrepresentation of material fact under the terms of the coverage 6360
and if the cancellation or nonrenewal is not based, either 6361
directly or indirectly, on any health status-related factor in 6362
relation to the enrollee. 6363

(C) An enrollee may appeal any action or decision of a health 6364
insuring corporation taken pursuant to section 2742(b) to (e) of 6365
the "Health Insurance Portability and Accountability Act of 1996," 6366
Pub. L. No. 104-191, 110 Stat. 1955, 42 U.S.C.A. 300gg-42, as 6367
amended. To appeal, the enrollee may submit a written complaint to 6368
the health insuring corporation pursuant to section 1751.19 of the 6369
Revised Code. The enrollee may, within thirty days after receiving 6370
a written response from the health insuring corporation, appeal 6371
the health insuring corporation's action or decision to the 6372
superintendent. 6373

(D) As used in this section, "health status-related factor" 6374
means any of the following: 6375

(1) Health status; 6376

(2) Medical condition, including both physical and mental 6377
illnesses; 6378

(3) Claims experience; 6379

(4) Receipt of health care; 6380

(5) Medical history; 6381

(6) Genetic information; 6382

(7) Evidence of insurability, including conditions arising 6383
out of acts of domestic violence; 6384

(8) Disability. 6385

Sec. 1751.20. (A) No health insuring corporation, or agent, 6386
employee, or representative of a health insuring corporation, 6387

shall use any advertisement or solicitation document, or shall 6388
engage in any activity, that is unfair, untrue, misleading, or 6389
deceptive. 6390

(B) No health insuring corporation shall use a name that is 6391
deceptively similar to the name or description of any insurance or 6392
surety corporation doing business in this state. 6393

(C) All solicitation documents, advertisements, evidences of 6394
coverage, and enrollee identification cards used by a health 6395
insuring corporation shall contain the health insuring 6396
corporation's name. The use of a trade name, an insurance group 6397
designation, the name of a parent company, the name of a division 6398
of an affiliated insurance company, a service mark, a slogan, a 6399
symbol, or other device, without the name of the health insuring 6400
corporation as stated in its articles of incorporation, shall not 6401
satisfy this requirement if the usage would have the capacity and 6402
tendency to mislead or deceive persons as to the true identity of 6403
the health insuring corporation. 6404

(D) No solicitation document or advertisement used by a 6405
health insuring corporation shall contain any words, symbols, or 6406
physical materials that are so similar in content, phraseology, 6407
shape, color, or other characteristic to those used by an agency 6408
of the federal government or this state, that prospective 6409
enrollees may be led to believe that the solicitation document or 6410
advertisement is connected with an agency of the federal 6411
government or this state. 6412

(E) A health insuring corporation that provides basic health 6413
care services may use the phrase "health maintenance organization" 6414
or the abbreviation "HMO" in its marketing name, advertising, 6415
solicitation documents, or marketing literature, or in reference 6416
to the phrase "doing business as" or the abbreviation "DBA." 6417

(F) This section does not apply to the coverage of 6418

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 6451
deposited securities as long as the health insuring corporation 6452
remains solvent. 6453

(B) The bond shall be issued by a surety company licensed 6454
with the department of insurance. The bond or deposit, or any 6455
replacement bond or deposit, shall be in a form acceptable to the 6456
superintendent, and shall remain in effect during the duration of 6457
the medicaid health insuring corporation's license and thereafter 6458
until all claims against the medicaid health insuring corporation 6459
have been paid in full. 6460

(C) Documentation of the bond acceptable to the 6461
superintendent of insurance shall be filed with the superintendent 6462
prior to the issuance of a certificate of authority. Annually, 6463
thirty days prior to the renewal of its certificate of authority, 6464
every medicaid health insuring corporation shall furnish the 6465
superintendent of insurance with evidence that the required bond 6466
is still in effect. 6467

(D) As used in this section: 6468

(1) "Contracted provider" means a provider that has a 6469
contract with a medicaid health insuring corporation to provide 6470
covered health care services to medicaid recipients. 6471

(2) "Medicaid health insuring corporation" means a health 6472
insuring corporation that provides health insurance coverage or 6473
otherwise assumes claims liabilities for medicaid recipients. 6474

(3) "Medicaid recipient" means a person eligible for medical 6475
assistance under the medicaid program ~~operated pursuant to Chapter~~ 6476
~~5111. of the Revised Code.~~ 6477

Sec. 1751.31. (A) Any changes in a health insuring 6478
corporation's solicitation document shall be filed with the 6479
superintendent of insurance. The superintendent, within sixty days 6480

of filing, may disapprove any solicitation document or amendment 6481
to it on any of the grounds stated in this section. Such 6482
disapproval shall be effected by written notice to the health 6483
insuring corporation. The notice shall state the grounds for 6484
disapproval and shall be issued in accordance with Chapter 119. of 6485
the Revised Code. 6486

(B) The solicitation document shall contain all information 6487
necessary to enable a consumer to make an informed choice as to 6488
whether or not to enroll in the health insuring corporation. The 6489
information shall include a specific description of the health 6490
care services to be available and the approximate number and type 6491
of full-time equivalent medical practitioners. The information 6492
shall be presented in the solicitation document in a manner that 6493
is clear, concise, and intelligible to prospective applicants in 6494
the proposed service area. 6495

(C) Every potential applicant whose subscription to a health 6496
care plan is solicited shall receive, at or before the time of 6497
solicitation, a solicitation document approved by the 6498
superintendent. 6499

(D) Notwithstanding division (A) of this section, a health 6500
insuring corporation may use a solicitation document that the 6501
corporation uses in connection with policies for beneficiaries of 6502
~~Title XVIII of the "Social Security Act," 49 Stat. 620 (1935), 42~~ 6503
~~U.S.C.A. 301, as amended~~ medicare program, pursuant to a medicare 6504
risk contract or medicare cost contract, or for policies for 6505
beneficiaries of the federal employees health benefits program 6506
pursuant to ~~5 U.S.C.A. 8905~~, or for policies for ~~beneficiaries of~~ 6507
~~Title XIX recipients~~ of the ~~"Social Security Act," 49 Stat. 620~~ 6508
~~(1935), 42 U.S.C.A. 301, as amended, known as the medical~~ 6509
~~assistance program or medicaid, provided by the department of job~~ 6510
~~and family services under Chapter 5111. of the Revised Code~~ 6511
program, or for policies for beneficiaries of any other federal 6512

health care program regulated by a federal regulatory body, or for 6513
policies for beneficiaries of contracts covering officers or 6514
employees of the state entered into by the department of 6515
administrative services, if both of the following apply: 6516

(1) The solicitation document has been approved by the United 6517
States department of health and human services, the United States 6518
office of personnel management, the department of ~~job and family~~ 6519
~~services~~ health care administration, or the department of 6520
administrative services. 6521

(2) The solicitation document is filed with the 6522
superintendent of insurance prior to use and is accompanied by 6523
documentation of approval from the United States department of 6524
health and human services, the United States office of personnel 6525
management, the department of ~~job and family services~~ health care 6526
administration, or the department of administrative services. 6527

(E) No health insuring corporation, or its agents or 6528
representatives, shall use monetary or other valuable 6529
consideration, engage in misleading or deceptive practices, or 6530
make untrue, misleading, or deceptive representations to induce 6531
enrollment. Nothing in this division shall prohibit incentive 6532
forms of remuneration such as commission sales programs for the 6533
health insuring corporation's employees and agents. 6534

(F) Any person obligated for any part of a premium rate in 6535
connection with an enrollment agreement, in addition to any right 6536
otherwise available to revoke an offer, may cancel such agreement 6537
within seventy-two hours after having signed the agreement or 6538
offer to enroll. Cancellation occurs when written notice of the 6539
cancellation is given to the health insuring corporation or its 6540
agents or other representatives. A notice of cancellation mailed 6541
to the health insuring corporation shall be considered to have 6542
been filed on its postmark date. 6543

(G) Nothing in this section shall prohibit healthy lifestyle programs. 6544
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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. 6546
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(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. 6557
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(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: 6666

(a) The employee ceases to be an eligible employee under 6667
division (A)(2)(c) or (d) of this section; 6668

(b) A period of six months expires after the date that the 6669
employee's coverage under the group contract would otherwise have 6670
terminated because of the termination of employment; 6671

(c) The employee fails to make a timely payment of a required 6672
contribution, in which event the coverage shall cease at the end 6673
of the coverage for which contributions were made; 6674

(d) The group contract is terminated, or the employer 6675
terminates participation under the contract, unless the employer 6676
replaces the coverage by similar coverage under another contract 6677
or other group health arrangement. If the employer replaces the 6678
contract with similar group health coverage, all of the following 6679
apply: 6680

(i) The member shall be covered under the replacement 6681
coverage, for the balance of the period that the member would have 6682
remained covered under the terminated coverage if it had not been 6683
terminated. 6684

(ii) The minimum level of benefits under the replacement 6685
coverage shall be the applicable level of benefits of the contract 6686
replaced reduced by any benefits payable under the contract 6687
replaced. 6688

(iii) The contract replaced shall continue to provide 6689
benefits to the extent of its accrued liabilities and extensions 6690
of benefits as if the replacement had not occurred. 6691

(D) This section does not apply to any group contract 6692
offering only supplemental health care services or specialty 6693
health care services. 6694

Sec. 1751.60. (A) Except as provided for in divisions (E) and 6695

(F) of this section, every provider or health care facility that 6696
contracts with a health insuring corporation to provide health 6697
care services to the health insuring corporation's enrollees or 6698
subscribers shall seek compensation for covered services solely 6699
from the health insuring corporation and not, under any 6700
circumstances, from the enrollees or subscribers, except for 6701
approved copayments and deductibles. 6702

(B) No subscriber or enrollee of a health insuring 6703
corporation is liable to any contracting provider or health care 6704
facility for the cost of any covered health care services, if the 6705
subscriber or enrollee has acted in accordance with the evidence 6706
of coverage. 6707

(C) Except as provided for in divisions (E) and (F) of this 6708
section, every contract between a health insuring corporation and 6709
provider or health care facility shall contain a provision 6710
approved by the superintendent of insurance requiring the provider 6711
or health care facility to seek compensation solely from the 6712
health insuring corporation and not, under any circumstances, from 6713
the subscriber or enrollee, except for approved copayments and 6714
deductibles. 6715

(D) Nothing in this section shall be construed as preventing 6716
a provider or health care facility from billing the enrollee or 6717
subscriber of a health insuring corporation for noncovered 6718
services. 6719

(E) Upon application by a health insuring corporation and a 6720
provider or health care facility, the superintendent may waive the 6721
requirements of divisions (A) and (C) of this section when, in 6722
addition to the reserve requirements contained in section 1751.28 6723
of the Revised Code, the health insuring corporation provides 6724
sufficient assurances to the superintendent that the provider or 6725
health care facility has been provided with financial guarantees. 6726
No waiver of the requirements of divisions (A) and (C) of this 6727

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;~~ 6758

(B) Coverage provided to recipients of medical assistance 6759
under the medicaid program ~~operated pursuant to Chapter 5111. of~~ 6760
~~the Revised Code.~~ 6761

Sec. 2108.01. As used in sections 2108.01 to 2108.12 of the 6762
Revised Code: 6763

(A) "Anatomical gift" means a donation of all or part of a 6764
human body to take effect upon or after death. 6765

(B) "Decedent" means a deceased individual and includes a 6766
stillborn infant or fetus. 6767

(C) If a will or other document by which an anatomical gift 6768
is made includes a valid specification of the intended donee, 6769
"donee" means the specified person or entity; otherwise, "donee" 6770
means, in the case of organs, an organ procurement organization 6771
that serves the region of the state where the body of the donor is 6772
located or, in the case of tissue or eyes, an organization 6773
entitled by law to recover the tissue or eyes from the donor's 6774
body. 6775

(D) "Donor" means an individual who makes an anatomical gift. 6776

(E) "Hospital" means any hospital operated in this state that 6777
is certified under ~~Title XVIII of the "Social Security Act," 49~~ 6778
~~Stat. 620 (1935), 42 U.S.C. 301, as amended~~ medicare program, or 6779
accredited by the joint commission on accreditation of healthcare 6780
organizations or the American osteopathic association. "Hospital" 6781
also means a facility licensed, accredited, registered, or 6782
approved as a hospital under the laws of any state, and includes a 6783
facility operated as a hospital by a state or a subdivision of the 6784
state, although not required to be licensed under state laws. 6785

(F) "Identification card" means an identification card issued 6786
under sections 4507.50 and 4507.51 of the Revised Code. 6787

(G) "Part" means any portion of a human body. 6788

(H) "Tissue" means any body part other than an organ or eye. 6789

(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. 6790
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(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. 6793
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(K) "Recovery agency" means a nonprofit organization incorporated under Chapter 1702. of the Revised Code that is one of the following: 6796
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(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; 6799
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(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; 6803
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(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. 6808
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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 6813
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recipient who is subject to the estate recovery program. The 6818
affidavit shall include all of the following information: 6819

(1) The name of the decedent; 6820

(2) The name of any person who gave notice that the decedent 6821
was a medicaid recipient and that person's relationship to the 6822
decedent; 6823

(3) The name of the financial institution; 6824

(4) The account number; 6825

(5) A description of the claim for estate recovery; 6826

(6) The amount of funds to be recovered. 6827

(B) A financial institution may release account proceeds to 6828
the administrator of the estate recovery program if all of the 6829
following apply: 6830

(1) The decedent held an account at the financial institution 6831
that was in the decedent's name only. 6832

(2) No estate has been, and it is reasonable to assume that 6833
no estate will be, opened for the decedent. 6834

(3) The decedent has no outstanding debts known to the 6835
administrator of the estate recovery program. 6836

(4) The financial institution has received no objections or 6837
has determined that no valid objections to release of proceeds 6838
have been received. 6839

(C) If proceeds have been released pursuant to division (B) 6840
of this section and the department of ~~job and family services~~ 6841
health care administration receives notice of a valid claim to the 6842
proceeds that has a higher priority under section 2117.25 of the 6843
Revised Code than the claim of the estate recovery program, the 6844
department may refund the proceeds to the financial institution or 6845
pay them to the person or government entity with the claim. 6846

Sec. 2113.06. Administration of the estate of an intestate 6847
shall be granted to persons mentioned in this section, in the 6848
following order: 6849

(A) To the surviving spouse of the deceased, if resident of 6850
the state; 6851

(B) To one of the next of kin of the deceased, resident of 6852
the state. 6853

If the persons entitled to administer the estate fail to take 6854
or renounce administration voluntarily, they shall be cited by the 6855
probate court for that purpose. 6856

If there are no persons entitled to administration, or if 6857
they are for any reason unsuitable for the discharge of the trust, 6858
or if without sufficient cause they neglect to apply within a 6859
reasonable time for the administration of the estate, their right 6860
to priority shall be lost, and the court shall commit the 6861
administration to some suitable person who is a resident of the 6862
state, or to the attorney general or the attorney general's 6863
designee, if the department of ~~job and family services~~ health care 6864
administration is seeking to recover ~~medical assistance~~ medicaid 6865
costs from the deceased pursuant to section ~~5111.11~~ 5162.40 or 6866
~~5111.111~~ 5162.41 of the Revised Code. Such person may be a 6867
creditor of the estate. 6868

This section applies to the appointment of an administrator 6869
de bonis non. 6870

Sec. 2117.061. (A) As used in this section: 6871

(1) "Medicaid estate recovery program" means the program 6872
instituted under section ~~5111.11~~ 5162.40 of the Revised Code. 6873

(2) "Permanently institutionalized individual" has the same 6874
meaning as in section ~~5111.11~~ 5162.40 of the Revised Code. 6875

(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 6907
responsible for the estate that knowingly making a false statement 6908
on the form is falsification under section 2921.13 of the Revised 6909
Code, a misdemeanor of the first degree. 6910

(E) The estate recovery program administrator shall present a 6911
claim for estate recovery to the person responsible for the estate 6912
or the person's legal representative not later than ninety days 6913
after the date on which the medicaid estate recovery reporting 6914
form is received under division (B) of this section or one year 6915
after the decedent's death, whichever is later. 6916

Sec. 2117.25. (A) Every executor or administrator shall 6917
proceed with diligence to pay the debts of the decedent and shall 6918
apply the assets in the following order: 6919

(1) Costs and expenses of administration; 6920

(2) An amount, not exceeding four thousand dollars, for 6921
funeral expenses that are included in the bill of a funeral 6922
director, funeral expenses other than those in the bill of a 6923
funeral director that are approved by the probate court, and an 6924
amount, not exceeding three thousand dollars, for burial and 6925
cemetery expenses, including that portion of the funeral 6926
director's bill allocated to cemetery expenses that have been paid 6927
to the cemetery by the funeral director. 6928

For purposes of this division, burial and cemetery expenses 6929
shall be limited to the following: 6930

(a) The purchase of a right of interment; 6931

(b) Monuments or other markers; 6932

(c) The outer burial container; 6933

(d) The cost of opening and closing the place of interment; 6934

(e) The urn. 6935

(3) The allowance for support made to the surviving spouse, 6936
minor children, or both under section 2106.13 of the Revised Code; 6937

(4) Debts entitled to a preference under the laws of the 6938
United States; 6939

(5) Expenses of the last sickness of the decedent; 6940

(6) If the total bill of a funeral director for funeral 6941
expenses exceeds four thousand dollars, then, in addition to the 6942
amount described in division (A)(2) of this section, an amount, 6943
not exceeding two thousand dollars, for funeral expenses that are 6944
included in the bill and that exceed four thousand dollars; 6945

(7) Personal property taxes, claims made under the estate 6946
recovery program instituted pursuant to section ~~5111.11~~ 5162.40 of 6947
the Revised Code, and obligations for which the decedent was 6948
personally liable to the state or any of its subdivisions; 6949

(8) Debts for manual labor performed for the decedent within 6950
twelve months preceding the decedent's death, not exceeding three 6951
hundred dollars to any one person; 6952

(9) Other debts for which claims have been presented and 6953
finally allowed. 6954

(B) The part of the bill of a funeral director that exceeds 6955
the total of six thousand dollars as described in divisions (A)(2) 6956
and (6) of this section, and the part of a claim included in 6957
division (A)(8) of this section that exceeds three hundred dollars 6958
shall be included as a debt under division (A)(9) of this section, 6959
depending upon the time when the claim for the additional amount 6960
is presented. 6961

(C) Any natural person or fiduciary who pays a claim of any 6962
creditor described in division (A) of this section shall be 6963
subrogated to the rights of that creditor proportionate to the 6964
amount of the payment and shall be entitled to reimbursement for 6965

that amount in accordance with the priority of payments set forth 6966
in that division. 6967

(D)(1) Chapters 2113. to 2125. of the Revised Code, relating 6968
to the manner in which and the time within which claims shall be 6969
presented, shall apply to claims set forth in divisions (A)(2), 6970
(6), and (8) of this section. Claims for an expense of 6971
administration or for the allowance for support need not be 6972
presented. The executor or administrator shall pay debts included 6973
in divisions (A)(4) and (7) of this section, of which the executor 6974
or administrator has knowledge, regardless of presentation. 6975

(2) The giving of written notice to an executor or 6976
administrator of a motion or application to revive an action 6977
pending against the decedent at the date of death shall be 6978
equivalent to the presentation of a claim to the executor or 6979
administrator for the purpose of determining the order of payment 6980
of any judgment rendered or decree entered in such an action. 6981

(E) No payments shall be made to creditors of one class until 6982
all those of the preceding class are fully paid or provided for. 6983
If the assets are insufficient to pay all the claims of one class, 6984
the creditors of that class shall be paid ratably. 6985

(F) If it appears at any time that the assets have been 6986
exhausted in paying prior or preferred charges, allowances, or 6987
claims, those payments shall be a bar to an action on any claim 6988
not entitled to that priority or preference. 6989

Sec. 2133.01. Unless the context otherwise requires, as used 6990
in sections 2133.01 to 2133.15 of the Revised Code: 6991

(A) "Adult" means an individual who is eighteen years of age 6992
or older. 6993

(B) "Attending physician" means the physician to whom a 6994
declarant or other patient, or the family of a declarant or other 6995

patient, has assigned primary responsibility for the treatment or 6996
care of the declarant or other patient, or, if the responsibility 6997
has not been assigned, the physician who has accepted that 6998
responsibility. 6999

(C) "Comfort care" means any of the following: 7000

(1) Nutrition when administered to diminish the pain or 7001
discomfort of a declarant or other patient, but not to postpone 7002
the declarant's or other patient's death; 7003

(2) Hydration when administered to diminish the pain or 7004
discomfort of a declarant or other patient, but not to postpone 7005
the declarant's or other patient's death; 7006

(3) Any other medical or nursing procedure, treatment, 7007
intervention, or other measure that is taken to diminish the pain 7008
or discomfort of a declarant or other patient, but not to postpone 7009
the declarant's or other patient's death. 7010

(D) "Consulting physician" means a physician who, in 7011
conjunction with the attending physician of a declarant or other 7012
patient, makes one or more determinations that are required to be 7013
made by the attending physician, or to be made by the attending 7014
physician and one other physician, by an applicable provision of 7015
this chapter, to a reasonable degree of medical certainty and in 7016
accordance with reasonable medical standards. 7017

(E) "Declarant" means any adult who has executed a 7018
declaration in accordance with section 2133.02 of the Revised 7019
Code. 7020

(F) "Declaration" means a written document executed in 7021
accordance with section 2133.02 of the Revised Code. 7022

(G) "Durable power of attorney for health care" means a 7023
document created pursuant to sections 1337.11 to 1337.17 of the 7024
Revised Code. 7025

(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.	7026 7027 7028
(I) "Health care facility" means any of the following:	7029
(1) A hospital;	7030
(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;	7031 7032 7033
(3) A nursing home or residential care facility, as defined in section 3721.01 of the Revised Code;	7034 7035
(4) A home health agency and any residential facility where a person is receiving care under the direction of a home health agency;	7036 7037 7038
(5) An intermediate care facility for the mentally retarded.	7039
(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.	7040 7041 7042 7043 7044 7045
(K) "Home health agency" has the same meaning as in section 3701.881 of the Revised Code.	7046 7047
(L) "Hospice care program" has the same meaning as in section 3712.01 of the Revised Code.	7048 7049
(M) "Hospital" has the same meanings as in sections 2108.01, 3701.01, and 5122.01 of the Revised Code.	7050 7051
(N) "Hydration" means fluids that are artificially or technologically administered.	7052 7053
(O) "Incompetent" has the same meaning as in section 2111.01	7054

of the Revised Code. 7055

(P) "Intermediate care facility for the mentally retarded" 7056
has the same meaning as in section ~~5111.20~~ 5164.01 of the Revised 7057
Code. 7058

(Q) "Life-sustaining treatment" means any medical procedure, 7059
treatment, intervention, or other measure that, when administered 7060
to a qualified patient or other patient, will serve principally to 7061
prolong the process of dying. 7062

(R) "Nurse" means a person who is licensed to practice 7063
nursing as a registered nurse or to practice practical nursing as 7064
a licensed practical nurse pursuant to Chapter 4723. of the 7065
Revised Code. 7066

(S) "Nursing home" has the same meaning as in section 3721.01 7067
of the Revised Code. 7068

(T) "Nutrition" means sustenance that is artificially or 7069
technologically administered. 7070

(U) "Permanently unconscious state" means a state of 7071
permanent unconsciousness in a declarant or other patient that, to 7072
a reasonable degree of medical certainty as determined in 7073
accordance with reasonable medical standards by the declarant's or 7074
other patient's attending physician and one other physician who 7075
has examined the declarant or other patient, is characterized by 7076
both of the following: 7077

(1) Irreversible unawareness of one's being and environment. 7078

(2) Total loss of cerebral cortical functioning, resulting in 7079
the declarant or other patient having no capacity to experience 7080
pain or suffering. 7081

(V) "Person" has the same meaning as in section 1.59 of the 7082
Revised Code and additionally includes political subdivisions and 7083
governmental agencies, boards, commissions, departments, 7084

institutions, offices, and other instrumentalities. 7085

(W) "Physician" means a person who is authorized under 7086
Chapter 4731. of the Revised Code to practice medicine and surgery 7087
or osteopathic medicine and surgery. 7088

(X) "Political subdivision" and "state" have the same 7089
meanings as in section 2744.01 of the Revised Code. 7090

(Y) "Professional disciplinary action" means action taken by 7091
the board or other entity that regulates the professional conduct 7092
of health care personnel, including the state medical board and 7093
the board of nursing. 7094

(Z) "Qualified patient" means an adult who has executed a 7095
declaration and has been determined to be in a terminal condition 7096
or in a permanently unconscious state. 7097

(AA) "Terminal condition" means an irreversible, incurable, 7098
and untreatable condition caused by disease, illness, or injury 7099
from which, to a reasonable degree of medical certainty as 7100
determined in accordance with reasonable medical standards by a 7101
declarant's or other patient's attending physician and one other 7102
physician who has examined the declarant or other patient, both of 7103
the following apply: 7104

(1) There can be no recovery. 7105

(2) Death is likely to occur within a relatively short time 7106
if life-sustaining treatment is not administered. 7107

(BB) "Tort action" means a civil action for damages for 7108
injury, death, or loss to person or property, other than a civil 7109
action for damages for breach of a contract or another agreement 7110
between persons. 7111

Sec. 2151.3514. (A) As used in this section: 7112

(1) "Alcohol and drug addiction program" has the same meaning 7113

as in section 3793.01 of the Revised Code; 7114

(2) "Chemical dependency" means either of the following: 7115

(a) The chronic and habitual use of alcoholic beverages to 7116
the extent that the user no longer can control the use of alcohol 7117
or endangers the user's health, safety, or welfare or that of 7118
others; 7119

(b) The use of a drug of abuse to the extent that the user 7120
becomes physically or psychologically dependent on the drug or 7121
endangers the user's health, safety, or welfare or that of others. 7122

(3) "Drug of abuse" has the same meaning as in section 7123
3719.011 of the Revised Code. 7124

~~(4) "Medicaid" means the program established under Chapter 7125
5111. of the Revised Code. 7126~~

(B) If the juvenile court issues an order of temporary 7127
custody or protective supervision under division (A) of section 7128
2151.353 of the Revised Code with respect to a child adjudicated 7129
to be an abused, neglected, or dependent child and the alcohol or 7130
other drug addiction of a parent or other caregiver of the child 7131
was the basis for the adjudication of abuse, neglect, or 7132
dependency, the court shall issue an order requiring the parent or 7133
other caregiver to submit to an assessment and, if needed, 7134
treatment from an alcohol and drug addiction program certified by 7135
the department of alcohol and drug addiction services. The court 7136
may order the parent or other caregiver to submit to alcohol or 7137
other drug testing during, after, or both during and after, the 7138
treatment. The court shall send any order issued pursuant to this 7139
division to the public children services agency that serves the 7140
county in which the court is located for use as described in 7141
section 340.15 of the Revised Code. 7142

(C) Any order requiring alcohol or other drug testing that is 7143
issued pursuant to division (B) of this section shall require one 7144

alcohol or other drug test to be conducted each month during a 7145
period of twelve consecutive months beginning the month 7146
immediately following the month in which the order for alcohol or 7147
other drug testing is issued. Arrangements for administering the 7148
alcohol or other drug tests, as well as funding the costs of the 7149
tests, shall be locally determined in accordance with sections 7150
340.033 and 340.15 of the Revised Code. If a parent or other 7151
caregiver required to submit to alcohol or other drug tests under 7152
this section is not a recipient of medicaid, the agency that 7153
refers the parent or caregiver for the tests may require the 7154
parent or caregiver to reimburse the agency for the cost of 7155
conducting the tests. 7156

(D) The certified alcohol and drug addiction program that 7157
conducts any alcohol or other drug tests ordered in accordance 7158
with divisions (B) and (C) of this section shall send the results 7159
of the tests, along with the program's recommendations as to the 7160
benefits of continued treatment, to the court and to the public 7161
children services agency providing services to the involved 7162
family, according to federal regulations set forth in 42 C.F.R. 7163
Part 2, and division (B) of section 340.15 of the Revised Code. 7164
The court shall consider the results and the recommendations sent 7165
to it under this division in any adjudication or review by the 7166
court, according to section 2151.353, 2151.414, or 2151.419 of the 7167
Revised Code. 7168

Sec. 2305.234. (A) As used in this section: 7169

(1) "Chiropractic claim," "medical claim," and "optometric 7170
claim" have the same meanings as in section 2305.113 of the 7171
Revised Code. 7172

(2) "Dental claim" has the same meaning as in section 7173
2305.113 of the Revised Code, except that it does not include any 7174
claim arising out of a dental operation or any derivative claim 7175

for relief that arises out of a dental operation. 7176

(3) "Governmental health care program" has the same meaning 7177
as in section 4731.65 of the Revised Code. 7178

(4) "Health care facility or location" means a hospital, 7179
clinic, ambulatory surgical facility, office of a health care 7180
professional or associated group of health care professionals, 7181
training institution for health care professionals, or any other 7182
place where medical, dental, or other health-related diagnosis, 7183
care, or treatment is provided to a person. 7184

(5) "Health care professional" means any of the following who 7185
provide medical, dental, or other health-related diagnosis, care, 7186
or treatment: 7187

(a) Physicians authorized under Chapter 4731. of the Revised 7188
Code to practice medicine and surgery or osteopathic medicine and 7189
surgery; 7190

(b) Registered nurses and licensed practical nurses licensed 7191
under Chapter 4723. of the Revised Code and individuals who hold a 7192
certificate of authority issued under that chapter that authorizes 7193
the practice of nursing as a certified registered nurse 7194
anesthetist, clinical nurse specialist, certified nurse-midwife, 7195
or certified nurse practitioner; 7196

(c) Physician assistants authorized to practice under Chapter 7197
4730. of the Revised Code; 7198

(d) Dentists and dental hygienists licensed under Chapter 7199
4715. of the Revised Code; 7200

(e) Physical therapists, physical therapist assistants, 7201
occupational therapists, and occupational therapy assistants 7202
licensed under Chapter 4755. of the Revised Code; 7203

(f) Chiropractors licensed under Chapter 4734. of the Revised 7204
Code; 7205

(g) Optometrists licensed under Chapter 4725. of the Revised Code;	7206 7207
(h) Podiatrists authorized under Chapter 4731. of the Revised Code to practice podiatry;	7208 7209
(i) Dietitians licensed under Chapter 4759. of the Revised Code;	7210 7211
(j) Pharmacists licensed under Chapter 4729. of the Revised Code;	7212 7213
(k) Emergency medical technicians-basic, emergency medical technicians-intermediate, and emergency medical technicians-paramedic, certified under Chapter 4765. of the Revised Code;	7214 7215 7216 7217
(l) Respiratory care professionals licensed under Chapter 4761. of the Revised Code;	7218 7219
(m) Speech-language pathologists and audiologists licensed under Chapter 4753. of the Revised Code.	7220 7221
(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.	7222 7223 7224 7225 7226 7227 7228
(7) "Indigent and uninsured person" means a person who meets all of the following requirements:	7229 7230
(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.	7231 7232 7233 7234 7235

(b) The person is ~~not eligible to receive medical assistance~~ 7236
~~under Chapter 5111. ineligible for the medicaid program, the~~ 7237
disability medical assistance ~~under Chapter 5115. of the Revised~~ 7238
~~Code or program, and~~ assistance under any other governmental 7239
health care program. 7240

(c) Either of the following applies: 7241

(i) The person is not a policyholder, certificate holder, 7242
insured, contract holder, subscriber, enrollee, member, 7243
beneficiary, or other covered individual under a health insurance 7244
or health care policy, contract, or plan. 7245

(ii) The person is a policyholder, certificate holder, 7246
insured, contract holder, subscriber, enrollee, member, 7247
beneficiary, or other covered individual under a health insurance 7248
or health care policy, contract, or plan, but the insurer, policy, 7249
contract, or plan denies coverage or is the subject of insolvency 7250
or bankruptcy proceedings in any jurisdiction. 7251

(8) "Nonprofit health care referral organization" means an 7252
entity that is not operated for profit and refers patients to, or 7253
arranges for the provision of, health-related diagnosis, care, or 7254
treatment by a health care professional or health care worker. 7255

(9) "Operation" means any procedure that involves cutting or 7256
otherwise infiltrating human tissue by mechanical means, including 7257
surgery, laser surgery, ionizing radiation, therapeutic 7258
ultrasound, or the removal of intraocular foreign bodies. 7259

"Operation" does not include the administration of medication by 7260
injection, unless the injection is administered in conjunction 7261
with a procedure infiltrating human tissue by mechanical means 7262
other than the administration of medicine by injection. 7263

"Operation" does not include routine dental restorative 7264
procedures, the scaling of teeth, or extractions of teeth that are 7265
not impacted. 7266

(10) "Tort action" means a civil action for damages for 7267
injury, death, or loss to person or property other than a civil 7268
action for damages for a breach of contract or another agreement 7269
between persons or government entities. 7270

(11) "Volunteer" means an individual who provides any 7271
medical, dental, or other health-care related diagnosis, care, or 7272
treatment without the expectation of receiving and without receipt 7273
of any compensation or other form of remuneration from an indigent 7274
and uninsured person, another person on behalf of an indigent and 7275
uninsured person, any health care facility or location, any 7276
nonprofit health care referral organization, or any other person 7277
or government entity. 7278

(12) "Community control sanction" has the same meaning as in 7279
section 2929.01 of the Revised Code. 7280

(13) "Deep sedation" means a drug-induced depression of 7281
consciousness during which a patient cannot be easily aroused but 7282
responds purposefully following repeated or painful stimulation, a 7283
patient's ability to independently maintain ventilatory function 7284
may be impaired, a patient may require assistance in maintaining a 7285
patent airway and spontaneous ventilation may be inadequate, and 7286
cardiovascular function is usually maintained. 7287

(14) "General anesthesia" means a drug-induced loss of 7288
consciousness during which a patient is not arousable, even by 7289
painful stimulation, the ability to independently maintain 7290
ventilatory function is often impaired, a patient often requires 7291
assistance in maintaining a patent airway, positive pressure 7292
ventilation may be required because of depressed spontaneous 7293
ventilation or drug-induced depression of neuromuscular function, 7294
and cardiovascular function may be impaired. 7295

(B)(1) Subject to divisions (F) and (G)(3) of this section, a 7296
health care professional who is a volunteer and complies with 7297

division (B)(2) of this section is not liable in damages to any 7298
person or government entity in a tort or other civil action, 7299
including an action on a medical, dental, chiropractic, 7300
optometric, or other health-related claim, for injury, death, or 7301
loss to person or property that allegedly arises from an action or 7302
omission of the volunteer in the provision to an indigent and 7303
uninsured person of medical, dental, or other health-related 7304
diagnosis, care, or treatment, including the provision of samples 7305
of medicine and other medical products, unless the action or 7306
omission constitutes willful or wanton misconduct. 7307

(2) To qualify for the immunity described in division (B)(1) 7308
of this section, a health care professional shall do all of the 7309
following prior to providing diagnosis, care, or treatment: 7310

(a) Determine, in good faith, that the indigent and uninsured 7311
person is mentally capable of giving informed consent to the 7312
provision of the diagnosis, care, or treatment and is not subject 7313
to duress or under undue influence; 7314

(b) Inform the person of the provisions of this section, 7315
including notifying the person that, by giving informed consent to 7316
the provision of the diagnosis, care, or treatment, the person 7317
cannot hold the health care professional liable for damages in a 7318
tort or other civil action, including an action on a medical, 7319
dental, chiropractic, optometric, or other health-related claim, 7320
unless the action or omission of the health care professional 7321
constitutes willful or wanton misconduct; 7322

(c) Obtain the informed consent of the person and a written 7323
waiver, signed by the person or by another individual on behalf of 7324
and in the presence of the person, that states that the person is 7325
mentally competent to give informed consent and, without being 7326
subject to duress or under undue influence, gives informed consent 7327
to the provision of the diagnosis, care, or treatment subject to 7328
the provisions of this section. A written waiver under division 7329

(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. 7424

(3) This section does not grant an immunity from tort or 7425
other civil liability to a health care professional, health care 7426
worker, nonprofit health care referral organization, or health 7427
care facility or location for actions that are outside the scope 7428
of authority of health care professionals or health care workers. 7429

(4) This section does not affect any legal responsibility of 7430
a health care professional, health care worker, or nonprofit 7431
health care referral organization to comply with any applicable 7432
law of this state or rule of an agency of this state. 7433

(5) This section does not affect any legal responsibility of 7434
a health care facility or location to comply with any applicable 7435
law of this state, rule of an agency of this state, or local code, 7436
ordinance, or regulation that pertains to or regulates building, 7437
housing, air pollution, water pollution, sanitation, health, fire, 7438
zoning, or safety. 7439

Sec. 2307.65. (A) The attorney general may bring a civil 7440
action in the Franklin county court of common pleas on behalf of 7441
the department of ~~job and family services~~ health care 7442
administration, and the prosecuting attorney of the county in 7443
which a violation of division (B) of section 2913.401 of the 7444
Revised Code occurs may bring a civil action in the court of 7445
common pleas of that county on behalf of the county department of 7446
job and family services, against a person who violates division 7447
(B) of section 2913.401 of the Revised Code for the recovery of 7448
the amount of benefits paid on behalf of a person that either 7449
department would not have paid but for the violation minus any 7450
amounts paid in restitution under division (C)(2) of section 7451
2913.401 of the Revised Code and for reasonable attorney's fees 7452
and all other fees and costs of litigation. 7453

(B) In a civil action brought under division (A) of this 7454

section, if the defendant failed to disclose a transfer of 7455
property in violation of division (B)(3) of section 2913.401 of 7456
the Revised Code, the court may also grant any of the following 7457
relief to the extent permitted by 42 U.S.C. 1396p: 7458

(1) Avoidance of the transfer of property that was not 7459
disclosed in violation of division (B)(3) of section 2913.401 of 7460
the Revised Code to the extent of the amount of benefits the 7461
department would not have paid but for the violation; 7462

(2) An order of attachment or garnishment against the 7463
property in accordance with Chapter 2715. or 2716. of the Revised 7464
Code; 7465

(3) An injunction against any further disposition by the 7466
transferor or transferee, or both, of the property the transfer of 7467
which was not disclosed in violation of division (B)(3) of section 7468
2913.401 of the Revised Code or against the disposition of other 7469
property by the transferor or transferee; 7470

(4) Appointment of a receiver to take charge of the property 7471
transferred or of other property of the transferee; 7472

(5) Any other relief that the court considers just and 7473
equitable. 7474

(C) To the extent permitted by 42 U.S.C. 1396p, the 7475
department of ~~job and family services~~ health care administration 7476
or the county department of job and family services may enforce a 7477
judgment obtained under this section by levying on property the 7478
transfer of which was not disclosed in violation of division 7479
(B)(3) of section 2913.401 of the Revised Code or on the proceeds 7480
of the transfer of that property in accordance with Chapter 2329. 7481
of the Revised Code. 7482

(D) The remedies provided in divisions (B) and (C) of this 7483
section do not apply if the transferee of the property the 7484
transfer of which was not disclosed in violation of division 7485

(B)(3) of section 2913.401 of the Revised Code acquired the 7486
property in good faith and for fair market value. 7487

(E) The remedies provided in this section are not exclusive 7488
and do not preclude the use of any other criminal or civil remedy 7489
for any act that is in violation of section 2913.401 of the 7490
Revised Code. 7491

(F) Amounts of medicaid benefits paid and recovered in an 7492
action brought under this section shall be credited to the general 7493
revenue fund, and any applicable federal share shall be returned 7494
to the appropriate agency or department of the United States. 7495

Sec. 2335.39. (A) As used in this section: 7496

(1) "Court" means any court of record. 7497

(2) "Eligible party" means a party to an action or appeal 7498
involving the state, other than the following: 7499

(a) The state; 7500

(b) An individual whose net worth exceeded one million 7501
dollars at the time the action or appeal was filed; 7502

(c) A sole owner of an unincorporated business that had, or a 7503
partnership, corporation, association, or organization that had, a 7504
net worth exceeding five million dollars at the time the action or 7505
appeal was filed, except that an organization that is described in 7506
subsection 501(c)(3) and is tax exempt under subsection 501(a) of 7507
the Internal Revenue Code shall not be excluded as an eligible 7508
party under this division because of its net worth; 7509

(d) A sole owner of an unincorporated business that employed, 7510
or a partnership, corporation, association, or organization that 7511
employed, more than five hundred persons at the time the action or 7512
appeal was filed. 7513

(3) "Fees" means reasonable attorney's fees, in an amount not 7514

to exceed seventy-five dollars per hour or a higher hourly fee 7515
approved by the court. 7516

(4) "Internal Revenue Code" means the "Internal Revenue Code 7517
of 1954," 68A Stat. 3, 26 U.S.C. 1, as amended. 7518

(5) "Prevailing eligible party" means an eligible party that 7519
prevails in an action or appeal involving the state. 7520

(6) "State" has the same meaning as in section 2743.01 of the 7521
Revised Code. 7522

(B)(1) Except as provided in divisions (B)(2) and (F) of this 7523
section, in a civil action, or appeal of a judgment in a civil 7524
action, to which the state is a party, or in an appeal of an 7525
adjudication order of an agency pursuant to section 119.12 of the 7526
Revised Code, the prevailing eligible party is entitled, upon 7527
filing a motion in accordance with this division, to compensation 7528
for fees incurred by that party in connection with the action or 7529
appeal. Compensation, when payable to a prevailing eligible party 7530
under this section, is in addition to any other costs and expenses 7531
that may be awarded to that party by the court pursuant to law or 7532
rule. 7533

A prevailing eligible party that desires an award of 7534
compensation for fees shall file a motion requesting the award 7535
with the court within thirty days after the court enters final 7536
judgment in the action or appeal. The motion shall do all of the 7537
following: 7538

(a) Identify the party; 7539

(b) Indicate that the party is the prevailing eligible party 7540
and is entitled to receive an award of compensation for fees; 7541

(c) Include a statement that the state's position in 7542
initiating the matter in controversy was not substantially 7543
justified; 7544

(d) Indicate the amount sought as an award; 7545

(e) Itemize all fees sought in the requested award. The 7546
itemization shall include a statement from any attorney who 7547
represented the prevailing eligible party, that indicates the fees 7548
charged, the actual time expended, and the rate at which the fees 7549
were calculated. 7550

(2) Upon the filing of a motion under this section, the court 7551
shall review the request for the award of compensation for fees 7552
and determine whether the position of the state in initiating the 7553
matter in controversy was substantially justified, whether special 7554
circumstances make an award unjust, and whether the prevailing 7555
eligible party engaged in conduct during the course of the action 7556
or appeal that unduly and unreasonably protracted the final 7557
resolution of the matter in controversy. The court shall issue an 7558
order, in writing, on the motion of the prevailing eligible party, 7559
which order shall include a statement indicating whether an award 7560
has been granted, the findings and conclusions underlying it, the 7561
reasons or bases for the findings and conclusions, and, if an 7562
award has been granted, its amount. The order shall be included in 7563
the record of the action or appeal, and the clerk of the court 7564
shall mail a certified copy of it to the state and the prevailing 7565
eligible party. 7566

With respect to a motion under this section, the state has 7567
the burden of proving that its position in initiating the matter 7568
in controversy was substantially justified, that special 7569
circumstances make an award unjust, or that the prevailing 7570
eligible party engaged in conduct during the course of the action 7571
or appeal that unduly and unreasonably protracted the final 7572
resolution of the matter in controversy. 7573

A court considering a motion under this section may deny an 7574
award entirely, or reduce the amount of an award that otherwise 7575
would be payable, to a prevailing eligible party only as follows: 7576

(a) If the court determines that the state has sustained its 7577
burden of proof that its position in initiating the matter in 7578
controversy was substantially justified or that special 7579
circumstances make an award unjust, the motion shall be denied; 7580

(b) If the court determines that the state has sustained its 7581
burden of proof that the prevailing eligible party engaged in 7582
conduct during the course of the action or appeal that unduly and 7583
unreasonably protracted the final resolution of the matter in 7584
controversy, the court may reduce the amount of an award, or deny 7585
an award, to that party to the extent of that conduct. 7586

An order of a court considering a motion under this section 7587
is appealable as in other cases, by a prevailing eligible party 7588
that is denied an award or receives a reduced award. If the case 7589
is an appeal of the adjudication order of an agency pursuant to 7590
section 119.12 of the Revised Code, the agency may appeal an order 7591
granting an award. The order of the court may be modified by the 7592
appellate court only if it finds that the grant or the failure to 7593
grant an award, or the calculation of the amount of an award, 7594
involved an abuse of discretion. 7595

(C) Compensation for fees awarded to a prevailing eligible 7596
party under this section may be paid by the specific branch of the 7597
state government or the state department, board, office, 7598
commission, agency, institution, or other instrumentality over 7599
which the party prevailed in the action or appeal from any funds 7600
available to it for payment of such compensation. If compensation 7601
is not paid from such funds or such funds are not available, upon 7602
the filing of the court's order in favor of the prevailing 7603
eligible party with the clerk of the court of claims, the order 7604
shall be treated as if it were a judgment under Chapter 2743. of 7605
the Revised Code and be payable in accordance with the procedures 7606
specified in section 2743.19 of the Revised Code, except that 7607
interest shall not be paid in relation to the award. 7608

(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: 7639

(a) An adjudication order entered after a hearing described 7640
in division (F) of section 119.092 of the Revised Code; 7641

(b) A prevailing eligible party represented in the appeal by 7642
an attorney who was paid pursuant to an appropriation by the 7643
federal or state government or a local government; 7644

(c) An administrative appeal decision made under section 7645
5101.35 or 5160.34 of the Revised Code. 7646

Sec. 2505.02. (A) As used in this section: 7647

(1) "Substantial right" means a right that the United States 7648
Constitution, the Ohio Constitution, a statute, the common law, or 7649
a rule of procedure entitles a person to enforce or protect. 7650

(2) "Special proceeding" means an action or proceeding that 7651
is specially created by statute and that prior to 1853 was not 7652
denoted as an action at law or a suit in equity. 7653

(3) "Provisional remedy" means a proceeding ancillary to an 7654
action, including, but not limited to, a proceeding for a 7655
preliminary injunction, attachment, discovery of privileged 7656
matter, suppression of evidence, a prima-facie showing pursuant to 7657
section 2307.85 or 2307.86 of the Revised Code, a prima-facie 7658
showing pursuant to section 2307.92 of the Revised Code, or a 7659
finding made pursuant to division (A)(3) of section 2307.93 of the 7660
Revised Code. 7661

(B) An order is a final order that may be reviewed, affirmed, 7662
modified, or reversed, with or without retrial, when it is one of 7663
the following: 7664

(1) An order that affects a substantial right in an action 7665
that in effect determines the action and prevents a judgment; 7666

(2) An order that affects a substantial right made in a 7667

special proceeding or upon a summary application in an action 7668
after judgment; 7669

(3) An order that vacates or sets aside a judgment or grants 7670
a new trial; 7671

(4) An order that grants or denies a provisional remedy and 7672
to which both of the following apply: 7673

(a) The order in effect determines the action with respect to 7674
the provisional remedy and prevents a judgment in the action in 7675
favor of the appealing party with respect to the provisional 7676
remedy. 7677

(b) The appealing party would not be afforded a meaningful or 7678
effective remedy by an appeal following final judgment as to all 7679
proceedings, issues, claims, and parties in the action. 7680

(5) An order that determines that an action may or may not be 7681
maintained as a class action; 7682

(6) An order determining the constitutionality of any changes 7683
to the Revised Code made by Am. Sub. S.B. 281 of the 124th general 7684
assembly, including the amendment of sections 1751.67, 2117.06, 7685
2305.11, 2305.15, 2305.234, 2317.02, 2317.54, 2323.56, 2711.21, 7686
2711.22, 2711.23, 2711.24, 2743.02, 2743.43, 2919.16, 3923.63, 7687
3923.64, 4705.15, and ~~5111.018~~ 5163.17, and the enactment of 7688
sections 2305.113, 2323.41, 2323.43, and 2323.55 of the Revised 7689
Code or any changes made by Sub. S.B. 80 of the 125th general 7690
assembly, including the amendment of sections 2125.02, 2305.10, 7691
2305.131, 2315.18, 2315.19, and 2315.21 of the Revised Code. 7692

(C) When a court issues an order that vacates or sets aside a 7693
judgment or grants a new trial, the court, upon the request of 7694
either party, shall state in the order the grounds upon which the 7695
new trial is granted or the judgment vacated or set aside. 7696

(D) This section applies to and governs any action, including 7697

an appeal, that is pending in any court on July 22, 1998, and all 7698
claims filed or actions commenced on or after July 22, 1998, 7699
notwithstanding any provision of any prior statute or rule of law 7700
of this state. 7701

Sec. 2705.02. A person guilty of any of the following acts 7702
may be punished as for a contempt: 7703

(A) Disobedience of, or resistance to, a lawful writ, 7704
process, order, rule, judgment, or command of a court or officer; 7705

(B) Misbehavior of an officer of the court in the performance 7706
of official duties, or in official transactions; 7707

(C) A failure to obey a subpoena duly served, or a refusal to 7708
be sworn or to answer as a witness, when lawfully required; 7709

(D) The rescue, or attempted rescue, of a person or of 7710
property in the custody of an officer by virtue of an order or 7711
process of court held by the officer; 7712

(E) A failure upon the part of a person recognized to appear 7713
as a witness in a court to appear in compliance with the terms of 7714
the person's recognizance; 7715

(F) A failure to comply with an order issued pursuant to 7716
section 3109.19 or 3111.81 of the Revised Code; 7717

(G) A failure to obey a subpoena issued by the department of 7718
job and family services or a child support enforcement agency 7719
pursuant to section 5101.37 of the Revised Code; 7720

(H) A failure to obey a subpoena issued by the department of 7721
health care administration pursuant to section 5160.28 of the 7722
Revised Code; 7723

(I) A willful failure to submit to genetic testing, or a 7724
willful failure to submit a child to genetic testing, as required 7725
by an order for genetic testing issued under section 3111.41 of 7726

the Revised Code. 7727

Sec. 2744.05. Notwithstanding any other provisions of the 7728
Revised Code or rules of a court to the contrary, in an action 7729
against a political subdivision to recover damages for injury, 7730
death, or loss to person or property caused by an act or omission 7731
in connection with a governmental or proprietary function: 7732

(A) Punitive or exemplary damages shall not be awarded. 7733

(B)(1) If a claimant receives or is entitled to receive 7734
benefits for injuries or loss allegedly incurred from a policy or 7735
policies of insurance or any other source, the benefits shall be 7736
disclosed to the court, and the amount of the benefits shall be 7737
deducted from any award against a political subdivision recovered 7738
by that claimant. No insurer or other person is entitled to bring 7739
an action under a subrogation provision in an insurance or other 7740
contract against a political subdivision with respect to those 7741
benefits. 7742

The amount of the benefits shall be deducted from an award 7743
against a political subdivision under division (B)(1) of this 7744
section regardless of whether the claimant may be under an 7745
obligation to pay back the benefits upon recovery, in whole or in 7746
part, for the claim. A claimant whose benefits have been deducted 7747
from an award under division (B)(1) of this section is not 7748
considered fully compensated and shall not be required to 7749
reimburse a subrogated claim for benefits deducted from an award 7750
pursuant to division (B)(1) of this section. 7751

(2) Nothing in division (B)(1) of this section shall be 7752
construed to do ~~either~~ any of the following: 7753

(a) Limit the rights of a beneficiary under a life insurance 7754
policy or the rights of sureties under fidelity or surety bonds; 7755

(b) Prohibit the department of ~~job and family services~~ health 7756

care administration from recovering from the political 7757
subdivision, pursuant to section ~~5101.58~~ 5160.38 of the Revised 7758
Code, the cost of medical assistance benefits provided under 7759
~~Chapter 5107., 5111., or 5115. of the Revised Code~~ the medicaid 7760
program or disability medical assistance program. 7761

(C)(1) There shall not be any limitation on compensatory 7762
damages that represent the actual loss of the person who is 7763
awarded the damages. However, except in wrongful death actions 7764
brought pursuant to Chapter 2125. of the Revised Code, damages 7765
that arise from the same cause of action, transaction or 7766
occurrence, or series of transactions or occurrences and that do 7767
not represent the actual loss of the person who is awarded the 7768
damages shall not exceed two hundred fifty thousand dollars in 7769
favor of any one person. The limitation on damages that do not 7770
represent the actual loss of the person who is awarded the damages 7771
provided in this division does not apply to court costs that are 7772
awarded to a plaintiff, or to interest on a judgment rendered in 7773
favor of a plaintiff, in an action against a political 7774
subdivision. 7775

(2) As used in this division, "the actual loss of the person 7776
who is awarded the damages" includes all of the following: 7777

(a) All wages, salaries, or other compensation lost by the 7778
person injured as a result of the injury, including wages, 7779
salaries, or other compensation lost as of the date of a judgment 7780
and future expected lost earnings of the person injured; 7781

(b) All expenditures of the person injured or another person 7782
on behalf of the person injured for medical care or treatment, for 7783
rehabilitation services, or for other care, treatment, services, 7784
products, or accommodations that were necessary because of the 7785
injury; 7786

(c) All expenditures to be incurred in the future, as 7787

determined by the court, by the person injured or another person 7788
on behalf of the person injured for medical care or treatment, for 7789
rehabilitation services, or for other care, treatment, services, 7790
products, or accommodations that will be necessary because of the 7791
injury; 7792

(d) All expenditures of a person whose property was injured 7793
or destroyed or of another person on behalf of the person whose 7794
property was injured or destroyed in order to repair or replace 7795
the property that was injured or destroyed; 7796

(e) All expenditures of the person injured or of the person 7797
whose property was injured or destroyed or of another person on 7798
behalf of the person injured or of the person whose property was 7799
injured or destroyed in relation to the actual preparation or 7800
presentation of the claim involved; 7801

(f) Any other expenditures of the person injured or of the 7802
person whose property was injured or destroyed or of another 7803
person on behalf of the person injured or of the person whose 7804
property was injured or destroyed that the court determines 7805
represent an actual loss experienced because of the personal or 7806
property injury or property loss. 7807

"The actual loss of the person who is awarded the damages" 7808
does not include any fees paid or owed to an attorney for any 7809
services rendered in relation to a personal or property injury or 7810
property loss, and does not include any damages awarded for pain 7811
and suffering, for the loss of society, consortium, companionship, 7812
care, assistance, attention, protection, advice, guidance, 7813
counsel, instruction, training, or education of the person 7814
injured, for mental anguish, or for any other intangible loss. 7815

Sec. 2903.33. As used in sections 2903.33 to 2903.36 of the 7816
Revised Code: 7817

(A) "Care facility" means any of the following:	7818
(1) Any "home" as defined in section 3721.10 or 5111.20	7819
<u>5164.01</u> of the Revised Code;	7820
(2) Any "residential facility" as defined in section 5123.19	7821
of the Revised Code;	7822
(3) Any institution or facility operated or provided by the	7823
department of mental health or by the department of mental	7824
retardation and developmental disabilities pursuant to sections	7825
5119.02 and 5123.03 of the Revised Code;	7826
(4) Any "residential facility" as defined in section 5119.22	7827
of the Revised Code;	7828
(5) Any unit of any hospital, as defined in section 3701.01	7829
of the Revised Code, that provides the same services as a nursing	7830
home, as defined in section 3721.01 of the Revised Code;	7831
(6) Any institution, residence, or facility that provides,	7832
for a period of more than twenty-four hours, whether for a	7833
consideration or not, accommodations to one individual or two	7834
unrelated individuals who are dependent upon the services of	7835
others;	7836
(7) Any "adult care facility" as defined in section 3722.01	7837
of the Revised Code;	7838
(8) Any adult foster home certified by the department of	7839
aging or its designee under section 173.36 of the Revised Code;	7840
(9) Any "community alternative home" as defined in section	7841
3724.01 of the Revised Code.	7842
(B) "Abuse" means knowingly causing physical harm or	7843
recklessly causing serious physical harm to a person by physical	7844
contact with the person or by the inappropriate use of a physical	7845
or chemical restraint, medication, or isolation on the person.	7846
(C)(1) "Gross neglect" means knowingly failing to provide a	7847

person with any treatment, care, goods, or service that is 7848
necessary to maintain the health or safety of the person when the 7849
failure results in physical harm or serious physical harm to the 7850
person. 7851

(2) "Neglect" means recklessly failing to provide a person 7852
with any treatment, care, goods, or service that is necessary to 7853
maintain the health or safety of the person when the failure 7854
results in serious physical harm to the person. 7855

(D) "Inappropriate use of a physical or chemical restraint, 7856
medication, or isolation" means the use of physical or chemical 7857
restraint, medication, or isolation as punishment, for staff 7858
convenience, excessively, as a substitute for treatment, or in 7859
quantities that preclude habilitation and treatment. 7860

Sec. 2913.40. (A) As used in this section: 7861

(1) "Statement or representation" means any oral, written, 7862
electronic, electronic impulse, or magnetic communication that is 7863
used to identify an item of goods or a service for which 7864
reimbursement may be made under the ~~medical assistance~~ medicaid 7865
program or that states income and expense and is or may be used to 7866
determine a rate of reimbursement under the ~~medical assistance~~ 7867
medicaid program. 7868

(2) "~~Medical assistance program~~" means the program 7869
established by the department of job and family services to 7870
provide medical assistance under section 5111.01 of the Revised 7871
Code and the medicaid program of Title XIX of the "Social Security 7872
Act," 49 Stat. 620 (1935), 42 U.S.C. 301, as amended. 7873

(3) "Provider" means any person who has signed a provider 7874
agreement with the department of ~~job and family services~~ health 7875
care administration to provide goods or services pursuant to the 7876
~~medical assistance~~ medicaid program or any person who has signed 7877

an agreement with a party to such a provider agreement under which 7878
the person agrees to provide goods or services that are 7879
reimbursable under the ~~medical assistance~~ medicaid program. 7880

~~(4)~~(3) "Provider agreement" means an oral or written 7881
agreement between the department of ~~job and family services~~ health 7882
care administration and a person in which the person agrees to 7883
provide goods or services under the ~~medical assistance~~ medicaid 7884
program. 7885

~~(5)~~(4) "Recipient" means any individual who receives goods or 7886
services from a provider under the ~~medical assistance~~ medicaid 7887
program. 7888

~~(6)~~(5) "Records" means any medical, professional, financial, 7889
or business records relating to the treatment or care of any 7890
recipient, to goods or services provided to any recipient, or to 7891
rates paid for goods or services provided to any recipient and any 7892
records that are required by the rules of the director of ~~job and~~ 7893
~~family services~~ health care administration to be kept for the 7894
~~medical assistance~~ medicaid program. 7895

(B) No person shall knowingly make or cause to be made a 7896
false or misleading statement or representation for use in 7897
obtaining reimbursement from the ~~medical assistance~~ medicaid 7898
program. 7899

(C) No person, with purpose to commit fraud or knowing that 7900
the person is facilitating a fraud, shall do either of the 7901
following: 7902

(1) Contrary to the terms of the person's provider agreement, 7903
charge, solicit, accept, or receive for goods or services that the 7904
person provides under the ~~medical assistance~~ medicaid program any 7905
property, money, or other consideration in addition to the amount 7906
of reimbursement under the ~~medical assistance~~ medicaid program and 7907
the person's provider agreement for the goods or services and any 7908

deductibles or co-payments authorized by section ~~5111.0112~~ 5162.35 7909
of the Revised Code or rules adopted pursuant to section ~~5111.01,~~ 7910
~~5111.011, or 5111.02~~ 5162.20 or 5163.15 of the Revised Code. 7911

(2) Solicit, offer, or receive any remuneration, other than 7912
any deductibles or co-payments authorized by section ~~5111.0112~~ 7913
5162.35 of the Revised Code or rules adopted under section 7914
~~5111.01, 5111.011, 5162.20~~ or ~~5111.02~~ 5163.15 of the Revised Code, 7915
in cash or in kind, including, but not limited to, a kickback or 7916
rebate, in connection with the furnishing of goods or services for 7917
which whole or partial reimbursement is or may be made under the 7918
~~medical assistance~~ medicaid program. 7919

(D) No person, having submitted a claim for or provided goods 7920
or services under the ~~medical assistance~~ medicaid program, shall 7921
do either of the following for a period of at least six years 7922
after a reimbursement pursuant to that claim, or a reimbursement 7923
for those goods or services, is received under the ~~medical~~ 7924
~~assistance~~ medicaid program: 7925

(1) Knowingly alter, falsify, destroy, conceal, or remove any 7926
records that are necessary to fully disclose the nature of all 7927
goods or services for which the claim was submitted, or for which 7928
reimbursement was received, by the person; 7929

(2) Knowingly alter, falsify, destroy, conceal, or remove any 7930
records that are necessary to disclose fully all income and 7931
expenditures upon which rates of reimbursements were based for the 7932
person. 7933

(E) Whoever violates this section is guilty of medicaid 7934
fraud. Except as otherwise provided in this division, medicaid 7935
fraud is a misdemeanor of the first degree. If the value of 7936
property, services, or funds obtained in violation of this section 7937
is five hundred dollars or more and is less than five thousand 7938
dollars, medicaid fraud is a felony of the fifth degree. If the 7939

value of property, services, or funds obtained in violation of 7940
this section is five thousand dollars or more and is less than one 7941
hundred thousand dollars, medicaid fraud is a felony of the fourth 7942
degree. If the value of the property, services, or funds obtained 7943
in violation of this section is one hundred thousand dollars or 7944
more, medicaid fraud is a felony of the third degree. 7945

(F) Upon application of the governmental agency, office, or 7946
other entity that conducted the investigation and prosecution in a 7947
case under this section, the court shall order any person who is 7948
convicted of a violation of this section for receiving any 7949
reimbursement for furnishing goods or services under the ~~medical~~ 7950
~~assistance~~ medicaid program to which the person is not entitled to 7951
pay to the applicant its cost of investigating and prosecuting the 7952
case. The costs of investigation and prosecution that a defendant 7953
is ordered to pay pursuant to this division shall be in addition 7954
to any other penalties for the receipt of that reimbursement that 7955
are provided in this section, section ~~5111.03~~ 5163.03 of the 7956
Revised Code, or any other provision of law. 7957

(G) The provisions of this section are not intended to be 7958
exclusive remedies and do not preclude the use of any other 7959
criminal or civil remedy for any act that is in violation of this 7960
section. 7961

Sec. 2913.401. (A) As used in this section: 7962

(1) "Medicaid benefits" means benefits under the ~~medical~~ 7963
~~assistance~~ medicaid program ~~established under Chapter 5111. of the~~ 7964
~~Revised Code.~~ 7965

(2) "Property" means any real or personal property or other 7966
asset in which a person has any legal title or interest. 7967

(B) No person shall knowingly do any of the following in an 7968
application for medicaid benefits or in a document that requires a 7969

disclosure of assets for the purpose of determining eligibility to receive medicaid benefits: 7970
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(1) Make or cause to be made a false or misleading statement; 7972

(2) Conceal an interest in property; 7973

(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; 7974
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(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. 7979
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(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. 7986
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(2) In addition to imposing a sentence under division (C)(1) of this section, the court shall order that a person who is guilty 7999
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of medicaid eligibility fraud make restitution in the full amount 8001
of any medicaid benefits paid on behalf of an applicant for or 8002
recipient of medicaid benefits for which the applicant or 8003
recipient was not eligible, plus interest at the rate applicable 8004
to judgments on unreimbursed amounts from the date on which the 8005
benefits were paid to the date on which restitution is made. 8006

(3) The remedies and penalties provided in this section are 8007
not exclusive and do not preclude the use of any other criminal or 8008
civil remedy for any act that is in violation of this section. 8009

(D) This section does not apply to a person who fully 8010
disclosed in an application for medicaid benefits or in a document 8011
that requires a disclosure of assets for the purpose of 8012
determining eligibility to receive medicaid benefits all of the 8013
interests in property of the applicant for or recipient of 8014
medicaid benefits, all transfers of property by the applicant for 8015
or recipient of medicaid benefits, and the circumstances of all 8016
those transfers. 8017

(E) Any amounts of medicaid benefits recovered as restitution 8018
under this section and any interest on those amounts shall be 8019
credited to the general revenue fund, and any applicable federal 8020
share shall be returned to the appropriate agency or department of 8021
the United States. 8022

Sec. 2921.01. As used in sections 2921.01 to 2921.45 of the 8023
Revised Code: 8024

(A) "Public official" means any elected or appointed officer, 8025
or employee, or agent of the state or any political subdivision, 8026
whether in a temporary or permanent capacity, and includes, but is 8027
not limited to, legislators, judges, and law enforcement officers. 8028

(B) "Public servant" means any of the following: 8029

(1) Any public official; 8030

(2) Any person performing ad hoc a governmental function, 8031
including, but not limited to, a juror, member of a temporary 8032
commission, master, arbitrator, advisor, or consultant; 8033

(3) A person who is a candidate for public office, whether or 8034
not the person is elected or appointed to the office for which the 8035
person is a candidate. A person is a candidate for purposes of 8036
this division if the person has been nominated according to law 8037
for election or appointment to public office, or if the person has 8038
filed a petition or petitions as required by law to have the 8039
person's name placed on the ballot in a primary, general, or 8040
special election, or if the person campaigns as a write-in 8041
candidate in any primary, general, or special election. 8042

(C) "Party official" means any person who holds an elective 8043
or appointive post in a political party in the United States or 8044
this state, by virtue of which the person directs, conducts, or 8045
participates in directing or conducting party affairs at any level 8046
of responsibility. 8047

(D) "Official proceeding" means any proceeding before a 8048
legislative, judicial, administrative, or other governmental 8049
agency or official authorized to take evidence under oath, and 8050
includes any proceeding before a referee, hearing examiner, 8051
commissioner, notary, or other person taking testimony or a 8052
deposition in connection with an official proceeding. 8053

(E) "Detention" means arrest; confinement in any vehicle 8054
subsequent to an arrest; confinement in any public or private 8055
facility for custody of persons charged with or convicted of crime 8056
in this state or another state or under the laws of the United 8057
States or alleged or found to be a delinquent child or unruly 8058
child in this state or another state or under the laws of the 8059
United States; hospitalization, institutionalization, or 8060
confinement in any public or private facility that is ordered 8061
pursuant to or under the authority of section 2945.37, 2945.371, 8062

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~~" 8095
have has the same ~~meanings~~ meaning as in section 2913.40 of the 8096
Revised Code. 8097

Sec. 2921.13. (A) No person shall knowingly make a false 8098
statement, or knowingly swear or affirm the truth of a false 8099
statement previously made, when any of the following applies: 8100

(1) The statement is made in any official proceeding. 8101

(2) The statement is made with purpose to incriminate 8102
another. 8103

(3) The statement is made with purpose to mislead a public 8104
official in performing the public official's official function. 8105

(4) The statement is made with purpose to secure the payment 8106
of unemployment compensation; Ohio works first; prevention, 8107
retention, and contingency benefits and services; disability 8108
financial assistance; retirement benefits; economic development 8109
assistance, as defined in section 9.66 of the Revised Code; or 8110
other benefits administered by a governmental agency or paid out 8111
of a public treasury. 8112

(5) The statement is made with purpose to secure the issuance 8113
by a governmental agency of a license, permit, authorization, 8114
certificate, registration, release, or provider agreement. 8115

(6) The statement is sworn or affirmed before a notary public 8116
or another person empowered to administer oaths. 8117

(7) The statement is in writing on or in connection with a 8118
report or return that is required or authorized by law. 8119

(8) The statement is in writing and is made with purpose to 8120
induce another to extend credit to or employ the offender, to 8121
confer any degree, diploma, certificate of attainment, award of 8122
excellence, or honor on the offender, or to extend to or bestow 8123
upon the offender any other valuable benefit or distinction, when 8124

the person to whom the statement is directed relies upon it to 8125
that person's detriment. 8126

(9) The statement is made with purpose to commit or 8127
facilitate the commission of a theft offense. 8128

(10) The statement is knowingly made to a probate court in 8129
connection with any action, proceeding, or other matter within its 8130
jurisdiction, either orally or in a written document, including, 8131
but not limited to, an application, petition, complaint, or other 8132
pleading, or an inventory, account, or report. 8133

(11) The statement is made on an account, form, record, 8134
stamp, label, or other writing that is required by law. 8135

(12) The statement is made in connection with the purchase of 8136
a firearm, as defined in section 2923.11 of the Revised Code, and 8137
in conjunction with the furnishing to the seller of the firearm of 8138
a fictitious or altered driver's or commercial driver's license or 8139
permit, a fictitious or altered identification card, or any other 8140
document that contains false information about the purchaser's 8141
identity. 8142

(13) The statement is made in a document or instrument of 8143
writing that purports to be a judgment, lien, or claim of 8144
indebtedness and is filed or recorded with the secretary of state, 8145
a county recorder, or the clerk of a court of record. 8146

(14) The statement is made with purpose to obtain an Ohio's 8147
best Rx program enrollment card under section ~~173.773~~ 5169.073 of 8148
the Revised Code or a payment under section ~~173.801~~ 5169.101 of 8149
the Revised Code. 8150

(15) The statement is made in an application filed with a 8151
county sheriff pursuant to section 2923.125 of the Revised Code in 8152
order to obtain or renew a license to carry a concealed handgun or 8153
is made in an affidavit submitted to a county sheriff to obtain a 8154
temporary emergency license to carry a concealed handgun under 8155

section 2923.1213 of the Revised Code. 8156

(16) The statement is required under section 5743.72 of the 8157
Revised Code in connection with the person's purchase of 8158
cigarettes or tobacco products in a delivery sale. 8159

(B) No person, in connection with the purchase of a firearm, 8160
as defined in section 2923.11 of the Revised Code, shall knowingly 8161
furnish to the seller of the firearm a fictitious or altered 8162
driver's or commercial driver's license or permit, a fictitious or 8163
altered identification card, or any other document that contains 8164
false information about the purchaser's identity. 8165

(C) No person, in an attempt to obtain a license to carry a 8166
concealed handgun under section 2923.125 of the Revised Code, 8167
shall knowingly present to a sheriff a fictitious or altered 8168
document that purports to be certification of the person's 8169
competence in handling a handgun as described in division (B)(3) 8170
of section 2923.125 of the Revised Code. 8171

(D) It is no defense to a charge under division (A)(6) of 8172
this section that the oath or affirmation was administered or 8173
taken in an irregular manner. 8174

(E) If contradictory statements relating to the same fact are 8175
made by the offender within the period of the statute of 8176
limitations for falsification, it is not necessary for the 8177
prosecution to prove which statement was false but only that one 8178
or the other was false. 8179

(F)(1) Whoever violates division (A)(1), (2), (3), (4), (5), 8180
(6), (7), (8), (10), (11), (13), (14), or (16) of this section is 8181
guilty of falsification, a misdemeanor of the first degree. 8182

(2) Whoever violates division (A)(9) of this section is 8183
guilty of falsification in a theft offense. Except as otherwise 8184
provided in this division, falsification in a theft offense is a 8185
misdemeanor of the first degree. If the value of the property or 8186

services stolen is five hundred dollars or more and is less than 8187
five thousand dollars, falsification in a theft offense is a 8188
felony of the fifth degree. If the value of the property or 8189
services stolen is five thousand dollars or more and is less than 8190
one hundred thousand dollars, falsification in a theft offense is 8191
a felony of the fourth degree. If the value of the property or 8192
services stolen is one hundred thousand dollars or more, 8193
falsification in a theft offense is a felony of the third degree. 8194

(3) Whoever violates division (A)(12) or (B) of this section 8195
is guilty of falsification to purchase a firearm, a felony of the 8196
fifth degree. 8197

(4) Whoever violates division (A)(15) or (C) of this section 8198
is guilty of falsification to obtain a concealed handgun license, 8199
a felony of the fourth degree. 8200

(G) A person who violates this section is liable in a civil 8201
action to any person harmed by the violation for injury, death, or 8202
loss to person or property incurred as a result of the commission 8203
of the offense and for reasonable attorney's fees, court costs, 8204
and other expenses incurred as a result of prosecuting the civil 8205
action commenced under this division. A civil action under this 8206
division is not the exclusive remedy of a person who incurs 8207
injury, death, or loss to person or property as a result of a 8208
violation of this section. 8209

Sec. 2945.401. (A) A defendant found incompetent to stand 8210
trial and committed pursuant to section 2945.39 of the Revised 8211
Code or a person found not guilty by reason of insanity and 8212
committed pursuant to section 2945.40 of the Revised Code shall 8213
remain subject to the jurisdiction of the trial court pursuant to 8214
that commitment, and to the provisions of this section, until the 8215
final termination of the commitment as described in division 8216
(J)(1) of this section. If the jurisdiction is terminated under 8217

this division because of the final termination of the commitment 8218
resulting from the expiration of the maximum prison term or term 8219
of imprisonment described in division (J)(1)(b) of this section, 8220
the court or prosecutor may file an affidavit for the civil 8221
commitment of the defendant or person pursuant to Chapter 5122. or 8222
5123. of the Revised Code. 8223

(B) A hearing conducted under any provision of sections 8224
2945.37 to 2945.402 of the Revised Code shall not be conducted in 8225
accordance with Chapters 5122. and 5123. of the Revised Code. Any 8226
person who is committed pursuant to section 2945.39 or 2945.40 of 8227
the Revised Code shall not voluntarily admit the person or be 8228
voluntarily admitted to a hospital or institution pursuant to 8229
section 5122.02, 5122.15, 5123.69, or 5123.76 of the Revised Code. 8230
All other provisions of Chapters 5122. and 5123. of the Revised 8231
Code regarding hospitalization or institutionalization shall apply 8232
to the extent they are not in conflict with this chapter. A 8233
commitment under section 2945.39 or 2945.40 of the Revised Code 8234
shall not be terminated and the conditions of the commitment shall 8235
not be changed except as otherwise provided in division (D)(2) of 8236
this section with respect to a mentally retarded person subject to 8237
institutionalization by court order or except by order of the 8238
trial court. 8239

(C) The hospital, facility, or program to which a defendant 8240
or person has been committed under section 2945.39 or 2945.40 of 8241
the Revised Code shall report in writing to the trial court, at 8242
the times specified in this division, as to whether the defendant 8243
or person remains a mentally ill person subject to hospitalization 8244
by court order or a mentally retarded person subject to 8245
institutionalization by court order and, in the case of a 8246
defendant committed under section 2945.39 of the Revised Code, as 8247
to whether the defendant remains incompetent to stand trial. The 8248
hospital, facility, or program shall make the reports after the 8249

initial six months of treatment and every two years after the 8250
initial report is made. The trial court shall provide copies of 8251
the reports to the prosecutor and to the counsel for the defendant 8252
or person. Within thirty days after its receipt pursuant to this 8253
division of a report from a hospital, facility, or program, the 8254
trial court shall hold a hearing on the continued commitment of 8255
the defendant or person or on any changes in the conditions of the 8256
commitment of the defendant or person. The defendant or person may 8257
request a change in the conditions of confinement, and the trial 8258
court shall conduct a hearing on that request if six months or 8259
more have elapsed since the most recent hearing was conducted 8260
under this section. 8261

(D)(1) Except as otherwise provided in division (D)(2) of 8262
this section, when a defendant or person has been committed under 8263
section 2945.39 or 2945.40 of the Revised Code, at any time after 8264
evaluating the risks to public safety and the welfare of the 8265
defendant or person, the chief clinical officer of the hospital, 8266
facility, or program to which the defendant or person is committed 8267
may recommend a termination of the defendant's or person's 8268
commitment or a change in the conditions of the defendant's or 8269
person's commitment. 8270

Except as otherwise provided in division (D)(2) of this 8271
section, if the chief clinical officer recommends on-grounds 8272
unsupervised movement, off-grounds supervised movement, or 8273
nonsecured status for the defendant or person or termination of 8274
the defendant's or person's commitment, the following provisions 8275
apply: 8276

(a) If the chief clinical officer recommends on-grounds 8277
unsupervised movement or off-grounds supervised movement, the 8278
chief clinical officer shall file with the trial court an 8279
application for approval of the movement and shall send a copy of 8280
the application to the prosecutor. Within fifteen days after 8281

receiving the application, the prosecutor may request a hearing on 8282
the application and, if a hearing is requested, shall so inform 8283
the chief clinical officer. If the prosecutor does not request a 8284
hearing within the fifteen-day period, the trial court shall 8285
approve the application by entering its order approving the 8286
requested movement or, within five days after the expiration of 8287
the fifteen-day period, shall set a date for a hearing on the 8288
application. If the prosecutor requests a hearing on the 8289
application within the fifteen-day period, the trial court shall 8290
hold a hearing on the application within thirty days after the 8291
hearing is requested. If the trial court, within five days after 8292
the expiration of the fifteen-day period, sets a date for a 8293
hearing on the application, the trial court shall hold the hearing 8294
within thirty days after setting the hearing date. At least 8295
fifteen days before any hearing is held under this division, the 8296
trial court shall give the prosecutor written notice of the date, 8297
time, and place of the hearing. At the conclusion of each hearing 8298
conducted under this division, the trial court either shall 8299
approve or disapprove the application and shall enter its order 8300
accordingly. 8301

(b) If the chief clinical officer recommends termination of 8302
the defendant's or person's commitment at any time or if the chief 8303
clinical officer recommends the first of any nonsecured status for 8304
the defendant or person, the chief clinical officer shall send 8305
written notice of this recommendation to the trial court and to 8306
the local forensic center. The local forensic center shall 8307
evaluate the committed defendant or person and, within thirty days 8308
after its receipt of the written notice, shall submit to the trial 8309
court and the chief clinical officer a written report of the 8310
evaluation. The trial court shall provide a copy of the chief 8311
clinical officer's written notice and of the local forensic 8312
center's written report to the prosecutor and to the counsel for 8313
the defendant or person. Upon the local forensic center's 8314

submission of the report to the trial court and the chief clinical 8315
officer, all of the following apply: 8316

(i) If the forensic center disagrees with the recommendation 8317
of the chief clinical officer, it shall inform the chief clinical 8318
officer and the trial court of its decision and the reasons for 8319
the decision. The chief clinical officer, after consideration of 8320
the forensic center's decision, shall either withdraw, proceed 8321
with, or modify and proceed with the recommendation. If the chief 8322
clinical officer proceeds with, or modifies and proceeds with, the 8323
recommendation, the chief clinical officer shall proceed in 8324
accordance with division (D)(1)(b)(iii) of this section. 8325

(ii) If the forensic center agrees with the recommendation of 8326
the chief clinical officer, it shall inform the chief clinical 8327
officer and the trial court of its decision and the reasons for 8328
the decision, and the chief clinical officer shall proceed in 8329
accordance with division (D)(1)(b)(iii) of this section. 8330

(iii) If the forensic center disagrees with the 8331
recommendation of the chief clinical officer and the chief 8332
clinical officer proceeds with, or modifies and proceeds with, the 8333
recommendation or if the forensic center agrees with the 8334
recommendation of the chief clinical officer, the chief clinical 8335
officer shall work with the board of alcohol, drug addiction, and 8336
mental health services or community mental health board serving 8337
the area, as appropriate, to develop a plan to implement the 8338
recommendation. If the defendant or person is on medication, the 8339
plan shall include, but shall not be limited to, a system to 8340
monitor the defendant's or person's compliance with the prescribed 8341
medication treatment plan. The system shall include a schedule 8342
that clearly states when the defendant or person shall report for 8343
a medication compliance check. The medication compliance checks 8344
shall be based upon the effective duration of the prescribed 8345
medication, taking into account the route by which it is taken, 8346

and shall be scheduled at intervals sufficiently close together to 8347
detect a potential increase in mental illness symptoms that the 8348
medication is intended to prevent. 8349

The chief clinical officer, after consultation with the board 8350
of alcohol, drug addiction, and mental health services or the 8351
community mental health board serving the area, shall send the 8352
recommendation and plan developed under division (D)(1)(b)(iii) of 8353
this section, in writing, to the trial court, the prosecutor and 8354
the counsel for the committed defendant or person. The trial court 8355
shall conduct a hearing on the recommendation and plan developed 8356
under division (D)(1)(b)(iii) of this section. Divisions (D)(1)(c) 8357
and (d) and (E) to (J) of this section apply regarding the 8358
hearing. 8359

(c) If the chief clinical officer's recommendation is for 8360
nonsecured status or termination of commitment, the prosecutor may 8361
obtain an independent expert evaluation of the defendant's or 8362
person's mental condition, and the trial court may continue the 8363
hearing on the recommendation for a period of not more than thirty 8364
days to permit time for the evaluation. 8365

The prosecutor may introduce the evaluation report or present 8366
other evidence at the hearing in accordance with the Rules of 8367
Evidence. 8368

(d) The trial court shall schedule the hearing on a chief 8369
clinical officer's recommendation for nonsecured status or 8370
termination of commitment and shall give reasonable notice to the 8371
prosecutor and the counsel for the defendant or person. Unless 8372
continued for independent evaluation at the prosecutor's request 8373
or for other good cause, the hearing shall be held within thirty 8374
days after the trial court's receipt of the recommendation and 8375
plan. 8376

(2)(a) Division (D)(1) of this section does not apply to 8377

on-grounds unsupervised movement of a defendant or person who has 8378
been committed under section 2945.39 or 2945.40 of the Revised 8379
Code, who is a mentally retarded person subject to 8380
institutionalization by court order, and who is being provided 8381
residential habilitation, care, and treatment in a facility 8382
operated by the department of mental retardation and developmental 8383
disabilities. 8384

(b) If, pursuant to section 2945.39 of the Revised Code, the 8385
trial court commits a defendant who is found incompetent to stand 8386
trial and who is a mentally retarded person subject to 8387
institutionalization by court order, if the defendant is being 8388
provided residential habilitation, care, and treatment in a 8389
facility operated by the department of mental retardation and 8390
developmental disabilities, if an individual who is conducting a 8391
survey for the department of health to determine the facility's 8392
compliance with the certification requirements of the medicaid 8393
program ~~under chapter 5111. of the Revised Code and Title XIX of~~ 8394
~~the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301,~~ 8395
~~as amended,~~ cites the defendant's receipt of the residential 8396
habilitation, care, and treatment in the facility as being 8397
inappropriate under the certification requirements, if the 8398
defendant's receipt of the residential habilitation, care, and 8399
treatment in the facility potentially jeopardizes the facility's 8400
continued receipt of federal medicaid moneys, and if as a result 8401
of the citation the chief clinical officer of the facility 8402
determines that the conditions of the defendant's commitment 8403
should be changed, the department of mental retardation and 8404
developmental disabilities may cause the defendant to be removed 8405
from the particular facility and, after evaluating the risks to 8406
public safety and the welfare of the defendant and after 8407
determining whether another type of placement is consistent with 8408
the certification requirements, may place the defendant in another 8409
facility that the department selects as an appropriate facility 8410

for the defendant's continued receipt of residential habilitation, 8411
care, and treatment and that is a no less secure setting than the 8412
facility in which the defendant had been placed at the time of the 8413
citation. Within three days after the defendant's removal and 8414
alternative placement under the circumstances described in 8415
division (D)(2)(b) of this section, the department of mental 8416
retardation and developmental disabilities shall notify the trial 8417
court and the prosecutor in writing of the removal and alternative 8418
placement. 8419

The trial court shall set a date for a hearing on the removal 8420
and alternative placement, and the hearing shall be held within 8421
twenty-one days after the trial court's receipt of the notice from 8422
the department of mental retardation and developmental 8423
disabilities. At least ~~ten days~~ ten days before the hearing is 8424
held, the trial court shall give the prosecutor, the department of 8425
mental retardation and developmental disabilities, and the counsel 8426
for the defendant written notice of the date, time, and place of 8427
the hearing. At the hearing, the trial court shall consider the 8428
citation issued by the individual who conducted the survey for the 8429
department of health to be prima-facie evidence of the fact that 8430
the defendant's commitment to the particular facility was 8431
inappropriate under the certification requirements of the medicaid 8432
program ~~under Chapter 5111. of the Revised Code and Title XIX of~~ 8433
~~the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301,~~ 8434
~~as amended,~~ and potentially jeopardizes the particular facility's 8435
continued receipt of federal medicaid moneys. At the conclusion of 8436
the hearing, the trial court may approve or disapprove the 8437
defendant's removal and alternative placement. If the trial court 8438
approves the defendant's removal and alternative placement, the 8439
department of mental retardation and developmental disabilities 8440
may continue the defendant's alternative placement. If the trial 8441
court disapproves the defendant's removal and alternative 8442
placement, it shall enter an order modifying the defendant's 8443

removal and alternative placement, but that order shall not 8444
require the department of mental retardation and developmental 8445
disabilities to replace the defendant for purposes of continued 8446
residential habilitation, care, and treatment in the facility 8447
associated with the citation issued by the individual who 8448
conducted the survey for the department of health. 8449

(E) In making a determination under this section regarding 8450
nonsecured status or termination of commitment, the trial court 8451
shall consider all relevant factors, including, but not limited 8452
to, all of the following: 8453

(1) Whether, in the trial court's view, the defendant or 8454
person currently represents a substantial risk of physical harm to 8455
the defendant or person or others; 8456

(2) Psychiatric and medical testimony as to the current 8457
mental and physical condition of the defendant or person; 8458

(3) Whether the defendant or person has insight into the 8459
defendant's or person's condition so that the defendant or person 8460
will continue treatment as prescribed or seek professional 8461
assistance as needed; 8462

(4) The grounds upon which the state relies for the proposed 8463
commitment; 8464

(5) Any past history that is relevant to establish the 8465
defendant's or person's degree of conformity to the laws, rules, 8466
regulations, and values of society; 8467

(6) If there is evidence that the defendant's or person's 8468
mental illness is in a state of remission, the medically suggested 8469
cause and degree of the remission and the probability that the 8470
defendant or person will continue treatment to maintain the 8471
remissive state of the defendant's or person's illness should the 8472
defendant's or person's commitment conditions be altered. 8473

(F) At any hearing held pursuant to division (C) or (D)(1) or 8474
(2) of this section, the defendant or the person shall have all 8475
the rights of a defendant or person at a commitment hearing as 8476
described in section 2945.40 of the Revised Code. 8477

(G) In a hearing held pursuant to division (C) or (D)(1) of 8478
this section, the prosecutor has the burden of proof as follows: 8479

(1) For a recommendation of termination of commitment, to 8480
show by clear and convincing evidence that the defendant or person 8481
remains a mentally ill person subject to hospitalization by court 8482
order or a mentally retarded person subject to 8483
institutionalization by court order; 8484

(2) For a recommendation for a change in the conditions of 8485
the commitment to a less restrictive status, to show by clear and 8486
convincing evidence that the proposed change represents a threat 8487
to public safety or a threat to the safety of any person. 8488

(H) In a hearing held pursuant to division (C) or (D)(1) or 8489
(2) of this section, the prosecutor shall represent the state or 8490
the public interest. 8491

(I) At the conclusion of a hearing conducted under division 8492
(D)(1) of this section regarding a recommendation from the chief 8493
clinical officer of a hospital, program, or facility, the trial 8494
court may approve, disapprove, or modify the recommendation and 8495
shall enter an order accordingly. 8496

(J)(1) A defendant or person who has been committed pursuant 8497
to section 2945.39 or 2945.40 of the Revised Code continues to be 8498
under the jurisdiction of the trial court until the final 8499
termination of the commitment. For purposes of division (J) of 8500
this section, the final termination of a commitment occurs upon 8501
the earlier of one of the following: 8502

(a) The defendant or person no longer is a mentally ill 8503
person subject to hospitalization by court order or a mentally 8504

retarded person subject to institutionalization by court order, as 8505
determined by the trial court; 8506

(b) The expiration of the maximum prison term or term of 8507
imprisonment that the defendant or person could have received if 8508
the defendant or person had been convicted of the most serious 8509
offense with which the defendant or person is charged or in 8510
relation to which the defendant or person was found not guilty by 8511
reason of insanity; 8512

(c) The trial court enters an order terminating the 8513
commitment under the circumstances described in division 8514
(J)(2)(a)(ii) of this section. 8515

(2)(a) If a defendant is found incompetent to stand trial and 8516
committed pursuant to section 2945.39 of the Revised Code, if 8517
neither of the circumstances described in divisions (J)(1)(a) and 8518
(b) of this section applies to that defendant, and if a report 8519
filed with the trial court pursuant to division (C) of this 8520
section indicates that the defendant presently is competent to 8521
stand trial or if, at any other time during the period of the 8522
defendant's commitment, the prosecutor, the counsel for the 8523
defendant, or the chief clinical officer of the hospital, 8524
facility, or program to which the defendant is committed files an 8525
application with the trial court alleging that the defendant 8526
presently is competent to stand trial and requesting a hearing on 8527
the competency issue or the trial court otherwise has reasonable 8528
cause to believe that the defendant presently is competent to 8529
stand trial and determines on its own motion to hold a hearing on 8530
the competency issue, the trial court shall schedule a hearing on 8531
the competency of the defendant to stand trial, shall give the 8532
prosecutor, the counsel for the defendant, and the chief clinical 8533
officer notice of the date, time, and place of the hearing at 8534
least fifteen days before the hearing, and shall conduct the 8535
hearing within thirty days of the filing of the application or of 8536

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, 8569
that the defendant's commitment to the hospital, facility, or 8570
program shall be continued, and that the defendant remains subject 8571
to the jurisdiction of the trial court pursuant to that 8572
commitment, and to the provisions of this section, until the final 8573
termination of the commitment as described in division (J)(1) of 8574
this section. 8575

Sec. 3101.051. (A) Except as provided in division (B) of this 8576
section, a probate court shall make available to any person for 8577
inspection the records pertaining to the issuance of marriage 8578
licenses as provided under section 149.43 of the Revised Code. 8579

(B) Before it makes available to a person any records 8580
pertaining to the issuance of a marriage license as described in 8581
division (A) of this section, subject to division (C) of this 8582
section, a probate court shall delete or otherwise remove any 8583
social security numbers of the parties to a marriage so that they 8584
are not available to the person inspecting the records. 8585

(C) Division (B) of this section does not apply in any of the 8586
following circumstances: 8587

(1) If the records in question are inspected by authorized 8588
personnel of the division of child support in the department of 8589
job and family services under section ~~5101.31~~ 5160.66 of the 8590
Revised Code; 8591

(2) If the records in question are inspected by law 8592
enforcement personnel for purposes of a criminal investigation; 8593

(3) If the records in question with the social security 8594
numbers are necessary for use in a civil or criminal trial and the 8595
release of the records with the social security numbers is ordered 8596
by a court with jurisdiction over the trial; 8597

(4) If the records in question are inspected by either party 8598

to the marriage to which the records pertain; 8599

(5) If the court possessed the records in question prior to 8600
~~the effective date of this section~~ February 12, 2001. 8601

Sec. 3107.083. Not later than ninety days after June 20, 8602
1996, the director of job and family services shall do all of the 8603
following: 8604

(A)(1) For a parent of a child who, if adopted, will be an 8605
adopted person as defined in section 3107.45 of the Revised Code, 8606
prescribe a form that has the following six components: 8607

(a) A component the parent signs under section 3107.071, 8608
3107.081, or 5103.151 of the Revised Code to indicate the 8609
requirements of section 3107.082 or 5103.152 of the Revised Code 8610
have been met. The component shall be as follows: 8611

"Statement Concerning Ohio Law and Adoption Materials 8612

By signing this component of this form, I acknowledge that it 8613
has been explained to me, and I understand, that, if I check the 8614
space on the next component of this form that indicates that I 8615
authorize the release, the adoption file maintained by the Ohio 8616
Department of Health, which contains identifying information about 8617
me at the time of my child's birth, will be released, on request, 8618
to the adoptive parent when the adoptee is at least age eighteen 8619
but younger than age twenty-one and to the adoptee when he or she 8620
is age twenty-one or older. It has also been explained to me, and 8621
I understand, that I may prohibit the release of identifying 8622
information about me contained in the adoption file by checking 8623
the space on the next component of this form that indicates that I 8624
do not authorize the release of the identifying information. It 8625
has additionally been explained to me, and I understand, that I 8626
may change my mind regarding the decision I make on the next 8627
component of this form at any time and as many times as I desire 8628
by signing, dating, and having filed with the Ohio Department of 8629

Health a denial of release form or authorization of release form 8630
prescribed and provided by the Department of Health and providing 8631
the Department two items of identification. 8632

By signing this component of this form, I also acknowledge 8633
that I have been provided a copy of written materials about 8634
adoption prepared by the Ohio Department of Job and Family 8635
Services, the adoption process and ramifications of consenting to 8636
adoption or entering into a voluntary permanent custody surrender 8637
agreement have been discussed with me, and I have been provided 8638
the opportunity to review the materials and ask questions about 8639
the materials and discussion. 8640

Signature of biological parent: 8641

Signature of witness: 8642

Date: " 8643

(b) A component the parent signs under section 3107.071, 8644
3107.081, or 5103.151 of the Revised Code regarding the parent's 8645
decision whether to allow identifying information about the parent 8646
contained in an adoption file maintained by the department of 8647
health to be released to the parent's child and adoptive parent 8648
pursuant to section 3107.47 of the Revised Code. The component 8649
shall be as follows: 8650

"Statement Regarding Release of Identifying Information 8651

The purpose of this component of this form is to allow a 8652
biological parent to decide whether to allow the Ohio Department 8653
of Health to provide an adoptee and adoptive parent identifying 8654
information about the adoptee's biological parent contained in an 8655
adoption file maintained by the Department. Please check one of 8656
the following spaces: 8657

..... YES, I authorize the Ohio Department of Health to 8658
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 8659
information about me to the adoptive parent or
adoptee.

Signature of biological parent: 8660

Signature of witness: 8661

Date: " 8662

(c) A component the parent, if the mother of the child, 8663
completes and signs under section 3107.071, 3107.081, or 5103.151 8664
of the Revised Code to indicate, to the extent of the mother's 8665
knowledge, all of the following: 8666

(i) Whether the mother, during her pregnancy, was a recipient 8667
of the ~~medical assistance~~ medicaid program ~~established under~~ 8668
~~Chapter 5111. of the Revised Code~~ or other public health insurance 8669
program and, if so, the dates her eligibility began and ended; 8670

(ii) Whether the mother, during her pregnancy, was covered by 8671
private health insurance and, if so, the dates the coverage began 8672
and ended, the name of the insurance provider, the type of 8673
coverage, and the identification number of the coverage; 8674

(iii) The name and location of the hospital, freestanding 8675
birth center, or other place where the mother gave birth and, if 8676
different, received medical care immediately after giving birth; 8677

(iv) The expenses of the obstetrical and neonatal care; 8678

(v) Whether the mother has been informed that the adoptive 8679
parent or the agency or attorney arranging the adoption are to pay 8680
expenses involved in the adoption, including expenses the mother 8681
has paid and expects to receive or has received reimbursement, 8682
and, if so, what expenses are to be or have been paid and an 8683
estimate of the expenses; 8684

(vi) Any other information related to expenses the department 8685

determines appropriate to be included in this component. 8686

(d) A component the parent may sign to authorize the agency 8687
or attorney arranging the adoption to provide to the child or 8688
adoptive parent materials, other than photographs of the parent, 8689
that the parent requests be given to the child or adoptive parent 8690
pursuant to section 3107.68 of the Revised Code. 8691

(e) A component the parent may sign to authorize the agency 8692
or attorney arranging the adoption to provide to the child or 8693
adoptive parent photographs of the parent pursuant to section 8694
3107.68 of the Revised Code. 8695

(f) A component the parent may sign to authorize the agency 8696
or attorney arranging the adoption to provide to the child or 8697
adoptive parent the first name of the parent pursuant to section 8698
3107.68 of the Revised Code. 8699

(2) State at the bottom of the form that the parent is to 8700
receive a copy of the form the parent signed. 8701

(3) Provide copies of the form prescribed under this division 8702
to probate and juvenile courts, public children services agencies, 8703
private child placing agencies, private noncustodial agencies, 8704
attorneys, and persons authorized to take acknowledgments. 8705

(B)(1) For a parent of a child who, if adopted, will become 8706
an adopted person as defined in section 3107.39 of the Revised 8707
Code, prescribe a form that has the following five components: 8708

(a) A component the parent signs under section 3107.071, 8709
3107.081, or 5103.151 of the Revised Code to attest that the 8710
requirement of division (A) of section 3107.082 or division (A) of 8711
section 5103.152 of the Revised Code has been met; 8712

(b) A component the parent, if the mother of the child, 8713
completes and signs under section 3107.071, 3107.081, or 5103.151 8714
of the Revised Code to indicate, to the extent of the mother's 8715

knowledge, all of the following: 8716

(i) Whether the mother, during her pregnancy, was a recipient 8717
of the ~~medical assistance~~ medicaid program ~~established under~~ 8718
~~Chapter 5111. of the Revised Code~~ or other public health insurance 8719
program and, if so, the dates her eligibility began and ended; 8720

(ii) Whether the mother, during her pregnancy, was covered by 8721
private health insurance and, if so, the dates the coverage began 8722
and ended, the name of the insurance provider, the type of 8723
coverage, and the identification number of the coverage; 8724

(iii) The name and location of the hospital, freestanding 8725
birth center, or other place where the mother gave birth and, if 8726
different, received medical care immediately after giving birth; 8727

(iv) The expenses of the obstetrical and neonatal care; 8728

(v) Whether the mother has been informed that the adoptive 8729
parent or the agency or attorney arranging the adoption are to pay 8730
expenses involved in the adoption, including expenses the mother 8731
has paid and expects to receive or has received reimbursement for, 8732
and, if so, what expenses are to be or have been paid and an 8733
estimate of the expenses; 8734

(vi) Any other information related to expenses the department 8735
determines appropriate to be included in the component. 8736

(c) A component the parent may sign to authorize the agency 8737
or attorney arranging the adoption to provide to the child or 8738
adoptive parent materials, other than photographs of the parent, 8739
that the parent requests be given to the child or adoptive parent 8740
pursuant to section 3107.68 of the Revised Code. 8741

(d) A component the parent may sign to authorize the agency 8742
or attorney arranging the adoption to provide to the child or 8743
adoptive parent photographs of the parent pursuant to section 8744
3107.68 of the Revised Code. 8745

(e) A component the parent may sign to authorize the agency 8746
or attorney arranging the adoption to provide to the child or 8747
adoptive parent the first name of the parent pursuant to section 8748
3107.68 of the Revised Code. 8749

(2) State at the bottom of the form that the parent is to 8750
receive a copy of the form the parent signed. 8751

(3) Provide copies of the form prescribed under this division 8752
to probate and juvenile courts, public children services agencies, 8753
private child placing agencies, private noncustodial agencies, and 8754
attorneys. 8755

(C) Prepare the written materials about adoption that are 8756
required to be given to parents under division (A) of section 8757
3107.082 and division (A) of section 5103.152 of the Revised Code. 8758
The materials shall provide information about the adoption 8759
process, including ramifications of a parent consenting to a 8760
child's adoption or entering into a voluntary permanent custody 8761
surrender agreement. The materials also shall include referral 8762
information for professional counseling and adoption support 8763
organizations. The director shall provide the materials to 8764
assessors. 8765

(D) Adopt rules in accordance with Chapter 119. of the 8766
Revised Code specifying the documents that must be filed with a 8767
probate court under divisions (B) and (D) of section 3107.081 of 8768
the Revised Code and a juvenile court under divisions (C) and (E) 8769
of section 5103.151 of the Revised Code. 8770

Sec. 3111.04. (A) An action to determine the existence or 8771
nonexistence of the father and child relationship may be brought 8772
by the child or the child's personal representative, the child's 8773
mother or her personal representative, a man alleged or alleging 8774
himself to be the child's father, the child support enforcement 8775
agency of the county in which the child resides if the child's 8776

mother, father, or alleged father is a recipient of public 8777
assistance or of services under Title IV-D of the "Social Security 8778
Act," 88 Stat. 2351 (1975), 42 U.S.C.A. 651, as amended, or the 8779
alleged father's personal representative. 8780

(B) An agreement does not bar an action under this section. 8781

(C) If an action under this section is brought before the 8782
birth of the child and if the action is contested, all 8783
proceedings, except service of process and the taking of 8784
depositions to perpetuate testimony, may be stayed until after the 8785
birth. 8786

(D) A recipient of public assistance or of services under 8787
Title IV-D of the "Social Security Act," 88 Stat. 2351 (1975), 42 8788
U.S.C.A. 651, as amended, shall cooperate with the child support 8789
enforcement agency of the county in which a child resides to 8790
obtain an administrative determination pursuant to sections 8791
3111.38 to 3111.54 of the Revised Code, or, if necessary, a court 8792
determination pursuant to sections 3111.01 to 3111.18 of the 8793
Revised Code, of the existence or nonexistence of a parent and 8794
child relationship between the father and the child. If the 8795
recipient fails to cooperate, the agency may commence an action to 8796
determine the existence or nonexistence of a parent and child 8797
relationship between the father and the child pursuant to sections 8798
3111.01 to 3111.18 of the Revised Code. 8799

(E) As used in this section, "public assistance" means 8800
medical assistance under ~~Chapter 5111. of the Revised Code~~ 8801
medicaid program, assistance under Chapter 5107. of the Revised 8802
Code, disability financial assistance under Chapter 5115. of the 8803
Revised Code, or the disability medical assistance ~~under Chapter~~ 8804
~~5115. of the Revised Code~~ program. 8805

Sec. 3111.72. The contract between the department of job and 8806
family services and a local hospital shall require all of the 8807

following: 8808

(A) That the hospital provide a staff person to meet with 8809
each unmarried mother who gave birth in or en route to the 8810
hospital within twenty-four hours of the birth or before the 8811
mother is released from the hospital; 8812

(B) That the staff person attempt to meet with the father of 8813
the unmarried mother's child if possible; 8814

(C) That the staff person explain to the unmarried mother and 8815
the father, if he is present, the benefit to the child of 8816
establishing a parent and child relationship between the father 8817
and the child and the various proper procedures for establishing a 8818
parent and child relationship; 8819

(D) That the staff person present to the unmarried mother 8820
and, if possible, the father, the pamphlet or statement regarding 8821
the rights and responsibilities of a natural parent that is 8822
prepared and provided by the department of job and family services 8823
pursuant to section 3111.32 of the Revised Code; 8824

(E) That the staff person provide the mother and, if 8825
possible, the father, all forms and statements necessary to 8826
voluntarily establish a parent and child relationship, including, 8827
but not limited to, the acknowledgment of paternity affidavit 8828
prepared by the department of job and family services pursuant to 8829
section 3111.31 of the Revised Code; 8830

(F) That the staff person, at the request of both the mother 8831
and father, help the mother and father complete any form or 8832
statement necessary to establish a parent and child relationship; 8833

(G) That the hospital provide a notary public to notarize an 8834
acknowledgment of paternity affidavit signed by the mother and 8835
father; 8836

(H) That the staff person present to an unmarried mother who 8837

is not participating in the Ohio works first program established 8838
under Chapter 5107. or receiving ~~medical assistance under Chapter~~ 8839
~~5111. of the Revised Code~~ medicaid an application for Title IV-D 8840
services; 8841

(I) That the staff person forward any completed 8842
acknowledgment of paternity, no later than ten days after it is 8843
completed, to the office of child support in the department of job 8844
and family services; 8845

(J) That the department of job and family services pay the 8846
hospital twenty dollars for every correctly signed and notarized 8847
acknowledgment of paternity affidavit from the hospital. 8848

Sec. 3119.54. ~~If~~ (A) As used in this section: 8849

(1) "Eligible party" means a party to a child support order 8850
issued in accordance with section 3119.30 of the Revised Code who 8851
is eligible for a medical assistance program. 8852

(2) "Medical assistance program" means either of the 8853
following: 8854

(a) The medicaid program. 8855

(b) The disability medical assistance program established 8856
under Chapter 5115. of the Revised Code. 8857

(B) If either party to a child support order issued in 8858
accordance with section 3119.30 of the Revised Code is an eligible 8859
~~for medical assistance under Chapter 5111. or 5115. of the Revised~~ 8860
~~Code~~ party and the other party has obtained health insurance 8861
coverage, the ~~party~~ eligible for medical assistance party shall 8862
notify any ~~physician, hospital, or other~~ provider of medical 8863
services ~~for which~~ covered by the eligible party's medical 8864
assistance ~~is available~~ program of the name and address of the 8865
other party's insurer and of the number of the other party's 8866
health insurance or health care policy, contract, or plan. Any 8867

~~physician, hospital, or other provider of medical services for~~ 8868
~~which medical assistance is available under Chapter 5111. or 5115.~~ 8869
~~of the Revised Code~~ who is notified under this ~~division~~ section of 8870
the existence of a health insurance or health care policy, 8871
contract, or plan with coverage for children who are eligible for 8872
a medical assistance program shall first bill the insurer for any 8873
services provided for those children. If the insurer fails to pay 8874
all or any part of a claim filed under this section and the 8875
services for which the claim is filed are covered by ~~Chapter 5111.~~ 8876
~~or 5115. of the Revised Code~~ the children's medical assistance 8877
program, the ~~physician, hospital, or other~~ medical services 8878
provider shall bill the remaining unpaid costs of the services in 8879
accordance with ~~Chapter 5111. or 5115. of the Revised Code~~ the law 8880
governing the children's medical assistance program. 8881

Sec. 3121.441. (A) Notwithstanding the provisions of this 8882
chapter, Chapters 3119., 3123., and 3125., and sections 3770.071 8883
and 5107.20 of the Revised Code providing for the office of child 8884
support in the department of job and family services to collect, 8885
withhold, or deduct spousal support, when a court pursuant to 8886
section 3105.18 or 3105.65 of the Revised Code issues or modifies 8887
an order requiring an obligor to pay spousal support or grants or 8888
modifies a decree of dissolution of marriage incorporating a 8889
separation agreement that provides for spousal support, or at any 8890
time after the issuance, granting, or modification of an order or 8891
decree of that type, the court may permit the obligor to make the 8892
spousal support payments directly to the obligee instead of to the 8893
office if the obligee and the obligor have no minor children born 8894
as a result of their marriage and the obligee has not assigned the 8895
spousal support amounts to the department pursuant to section 8896
~~5101.59 or 5107.20 or 5160.37~~ of the Revised Code. 8897

(B) A court that permits an obligor to make spousal support 8898
payments directly to the obligee pursuant to division (A) of this 8899

section shall order the obligor to make the spousal support 8900
payments as a check, as a money order, or in any other form that 8901
establishes a clear record of payment. 8902

(C) If a court permits an obligor to make spousal support 8903
payments directly to an obligee pursuant to division (A) of this 8904
section and the obligor is in default in making any spousal 8905
support payment to the obligee, the court, upon motion of the 8906
obligee or on its own motion, may rescind the permission granted 8907
under that division. After the rescission, the court shall 8908
determine the amount of arrearages in the spousal support payments 8909
and order the obligor to make to the office of child support in 8910
the department of job and family services any spousal support 8911
payments that are in arrears and any future spousal support 8912
payments. Upon the issuance of the order of the court under this 8913
division, the provisions of this chapter, Chapters 3119., 3123., 8914
and 3125., and sections 3770.071 and 5107.20 of the Revised Code 8915
apply with respect to the collection, withholding, or deduction of 8916
the obligor's spousal support payments that are the subject of 8917
that order of the court. 8918

Sec. 3121.898. The As used in this section, "state agency" 8919
means every department, bureau, board, commission, office, or 8920
other organized body established by the constitution or laws of 8921
this state for the exercise of state government; every entity of 8922
county government that is subject to the rules of a state agency; 8923
and every contractual agent of a state agency. 8924

The department of job and family services shall use the new 8925
hire reports it receives for any of the following purposes set 8926
forth in 42 U.S.C. 653a, as amended, including: 8927

(A) To locate individuals for the purposes of establishing 8928
paternity and for establishing, modifying, and enforcing child 8929
support orders. 8930

(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 8992
state teachers retirement system, or other information the board 8993
determines to be confidential. 8994

(2) "Retirant" has the same meaning as in section 3307.50 of 8995
the Revised Code. 8996

(B) The records of the board shall be open to public 8997
inspection, except for the following, which shall be excluded, 8998
except with the written authorization of the individual concerned: 8999

(1) The individual's personal records provided for in section 9000
3307.23 of the Revised Code; 9001

(2) The individual's personal history record; 9002

(3) Any information identifying, by name and address, the 9003
amount of a monthly allowance or benefit paid to the individual. 9004

(C) All medical reports and recommendations under sections 9005
3307.62, 3307.64, and 3307.66 of the Revised Code are privileged, 9006
except that copies of such medical reports or recommendations 9007
shall be made available to the personal physician, attorney, or 9008
authorized agent of the individual concerned upon written release 9009
received from the individual or the individual's agent, or, when 9010
necessary for the proper administration of the fund, to the board 9011
assigned physician. 9012

(D) Any person who is a member or contributor of the system 9013
shall be furnished, on written request, with a statement of the 9014
amount to the credit of the person's account. The board need not 9015
answer more than one request of a person in any one year. 9016

(E) Notwithstanding the exceptions to public inspection in 9017
division (B) of this section, the board may furnish the following 9018
information: 9019

(1) If a member, former member, retirant, contributor, or 9020
former contributor is subject to an order issued under section 9021

2907.15 of the Revised Code or is convicted of or pleads guilty to 9022
a violation of section 2921.41 of the Revised Code, on written 9023
request of a prosecutor as defined in section 2935.01 of the 9024
Revised Code, the board shall furnish to the prosecutor the 9025
information requested from the individual's personal history 9026
record. 9027

(2) Pursuant to a court or administrative order issued under 9028
section 3119.80, 3119.81, 3121.02, 3121.03, or 3123.06 of the 9029
Revised Code, the board shall furnish to a court or child support 9030
enforcement agency the information required under that section. 9031

(3) At the written request of any person, the board shall 9032
provide to the person a list of the names and addresses of 9033
members, former members, retirants, contributors, former 9034
contributors, or beneficiaries. The costs of compiling, copying, 9035
and mailing the list shall be paid by such person. 9036

(4) Within fourteen days after receiving ~~from the director of~~ 9037
~~job and family services~~ a list of the names and social security 9038
numbers of recipients of public assistance pursuant to section 9039
5101.181 of the Revised Code or a list of the names and social 9040
security numbers of public medical assistance program recipients 9041
pursuant to section 5160.43 of the Revised Code, the board shall 9042
inform the auditor of state of the name, current or most recent 9043
employer address, and social security number of each member whose 9044
name and social security number are the same as that of a person 9045
whose name or social security number ~~was submitted by the director~~ 9046
is included on the list. The board and its employees shall, except 9047
for purposes of furnishing the auditor of state with information 9048
required by this section, preserve the confidentiality of 9049
recipients of public assistance in compliance with ~~division (A) of~~ 9050
section 5101.181 of the Revised Code and preserve the 9051
confidentiality of public medical assistance program recipients in 9052
compliance with section 5160.43 of the Revised Code. 9053

(5) The system shall comply with orders issued under section 9054
3105.87 of the Revised Code. 9055

On the written request of an alternate payee, as defined in 9056
section 3105.80 of the Revised Code, the system shall furnish to 9057
the alternate payee information on the amount and status of any 9058
amounts payable to the alternate payee under an order issued under 9059
section 3105.171 or 3105.65 of the Revised Code. 9060

(6) At the request of any person, the board shall make 9061
available to the person copies of all documents, including 9062
resumes, in the board's possession regarding filling a vacancy of 9063
a contributing member or retired teacher member of the board. The 9064
person who made the request shall pay the cost of compiling, 9065
copying, and mailing the documents. The information described in 9066
this division is a public record. 9067

(F) A statement that contains information obtained from the 9068
system's records that is signed by an officer of the retirement 9069
system and to which the system's official seal is affixed, or 9070
copies of the system's records to which the signature and seal are 9071
attached, shall be received as true copies of the system's records 9072
in any court or before any officer of this state. 9073

Sec. 3309.22. (A)(1) As used in this division, "personal 9074
history record" means information maintained by the board on an 9075
individual who is a member, former member, contributor, former 9076
contributor, retirant, or beneficiary that includes the address, 9077
telephone number, social security number, record of contributions, 9078
correspondence with the system, and other information the board 9079
determines to be confidential. 9080

(2) The records of the board shall be open to public 9081
inspection, except for the following, which shall be excluded, 9082
except with the written authorization of the individual concerned: 9083

(a) The individual's statement of previous service and other information as provided for in section 3309.28 of the Revised Code; 9084
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(b) Any information identifying by name and address the amount of a monthly allowance or benefit paid to the individual; 9087
9088

(c) The individual's personal history record. 9089

(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. 9090
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(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. 9097
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(D) Notwithstanding the exceptions to public inspection in division (A)(2) of this section, the board may furnish the following information: 9101
9102
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(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. 9104
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(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 9112
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enforcement agency the information required under that section. 9115

(3) At the written request of any person, the board shall 9116
provide to the person a list of the names and addresses of 9117
members, former members, retirants, contributors, former 9118
contributors, or beneficiaries. The costs of compiling, copying, 9119
and mailing the list shall be paid by such person. 9120

(4) Within fourteen days after receiving ~~from the director of~~ 9121
~~job and family services~~ a list of the names and social security 9122
numbers of recipients of public assistance pursuant to section 9123
5101.181 of the Revised Code or a list of the names and social 9124
security numbers of public medical assistance program recipients 9125
pursuant to section 5160.43 of the Revised Code, the board shall 9126
inform the auditor of state of the name, current or most recent 9127
employer address, and social security number of each contributor 9128
whose name and social security number are the same as that of a 9129
person whose name or social security number ~~was submitted by the~~ 9130
~~director~~ is included on the list. The board and its employees 9131
shall, except for purposes of furnishing the auditor of state with 9132
information required by this section, preserve the confidentiality 9133
of recipients of public assistance in compliance with ~~division (A)~~ 9134
~~of~~ section 5101.181 of the Revised Code and preserve the 9135
confidentiality of public medical assistance program recipients in 9136
compliance with section 5160.43 of the Revised Code. 9137

(5) The system shall comply with orders issued under section 9138
3105.87 of the Revised Code. 9139

On the written request of an alternate payee, as defined in 9140
section 3105.80 of the Revised Code, the system shall furnish to 9141
the alternate payee information on the amount and status of any 9142
amounts payable to the alternate payee under an order issued under 9143
section 3105.171 or 3105.65 of the Revised Code. 9144

(6) At the request of any person, the board shall make 9145

available to the person copies of all documents, including 9146
resumes, in the board's possession regarding filling a vacancy of 9147
an employee member or retirant member of the board. The person who 9148
made the request shall pay the cost of compiling, copying, and 9149
mailing the documents. The information described in this division 9150
is a public record. 9151

(E) A statement that contains information obtained from the 9152
system's records that is signed by an officer of the retirement 9153
system and to which the system's official seal is affixed, or 9154
copies of the system's records to which the signature and seal are 9155
attached, shall be received as true copies of the system's records 9156
in any court or before any officer of this state. 9157

Sec. 3313.714. (A) As used in this section: 9158

(1) "Board of education" means the board of education of a 9159
city, local, exempted village, or joint vocational school 9160
district. 9161

(2) "Healthcheck" means the early and periodic screening, 9162
diagnosis, and treatment program, a component of the ~~medical~~ 9163
~~assistance~~ medicaid program established under Title XIX of the 9164
~~"Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 302, as~~ 9165
~~amended, and Chapter 5111. of the Revised Code.~~ 9166

(3) "Pupil" means a person under age twenty-two enrolled in 9167
the schools of a city, local, exempted village, or joint 9168
vocational school district. 9169

(4) "Parent" means either parent with the following 9170
exceptions: 9171

(a) If one parent has custody by court order, "parent" means 9172
the parent with custody. 9173

(b) If neither parent has legal custody, "parent" means the 9174
person or government entity with legal custody. 9175

(c) The child's legal guardian or a person who has accepted responsibility for the health, safety, and welfare of the child. 9176
9177

(B) At the request of the department of ~~job and family services~~ health care administration, a board of education shall 9178
9179
establish and conduct a healthcheck program for pupils enrolled in 9180
the schools of the district who are medicaid recipients ~~of medical assistance under Chapter 5111. of the Revised Code~~. At the request 9181
9182
of a board of education, the department may authorize the board to 9183
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establish a healthcheck program. A board that establishes a 9184
healthcheck program shall enter into a ~~medical assistance~~ medicaid 9185
9186
provider agreement with the department. 9186

A healthcheck program established by a board of education 9187
shall be conducted in accordance with rules adopted by the 9188
director of ~~job and family services~~ health care administration 9189
under division (F) of this section. The healthcheck program shall 9190
include all of the following components: 9191

(1) A comprehensive health and development history; 9192

(2) A comprehensive physical examination; 9193

(3) A developmental assessment; 9194

(4) A nutritional assessment; 9195

(5) A vision assessment; 9196

(6) A hearing assessment; 9197

(7) An immunization assessment; 9198

(8) Lead screening and laboratory tests ordered by a doctor 9199
of medicine or osteopathic medicine as part of one of the other 9200
components; 9201

(9) Such other assessment as may be required by the 9202
department of ~~job and family services~~ health care administration 9203
in accordance with the requirements of the healthcheck program. 9204

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 9237
the school in which the pupil is enrolled. If the parent does not 9238
return a signed form indicating denial of consent within two weeks 9239
after the date the notice is sent, the school district and the 9240
department of ~~job and family services~~ health care administration 9241
shall deem the parent to have consented to examination of the 9242
parent's child under the healthcheck program. In the case of a 9243
pupil age eighteen or older, the notice shall be given to the 9244
pupil, and the school district and the department of ~~job and~~ 9245
~~family services~~ shall deem the pupil to have consented to 9246
examination unless the pupil returns the signed form indicating 9247
the pupil's denial of consent. 9248

(D)(1) As used in this division: 9249

(a) "Nonfederal share" means the portion of expenditures for 9250
services that is required under the ~~medical assistance~~ medicaid 9251
program to be paid for with state or local government funds. 9252

(b) "Federal financial participation" means the portion of 9253
expenditures for services that is reimbursed under the ~~medical~~ 9254
~~assistance~~ medicaid program with federal funds. 9255

(2) At the request of a board of education, the ~~state~~ 9256
department may enter into an agreement with board under which the 9257
board provides medical services to a medicaid recipient of ~~medical~~ 9258
~~assistance~~ that are reimbursable under the ~~medical assistance~~ 9259
medicaid program but not under the healthcheck program. The 9260
agreement may be for a term specified in the agreement and 9261
renewable by mutual consent of the board and the department, or 9262
may continue in force as long as agreeable to the board and the 9263
department. 9264

The board shall use state or local funds of the district to 9265
pay the nonfederal share of expenditures for services provided 9266
under this division. Prior to entering into or renewing an 9267

agreement and at any other time requested by the department while 9268
the agreement is in force, the board shall certify to the 9269
department in accordance with the rules adopted under division (F) 9270
of this section that it will have sufficient state or local funds 9271
to pay the nonfederal share of expenditures under this division. 9272
If the board fails to make the certification, the department shall 9273
not enter into or renew the agreement. If an agreement has been 9274
entered into, it shall be void unless the board makes the 9275
certification not later than fifteen days after receiving notice 9276
from the department that the certification is due. The board shall 9277
report to the department, in accordance with the rules, the amount 9278
of state or local funds it spends to provide services under this 9279
division. 9280

The department shall reimburse the board the federal 9281
financial participation allowed for the board's expenditures for 9282
services under this division. The total of the nonfederal share 9283
spent by the board and the federal financial participation 9284
reimbursed by the department for a service rendered under this 9285
division shall be an amount agreed to by the board and the 9286
department, but shall not exceed the maximum reimbursable for that 9287
service under rules adopted by the director of ~~job and family~~ 9288
~~services~~ health care administration under ~~Chapter 5111. section~~ 9289
5163.15 of the Revised Code. The rules adopted under division (F) 9290
of this section shall include procedures under which the 9291
department will recover from a board overpayments and subsequent 9292
federal audit disallowances of federal financial participation 9293
reimbursed by the department. 9294

(E) A board of education shall provide services under 9295
division (D) of this section and under its healthcheck program as 9296
provided in division (E)(1), (2), or (3) of this section: 9297

(1) By having the services performed by physicians, dentists, 9298
and nurses employed by the board; 9299

(2) By contracting with physicians, dentists, nurses, and 9300
other providers of services who have ~~medical assistance~~ medicaid 9301
provider agreements with the department of ~~job and family services~~ 9302
health care administration; 9303

(3) By having some of the services performed by persons 9304
described in division (E)(1) of this section and others performed 9305
by persons described in division (E)(2) of this section. 9306

(F) The director of ~~job and family services~~ health care 9307
administration shall adopt rules in accordance with Chapter 119. 9308
of the Revised Code governing healthcheck programs conducted under 9309
this section and services provided under division (D) of this 9310
section. 9311

Sec. 3313.715. The board of education of a school district 9312
may request from the director of mental retardation and 9313
developmental disabilities the appropriate identification numbers 9314
for all students residing in the district who are ~~medical~~ 9315
~~assistance~~ medicaid recipients ~~under Chapter 5111. of the Revised~~ 9316
~~Code~~. The director shall furnish such numbers upon receipt of 9317
lists of student names furnished by the district board, in such 9318
form as the director may require. 9319

The director of ~~job and family services~~ health care 9320
administration shall provide the director of mental retardation 9321
and developmental disabilities with the data necessary for 9322
compliance with this section. 9323

Section 3319.321 of the Revised Code does not apply to the 9324
release of student names or other data to the director of mental 9325
retardation and developmental disabilities for the purposes of 9326
this section. Chapter 1347. of the Revised Code does not apply to 9327
information required to be kept by a school board or the 9328
departments of ~~job and family services~~ health care administration 9329
or mental retardation and developmental disabilities to the extent 9330

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) 9361
of section 3317.03 of the Revised Code; minus the FTE of students 9362
reported under division (B)(6), (7), (8), (9), (10), (11), or (12) 9363
of that section who are enrolled in a vocational education class 9364
or receiving special education; and minus twenty per cent of the 9365
students enrolled concurrently in a joint vocational school 9366
district. 9367

(5) "State share percentage" has the same meaning as in 9368
section 3317.022 of the Revised Code. 9369

(6) "VEPD" means a school district or group of school 9370
districts designated by the department of education as being 9371
responsible for the planning for and provision of vocational 9372
education services to students within the district or group. 9373

(7) "Lead district" means a school district, including a 9374
joint vocational school district, designated by the department as 9375
a VEPD, or designated to provide primary vocational education 9376
leadership within a VEPD composed of a group of districts. 9377

(B) If the district employs less than one full-time 9378
equivalent classroom teacher for each twenty-five pupils in the 9379
regular student population in any school district, deduct the sum 9380
of the amounts obtained from the following computations: 9381

(1) Divide the number of the district's full-time equivalent 9382
classroom teachers employed by one twenty-fifth; 9383

(2) Subtract the quotient in (1) from the district's regular 9384
student population; 9385

(3) Multiply the difference in (2) by seven hundred fifty-two 9386
dollars. 9387

(C) If a positive amount, add one-half of the amount obtained 9388
by multiplying the number of full-time equivalent classroom 9389
teachers by: 9390

(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 9453
agreement, deduct an amount equal to such payments if the district 9454
school board notifies the department in writing that it wishes to 9455
have such payments deducted. 9456

(2) If the district is entitled to receive payments from 9457
another district that has notified the department to deduct such 9458
payments under division (I)(1) of this section, add the amount of 9459
such payments. 9460

(J) If the district is required to pay an amount of funds to 9461
a cooperative education district pursuant to a provision described 9462
by division (B)(4) of section 3311.52 or division (B)(8) of 9463
section 3311.521 of the Revised Code, deduct such amounts as 9464
provided under that provision and credit those amounts to the 9465
cooperative education district for payment to the district under 9466
division (B)(1) of section 3317.19 of the Revised Code. 9467

(K)(1) If a district is educating a student entitled to 9468
attend school in another district pursuant to a shared education 9469
contract, compact, or cooperative education agreement other than 9470
an agreement entered into pursuant to section 3313.842 of the 9471
Revised Code, credit to that educating district on an FTE basis 9472
both of the following: 9473

(a) An amount equal to the greater of the following: 9474

(i) The fiscal year 2005 formula amount times the fiscal year 9475
2005 cost of doing business factor of the school district where 9476
the student is entitled to attend school pursuant to section 9477
3313.64 or 3313.65 of the Revised Code; 9478

(ii) The sum of (the current formula amount times the current 9479
cost-of-doing-business factor of the school district when the 9480
student is entitled to attend school pursuant to section 3313.64 9481
or 3313.65 of the Revised Code) plus the per pupil amount of the 9482
base funding supplements specified in divisions (C)(1) to (4) of 9483

section 3317.012 of the Revised Code. 9484

(b) An amount equal to the current formula amount times the 9485
state share percentage times any multiple applicable to the 9486
student pursuant to section 3317.013 or 3317.014 of the Revised 9487
Code. 9488

(2) Deduct any amount credited pursuant to division (K)(1) of 9489
this section from amounts paid to the school district in which the 9490
student is entitled to attend school pursuant to section 3313.64 9491
or 3313.65 of the Revised Code. 9492

(3) If the district is required by a shared education 9493
contract, compact, or cooperative education agreement to make 9494
payments to an educational service center, deduct the amounts from 9495
payments to the district and add them to the amounts paid to the 9496
service center pursuant to section 3317.11 of the Revised Code. 9497

(L)(1) If a district, including a joint vocational school 9498
district, is a lead district of a VEPD, credit to that district 9499
the amounts calculated for all the school districts within that 9500
VEPD pursuant to division (E)(2) of section 3317.022 of the 9501
Revised Code. 9502

(2) Deduct from each appropriate district that is not a lead 9503
district, the amount attributable to that district that is 9504
credited to a lead district under division (L)(1) of this section. 9505

(M) If the department pays a joint vocational school district 9506
under division (G)(4) of section 3317.16 of the Revised Code for 9507
excess costs of providing special education and related services 9508
to a handicapped student, as calculated under division (G)(2) of 9509
that section, the department shall deduct the amount of that 9510
payment from the city, local, or exempted village school district 9511
that is responsible as specified in that section for the excess 9512
costs. 9513

(N)(1) If the district reports an amount of excess cost for 9514

special education services for a child under division (C) of 9515
section 3323.14 of the Revised Code, the department shall pay that 9516
amount to the district. 9517

(2) If the district reports an amount of excess cost for 9518
special education services for a child under division (C) of 9519
section 3323.14 of the Revised Code, the department shall deduct 9520
that amount from the district of residence of that child. 9521

(0) If the department of ~~job and family services~~ health care 9522
administration presents to the department of education a payment 9523
request through an intrastate transfer voucher for the nonfederal 9524
share of reimbursements made to a school district for medicaid 9525
services provided by the district, the department of education 9526
shall pay the amount of that request to the department of ~~job and~~ 9527
~~family services~~ health care administration and shall deduct the 9528
amount of that payment from the district. 9529

Sec. 3323.021. As used in this section, "participating county 9530
MR/DD board" means a county board of mental retardation and 9531
developmental disabilities electing to participate in the 9532
provision of or contracting for educational services for children 9533
under division (D) of section 5126.05 of the Revised Code. 9534

(A) When a school district, educational service center, or 9535
participating county MR/DD board enters into an agreement or 9536
contract with another school district, educational service center, 9537
or participating county MR/DD board to provide educational 9538
services to a disabled child during a school year, both of the 9539
following shall apply: 9540

(1) Beginning with fiscal year 1999, if the provider of the 9541
services intends to increase the amount it charges for some or all 9542
of those services during the next school year or if the provider 9543
intends to cease offering all or part of those services during the 9544
next school year, the provider shall notify the entity for which 9545

the services are provided of these intended changes no later ~~that~~ 9546
than the first day of March of the current fiscal year. 9547

(2) Beginning with fiscal year 1999, if the entity for which 9548
services are provided intends to cease obtaining those services 9549
from the provider for the next school year or intends to change 9550
the type or amount of services it obtains from the provider for 9551
the next school year, the entity shall notify the service provider 9552
of these intended changes no later than the first day of March of 9553
the current fiscal year. 9554

(B) School districts, educational service centers, 9555
participating county MR/DD boards, and other applicable 9556
governmental entities shall collaborate where possible to maximize 9557
federal sources of revenue to provide additional funds for special 9558
education related services for disabled children. Annually, each 9559
school district shall report to the department of education any 9560
amounts of money the district received through ~~such medical~~ 9561
~~assistance~~ the medicaid program. 9562

(C) The state board of education, the department of mental 9563
retardation and developmental disabilities, and the department of 9564
~~job and family services~~ health care administration shall develop 9565
working agreements for pursuing additional funds for services for 9566
disabled children. 9567

Sec. 3599.45. (A) No candidate for the office of attorney 9568
general or county prosecutor or such a candidate's campaign 9569
committee shall knowingly accept any contribution from a provider 9570
of services or goods under contract with the department of ~~job and~~ 9571
~~family services~~ health care administration pursuant to the 9572
medicaid program ~~of Title XIX of the "Social Security Act," 49~~ 9573
~~Stat. 620 (1935), 42 U.S.C. 301, as amended,~~ or from any person 9574
having an ownership interest in the provider. 9575

As used in this section "candidate," "campaign committee," 9576

and "contribution" have the same meaning as in section 3517.01 of 9577
the Revised Code. 9578

(B) Whoever violates this section is guilty of a misdemeanor 9579
of the first degree. 9580

Sec. 3701.023. (A) The department of health shall review 9581
applications for eligibility for the program for medically 9582
handicapped children that are submitted to the department by city 9583
and general health districts and physician providers approved in 9584
accordance with division (C) of this section. The department shall 9585
determine whether the applicants meet the medical and financial 9586
eligibility requirements established by the public health council 9587
pursuant to division (A)(1) of section 3701.021 of the Revised 9588
Code, and by the department in the manual of operational 9589
procedures and guidelines for the program for medically 9590
handicapped children developed pursuant to division (B) of that 9591
section. Referrals of potentially eligible children for the 9592
program may be submitted to the department on behalf of the child 9593
by parents, guardians, public health nurses, or any other 9594
interested person. The department of health may designate other 9595
agencies to refer applicants to the department of health. 9596

(B) In accordance with the procedures established in rules 9597
adopted under division (A)(4) of section 3701.021 of the Revised 9598
Code, the department of health shall authorize a provider or 9599
providers to provide to any Ohio resident under twenty-one years 9600
of age, without charge to the resident or the resident's family 9601
and without restriction as to the economic status of the resident 9602
or the resident's family, diagnostic services necessary to 9603
determine whether the resident has a medically handicapping or 9604
potentially medically handicapping condition. 9605

(C) The department of health shall review the applications of 9606
health professionals, hospitals, medical equipment suppliers, and 9607

other individuals, groups, or agencies that apply to become 9608
providers. The department shall enter into a written agreement 9609
with each applicant who is determined, pursuant to the 9610
requirements set forth in rules adopted under division (A)(2) of 9611
section 3701.021 of the Revised Code, to be eligible to be a 9612
provider in accordance with the provider agreement required by the 9613
~~medical assistance medicaid program established under section~~ 9614
~~5111.01 of the Revised Code.~~ No provider shall charge a medically 9615
handicapped child or the child's parent or guardian for services 9616
authorized by the department under division (B) or (D) of this 9617
section. 9618

The department, in accordance with rules adopted under 9619
division (A)(3) of section 3701.021 of the Revised Code, may 9620
disqualify any provider from further participation in the program 9621
for violating any requirement set forth in rules adopted under 9622
division (A)(2) of that section. The disqualification shall not 9623
take effect until a written notice, specifying the requirement 9624
violated and describing the nature of the violation, has been 9625
delivered to the provider and the department has afforded the 9626
provider an opportunity to appeal the disqualification under 9627
division (H) of this section. 9628

(D) The department of health shall evaluate applications from 9629
city and general health districts and approved physician providers 9630
for authorization to provide treatment services, service 9631
coordination, and related goods to children determined to be 9632
eligible for the program for medically handicapped children 9633
pursuant to division (A) of this section. The department shall 9634
authorize necessary treatment services, service coordination, and 9635
related goods for each eligible child in accordance with an 9636
individual plan of treatment for the child. As an alternative, the 9637
department may authorize payment of health insurance premiums on 9638
behalf of eligible children when the department determines, in 9639

accordance with criteria set forth in rules adopted under division 9640
(A)(9) of section 3701.021 of the Revised Code, that payment of 9641
the premiums is cost-effective. 9642

(E) The department of health shall pay, from appropriations 9643
to the department, any necessary expenses, including but not 9644
limited to, expenses for diagnosis, treatment, service 9645
coordination, supportive services, transportation, and accessories 9646
and their upkeep, provided to medically handicapped children, 9647
provided that the provision of the goods or services is authorized 9648
by the department under division (B) or (D) of this section. Money 9649
appropriated to the department of health may also be expended for 9650
reasonable administrative costs incurred by the program. The 9651
department of health also may purchase liability insurance 9652
covering the provision of services under the program for medically 9653
handicapped children by physicians and other health care 9654
professionals. 9655

Payments made to providers by the department of health 9656
pursuant to this division for inpatient hospital care, outpatient 9657
care, and all other medical assistance furnished to eligible 9658
recipients shall be made in accordance with rules adopted by the 9659
public health council pursuant to division (A) of section 3701.021 9660
of the Revised Code. 9661

The departments of health and ~~job and family services~~ health 9662
care administration shall jointly implement procedures to ensure 9663
that duplicate payments are not made under the program for 9664
medically handicapped children and the ~~medical assistance~~ medicaid 9665
program ~~established under section 5111.01 of the Revised Code~~ and 9666
to identify and recover duplicate payments. 9667

(F) At the time of applying for participation in the program 9668
for medically handicapped children, a medically handicapped child 9669
or the child's parent or guardian shall disclose the identity of 9670
any third party against whom the child or the child's parent or 9671

guardian has or may have a right of recovery for goods and 9672
services provided under division (B) or (D) of this section. The 9673
department of health shall require a medically handicapped child 9674
who receives services from the program or the child's parent or 9675
guardian to apply for all third-party benefits for which the child 9676
may be eligible and require the child, parent, or guardian to 9677
apply all third-party benefits received to the amount determined 9678
under division (E) of this section as the amount payable for goods 9679
and services authorized under division (B) or (D) of this section. 9680
The department is the payer of last resort and shall pay for 9681
authorized goods or services, up to the amount determined under 9682
division (E) of this section for the authorized goods or services, 9683
only to the extent that payment for the authorized goods or 9684
services is not made through third-party benefits. When a third 9685
party fails to act on an application or claim for benefits by a 9686
medically handicapped child or the child's parent or guardian, the 9687
department shall pay for the goods or services only after ninety 9688
days have elapsed since the date the child, parents, or guardians 9689
made an application or claim for all third-party benefits. 9690
Third-party benefits received shall be applied to the amount 9691
determined under division (E) of this section. Third-party 9692
payments for goods and services not authorized under division (B) 9693
or (D) of this section shall not be applied to payment amounts 9694
determined under division (E) of this section. Payment made by the 9695
department shall be considered payment in full of the amount 9696
determined under division (E) of this section. Medicaid payments 9697
for persons eligible for the ~~medical assistance~~ medicaid program 9698
~~established under section 5111.01 of the Revised Code~~ shall be 9699
considered payment in full of the amount determined under division 9700
(E) of this section. 9701

(G) The department of health shall administer a program to 9702
provide services to Ohio residents who are twenty-one or more 9703
years of age who have cystic fibrosis and who meet the eligibility 9704

requirements established by the rules of the public health council 9705
pursuant to division (A)(7) of section 3701.021 of the Revised 9706
Code, subject to all provisions of this section, but not subject 9707
to section 3701.024 of the Revised Code. 9708

(H) The department of health shall provide for appeals, in 9709
accordance with rules adopted under section 3701.021 of the 9710
Revised Code, of denials of applications for the program for 9711
medically handicapped children under division (A) or (D) of this 9712
section, disqualification of providers, or amounts paid under 9713
division (E) of this section. Appeals under this division are not 9714
subject to Chapter 119. of the Revised Code. 9715

The department may designate ombudspersons to assist 9716
medically handicapped children or their parents or guardians, upon 9717
the request of the children, parents, or guardians, in filing 9718
appeals under this division and to serve as children's, parents', 9719
or guardians' advocates in matters pertaining to the 9720
administration of the program for medically handicapped children 9721
and eligibility for program services. The ombudspersons shall 9722
receive no compensation but shall be reimbursed by the department, 9723
in accordance with rules of the office of budget and management, 9724
for their actual and necessary travel expenses incurred in the 9725
performance of their duties. 9726

(I) The department of health, and city and general health 9727
districts providing service coordination pursuant to division 9728
(A)(2) of section 3701.024 of the Revised Code, shall provide 9729
service coordination in accordance with the standards set forth in 9730
the rules adopted under section 3701.021 of the Revised Code, 9731
without charge, and without restriction as to economic status. 9732

Sec. 3701.024. (A)(1) Under a procedure established in rules 9733
adopted under section 3701.021 of the Revised Code, the department 9734
of health shall determine the amount each county shall provide 9735

annually for the program for medically handicapped children, based 9736
on a proportion of the county's total general property tax 9737
duplicate, not to exceed one-tenth of a mill, and charge the 9738
county for any part of expenses incurred under the program for 9739
treatment services on behalf of medically handicapped children 9740
having legal settlement in the county that is not paid from 9741
federal funds or through the ~~medical assistance~~ medicaid program 9742
~~established under section 5111.01 of the Revised Code.~~ The 9743
department shall not charge the county for expenses exceeding the 9744
difference between the amount determined under division (A)(1) of 9745
this section and any amounts retained under divisions (A)(2) and 9746
(3) of this section. 9747

All amounts collected by the department under division (A)(1) 9748
of this section shall be deposited into the state treasury to the 9749
credit of the medically handicapped children-county assessment 9750
fund, which is hereby created. The fund shall be used by the 9751
department to comply with sections 3701.021 to 3701.028 of the 9752
Revised Code. 9753

(2) The department, in accordance with rules adopted under 9754
section 3701.021 of the Revised Code, may allow each county to 9755
retain up to ten per cent of the amount determined under division 9756
(A)(1) of this section to provide funds to city or general health 9757
districts of the county with which the districts shall provide 9758
service coordination, public health nursing, or transportation 9759
services for medically handicapped children. 9760

(3) In addition to any amount retained under division (A)(2) 9761
of this section, the department, in accordance with rules adopted 9762
under section 3701.021 of the Revised Code, may allow counties 9763
that it determines have significant numbers of potentially 9764
eligible medically handicapped children to retain an amount equal 9765
to the difference between: 9766

(a) Twenty-five per cent of the amount determined under 9767

division (A)(1) of this section; 9768

(b) Any amount retained under division (A)(2) of this 9769
section. 9770

Counties shall use amounts retained under division (A)(3) of 9771
this section to provide funds to city or general health districts 9772
of the county with which the districts shall conduct outreach 9773
activities to increase participation in the program for medically 9774
handicapped children. 9775

(4) Prior to any increase in the millage charged to a county, 9776
the public health council shall hold a public hearing on the 9777
proposed increase and shall give notice of the hearing to each 9778
board of county commissioners that would be affected by the 9779
increase at least thirty days prior to the date set for the 9780
hearing. Any county commissioner may appear and give testimony at 9781
the hearing. Any increase in the millage any county is required to 9782
provide for the program for medically handicapped children shall 9783
be determined, and notice of the amount of the increase shall be 9784
provided to each affected board of county commissioners, no later 9785
than the first day of June of the fiscal year next preceding the 9786
fiscal year in which the increase will take effect. 9787

(B) Each board of county commissioners shall establish a 9788
medically handicapped children's fund and shall appropriate 9789
thereto an amount, determined in accordance with division (A)(1) 9790
of this section, for the county's share in providing medical, 9791
surgical, and other aid to medically handicapped children residing 9792
in such county and for the purposes specified in divisions (A)(2) 9793
and (3) of this section. Each county shall use money retained 9794
under divisions (A)(2) and (3) of this section only for the 9795
purposes specified in those divisions. 9796

Sec. 3701.027. The department of health shall administer 9797
funds received from the "Maternal and Child Health Block Grant," 9798

Title V of the "Social Security Act," 95 Stat. 818 (1981), 42 9799
U.S.C.A. 701, as amended, for programs including the program for 9800
medically handicapped children, and to provide technical 9801
assistance and consultation to city and general health districts 9802
and local health planning organizations in implementing local, 9803
community-based, family-centered, coordinated systems of care for 9804
medically handicapped children. The department may make grants to 9805
persons and other entities for the provision of services with the 9806
funds. In addition, the department may use the funds to purchase 9807
liability insurance covering the provision of services under the 9808
programs by physicians and other health care professionals, and to 9809
pay health insurance premiums on behalf of medically handicapped 9810
children participating in the program for medically handicapped 9811
children when the department determines, in accordance with 9812
criteria set forth in rules adopted under division (A)(9) of 9813
section 3701.021 of the Revised Code, that payment of the premiums 9814
is cost effective. 9815

In determining eligibility for services provided with funds 9816
received from the "Maternal and Child Health Block Grant," the 9817
department may use the application form established under section 9818
~~5111.013~~ 5162.15 of the Revised Code. The department may require 9819
applicants to furnish their social security numbers. 9820

Sec. 3701.043. If authorized by federal statute or 9821
regulation, the director of health may establish and collect fees 9822
for conducting the initial certification of any person or entity 9823
as a provider of health services for purposes of the medicare 9824
program ~~established under Title XVIII of the Social Security Act,~~ 9825
~~49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended.~~ The fee 9826
established for conducting an initial medicare certification shall 9827
not exceed the actual and necessary costs incurred by the 9828
department of health in conducting the certification. 9829

All fees collected under this section shall be deposited into 9830
the state treasury to the credit of the medicare initial 9831
certification fund, which is hereby created. Money credited to the 9832
fund shall be used solely to pay the costs of conducting initial 9833
medicare certifications. 9834

Sec. 3701.132. The department of health is hereby designated 9835
as the state agency to administer the "special supplemental 9836
nutrition program for women, infants, and children" established 9837
under the "Child Nutrition Act of 1966," 80 Stat. 885, 42 U.S.C. 9838
1786, as amended. The public health council may adopt rules 9839
pursuant to Chapter 119. of the Revised Code as necessary for 9840
administering the program. The rules may include civil money 9841
penalties for violations of the rules. 9842

In determining eligibility for services provided under the 9843
program, the department may use the application form established 9844
under section ~~5111.013~~ 5162.15 of the Revised Code for the healthy 9845
start program. The department may require applicants to furnish 9846
their social security numbers. 9847

If the department determines that a vendor has committed an 9848
act with respect to the program that federal statutes or 9849
regulations or state statutes or rules prohibit, the department 9850
shall take action against the vendor in the manner required by 7 9851
C.F.R. part 246, including imposition of a civil money penalty in 9852
accordance with 7 C.F.R. 246.12, or rules adopted under this 9853
section. 9854

Sec. 3701.243. (A) Except as provided in this section or 9855
section 3701.248 of the Revised Code, no person or agency of state 9856
or local government that acquires the information while providing 9857
any health care service or while in the employ of a health care 9858
facility or health care provider shall disclose or compel another 9859

to disclose any of the following: 9860

(1) The identity of any individual on whom an HIV test is 9861
performed; 9862

(2) The results of an HIV test in a form that identifies the 9863
individual tested; 9864

(3) The identity of any individual diagnosed as having AIDS 9865
or an AIDS-related condition. 9866

(B)(1) Except as provided in divisions (B)(2), (C), (D), and 9867
(F) of this section, the results of an HIV test or the identity of 9868
an individual on whom an HIV test is performed or who is diagnosed 9869
as having AIDS or an AIDS-related condition may be disclosed only 9870
to the following: 9871

(a) The individual who was tested or the individual's legal 9872
guardian, and the individual's spouse or any sexual partner; 9873

(b) A person to whom disclosure is authorized by a written 9874
release, executed by the individual tested or by the individual's 9875
legal guardian and specifying to whom disclosure of the test 9876
results or diagnosis is authorized and the time period during 9877
which the release is to be effective; 9878

(c) The individual's physician; 9879

(d) The department of health or a health commissioner to 9880
which reports are made under section 3701.24 of the Revised Code; 9881

(e) A health care facility or provider that procures, 9882
processes, distributes, or uses a human body part from a deceased 9883
individual, donated for a purpose specified in Chapter 2108. of 9884
the Revised Code, and that needs medical information about the 9885
deceased individual to ensure that the body part is medically 9886
acceptable for its intended purpose; 9887

(f) Health care facility staff committees or accreditation or 9888
oversight review organizations conducting program monitoring, 9889

program evaluation, or service reviews; 9890

(g) A health care provider, emergency medical services 9891
worker, or peace officer who sustained a significant exposure to 9892
the body fluids of another individual, if that individual was 9893
tested pursuant to division (E)(6) of section 3701.242 of the 9894
Revised Code, except that the identity of the individual tested 9895
shall not be revealed; 9896

(h) To law enforcement authorities pursuant to a search 9897
warrant or a subpoena issued by or at the request of a grand jury, 9898
a prosecuting attorney, a city director of law or similar chief 9899
legal officer of a municipal corporation, or a village solicitor, 9900
in connection with a criminal investigation or prosecution. 9901

(2) The results of an HIV test or a diagnosis of AIDS or an 9902
AIDS-related condition may be disclosed to a health care provider, 9903
or an authorized agent or employee of a health care facility or a 9904
health care provider, if the provider, agent, or employee has a 9905
medical need to know the information and is participating in the 9906
diagnosis, care, or treatment of the individual on whom the test 9907
was performed or who has been diagnosed as having AIDS or an 9908
AIDS-related condition. 9909

This division does not impose a standard of disclosure 9910
different from the standard for disclosure of all other specific 9911
information about a patient to health care providers and 9912
facilities. Disclosure may not be requested or made solely for the 9913
purpose of identifying an individual who has a positive HIV test 9914
result or has been diagnosed as having AIDS or an AIDS-related 9915
condition in order to refuse to treat the individual. Referral of 9916
an individual to another health care provider or facility based on 9917
reasonable professional judgment does not constitute refusal to 9918
treat the individual. 9919

(3) Not later than ninety days after November 1, 1989, each 9920

health care facility in this state shall establish a protocol to 9921
be followed by employees and individuals affiliated with the 9922
facility in making disclosures authorized by division (B)(2) of 9923
this section. A person employed by or affiliated with a health 9924
care facility who determines in accordance with the protocol 9925
established by the facility that a disclosure is authorized by 9926
division (B)(2) of this section is immune from liability to any 9927
person in a civil action for damages for injury, death, or loss to 9928
person or property resulting from the disclosure. 9929

(C)(1) Any person or government agency may seek access to or 9930
authority to disclose the HIV test records of an individual in 9931
accordance with the following provisions: 9932

(a) The person or government agency shall bring an action in 9933
a court of common pleas requesting disclosure of or authority to 9934
disclose the results of an HIV test of a specific individual, who 9935
shall be identified in the complaint by a pseudonym but whose name 9936
shall be communicated to the court confidentially, pursuant to a 9937
court order restricting the use of the name. The court shall 9938
provide the individual with notice and an opportunity to 9939
participate in the proceedings if the individual is not named as a 9940
party. Proceedings shall be conducted in chambers unless the 9941
individual agrees to a hearing in open court. 9942

(b) The court may issue an order granting the plaintiff 9943
access to or authority to disclose the test results only if the 9944
court finds by clear and convincing evidence that the plaintiff 9945
has demonstrated a compelling need for disclosure of the 9946
information that cannot be accommodated by other means. In 9947
assessing compelling need, the court shall weigh the need for 9948
disclosure against the privacy right of the individual tested and 9949
against any disservice to the public interest that might result 9950
from the disclosure, such as discrimination against the individual 9951
or the deterrence of others from being tested. 9952

(c) If the court issues an order, it shall guard against 9953
unauthorized disclosure by specifying the persons who may have 9954
access to the information, the purposes for which the information 9955
shall be used, and prohibitions against future disclosure. 9956

(2) A person or government agency that considers it necessary 9957
to disclose the results of an HIV test of a specific individual in 9958
an action in which it is a party may seek authority for the 9959
disclosure by filing an in camera motion with the court in which 9960
the action is being heard. In hearing the motion, the court shall 9961
employ procedures for confidentiality similar to those specified 9962
in division (C)(1) of this section. The court shall grant the 9963
motion only if it finds by clear and convincing evidence that a 9964
compelling need for the disclosure has been demonstrated. 9965

(3) Except for an order issued in a criminal prosecution or 9966
an order under division (C)(1) or (2) of this section granting 9967
disclosure of the result of an HIV test of a specific individual, 9968
a court shall not compel a blood bank, hospital blood center, or 9969
blood collection facility to disclose the result of HIV tests 9970
performed on the blood of voluntary donors in a way that reveals 9971
the identity of any donor. 9972

(4) In a civil action in which the plaintiff seeks to recover 9973
damages from an individual defendant based on an allegation that 9974
the plaintiff contracted the HIV virus as a result of actions of 9975
the defendant, the prohibitions against disclosure in this section 9976
do not bar discovery of the results of any HIV test given to the 9977
defendant or any diagnosis that the defendant suffers from AIDS or 9978
an AIDS-related condition. 9979

(D) The results of an HIV test or the identity of an 9980
individual on whom an HIV test is performed or who is diagnosed as 9981
having AIDS or an AIDS-related condition may be disclosed to a 9982
federal, state, or local government agency, or the official 9983
representative of such an agency, for purposes of the ~~medical~~ 9984

~~assistance medicaid program established under section 5111.01 of~~ 9985
~~the Revised Code, the medicare program established under Title~~ 9986
~~XVIII of the "Social Security Act," 49 Stat. 620 (1935) 42~~ 9987
~~U.S.C.A. 301, as amended, or any other public assistance program.~~ 9988

(E) Any disclosure pursuant to this section shall be in 9989
writing and accompanied by a written statement that includes the 9990
following or substantially similar language: "This information has 9991
been disclosed to you from confidential records protected from 9992
disclosure by state law. You shall make no further disclosure of 9993
this information without the specific, written, and informed 9994
release of the individual to whom it pertains, or as otherwise 9995
permitted by state law. A general authorization for the release of 9996
medical or other information is not sufficient for the purpose of 9997
the release of HIV test results or diagnoses." 9998

(F) An individual who knows that the individual has received 9999
a positive result on an HIV test or has been diagnosed as having 10000
AIDS or an AIDS-related condition shall disclose this information 10001
to any other person with whom the individual intends to make 10002
common use of a hypodermic needle or engage in sexual conduct as 10003
defined in section 2907.01 of the Revised Code. An individual's 10004
compliance with this division does not prohibit a prosecution of 10005
the individual for a violation of division (B) of section 2903.11 10006
of the Revised Code. 10007

(G) Nothing in this section prohibits the introduction of 10008
evidence concerning an HIV test of a specific individual in a 10009
criminal proceeding. 10010

Sec. 3701.507. (A) To assist in implementing sections 10011
3701.503 to 3701.509 of the Revised Code, the medically 10012
handicapped children's medical advisory council created in section 10013
3701.025 of the Revised Code shall appoint a permanent infant 10014
hearing screening subcommittee. The subcommittee shall consist of 10015

the following members:	10016
(1) One otolaryngologist;	10017
(2) One neonatologist;	10018
(3) One pediatrician;	10019
(4) One neurologist;	10020
(5) One hospital administrator;	10021
(6) Two or more audiologists who are experienced in infant hearing screening and evaluation;	10022 10023
(7) One speech-language pathologist licensed under section 4753.07 of the Revised Code;	10024 10025
(8) Two persons who are each a parent of a hearing-impaired child;	10026 10027
(9) One geneticist;	10028
(10) One epidemiologist;	10029
(11) One adult who is deaf or hearing impaired;	10030
(12) One representative from an organization for the deaf or hearing impaired;	10031 10032
(13) One family advocate;	10033
(14) One nurse from a well-baby neonatal nursery;	10034
(15) One nurse from a special care neonatal nursery;	10035
(16) One teacher of the deaf who works with infants and toddlers;	10036 10037
(17) One representative of the health insurance industry;	10038
(18) One representative of the bureau for children with medical handicaps;	10039 10040
(19) One representative of the department of education;	10041
(20) One representative of the Ohio department of job and	10042

family services who has responsibilities regarding medicaid <u>health</u>	10043
<u>care administration;</u>	10044
(21) Any other person the advisory council appoints.	10045
(B) The infant hearing subcommittee shall:	10046
(1) Consult with the director of health regarding the	10047
administration of sections 3701.503 to 3701.509 of the Revised	10048
Code;	10049
(2) Advise and make recommendations regarding proposed rules	10050
prior to their adoption by the public health council under section	10051
3701.508 of the Revised Code;	10052
(3) Consult with the director of health and advise and make	10053
recommendations regarding program development and implementation	10054
under sections 3701.503 to 3701.509 of the Revised Code, including	10055
all of the following:	10056
(a) Establishment under section 3701.504 of the Revised Code	10057
of the statewide hearing screening, tracking, and early	10058
intervention program to identify newborn and infant hearing	10059
impairment;	10060
(b) Identification of locations where hearing evaluations may	10061
be conducted;	10062
(c) Recommendations for methods and techniques of hearing	10063
screening and hearing evaluation;	10064
(d) Referral, data recording and compilation, and procedures	10065
to encourage follow-up hearing care;	10066
(e) Maintenance of a register of newborns and infants who do	10067
not pass the hearing screening;	10068
(f) Preparation of the information required by section	10069
3701.506 of the Revised Code and any other information the public	10070
health council requires the department of health to provide.	10071

Sec. 3701.74. (A) As used in this section and section	10072
3701.741 of the Revised Code:	10073
(1) "Ambulatory care facility" means a facility that provides	10074
medical, diagnostic, or surgical treatment to patients who do not	10075
require hospitalization, including a dialysis center, ambulatory	10076
surgical facility, cardiac catheterization facility, diagnostic	10077
imaging center, extracorporeal shock wave lithotripsy center, home	10078
health agency, inpatient hospice, birthing center, radiation	10079
therapy center, emergency facility, and an urgent care center.	10080
"Ambulatory care facility" does not include the private office of	10081
a physician or dentist, whether the office is for an individual or	10082
group practice.	10083
(2) "Chiropractor" means an individual licensed under Chapter	10084
4734. of the Revised Code to practice chiropractic.	10085
(3) "Emergency facility" means a hospital emergency	10086
department or any other facility that provides emergency medical	10087
services.	10088
(4) "Health care practitioner" means all of the following:	10089
(a) A dentist or dental hygienist licensed under Chapter	10090
4715. of the Revised Code;	10091
(b) A registered or licensed practical nurse licensed under	10092
Chapter 4723. of the Revised Code;	10093
(c) An optometrist licensed under Chapter 4725. of the	10094
Revised Code;	10095
(d) A dispensing optician, spectacle dispensing optician,	10096
contact lens dispensing optician, or spectacle-contact lens	10097
dispensing optician licensed under Chapter 4725. of the Revised	10098
Code;	10099
(e) A pharmacist licensed under Chapter 4729. of the Revised	10100
Code;	10101

(f) A physician;	10102
(g) A physician assistant authorized under Chapter 4730. of the Revised Code to practice as a physician assistant;	10103 10104
(h) A practitioner of a limited branch of medicine issued a certificate under Chapter 4731. of the Revised Code;	10105 10106
(i) A psychologist licensed under Chapter 4732. of the Revised Code;	10107 10108
(j) A chiropractor;	10109
(k) A hearing aid dealer or fitter licensed under Chapter 4747. of the Revised Code;	10110 10111
(l) A speech-language pathologist or audiologist licensed under Chapter 4753. of the Revised Code;	10112 10113
(m) An occupational therapist or occupational therapy assistant licensed under Chapter 4755. of the Revised Code;	10114 10115
(n) A physical therapist or physical therapy assistant licensed under Chapter 4755. of the Revised Code;	10116 10117
(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;	10118 10119 10120 10121
(p) A dietitian licensed under Chapter 4759. of the Revised Code;	10122 10123
(q) A respiratory care professional licensed under Chapter 4761. of the Revised Code;	10124 10125
(r) An emergency medical technician-basic, emergency medical technician-intermediate, or emergency medical technician-paramedic certified under Chapter 4765. of the Revised Code.	10126 10127 10128
(5) "Health care provider" means a hospital, ambulatory care facility, long-term care facility, pharmacy, emergency facility,	10129 10130

or health care practitioner. 10131

(6) "Hospital" has the same meaning as in section 3727.01 of 10132
the Revised Code. 10133

(7) "Long-term care facility" means a nursing home, 10134
residential care facility, or home for the aging, as those terms 10135
are defined in section 3721.01 of the Revised Code; an adult care 10136
facility, as defined in section 3722.01 of the Revised Code; a 10137
nursing facility or intermediate care facility for the mentally 10138
retarded, as those terms are defined in section ~~5111.20~~ 5164.01 of 10139
the Revised Code; a facility or portion of a facility certified as 10140
a skilled nursing facility under ~~Title XVIII~~ of the "~~Social~~ 10141
~~Security Act,~~" ~~49 Stat. 286 (1965), 42 U.S.C.A. 1395,~~ as amended 10142
medicare program. 10143

(8) "Medical record" means data in any form that pertains to 10144
a patient's medical history, diagnosis, prognosis, or medical 10145
condition and that is generated and maintained by a health care 10146
provider in the process of the patient's health care treatment. 10147

(9) "Medical records company" means a person who stores, 10148
locates, or copies medical records for a health care provider, or 10149
is compensated for doing so by a health care provider, and charges 10150
a fee for providing medical records to a patient or patient's 10151
representative. 10152

(10) "Patient" means either of the following: 10153

(a) An individual who received health care treatment from a 10154
health care provider; 10155

(b) A guardian, as defined in section 1337.11 of the Revised 10156
Code, of an individual described in division (A)(10)(a) of this 10157
section. 10158

(11) "Patient's personal representative" means a minor 10159
patient's parent or other person acting in loco parentis, a 10160

court-appointed guardian, or a person with durable power of 10161
attorney for health care for a patient, the executor or 10162
administrator of the patient's estate, or the person responsible 10163
for the patient's estate if it is not to be probated. "Patient's 10164
personal representative" does not include an insurer authorized 10165
under Title XXXIX of the Revised Code to do the business of 10166
sickness and accident insurance in this state, a health insuring 10167
corporation holding a certificate of authority under Chapter 1751. 10168
of the Revised Code, or any other person not named in this 10169
division. 10170

(12) "Pharmacy" has the same meaning as in section 4729.01 of 10171
the Revised Code. 10172

(13) "Physician" means a person authorized under Chapter 10173
4731. of the Revised Code to practice medicine and surgery, 10174
osteopathic medicine and surgery, or podiatric medicine and 10175
surgery. 10176

(14) "Authorized person" means a person to whom a patient has 10177
given written authorization to act on the patient's behalf 10178
regarding the patient's medical record. 10179

(B) A patient, a patient's personal representative or an 10180
authorized person who wishes to examine or obtain a copy of part 10181
or all of a medical record shall submit to the health care 10182
provider a written request signed by the patient, personal 10183
representative, or authorized person dated not more than sixty 10184
days before the date on which it is submitted. The request shall 10185
indicate whether the copy is to be sent to the requestor, 10186
physician or chiropractor, or held for the requestor at the 10187
office of the health care provider. Within a reasonable time after 10188
receiving a request that meets the requirements of this division 10189
and includes sufficient information to identify the record 10190
requested, a health care provider that has the patient's medical 10191
records shall permit the patient to examine the record during 10192

regular business hours without charge or, on request, shall 10193
provide a copy of the record in accordance with section 3701.741 10194
of the Revised Code, except that if a physician or chiropractor 10195
who has treated the patient determines for clearly stated 10196
treatment reasons that disclosure of the requested record is 10197
likely to have an adverse effect on the patient, the health care 10198
provider shall provide the record to a physician or chiropractor 10199
designated by the patient. The health care provider shall take 10200
reasonable steps to establish the identity of the person making 10201
the request to examine or obtain a copy of the patient's record. 10202

(C) If a health care provider fails to furnish a medical 10203
record as required by division (B) of this section, the patient, 10204
personal representative, or authorized person who requested the 10205
record may bring a civil action to enforce the patient's right of 10206
access to the record. 10207

(D)(1) This section does not apply to medical records whose 10208
release is covered by section 173.20 or 3721.13 of the Revised 10209
Code, by Chapter 1347. or 5122. of the Revised Code, by 42 C.F.R. 10210
part 2, "Confidentiality of Alcohol and Drug Abuse Patient 10211
Records," or by 42 C.F.R. 483.10. 10212

(2) Nothing in this section is intended to supersede the 10213
confidentiality provisions of sections 2305.24, 2305.25, 2305.251, 10214
and 2305.252 of the Revised Code. 10215

Sec. 3701.741. (A) Through December 31, 2008, each health 10216
care provider and medical records company shall provide copies of 10217
medical records in accordance with this section. 10218

(B) Except as provided in divisions (C) and (E) of this 10219
section, a health care provider or medical records company that 10220
receives a request for a copy of a patient's medical record shall 10221
charge not more than the amounts set forth in this section. 10222

(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 10252
shall provide one copy without charge to the following: 10253

(a) The bureau of workers' compensation, in accordance with 10254
Chapters 4121. and 4123. of the Revised Code and the rules adopted 10255
under those chapters; 10256

(b) The industrial commission, in accordance with Chapters 10257
4121. and 4123. of the Revised Code and the rules adopted under 10258
those chapters; 10259

(c) The department of job and family services, in accordance 10260
with Chapter 5101. of the Revised Code and the rules adopted under 10261
those chapters; 10262

(d) The attorney general, in accordance with sections 2743.51 10263
to 2743.72 of the Revised Code and any rules that may be adopted 10264
under those sections; 10265

(e) A patient or patient's personal representative if the 10266
medical record is necessary to support a claim under Title II ~~or~~ 10267
~~Title XVI~~ of the "Social Security Act," 49 Stat. 620 (1935), 42 10268
U.S.C.A. 401 ~~and 1381~~, as amended, or the supplemental security 10269
income program and the request is accompanied by documentation 10270
that a claim has been filed. 10271

(2) Nothing in division (C)(1) of this section requires a 10272
health care provider or medical records company to provide a copy 10273
without charge to any person or entity not listed in division 10274
(C)(1) of this section. 10275

(D) Division (C) of this section shall not be construed to 10276
supersede any rule of the bureau of workers' compensation, the 10277
industrial commission, or the department of job and family 10278
services. 10279

(E) A health care provider or medical records company may 10280
enter into a contract with either of the following for the copying 10281

of medical records at a fee other than as provided in division (B)	10282
of this section:	10283
(1) A patient, a patient's personal representative, or an authorized person;	10284 10285
(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.	10286 10287 10288 10289
(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.	10290 10291 10292
Sec. 3701.881. (A) As used in this section:	10293
(1) "Applicant" means both of the following:	10294
(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;	10295 10296 10297
(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.	10298 10299 10300 10301 10302 10303 10304
(2) "Criminal records check" and "older adult" have the same meanings as in section 109.572 of the Revised Code.	10305 10306
(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:	10307 10308 10309 10310 10311

(a) Skilled nursing care;	10312
(b) Physical therapy;	10313
(c) Speech-language pathology;	10314
(d) Occupational therapy;	10315
(e) Medical social services;	10316
(f) Home health aide services.	10317
(4) "Home health aide services" means any of the following	10318
services provided by an individual employed with or contracted for	10319
by a home health agency:	10320
(a) Hands-on bathing or assistance with a tub bath or shower;	10321
(b) Assistance with dressing, ambulation, and toileting;	10322
(c) Catheter care but not insertion;	10323
(d) Meal preparation and feeding.	10324
(5) "Hospice care program" has the same meaning as in section	10325
3712.01 of the Revised Code.	10326
(6) "Medical social services" means services provided by a	10327
social worker under the direction of a patient's attending	10328
physician.	10329
(7) "Minor drug possession offense" has the same meaning as	10330
in section 2925.01 of the Revised Code.	10331
(8) "Nursing home," "residential care facility," and "skilled	10332
nursing care" have the same meanings as in section 3721.01 of the	10333
Revised Code.	10334
(9) "Occupational therapy" has the same meaning as in section	10335
4755.04 of the Revised Code.	10336
(10) "Physical therapy" has the same meaning as in section	10337
4755.40 of the Revised Code.	10338
(11) "Social worker" means a person licensed under Chapter	10339

4757. of the Revised Code to practice as a social worker or 10340
independent social worker. 10341

(12) "Speech-language pathology" has the same meaning as in 10342
section 4753.01 of the Revised Code. 10343

(B)(1) Except as provided in division (I) of this section, 10344
the chief administrator of a home health agency shall request the 10345
superintendent of the bureau of criminal identification and 10346
investigation to conduct a criminal records check with respect to 10347
each applicant. If the position may involve both responsibility 10348
for the care, custody, or control of a child and provision of 10349
direct care to an older adult, the chief administrator shall 10350
request that the superintendent conduct a single criminal records 10351
check for the applicant. If an applicant for whom a criminal 10352
records check request is required under this division does not 10353
present proof of having been a resident of this state for the 10354
five-year period immediately prior to the date upon which the 10355
criminal records check is requested or does not provide evidence 10356
that within that five-year period the superintendent has requested 10357
information about the applicant from the federal bureau of 10358
investigation in a criminal records check, the chief administrator 10359
shall request that the superintendent obtain information from the 10360
federal bureau of investigation as a part of the criminal records 10361
check for the applicant. Even if an applicant for whom a criminal 10362
records check request is required under this division presents 10363
proof that the applicant has been a resident of this state for 10364
that five-year period, the chief administrator may request that 10365
the superintendent include information from the federal bureau of 10366
investigation in the criminal records check. 10367

(2) Any person required by division (B)(1) of this section to 10368
request a criminal records check shall provide to each applicant 10369
for whom a criminal records check request is required under that 10370
division a copy of the form prescribed pursuant to division (C)(1) 10371

of section 109.572 of the Revised Code and a standard impression 10372
sheet prescribed pursuant to division (C)(2) of section 109.572 of 10373
the Revised Code, obtain the completed form and impression sheet 10374
from each applicant, and forward the completed form and impression 10375
sheet to the superintendent of the bureau of criminal 10376
identification and investigation at the time the chief 10377
administrator requests a criminal records check pursuant to 10378
division (B)(1) of this section. 10379

(3) An applicant who receives pursuant to division (B)(2) of 10380
this section a copy of the form prescribed pursuant to division 10381
(C)(1) of section 109.572 of the Revised Code and a copy of an 10382
impression sheet prescribed pursuant to division (C)(2) of that 10383
section and who is requested to complete the form and provide a 10384
set of fingerprint impressions shall complete the form or provide 10385
all the information necessary to complete the form and shall 10386
provide the impression sheets with the impressions of the 10387
applicant's fingerprints. If an applicant, upon request, fails to 10388
provide the information necessary to complete the form or fails to 10389
provide fingerprint impressions, the home health agency shall not 10390
employ that applicant for any position for which a criminal 10391
records check is required by division (B)(1) of this section. 10392

(C)(1) Except as provided in rules adopted by the department 10393
of health in accordance with division (F) of this section and 10394
subject to division (C)(3) of this section, no home health agency 10395
shall employ a person as a person responsible for the care, 10396
custody, or control of a child if the person previously has been 10397
convicted of or pleaded guilty to any of the following: 10398

(a) A violation of section 2903.01, 2903.02, 2903.03, 10399
2903.04, 2903.11, 2903.12, 2903.13, 2903.16, 2903.21, 2903.34, 10400
2905.01, 2905.02, 2905.05, 2907.02, 2907.03, 2907.04, 2907.05, 10401
2907.06, 2907.07, 2907.08, 2907.09, 2907.21, 2907.22, 2907.23, 10402
2907.25, 2907.31, 2907.32, 2907.321, 2907.322, 2907.323, 2911.01, 10403

2911.02, 2911.11, 2911.12, 2919.12, 2919.22, 2919.24, 2919.25, 10404
2923.12, 2923.13, 2923.161, 2925.02, 2925.03, 2925.04, 2925.05, 10405
2925.06, or 3716.11 of the Revised Code, a violation of section 10406
2905.04 of the Revised Code as it existed prior to July 1, 1996, a 10407
violation of section 2919.23 of the Revised Code that would have 10408
been a violation of section 2905.04 of the Revised Code as it 10409
existed prior to July 1, 1996, had the violation been committed 10410
prior to that date, a violation of section 2925.11 of the Revised 10411
Code that is not a minor drug possession offense, or felonious 10412
sexual penetration in violation of former section 2907.12 of the 10413
Revised Code; 10414

(b) A violation of an existing or former law of this state, 10415
any other state, or the United States that is substantially 10416
equivalent to any of the offenses listed in division (C)(1)(a) of 10417
this section. 10418

(2) Except as provided in rules adopted by the department of 10419
health in accordance with division (F) of this section and subject 10420
to division (C)(3) of this section, no home health agency shall 10421
employ a person in a position that involves providing direct care 10422
to an older adult if the person previously has been convicted of 10423
or pleaded guilty to any of the following: 10424

(a) A violation of section 2903.01, 2903.02, 2903.03, 10425
2903.04, 2903.11, 2903.12, 2903.13, 2903.16, 2903.21, 2903.34, 10426
2905.01, 2905.02, 2905.11, 2905.12, 2907.02, 2907.03, 2907.05, 10427
2907.06, 2907.07, 2907.08, 2907.09, 2907.12, 2907.25, 2907.31, 10428
2907.32, 2907.321, 2907.322, 2907.323, 2911.01, 2911.02, 2911.11, 10429
2911.12, 2911.13, 2913.02, 2913.03, 2913.04, 2913.11, 2913.21, 10430
2913.31, 2913.40, 2913.43, 2913.47, 2913.51, 2919.25, 2921.36, 10431
2923.12, 2923.13, 2923.161, 2925.02, 2925.03, 2925.11, 2925.13, 10432
2925.22, 2925.23, or 3716.11 of the Revised Code. 10433

(b) A violation of an existing or former law of this state, 10434
any other state, or the United States that is substantially 10435

equivalent to any of the offenses listed in division (C)(2)(a) of 10436
this section. 10437

(3)(a) A home health agency may employ conditionally an 10438
applicant for whom a criminal records check request is required 10439
under division (B) of this section as a person responsible for the 10440
care, custody, or control of a child until the criminal records 10441
check regarding the applicant required by this section is 10442
completed and the agency receives the results of the criminal 10443
records check. If the results of the criminal records check 10444
indicate that, pursuant to division (C)(1) of this section, the 10445
applicant does not qualify for employment, the agency shall 10446
release the applicant from employment unless the agency chooses to 10447
employ the applicant pursuant to division (F) of this section. 10448

(b)(i) A home health agency may employ conditionally an 10449
applicant for whom a criminal records check request is required 10450
under division (B) of this section in a position that involves 10451
providing direct care to an older adult or in a position that 10452
involves both responsibility for the care, custody, and control of 10453
a child and the provision of direct care to older adults prior to 10454
obtaining the results of a criminal records check regarding the 10455
individual, provided that the agency shall request a criminal 10456
records check regarding the individual in accordance with division 10457
(B)(1) of this section not later than five business days after the 10458
individual begins conditional employment. In the circumstances 10459
described in division (I)(2) of this section, a home health agency 10460
may employ conditionally in a position that involves providing 10461
direct care to an older adult an applicant who has been referred 10462
to the home health agency by an employment service that supplies 10463
full-time, part-time, or temporary staff for positions involving 10464
the direct care of older adults and for whom, pursuant to that 10465
division, a criminal records check is not required under division 10466
(B) of this section. In the circumstances described in division 10467

(I)(4) of this section, a home health agency may employ 10468
conditionally in a position that involves both responsibility for 10469
the care, custody, and control of a child and the provision of 10470
direct care to older adults an applicant who has been referred to 10471
the home health agency by an employment service that supplies 10472
full-time, part-time, or temporary staff for positions involving 10473
both responsibility for the care, custody, and control of a child 10474
and the provision of direct care to older adults and for whom, 10475
pursuant to that division, a criminal records check is not 10476
required under division (B) of this section. 10477

(ii) A home health agency that employs an individual 10478
conditionally under authority of division (C)(3)(b)(i) of this 10479
section shall terminate the individual's employment if the results 10480
of the criminal records check requested under division (B)(1) of 10481
this section or described in division (I)(2) or (4) of this 10482
section, other than the results of any request for information 10483
from the federal bureau of investigation, are not obtained within 10484
the period ending thirty days after the date the request is made. 10485
Regardless of when the results of the criminal records check are 10486
obtained, if the individual was employed conditionally in a 10487
position that involves the provision of direct care to older 10488
adults and the results indicate that the individual has been 10489
convicted of or pleaded guilty to any of the offenses listed or 10490
described in division (C)(2) of this section, or if the individual 10491
was employed conditionally in a position that involves both 10492
responsibility for the care, custody, and control of a child and 10493
the provision of direct care to older adults and the results 10494
indicate that the individual has been convicted of or pleaded 10495
guilty to any of the offenses listed or described in division 10496
(C)(1) or (2) of this section, the agency shall terminate the 10497
individual's employment unless the agency chooses to employ the 10498
individual pursuant to division (F) of this section. Termination 10499
of employment under this division shall be considered just cause 10500

for discharge for purposes of division (D)(2) of section 4141.29 10501
of the Revised Code if the individual makes any attempt to deceive 10502
the agency about the individual's criminal record. 10503

(D)(1) Each home health agency shall pay to the bureau of 10504
criminal identification and investigation the fee prescribed 10505
pursuant to division (C)(3) of section 109.572 of the Revised Code 10506
for each criminal records check conducted in accordance with that 10507
section upon the request pursuant to division (B)(1) of this 10508
section of the chief administrator of the home health agency. 10509

(2) A home health agency may charge an applicant a fee for 10510
the costs it incurs in obtaining a criminal records check under 10511
this section, unless the ~~medical assistance~~ medicaid program 10512
~~established under Chapter 5111. of the Revised Code~~ reimburses the 10513
agency for the costs. A fee charged under division (D)(2) of this 10514
section shall not exceed the amount of fees the agency pays under 10515
division (D)(1) of this section. If a fee is charged under 10516
division (D)(2) of this section, the agency shall notify the 10517
applicant at the time of the applicant's initial application for 10518
employment of the amount of the fee and that, unless the fee is 10519
paid, the agency will not consider the applicant for employment. 10520

(E) The report of any criminal records check conducted by the 10521
bureau of criminal identification and investigation in accordance 10522
with section 109.572 of the Revised Code and pursuant to a request 10523
made under division (B)(1) of this section is not a public record 10524
for the purposes of section 149.43 of the Revised Code and shall 10525
not be made available to any person other than the following: 10526

(1) The individual who is the subject of the criminal records 10527
check or the individual's representative; 10528

(2) The home health agency requesting the criminal records 10529
check or its representative; 10530

(3) The administrator of any other facility, agency, or 10531

program that provides direct care to older adults that is owned or 10532
operated by the same entity that owns or operates the home health 10533
agency; 10534

(4) Any court, hearing officer, or other necessary individual 10535
involved in a case dealing with a denial of employment of the 10536
applicant or dealing with employment or unemployment benefits of 10537
the applicant; 10538

(5) Any person to whom the report is provided pursuant to, 10539
and in accordance with, division (I)(1), (2), (3), or (4) of this 10540
section. 10541

(F) The department of health shall adopt rules in accordance 10542
with Chapter 119. of the Revised Code to implement this section. 10543
The rules shall specify circumstances under which the home health 10544
agency may employ a person who has been convicted of or pleaded 10545
guilty to an offense listed or described in division (C)(1) of 10546
this section but who meets standards in regard to rehabilitation 10547
set by the department or employ a person who has been convicted of 10548
or pleaded guilty to an offense listed or described in division 10549
(C)(2) of this section but meets personal character standards set 10550
by the department. 10551

(G) Any person required by division (B)(1) of this section to 10552
request a criminal records check shall inform each person, at the 10553
time of initial application for employment that the person is 10554
required to provide a set of fingerprint impressions and that a 10555
criminal records check is required to be conducted and 10556
satisfactorily completed in accordance with section 109.572 of the 10557
Revised Code if the person comes under final consideration for 10558
appointment or employment as a precondition to employment for that 10559
position. 10560

(H) In a tort or other civil action for damages that is 10561
brought as the result of an injury, death, or loss to person or 10562

property caused by an individual who a home health agency employs 10563
in a position that involves providing direct care to older adults, 10564
all of the following shall apply: 10565

(1) If the agency employed the individual in good faith and 10566
reasonable reliance on the report of a criminal records check 10567
requested under this section, the agency shall not be found 10568
negligent solely because of its reliance on the report, even if 10569
the information in the report is determined later to have been 10570
incomplete or inaccurate; 10571

(2) If the agency employed the individual in good faith on a 10572
conditional basis pursuant to division (C)(3)(b) of this section, 10573
the agency shall not be found negligent solely because it employed 10574
the individual prior to receiving the report of a criminal records 10575
check requested under this section; 10576

(3) If the agency in good faith employed the individual 10577
according to the personal character standards established in rules 10578
adopted under division (F) of this section, the agency shall not 10579
be found negligent solely because the individual prior to being 10580
employed had been convicted of or pleaded guilty to an offense 10581
listed or described in division (C)(1) or (2) of this section. 10582

(I)(1) The chief administrator of a home health agency is not 10583
required to request that the superintendent of the bureau of 10584
criminal identification and investigation conduct a criminal 10585
records check of an applicant for a position that involves the 10586
provision of direct care to older adults if the applicant has been 10587
referred to the agency by an employment service that supplies 10588
full-time, part-time, or temporary staff for positions involving 10589
the direct care of older adults and both of the following apply: 10590

(a) The chief administrator receives from the employment 10591
service or the applicant a report of the results of a criminal 10592
records check regarding the applicant that has been conducted by 10593

the superintendent within the one-year period immediately 10594
preceding the applicant's referral; 10595

(b) The report of the criminal records check demonstrates 10596
that the person has not been convicted of or pleaded guilty to an 10597
offense listed or described in division (C)(2) of this section, or 10598
the report demonstrates that the person has been convicted of or 10599
pleaded guilty to one or more of those offenses, but the home 10600
health agency chooses to employ the individual pursuant to 10601
division (F) of this section. 10602

(2) The chief administrator of a home health agency is not 10603
required to request that the superintendent of the bureau of 10604
criminal identification and investigation conduct a criminal 10605
records check of an applicant for a position that involves 10606
providing direct care to older adults and may employ the applicant 10607
conditionally in a position of that nature as described in this 10608
division, if the applicant has been referred to the agency by an 10609
employment service that supplies full-time, part-time, or 10610
temporary staff for positions involving the direct care of older 10611
adults and if the chief administrator receives from the employment 10612
service or the applicant a letter from the employment service that 10613
is on the letterhead of the employment service, dated, and signed 10614
by a supervisor or another designated official of the employment 10615
service and that states that the employment service has requested 10616
the superintendent to conduct a criminal records check regarding 10617
the applicant, that the requested criminal records check will 10618
include a determination of whether the applicant has been 10619
convicted of or pleaded guilty to any offense listed or described 10620
in division (C)(2) of this section, that, as of the date set forth 10621
on the letter, the employment service had not received the results 10622
of the criminal records check, and that, when the employment 10623
service receives the results of the criminal records check, it 10624
promptly will send a copy of the results to the home health 10625

agency. If a home health agency employs an applicant conditionally 10626
in accordance with this division, the employment service, upon its 10627
receipt of the results of the criminal records check, promptly 10628
shall send a copy of the results to the home health agency, and 10629
division (C)(3)(b) of this section applies regarding the 10630
conditional employment. 10631

(3) The chief administrator of a home health agency is not 10632
required to request that the superintendent of the bureau of 10633
criminal identification and investigation conduct a criminal 10634
records check of an applicant for a position that involves both 10635
responsibility for the care, custody, and control of a child and 10636
the provision of direct care to older adults if the applicant has 10637
been referred to the agency by an employment service that supplies 10638
full-time, part-time, or temporary staff for positions involving 10639
both responsibility for the care, custody, and control of a child 10640
and the provision of direct care to older adults and both of the 10641
following apply: 10642

(a) The chief administrator receives from the employment 10643
service or applicant a report of a criminal records check of the 10644
type described in division (I)(1)(a) of this section; 10645

(b) The report of the criminal records check demonstrates 10646
that the person has not been convicted of or pleaded guilty to an 10647
offense listed or described in division (C)(1) or (2) of this 10648
section, or the report demonstrates that the person has been 10649
convicted of or pleaded guilty to one or more of those offenses, 10650
but the home health agency chooses to employ the individual 10651
pursuant to division (F) of this section. 10652

(4) The chief administrator of a home health agency is not 10653
required to request that the superintendent of the bureau of 10654
criminal identification and investigation conduct a criminal 10655
records check of an applicant for a position that involves both 10656
responsibility for the care, custody, and control of a child and 10657

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 10689
facility, and the facility functions separately from a hospital's 10690
inpatient surgical service and from the offices of private 10691
physicians, podiatrists, and dentists. 10692

(b) Anesthesia is administered in the facility by an 10693
anesthesiologist or certified registered nurse anesthetist, and 10694
the facility functions separately from a hospital's inpatient 10695
surgical service and from the offices of private physicians, 10696
podiatrists, and dentists. 10697

(c) The facility applies to be certified by the United States 10698
centers for medicare and medicaid services as an ambulatory 10699
surgical center for purposes of reimbursement under Part B of the 10700
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. 10701
10702
10703

(d) The facility applies to be certified by a national 10704
accrediting body approved by the centers for medicare and medicaid 10705
services for purposes of deemed compliance with the conditions for 10706
participating in the medicare program as an ambulatory surgical 10707
center. 10708

(e) The facility bills or receives from any third-party 10709
payer, governmental health care program, or other person or 10710
government entity any ambulatory surgical facility fee that is 10711
billed or paid in addition to any fee for professional services. 10712

(f) The facility is held out to any person or government 10713
entity as an ambulatory surgical facility or similar facility by 10714
means of signage, advertising, or other promotional efforts. 10715

"Ambulatory surgical facility" does not include a hospital 10716
emergency department. 10717

(2) "Ambulatory surgical facility fee" means a fee for 10718
certain overhead costs associated with providing surgical services 10719

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 10749
establish quality standards for health care facilities. The 10750
standards may incorporate accreditation standards or other quality 10751
standards established by any entity recognized by the director. 10752

(C) Every ambulatory surgical facility shall require that 10753
each physician who practices at the facility comply with all 10754
relevant provisions in the Revised Code that relate to the 10755
obtaining of informed consent from a patient. 10756

(D) The director shall issue a license to each health care 10757
facility that makes application for a license and demonstrates to 10758
the director that it meets the quality standards established by 10759
the rules adopted under division (B) of this section and satisfies 10760
the informed consent compliance requirements specified in division 10761
(C) of this section. 10762

(E)(1) Except as provided in section 3702.301 of the Revised 10763
Code, no health care facility shall operate without a license 10764
issued under this section. 10765

(2) If the department of health finds that a physician who 10766
practices at a health care facility is not complying with any 10767
provision of the Revised Code related to the obtaining of informed 10768
consent from a patient, the department shall report its finding to 10769
the state medical board, the physician, and the health care 10770
facility. 10771

(3) This division does not create, and shall not be construed 10772
as creating, a new cause of action or substantive legal right 10773
against a health care facility and in favor of a patient who 10774
allegedly sustains harm as a result of the failure of the 10775
patient's physician to obtain informed consent from the patient 10776
prior to performing a procedure on or otherwise caring for the 10777
patient in the health care facility. 10778

(F) The rules adopted under division (B) of this section 10779

shall include all of the following: 10780

(1) Provisions governing application for, renewal, 10781
suspension, and revocation of a license under this section; 10782

(2) Provisions governing orders issued pursuant to section 10783
3702.32 of the Revised Code for a health care facility to cease 10784
its operations or to prohibit certain types of services provided 10785
by a health care facility; 10786

(3) Provisions governing the imposition under section 3702.32 10787
of the Revised Code of civil penalties for violations of this 10788
section or the rules adopted under this section, including a scale 10789
for determining the amount of the penalties. 10790

Sec. 3702.31. (A) The quality monitoring and inspection fund 10791
is hereby created in the state treasury. The director of health 10792
shall use the fund to administer and enforce this section and 10793
sections 3702.11 to 3702.20, 3702.30, 3702.301, and 3702.32 of the 10794
Revised Code and rules adopted pursuant to those sections. The 10795
director shall deposit in the fund any moneys collected pursuant 10796
to this section or section 3702.32 of the Revised Code. All 10797
investment earnings of the fund shall be credited to the fund. 10798

(B) The director of health shall adopt rules pursuant to 10799
Chapter 119. of the Revised Code establishing fees for both of the 10800
following: 10801

(1) Initial and renewal license applications submitted under 10802
section 3702.30 of the Revised Code. The fees established under 10803
division (B)(1) of this section shall not exceed the actual and 10804
necessary costs of performing the activities described in division 10805
(A) of this section. 10806

(2) Inspections conducted under section 3702.15 or 3702.30 of 10807
the Revised Code. The fees established under division (B)(2) of 10808
this section shall not exceed the actual and necessary costs 10809

incurred during an inspection, including any indirect costs 10810
incurred by the department for staff, salary, or other 10811
administrative costs. The director of health shall provide to each 10812
health care facility or provider inspected pursuant to section 10813
3702.15 or 3702.30 of the Revised Code a written statement of the 10814
fee. The statement shall itemize and total the costs incurred. 10815
Within fifteen days after receiving a statement from the director, 10816
the facility or provider shall forward the total amount of the fee 10817
to the director. 10818

(3) The fees described in divisions (B)(1) and (2) of this 10819
section shall meet both of the following requirements: 10820

(a) For each service described in section 3702.11 of the 10821
Revised Code, the fee shall not exceed one thousand seven hundred 10822
fifty dollars annually, except that the total fees charged to a 10823
health care provider under this section shall not exceed five 10824
thousand dollars annually. 10825

(b) The fee shall exclude any costs reimbursable by the 10826
United States centers for medicare and medicaid services as part 10827
of the certification process for the medicare program ~~established~~ 10828
~~under Title XVIII of the "Social Security Act," 79 Stat. 286~~ 10829
~~(1935), 42 U.S.C.A. 1395, as amended,~~ and the medicaid program 10830
~~established under Title XIX of the "Social Security Act," 79 Stat.~~ 10831
~~286 (1965), 42 U.S.C. 1396.~~ 10832

(4) The director shall not establish a fee for any service 10833
for which a licensure or inspection fee is paid by the health care 10834
provider to a state agency for the same or similar licensure or 10835
inspection. 10836

Sec. 3702.51. As used in sections 3702.51 to 3702.62 of the 10837
Revised Code: 10838

(A) "Applicant" means any person that submits an application 10839

for a certificate of need and who is designated in the application 10840
as the applicant. 10841

(B) "Person" means any individual, corporation, business 10842
trust, estate, firm, partnership, association, joint stock 10843
company, insurance company, government unit, or other entity. 10844

(C) "Certificate of need" means a written approval granted by 10845
the director of health to an applicant to authorize conducting a 10846
reviewable activity. 10847

(D) "Health service area" means a geographic region 10848
designated by the director of health under section 3702.58 of the 10849
Revised Code. 10850

(E) "Health service" means a clinically related service, such 10851
as a diagnostic, treatment, rehabilitative, or preventive service. 10852

(F) "Health service agency" means an agency designated to 10853
serve a health service area in accordance with section 3702.58 of 10854
the Revised Code. 10855

(G) "Health care facility" means: 10856

(1) A hospital registered under section 3701.07 of the 10857
Revised Code; 10858

(2) A nursing home licensed under section 3721.02 of the 10859
Revised Code, or by a political subdivision certified under 10860
section 3721.09 of the Revised Code; 10861

(3) A county home or a county nursing home as defined in 10862
section 5155.31 of the Revised Code that is certified under Title 10863
~~XVIII or XIX of the "Social Security Act," 49 Stat. 620 (1935), 42~~ 10864
~~U.S.C.A. 301, as amended~~ medicare program, or under the medicaid
program; 10865
10866

(4) A freestanding dialysis center; 10867

(5) A freestanding inpatient rehabilitation facility; 10868

- (6) An ambulatory surgical facility; 10869
- (7) A freestanding cardiac catheterization facility; 10870
- (8) A freestanding birthing center; 10871
- (9) A freestanding or mobile diagnostic imaging center; 10872
- (10) A freestanding radiation therapy center. 10873

A health care facility does not include the offices of 10874
private physicians and dentists whether for individual or group 10875
practice, residential facilities licensed under section 5123.19 of 10876
the Revised Code, or an institution for the sick that is operated 10877
exclusively for patients who use spiritual means for healing and 10878
for whom the acceptance of medical care is inconsistent with their 10879
religious beliefs, accredited by a national accrediting 10880
organization, exempt from federal income taxation under section 10881
501 of the Internal Revenue Code of 1986, 100 Stat. 2085, 26 10882
U.S.C.A. 1, as amended, and providing twenty-four hour nursing 10883
care pursuant to the exemption in division (E) of section 4723.32 10884
of the Revised Code from the licensing requirements of Chapter 10885
4723. of the Revised Code. 10886

(H) "Medical equipment" means a single unit of medical 10887
equipment or a single system of components with related functions 10888
that is used to provide health services. 10889

(I) "Third-party payer" means a health insuring corporation 10890
licensed under Chapter 1751. of the Revised Code, a health 10891
maintenance organization as defined in division (K) of this 10892
section, an insurance company that issues sickness and accident 10893
insurance in conformity with Chapter 3923. of the Revised Code, a 10894
state-financed health insurance program under Chapter 3701. or 10895
4123. ~~or 5111.~~ of the Revised Code, the medicaid program, or any 10896
self-insurance plan. 10897

(J) "Government unit" means the state and any county, 10898

municipal corporation, township, or other political subdivision of 10899
the state, or any department, division, board, or other agency of 10900
the state or a political subdivision. 10901

(K) "Health maintenance organization" means a public or 10902
private organization organized under the law of any state that is 10903
qualified under section 1310(d) of Title XIII of the "Public 10904
Health Service Act," 87 Stat. 931 (1973), 42 U.S.C. 300e-9. 10905

(L) "Existing health care facility" means either of the 10906
following: 10907

(1) A health care facility that is licensed or otherwise 10908
authorized to operate in this state in accordance with applicable 10909
law, is staffed and equipped to provide health care services, and 10910
is actively providing health services; 10911

(2) A health care facility that is licensed or has beds 10912
registered under section 3701.07 of the Revised Code as skilled 10913
nursing beds or long-term care beds and has provided services for 10914
at least three hundred sixty-five consecutive days within the 10915
twenty-four months immediately preceding the date a certificate of 10916
need application is filed with the director of health. 10917

(M) "State" means the state of Ohio, including, but not 10918
limited to, the general assembly, the supreme court, the offices 10919
of all elected state officers, and all departments, boards, 10920
offices, commissions, agencies, institutions, and other 10921
instrumentalities of the state of Ohio. "State" does not include 10922
political subdivisions. 10923

(N) "Political subdivision" means a municipal corporation, 10924
township, county, school district, and all other bodies corporate 10925
and politic responsible for governmental activities only in 10926
geographic areas smaller than that of the state to which the 10927
sovereign immunity of the state attaches. 10928

(O) "Affected person" means: 10929

(1) An applicant for a certificate of need, including an applicant whose application was reviewed comparatively with the application in question;	10930 10931 10932
(2) The person that requested the reviewability ruling in question;	10933 10934
(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;	10935 10936 10937 10938
(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;	10939 10940 10941
(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;	10942 10943 10944 10945
(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.	10946 10947 10948 10949
(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:	10950 10951 10952 10953
(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;	10954 10955 10956 10957
(2) Maintaining an active medical staff, the majority of which is comprised of osteopathic physicians;	10958 10959

(3) Maintaining a medical staff executive committee that has osteopathic physicians as a majority of its members.	10960 10961
(Q) "Ambulatory surgical facility" has the same meaning as in section 3702.30 of the Revised Code.	10962 10963
(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:	10964 10965 10966 10967
(1) The addition by any person of any of the following health services, regardless of the amount of operating costs or capital expenditures:	10968 10969 10970
(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;	10971 10972 10973 10974 10975 10976
(b) A cardiac catheterization service;	10977
(c) An open-heart surgery service;	10978
(d) Any new, experimental medical technology that is designated by rule of the public health council.	10979 10980
(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;	10981 10982 10983 10984 10985
(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;	10986 10987 10988
(b) The establishment, development, or construction of a new	10989

hospital or the relocation of an existing hospital;	10990
(c) The relocation of hospital beds, other than long-term care, perinatal, or pediatric intensive care beds, into or out of a rural area.	10991 10992 10993
(4)(a) The replacement of an existing hospital;	10994
(b) The replacement of an existing hospital obstetric or newborn care unit or freestanding birthing center.	10995 10996
(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:	10997 10998 10999 11000 11001
(i) When a contract enforceable under Ohio law is entered into for the construction, acquisition, lease, or financing of a capital asset;	11002 11003 11004
(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;	11005 11006 11007
(iii) In the case of donated property, on the date the gift is completed under applicable Ohio law.	11008 11009
(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.	11010 11011 11012 11013
(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;	11014 11015 11016 11017 11018 11019

- (7) Any of the following changes in perinatal bed capacity or 11020
pediatric intensive care bed capacity: 11021
- (a) An increase in bed capacity; 11022
- (b) A change in service or service-level designation of 11023
newborn care beds or obstetric beds in a hospital or freestanding 11024
birthing center, other than a change of service that is provided 11025
within the service-level designation of newborn care or obstetric 11026
beds as registered by the department of health; 11027
- (c) A relocation of perinatal or pediatric intensive care 11028
beds from one physical facility or site to another, excluding the 11029
relocation of beds within a hospital or freestanding birthing 11030
center or the relocation of beds among buildings of a hospital or 11031
freestanding birthing center at the same site. 11032
- (8) The expenditure of more than one hundred ten per cent of 11033
the maximum expenditure specified in a certificate of need; 11034
- (9) Any transfer of a certificate of need issued prior to 11035
April 20, 1995, from the person to whom it was issued to another 11036
person before the project that constitutes a reviewable activity 11037
is completed, any agreement that contemplates the transfer of a 11038
certificate of need issued prior to that date upon completion of 11039
the project, and any transfer of the controlling interest in an 11040
entity that holds a certificate of need issued prior to that date. 11041
However, the transfer of a certificate of need issued prior to 11042
that date or agreement to transfer such a certificate of need from 11043
the person to whom the certificate of need was issued to an 11044
affiliated or related person does not constitute a reviewable 11045
transfer of a certificate of need for the purposes of this 11046
division, unless the transfer results in a change in the person 11047
that holds the ultimate controlling interest in the certificate of 11048
need. 11049
- (10)(a) The acquisition by any person of any of the following 11050

medical equipment, regardless of the amount of operating costs or	11051
capital expenditure:	11052
(i) A cobalt radiation therapy unit;	11053
(ii) A linear accelerator;	11054
(iii) A gamma knife unit.	11055
(b) The acquisition by any person of medical equipment with a	11056
cost of two million dollars or more. The cost of acquiring medical	11057
equipment includes the sum of the following:	11058
(i) The greater of its fair market value or the cost of its	11059
lease or purchase;	11060
(ii) The cost of installation and any other activities	11061
essential to the acquisition of the equipment and its placement	11062
into service.	11063
(11) The addition of another cardiac catheterization	11064
laboratory to an existing cardiac catheterization service.	11065
(S) Except as provided in division (T) of this section,	11066
"reviewable activity" also means any of the following activities,	11067
none of which are subject to a termination date:	11068
(1) The establishment, development, or construction of a new	11069
long-term care facility;	11070
(2) The replacement of an existing long-term care facility;	11071
(3) The renovation of a long-term care facility that involves	11072
a capital expenditure of two million dollars or more, not	11073
including expenditures for equipment, staffing, or operational	11074
costs;	11075
(4) Any of the following changes in long-term care bed	11076
capacity:	11077
(a) An increase in bed capacity;	11078
(b) A relocation of beds from one physical facility or site	11079

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; 11080
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(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. 11083
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(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; 11086
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(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; 11092
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(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. 11095
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(T) "Reviewable activity" does not include any of the 11110

following activities:	11111
(1) Acquisition of computer hardware or software;	11112
(2) Acquisition of a telephone system;	11113
(3) Construction or acquisition of parking facilities;	11114
(4) Correction of cited deficiencies that are in violation of	11115
federal, state, or local fire, building, or safety laws and rules	11116
and that constitute an imminent threat to public health or safety;	11117
(5) Acquisition of an existing health care facility that does	11118
not involve a change in the number of the beds, by service, or in	11119
the number or type of health services;	11120
(6) Correction of cited deficiencies identified by	11121
accreditation surveys of the joint commission on accreditation of	11122
healthcare organizations or of the American osteopathic	11123
association;	11124
(7) Acquisition of medical equipment to replace the same or	11125
similar equipment for which a certificate of need has been issued	11126
if the replaced equipment is removed from service;	11127
(8) Mergers, consolidations, or other corporate	11128
reorganizations of health care facilities that do not involve a	11129
change in the number of beds, by service, or in the number or type	11130
of health services;	11131
(9) Construction, repair, or renovation of bathroom	11132
facilities;	11133
(10) Construction of laundry facilities, waste disposal	11134
facilities, dietary department projects, heating and air	11135
conditioning projects, administrative offices, and portions of	11136
medical office buildings used exclusively for physician services;	11137
(11) Acquisition of medical equipment to conduct research	11138
required by the United States food and drug administration or	11139
clinical trials sponsored by the national institute of health. Use	11140

of medical equipment that was acquired without a certificate of 11141
need under division (T)(11) of this section and for which 11142
premarket approval has been granted by the United States food and 11143
drug administration to provide services for which patients or 11144
reimbursement entities will be charged shall be a reviewable 11145
activity. 11146

(12) Removal of asbestos from a health care facility. 11147

Only that portion of a project that meets the requirements of 11148
division (T) of this section is not a reviewable activity. 11149

(U) "Small rural hospital" means a hospital that is located 11150
within a rural area, has fewer than one hundred beds, and to which 11151
fewer than four thousand persons were admitted during the most 11152
recent calendar year. 11153

(V) "Children's hospital" means any of the following: 11154

(1) A hospital registered under section 3701.07 of the 11155
Revised Code that provides general pediatric medical and surgical 11156
care, and in which at least seventy-five per cent of annual 11157
inpatient discharges for the preceding two calendar years were 11158
individuals less than eighteen years of age; 11159

(2) A distinct portion of a hospital registered under section 11160
3701.07 of the Revised Code that provides general pediatric 11161
medical and surgical care, has a total of at least one hundred 11162
fifty registered pediatric special care and pediatric acute care 11163
beds, and in which at least seventy-five per cent of annual 11164
inpatient discharges for the preceding two calendar years were 11165
individuals less than eighteen years of age; 11166

(3) A distinct portion of a hospital, if the hospital is 11167
registered under section 3701.07 of the Revised Code as a 11168
children's hospital and the children's hospital meets all the 11169
requirements of division (V)(1) of this section. 11170

(W) "Long-term care facility" means any of the following:	11171
(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;	11172 11173 11174
(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";	11175 11176 11177 11178
(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.	11179 11180 11181
(X) "Long-term care bed" means a bed in a long-term care facility.	11182 11183
(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.	11184 11185 11186 11187
(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.	11188 11189 11190 11191 11192 11193
(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.	11194 11195 11196 11197
(2) "Nonreviewability ruling" means a ruling issued under that division that a particular proposed project is not a reviewable activity.	11198 11199 11200

(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 11231
with such beds given the historical pattern of the applicant 11232
hospital's documented difficulty in placing skilled nursing 11233
patients. 11234

(B) To assist the director of health in monitoring the use of 11235
hospital beds recategorized as skilled nursing beds after August 11236
5, 1989, the public health council shall adopt rules specifying 11237
appropriate quarterly procedures for reporting to the department 11238
of health. 11239

(C) A patient may stay in a hospital bed that, after August 11240
5, 1989, has been recategorized as a skilled nursing bed for more 11241
than thirty days if the hospital is able to demonstrate that it 11242
made a good faith effort to place the patient in an accessible 11243
skilled nursing facility acceptable to the patient within the 11244
thirty-day period, but was unable to do so. 11245

(D) No hospital bed recategorized after August 5, 1989, as a 11246
skilled nursing bed shall be covered by a provider agreement under 11247
the ~~medical assistance~~ medicaid program ~~established under Chapter~~ 11248
~~5111. of the Revised Code.~~ 11249

(E) Nothing in this section requires a hospital to place a 11250
patient in any nursing home if the patient does not wish to be 11251
placed in the nursing home. Nothing in this section limits the 11252
ability of a hospital to file a certificate of need application 11253
for the addition of long-term care beds that meet the definition 11254
of "home" in section 3721.01 of the Revised Code. Nothing in this 11255
section limits the ability of the director to grant certificates 11256
of need necessary for hospitals to engage in demonstration 11257
projects authorized by the federal government for the purpose of 11258
enhancing long-term quality of care and cost containment. Nothing 11259
in this section limits the ability of hospitals to develop swing 11260
bed programs in accordance with federal regulations. 11261

No hospital that is granted a certificate of need after 11262
August 5, 1989, to recategorize hospital beds as skilled nursing 11263
beds is subject to sections 3721.01 to 3721.09 of the Revised 11264
Code. If the portion of the hospital in which the recategorized 11265
beds are located is certified as a skilled nursing facility under 11266
~~Title XVIII of the "Social Security Act," 49 Stat. 620 (1935), 42~~ 11267
~~U.S.C.A. 301, as amended~~ medicare program, that portion of the 11268
hospital is subject to sections 3721.10 to 3721.17 and sections 11269
3721.21 to 3721.34 of the Revised Code. If the beds are registered 11270
pursuant to section 3701.07 of the Revised Code as long-term care 11271
beds, the beds are subject to sections ~~3721.50~~ 5166.20 to ~~3721.58~~ 11272
5166.30 of the Revised Code. 11273

(F) The public health council shall adopt rules authorizing 11274
the creation of one or more nursing home placement clearinghouses. 11275
Any public or private agency or facility may apply to the 11276
department of health to serve as a nursing home placement 11277
clearinghouse, and the rules shall provide the procedure for 11278
application and process for designation of clearinghouses. 11279

The department may approve one or more clearinghouses, but in 11280
no event shall there be more than one nursing home placement 11281
clearinghouse in each county. Any nursing home may list with a 11282
nursing home placement clearinghouse the services it provides and 11283
the types of patients it is approved for and equipped to serve. 11284
The clearinghouse shall make reasonable efforts to update its 11285
information at least every six months. 11286

If an appropriate clearinghouse has been designated, each 11287
hospital granted a certificate of need after August 5, 1989, to 11288
recategorize hospital beds as skilled nursing beds shall, and any 11289
other hospital may, utilize the nursing home placement 11290
clearinghouse prior to admitting a patient to a skilled nursing 11291
bed within the hospital and prior to keeping a patient in a 11292
skilled nursing bed within a hospital in excess of thirty days. 11293

The department shall provide at least annually to all 11294
hospitals a list of the designated nursing home placement 11295
clearinghouses. 11296

Sec. 3702.62. (A) Any action pursuant to section 140.03, 11297
140.04, 140.05, 307.091, 313.21, 339.01, 339.021, 339.03, 339.06, 11298
339.08, 339.09, 339.12, 339.14, 513.05, 513.07, 513.08, 513.081, 11299
513.12, 513.15, 513.17, 513.171, 749.02, 749.03, 749.14, 749.16, 11300
749.20, 749.25, 749.28, 749.35, 1751.06, or 3707.29 of the Revised 11301
Code shall be taken in accordance with sections 3702.51 to 3702.61 11302
of the Revised Code. 11303

(B) A nursing home certified as an intermediate care facility 11304
for the mentally retarded under ~~Title XIX of the "Social Security~~ 11305
~~Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended~~ medicaid 11306
program, that is required to apply for licensure as a residential 11307
facility under section 5123.19 of the Revised Code is not, with 11308
respect to the portion of the home certified as an intermediate 11309
care facility for the mentally retarded, subject to sections 11310
3702.51 to 3702.61 of the Revised Code. 11311

Sec. 3702.63. As specified in former Section 11 of Am. Sub. 11312
S.B. 50 of the 121st general assembly, as amended by Am. Sub. H.B. 11313
405 of the 124th general assembly, all of the following apply: 11314

(A) The removal of former divisions (E) and (F) of section 11315
3702.52 of the Revised Code by Sections 1 and 2 of Am. Sub. S.B. 11316
50 of the 121st general assembly does not release the holders of 11317
certificates of need issued under those divisions from complying 11318
with any conditions on which the granting of the certificates of 11319
need was based, including the requirement of former division 11320
(E)(6) of that section that the holders not enter into medicaid 11321
provider agreements ~~under Chapter 5111. of the Revised Code and~~ 11322
~~Title XIX of the "Social Security Act," 49 Stat. 620 (1935), 42~~ 11323

~~U.S.C. 301, as amended,~~ for at least ten years following initial 11324
licensure of the long-term care facilities for which the 11325
certificates were granted. 11326

(B) The repeal of section 3702.55 of the Revised Code by 11327
Section 2 of Am. Sub. S.B. 50 of the 121st general assembly does 11328
not release the holders of certificates of need issued under that 11329
section from complying with any conditions on which the granting 11330
of the certificates of need was based, other than the requirement 11331
of division (A)(6) of that section that the holders not seek 11332
certification under ~~Title XVIII of the "Social Security Act"~~ 11333
medicare program for beds recategorized under the certificates. 11334
That repeal also does not eliminate the requirement that the 11335
director of health revoke the licensure of the beds under Chapter 11336
3721. of the Revised Code if a person to which their ownership is 11337
transferred fails, as required by division (A)(6) of the repealed 11338
section, to file within ten days after the transfer a sworn 11339
statement not to seek certification under ~~Title XIX of the "Social~~ 11340
~~Security Act"~~ the medicaid program for beds recategorized under 11341
the certificates of need. 11342

(C) The repeal of section 3702.56 of the Revised Code by 11343
Section 2 of Am. Sub. S.B. 50 of the 121st general assembly does 11344
not release the holders of certificates of need issued under that 11345
section from complying with any conditions on which the granting 11346
of the certificates of need was based. 11347

Sec. 3702.74. (A) A primary care physician who has signed a 11348
letter of intent under section 3702.73 of the Revised Code, the 11349
director of health, and the Ohio board of regents may enter into a 11350
contract for the physician's participation in the physician loan 11351
repayment program. A lending institution may also be a party to 11352
the contract. 11353

(B) The contract shall include all of the following 11354

obligations: 11355

(1) The primary care physician agrees to provide primary care 11356
services in the health resource shortage area identified in the 11357
letter of intent for at least two years or one year per twenty 11358
thousand dollars of repayment agreed to under division (B)(3) of 11359
this section, whichever is greater; 11360

(2) When providing primary care services in the health 11361
resource shortage area, the primary care physician agrees to do 11362
all of the following: 11363

(a) Provide primary care services for a minimum of forty 11364
hours per week; 11365

(b) Provide primary care services without regard to a 11366
patient's ability to pay; 11367

(c) Meet the conditions ~~prescribed by the "Social Security~~ 11368
~~Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended, and the~~ 11369
~~department of job and family services for participation in the~~ 11370
~~medical assistance medicaid program established under Chapter~~ 11371
~~5111. of the Revised Code~~ and enter into a contract with the 11372
department of health care administration to provide primary care 11373
services to medicaid recipients ~~of the medical assistance program;~~ 11374

(d) Meet the conditions established by the department of job 11375
and family services for participation in the disability medical 11376
assistance program ~~established under Chapter 5115. of the Revised~~ 11377
~~Code~~ and enter into a contract with the department to provide 11378
primary care services to recipients of disability medical 11379
assistance. 11380

(3) The Ohio board of regents agrees, as provided in section 11381
3702.75 of the Revised Code, to repay, so long as the primary care 11382
physician performs the service obligation agreed to under division 11383
(B)(1) of this section, all or part of the principal and interest 11384
of a government or other educational loan taken by the primary 11385

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. 11416

(2) When providing dental services in the dental health 11417
resource shortage area, the individual agrees to do all of the 11418
following: 11419

(a) Provide dental services for a minimum of forty hours per 11420
week; 11421

(b) Provide dental services without regard to a patient's 11422
ability to pay; 11423

(c) Meet the conditions ~~prescribed by the "Social Security~~ 11424
~~Act," 49 Stat. 620 (1935), 42 U.S.C. 301, as amended, and the~~ 11425
~~department of job and family services~~ for participation in the 11426
medicaid program ~~established under Chapter 5111. of the Revised~~ 11427
Code and enter into a contract with the department of health care 11428
administration to provide dental services to medicaid recipients. 11429

(3) The Ohio board of regents agrees, as provided in section 11430
3702.85 of the Revised Code, to repay, so long as the individual 11431
performs the service obligation agreed to under division (B)(1) of 11432
this section, all or part of the principal and interest of a 11433
government or other educational loan taken by the individual for 11434
expenses described in section 3702.85 of the Revised Code up to 11435
but not exceeding twenty thousand dollars per year of service. 11436

(4) The individual agrees to pay the board the following as 11437
damages if the individual fails to complete the service obligation 11438
agreed to under division (B)(1) of this section: 11439

(a) If the failure occurs during the first two years of the 11440
service obligation, three times the total amount the board has 11441
agreed to repay under division (B)(3) of this section; 11442

(b) If the failure occurs after the first two years of the 11443
service obligation, three times the amount the board is still 11444
obligated to repay under division (B)(3) of this section. 11445

(C) The contract may include any other terms agreed upon by 11446
the parties, including an assignment to the Ohio board of regents 11447
of the individual's duty to pay the principal and interest of a 11448
government or other educational loan taken by the individual for 11449
expenses described in section 3702.85 of the Revised Code. If the 11450
board assumes the individual's duty to pay a loan, the contract 11451
shall set forth the total amount of principal and interest to be 11452
paid, an amortization schedule, and the amount of each payment to 11453
be made under the schedule. 11454

(D) Not later than the thirty-first day of January of each 11455
year, the Ohio board of regents shall mail to each individual to 11456
whom or on whose behalf repayment is made under the dentist loan 11457
repayment program a statement showing the amount of principal and 11458
interest repaid by the board pursuant to the contract in the 11459
preceding year. The statement shall be sent by ordinary mail with 11460
address correction and forwarding requested in the manner 11461
prescribed by the United States postal service. 11462

Sec. 3712.07. (A) As used in this section, "terminal care 11463
facility for the homeless" means a facility that provides 11464
accommodations to homeless individuals who are terminally ill. 11465

(B) A person or public agency licensed under this chapter to 11466
provide a hospice care program may enter into an agreement with a 11467
terminal care facility for the homeless under which hospice care 11468
program services may be provided to individuals residing at the 11469
facility, if all of the following apply: 11470

(1) Each resident of the facility has been diagnosed by a 11471
physician as having a terminal condition and an anticipated life 11472
expectancy of six months or less; 11473

(2) No resident of the facility has a relative or other 11474
person willing or capable of providing the care necessary to cope 11475
with ~~his~~ the resident's terminal illness or is financially capable 11476

of hiring a person to provide such care; 11477

(3) Each resident of the facility is under the direct care of 11478
a physician; 11479

(4) No resident of the facility requires the staff of the 11480
facility to administer medication by injection; 11481

(5) The facility does not receive any remuneration, directly 11482
or indirectly, from the residents; 11483

(6) The facility does not receive any remuneration, directly 11484
or indirectly, from the ~~medical assistance~~ medicaid program 11485
~~established under section 5111.01 of the Revised Code or the~~ 11486
~~medicare program established under Title XVIII of the "Social~~ 11487
~~Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended;~~ 11488

(7) The facility meets all applicable state and federal 11489
health and safety standards, including standards for fire 11490
prevention, maintenance of safe and sanitary conditions, and 11491
proper preparation and storage of foods. 11492

(C) Hospice care program services may be provided at a 11493
terminal care facility for the homeless only by the personnel of 11494
the person or public agency that has entered into an agreement 11495
with the facility under this section. 11496

(D) A terminal care facility for the homeless that has 11497
entered into an agreement under this section may assist its 11498
residents with the self-administration of medication if the 11499
medication has been prescribed by a physician and is not 11500
administered by injection. In the event that a resident has 11501
entered the final stages of dying and is no longer mentally alert, 11502
the facility may administer medication to that resident if the 11503
medication has been prescribed by a physician and is not 11504
administered by injection. Determinations of whether an individual 11505
has entered the final stages of dying and is no longer mentally 11506
alert shall be based on directions from the personnel who provide 11507

hospice care program services at the facility. 11508

Sec. 3712.09. (A) As used in this section: 11509

(1) "Applicant" means a person who is under final 11510
consideration for employment with a hospice care program in a 11511
full-time, part-time, or temporary position that involves 11512
providing direct care to an older adult. "Applicant" does not 11513
include a person who provides direct care as a volunteer without 11514
receiving or expecting to receive any form of remuneration other 11515
than reimbursement for actual expenses. 11516

(2) "Criminal records check" and "older adult" have the same 11517
meanings as in section 109.572 of the Revised Code. 11518

(B)(1) Except as provided in division (I) of this section, 11519
the chief administrator of a hospice care program shall request 11520
that the superintendent of the bureau of criminal identification 11521
and investigation conduct a criminal records check with respect to 11522
each applicant. If an applicant for whom a criminal records check 11523
request is required under this division does not present proof of 11524
having been a resident of this state for the five-year period 11525
immediately prior to the date the criminal records check is 11526
requested or provide evidence that within that five-year period 11527
the superintendent has requested information about the applicant 11528
from the federal bureau of investigation in a criminal records 11529
check, the chief administrator shall request that the 11530
superintendent obtain information from the federal bureau of 11531
investigation as part of the criminal records check of the 11532
applicant. Even if an applicant for whom a criminal records check 11533
request is required under this division presents proof of having 11534
been a resident of this state for the five-year period, the chief 11535
administrator may request that the superintendent include 11536
information from the federal bureau of investigation in the 11537
criminal records check. 11538

(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, 11570
any other state, or the United States that is substantially 11571
equivalent to any of the offenses listed in division (C)(1)(a) of 11572
this section. 11573

(2)(a) A hospice care program may employ conditionally an 11574
applicant for whom a criminal records check request is required 11575
under division (B) of this section prior to obtaining the results 11576
of a criminal records check regarding the individual, provided 11577
that the program shall request a criminal records check regarding 11578
the individual in accordance with division (B)(1) of this section 11579
not later than five business days after the individual begins 11580
conditional employment. In the circumstances described in division 11581
(I)(2) of this section, a hospice care program may employ 11582
conditionally an applicant who has been referred to the hospice 11583
care program by an employment service that supplies full-time, 11584
part-time, or temporary staff for positions involving the direct 11585
care of older adults and for whom, pursuant to that division, a 11586
criminal records check is not required under division (B) of this 11587
section. 11588

(b) A hospice care program that employs an individual 11589
conditionally under authority of division (C)(2)(a) of this 11590
section shall terminate the individual's employment if the results 11591
of the criminal records check requested under division (B) of this 11592
section or described in division (I)(2) of this section, other 11593
than the results of any request for information from the federal 11594
bureau of investigation, are not obtained within the period ending 11595
thirty days after the date the request is made. Regardless of when 11596
the results of the criminal records check are obtained, if the 11597
results indicate that the individual has been convicted of or 11598
pleaded guilty to any of the offenses listed or described in 11599
division (C)(1) of this section, the program shall terminate the 11600
individual's employment unless the program chooses to employ the 11601

individual pursuant to division (F) of this section. Termination 11602
of employment under this division shall be considered just cause 11603
for discharge for purposes of division (D)(2) of section 4141.29 11604
of the Revised Code if the individual makes any attempt to deceive 11605
the program about the individual's criminal record. 11606

(D)(1) Each hospice care program shall pay to the bureau of 11607
criminal identification and investigation the fee prescribed 11608
pursuant to division (C)(3) of section 109.572 of the Revised Code 11609
for each criminal records check conducted pursuant to a request 11610
made under division (B) of this section. 11611

(2) A hospice care program may charge an applicant a fee not 11612
exceeding the amount the program pays under division (D)(1) of 11613
this section. A program may collect a fee only if both of the 11614
following apply: 11615

(a) The program notifies the person at the time of initial 11616
application for employment of the amount of the fee and that, 11617
unless the fee is paid, the person will not be considered for 11618
employment; 11619

(b) The ~~medical assistance~~ medicaid program ~~established under~~ 11620
~~Chapter 5111. of the Revised Code~~ does not reimburse the program 11621
the fee it pays under division (D)(1) of this section. 11622

(E) The report of a criminal records check conducted pursuant 11623
to a request made under this section is not a public record for 11624
the purposes of section 149.43 of the Revised Code and shall not 11625
be made available to any person other than the following: 11626

(1) The individual who is the subject of the criminal records 11627
check or the individual's representative; 11628

(2) The chief administrator of the program requesting the 11629
criminal records check or the administrator's representative; 11630

(3) The administrator of any other facility, agency, or 11631

program that provides direct care to older adults that is owned or 11632
operated by the same entity that owns or operates the hospice care 11633
program; 11634

(4) A court, hearing officer, or other necessary individual 11635
involved in a case dealing with a denial of employment of the 11636
applicant or dealing with employment or unemployment benefits of 11637
the applicant; 11638

(5) Any person to whom the report is provided pursuant to, 11639
and in accordance with, division (I)(1) or (2) of this section. 11640

(F) The public health council shall adopt rules in accordance 11641
with Chapter 119. of the Revised Code to implement this section. 11642
The rules shall specify circumstances under which a hospice care 11643
program may employ a person who has been convicted of or pleaded 11644
guilty to an offense listed or described in division (C)(1) of 11645
this section but meets personal character standards set by the 11646
council. 11647

(G) The chief administrator of a hospice care program shall 11648
inform each individual, at the time of initial application for a 11649
position that involves providing direct care to an older adult, 11650
that the individual is required to provide a set of fingerprint 11651
impressions and that a criminal records check is required to be 11652
conducted if the individual comes under final consideration for 11653
employment. 11654

(H) In a tort or other civil action for damages that is 11655
brought as the result of an injury, death, or loss to person or 11656
property caused by an individual who a hospice care program 11657
employs in a position that involves providing direct care to older 11658
adults, all of the following shall apply: 11659

(1) If the program employed the individual in good faith and 11660
reasonable reliance on the report of a criminal records check 11661
requested under this section, the program shall not be found 11662

negligent solely because of its reliance on the report, even if 11663
the information in the report is determined later to have been 11664
incomplete or inaccurate; 11665

(2) If the program employed the individual in good faith on a 11666
conditional basis pursuant to division (C)(2) of this section, the 11667
program shall not be found negligent solely because it employed 11668
the individual prior to receiving the report of a criminal records 11669
check requested under this section; 11670

(3) If the program in good faith employed the individual 11671
according to the personal character standards established in rules 11672
adopted under division (F) of this section, the program shall not 11673
be found negligent solely because the individual prior to being 11674
employed had been convicted of or pleaded guilty to an offense 11675
listed or described in division (C)(1) of this section. 11676

(I)(1) The chief administrator of a hospice care program is 11677
not required to request that the superintendent of the bureau of 11678
criminal identification and investigation conduct a criminal 11679
records check of an applicant if the applicant has been referred 11680
to the program by an employment service that supplies full-time, 11681
part-time, or temporary staff for positions involving the direct 11682
care of older adults and both of the following apply: 11683

(a) The chief administrator receives from the employment 11684
service or the applicant a report of the results of a criminal 11685
records check regarding the applicant that has been conducted by 11686
the superintendent within the one-year period immediately 11687
preceding the applicant's referral; 11688

(b) The report of the criminal records check demonstrates 11689
that the person has not been convicted of or pleaded guilty to an 11690
offense listed or described in division (C)(1) of this section, or 11691
the report demonstrates that the person has been convicted of or 11692
pleaded guilty to one or more of those offenses, but the hospice 11693

care program chooses to employ the individual pursuant to division 11694
(F) of this section. 11695

(2) The chief administrator of a hospice care program is not 11696
required to request that the superintendent of the bureau of 11697
criminal identification and investigation conduct a criminal 11698
records check of an applicant and may employ the applicant 11699
conditionally as described in this division, if the applicant has 11700
been referred to the program by an employment service that 11701
supplies full-time, part-time, or temporary staff for positions 11702
involving the direct care of older adults and if the chief 11703
administrator receives from the employment service or the 11704
applicant a letter from the employment service that is on the 11705
letterhead of the employment service, dated, and signed by a 11706
supervisor or another designated official of the employment 11707
service and that states that the employment service has requested 11708
the superintendent to conduct a criminal records check regarding 11709
the applicant, that the requested criminal records check will 11710
include a determination of whether the applicant has been 11711
convicted of or pleaded guilty to any offense listed or described 11712
in division (C)(1) of this section, that, as of the date set forth 11713
on the letter, the employment service had not received the results 11714
of the criminal records check, and that, when the employment 11715
service receives the results of the criminal records check, it 11716
promptly will send a copy of the results to the hospice care 11717
program. If a hospice care program employs an applicant 11718
conditionally in accordance with this division, the employment 11719
service, upon its receipt of the results of the criminal records 11720
check, promptly shall send a copy of the results to the hospice 11721
care program, and division (C)(2)(b) of this section applies 11722
regarding the conditional employment. 11723

Sec. 3721.01. (A) As used in sections 3721.01 to 3721.09 and 11724
3721.99 of the Revised Code: 11725

(1)(a) "Home" means an institution, residence, or facility 11726
that provides, for a period of more than twenty-four hours, 11727
whether for a consideration or not, accommodations to three or 11728
more unrelated individuals who are dependent upon the services of 11729
others, including a nursing home, residential care facility, home 11730
for the aging, and a veterans' home operated under Chapter 5907. 11731
of the Revised Code. 11732

(b) "Home" also means both of the following: 11733

(i) Any facility that a person, as defined in section 3702.51 11734
of the Revised Code, proposes for certification as a skilled 11735
nursing facility ~~or nursing facility~~ under ~~Title XVIII or XIX of~~ 11736
the ~~"Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301,~~ 11737
~~as amended~~ medicare program, or as a nursing facility under the 11738
medicaid program and for which a certificate of need, other than a 11739
certificate to recategorize hospital beds as described in section 11740
3702.522 of the Revised Code or division (R)(7)(d) of the version 11741
of section 3702.51 of the Revised Code in effect immediately prior 11742
to April 20, 1995, has been granted to the person under sections 11743
3702.51 to 3702.62 of the Revised Code after August 5, 1989; 11744

(ii) A county home or district home that is or has been 11745
licensed as a residential care facility. 11746

(c) "Home" does not mean any of the following: 11747

(i) Except as provided in division (A)(1)(b) of this section, 11748
a public hospital or hospital as defined in section 3701.01 or 11749
5122.01 of the Revised Code; 11750

(ii) A residential facility for mentally ill persons as 11751
defined under section 5119.22 of the Revised Code; 11752

(iii) A residential facility as defined in section 5123.19 of 11753
the Revised Code; 11754

(iv) A community alternative home as defined in section 11755

3724.01 of the Revised Code;	11756
(v) An adult care facility as defined in section 3722.01 of the Revised Code;	11757 11758
(vi) An alcohol or drug addiction program as defined in section 3793.01 of the Revised Code;	11759 11760
(vii) A facility licensed to provide methadone treatment under section 3793.11 of the Revised Code;	11761 11762
(viii) A facility providing services under contract with the department of mental retardation and developmental disabilities under section 5123.18 of the Revised Code;	11763 11764 11765
(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;	11766 11767 11768
(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 <u>medical assistance medicaid</u> 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;	11769 11770 11771 11772 11773 11774 11775 11776 11777 11778
(xi) A county home or district home that has never been licensed as a residential care facility.	11779 11780
(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.	11781 11782 11783 11784 11785

(3) "Mental impairment" does not mean mental illness as 11786
defined in section 5122.01 of the Revised Code or mental 11787
retardation as defined in section 5123.01 of the Revised Code. 11788

(4) "Skilled nursing care" means procedures that require 11789
technical skills and knowledge beyond those the untrained person 11790
possesses and that are commonly employed in providing for the 11791
physical, mental, and emotional needs of the ill or otherwise 11792
incapacitated. "Skilled nursing care" includes, but is not limited 11793
to, the following: 11794

(a) Irrigations, catheterizations, application of dressings, 11795
and supervision of special diets; 11796

(b) Objective observation of changes in the patient's 11797
condition as a means of analyzing and determining the nursing care 11798
required and the need for further medical diagnosis and treatment; 11799

(c) Special procedures contributing to rehabilitation; 11800

(d) Administration of medication by any method ordered by a 11801
physician, such as hypodermically, rectally, or orally, including 11802
observation of the patient after receipt of the medication; 11803

(e) Carrying out other treatments prescribed by the physician 11804
that involve a similar level of complexity and skill in 11805
administration. 11806

(5)(a) "Personal care services" means services including, but 11807
not limited to, the following: 11808

(i) Assisting residents with activities of daily living; 11809

(ii) Assisting residents with self-administration of 11810
medication, in accordance with rules adopted under section 3721.04 11811
of the Revised Code; 11812

(iii) Preparing special diets, other than complex therapeutic 11813
diets, for residents pursuant to the instructions of a physician 11814
or a licensed dietitian, in accordance with rules adopted under 11815

section 3721.04 of the Revised Code. 11816

(b) "Personal care services" does not include "skilled 11817
nursing care" as defined in division (A)(4) of this section. A 11818
facility need not provide more than one of the services listed in 11819
division (A)(5)(a) of this section to be considered to be 11820
providing personal care services. 11821

(6) "Nursing home" means a home used for the reception and 11822
care of individuals who by reason of illness or physical or mental 11823
impairment require skilled nursing care and of individuals who 11824
require personal care services but not skilled nursing care. A 11825
nursing home is licensed to provide personal care services and 11826
skilled nursing care. 11827

(7) "Residential care facility" means a home that provides 11828
either of the following: 11829

(a) Accommodations for seventeen or more unrelated 11830
individuals and supervision and personal care services for three 11831
or more of those individuals who are dependent on the services of 11832
others by reason of age or physical or mental impairment; 11833

(b) Accommodations for three or more unrelated individuals, 11834
supervision and personal care services for at least three of those 11835
individuals who are dependent on the services of others by reason 11836
of age or physical or mental impairment, and, to at least one of 11837
those individuals, any of the skilled nursing care authorized by 11838
section 3721.011 of the Revised Code. 11839

(8) "Home for the aging" means a home that provides services 11840
as a residential care facility and a nursing home, except that the 11841
home provides its services only to individuals who are dependent 11842
on the services of others by reason of both age and physical or 11843
mental impairment. 11844

The part or unit of a home for the aging that provides 11845
services only as a residential care facility is licensed as a 11846

residential care facility. The part or unit that may provide 11847
skilled nursing care beyond the extent authorized by section 11848
3721.011 of the Revised Code is licensed as a nursing home. 11849

(9) "County home" and "district home" mean a county home or 11850
district home operated under Chapter 5155. of the Revised Code. 11851

(B) The public health council may further classify homes. For 11852
the purposes of this chapter, any residence, institution, hotel, 11853
congregate housing project, or similar facility that meets the 11854
definition of a home under this section is such a home regardless 11855
of how the facility holds itself out to the public. 11856

(C) For purposes of this chapter, personal care services or 11857
skilled nursing care shall be considered to be provided by a 11858
facility if they are provided by a person employed by or 11859
associated with the facility or by another person pursuant to an 11860
agreement to which neither the resident who receives the services 11861
nor the resident's sponsor is a party. 11862

(D) Nothing in division (A)(4) of this section shall be 11863
construed to permit skilled nursing care to be imposed on an 11864
individual who does not require skilled nursing care. 11865

Nothing in division (A)(5) of this section shall be construed 11866
to permit personal care services to be imposed on an individual 11867
who is capable of performing the activity in question without 11868
assistance. 11869

(E) Division (A)(1)(c)(x) of this section does not prohibit a 11870
facility, infirmary, or other entity described in that division 11871
from seeking licensure under sections 3721.01 to 3721.09 of the 11872
Revised Code or certification under Title XVIII or XIX of the 11873
"Social Security Act." However, such a facility, infirmary, or 11874
entity that applies for licensure or certification must meet the 11875
requirements of those sections or titles and the rules adopted 11876
under them and obtain a certificate of need from the director of 11877

health under section 3702.52 of the Revised Code. 11878

(F) Nothing in this chapter, or rules adopted pursuant to it, 11879
shall be construed as authorizing the supervision, regulation, or 11880
control of the spiritual care or treatment of residents or 11881
patients in any home who rely upon treatment by prayer or 11882
spiritual means in accordance with the creed or tenets of any 11883
recognized church or religious denomination. 11884

Sec. 3721.011. (A) In addition to providing accommodations, 11885
supervision, and personal care services to its residents, a 11886
residential care facility may provide skilled nursing care to its 11887
residents as follows: 11888

(1) Supervision of special diets; 11889

(2) Application of dressings, in accordance with rules 11890
adopted under section 3721.04 of the Revised Code; 11891

(3) Subject to division (B)(1) of this section, 11892
administration of medication; 11893

(4) Subject to division (C) of this section, other skilled 11894
nursing care provided on a part-time, intermittent basis for not 11895
more than a total of one hundred twenty days in a twelve-month 11896
period; 11897

(5) Subject to division (D) of this section, skilled nursing 11898
care provided for more than one hundred twenty days in a 11899
twelve-month period to a hospice patient, as defined in section 11900
3712.01 of the Revised Code. 11901

A residential care facility may not admit or retain an 11902
individual requiring skilled nursing care that is not authorized 11903
by this section. A residential care facility may not provide 11904
skilled nursing care beyond the limits established by this 11905
section. 11906

(B)(1) A residential care facility may admit or retain an 11907

individual requiring medication, including biologicals, only if 11908
the individual's personal physician has determined in writing that 11909
the individual is capable of self-administering the medication or 11910
the facility provides for the medication to be administered to the 11911
individual by a home health agency certified under ~~Title XVIII of~~ 11912
the ~~"Social Security Act," 79 Stat. 620 (1965), 42 U.S.C.A. 1395,~~ 11913
~~as amended~~ medicare program; a hospice care program licensed under 11914
Chapter 3712. of the Revised Code; or a member of the staff of the 11915
residential care facility who is qualified to perform medication 11916
administration. Medication may be administered in a residential 11917
care facility only by the following persons authorized by law to 11918
administer medication: 11919

(a) A registered nurse licensed under Chapter 4723. of the 11920
Revised Code; 11921

(b) A licensed practical nurse licensed under Chapter 4723. 11922
of the Revised Code who holds proof of successful completion of a 11923
course in medication administration approved by the board of 11924
nursing and who administers the medication only at the direction 11925
of a registered nurse or a physician authorized under Chapter 11926
4731. of the Revised Code to practice medicine and surgery or 11927
osteopathic medicine and surgery; 11928

(c) A medication aide certified under Chapter 4723. of the 11929
Revised Code; 11930

(d) A physician authorized under Chapter 4731. of the Revised 11931
Code to practice medicine and surgery or osteopathic medicine and 11932
surgery. 11933

(2) In assisting a resident with self-administration of 11934
medication, any member of the staff of a residential care facility 11935
may do the following: 11936

(a) Remind a resident when to take medication and watch to 11937
ensure that the resident follows the directions on the container; 11938

(b) Assist a resident by taking the medication from the 11939
locked area where it is stored, in accordance with rules adopted 11940
pursuant to section 3721.04 of the Revised Code, and handing it to 11941
the resident. If the resident is physically unable to open the 11942
container, a staff member may open the container for the resident. 11943

(c) Assist a physically impaired but mentally alert resident, 11944
such as a resident with arthritis, cerebral palsy, or Parkinson's 11945
disease, in removing oral or topical medication from containers 11946
and in consuming or applying the medication, upon request by or 11947
with the consent of the resident. If a resident is physically 11948
unable to place a dose of medicine to the resident's mouth without 11949
spilling it, a staff member may place the dose in a container and 11950
place the container to the mouth of the resident. 11951

(C) A residential care facility may admit or retain 11952
individuals who require skilled nursing care beyond the 11953
supervision of special diets, application of dressings, or 11954
administration of medication, only if the care will be provided on 11955
a part-time, intermittent basis for not more than a total of one 11956
hundred twenty days in any twelve-month period. In accordance with 11957
Chapter 119. of the Revised Code, the public health council shall 11958
adopt rules specifying what constitutes the need for skilled 11959
nursing care on a part-time, intermittent basis. The council shall 11960
adopt rules that are consistent with rules pertaining to home 11961
health care adopted by the director of ~~job and family services~~ 11962
health care administration for the ~~medical assistance~~ medicaid 11963
program ~~established under Chapter 5111. of the Revised Code.~~ 11964
Skilled nursing care provided pursuant to this division may be 11965
provided by a home health agency certified under ~~Title XVIII of~~ 11966
the ~~"Social Security Act,"~~ medicare program, a hospice care 11967
program licensed under Chapter 3712. of the Revised Code, or a 11968
member of the staff of a residential care facility who is 11969
qualified to perform skilled nursing care. 11970

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 12001
available in the home for review by prospective patients and 12002
residents, their guardians, or other persons assisting in their 12003
placement, each inspection report completed pursuant to section 12004
3721.02 of the Revised Code and each statement of deficiencies and 12005
plan of correction completed and made available to the public 12006
under ~~Titles XVIII and XIX of the "Social Security Act," 49 Stat.~~ 12007
~~620 (1935), 42 U.S.C. 301, as amended~~ medicare program and 12008
medicaid program, and any rules promulgated under ~~Titles XVIII and~~ 12009
~~XIX~~ those programs, including such reports that result from life 12010
safety code and health inspections during the preceding three 12011
years, and shall post prominently within the home a notice of this 12012
requirement. 12013

Sec. 3721.022. (A) As used in this section: 12014

(1) "Nursing facility" has the same meaning as in section 12015
~~5111.20~~ 5164.01 of the Revised Code. 12016

(2) "Deficiency" and "survey" have the same meanings as in 12017
section ~~5111.35~~ 5164.50 of the Revised Code. 12018

(B) The department of health is hereby designated the state 12019
agency responsible for establishing and maintaining health 12020
standards and serving as the state survey agency for the purposes 12021
of ~~Titles XVIII and XIX of the "Social Security Act," 49 Stat. 620~~ 12022
~~(1935), 42 U.S.C.A. 301, as amended~~ the medicare and medicaid 12023
programs. The department shall carry out these functions in 12024
accordance with the regulations, guidelines, and procedures issued 12025
~~under Titles XVIII and XIX for the medicare and medicaid programs~~ 12026
by the United States secretary of health and human services and 12027
with sections ~~5111.35~~ 5164.50 to ~~5111.62~~ 5164.78 of the Revised 12028
Code. The director of health shall enter into agreements with 12029
regard to these functions with the department of ~~job and family~~ 12030
~~services~~ health care administration and the United States 12031

department of health and human services. The director may also 12032
enter into agreements with the department of ~~job and family~~ 12033
~~services~~ health care administration under which the department of 12034
health is designated to perform functions under sections ~~5111.35~~ 12035
5164.50 to ~~5111.62~~ 5164.78 of the Revised Code. 12036

The director, in accordance with Chapter 119. of the Revised 12037
Code, shall adopt rules necessary to implement the survey and 12038
certification requirements for skilled nursing facilities and 12039
nursing facilities established by the United States secretary of 12040
health and human services ~~under Titles XVIII and XIX of the~~ 12041
~~"Social Security Act,"~~ for the medicare and medicaid programs and 12042
the survey requirements established under sections ~~5111.35~~ 5164.50 12043
to ~~5111.62~~ 5164.78 of the Revised Code. The rules shall include an 12044
informal process by which a facility may obtain a review of 12045
deficiencies that have been cited on a statement of deficiencies 12046
made by the department of health under section ~~5111.42~~ 5164.58 of 12047
the Revised Code. The review shall be conducted by an employee of 12048
the department who did not participate in and was not otherwise 12049
involved in any way with the survey. If the employee conducting 12050
the review determines that any deficiency citation is unjustified, 12051
that determination shall be reflected clearly in all records 12052
relating to the survey. 12053

The director need not adopt as rules any of the regulations, 12054
guidelines, or procedures issued ~~under Titles XVIII and XIX of the~~ 12055
~~"Social Security Act"~~ for the medicare or medicaid programs by the 12056
United States secretary of health and human services. 12057

Sec. 3721.024. As used in this section, "nursing facility" 12058
has the same meaning as in section ~~5111.20~~ 5164.01 of the Revised 12059
Code. 12060

The department of health may establish a program of 12061
recognition of nursing facilities that provide the highest quality 12062

care to residents who are medicaid recipients of ~~medical~~ 12063
~~assistance under Chapter 5111. of the Revised Code.~~ The program 12064
may be funded with public funds appropriated by the general 12065
assembly for the purpose of the program or any funds appropriated 12066
for nursing home licensure. 12067

Sec. 3721.026. (A) As used in this section and section 12068
3721.027 of the Revised Code, "nursing facility" and "survey" have 12069
the same meanings as in section ~~5111.35~~ 5164.50 of the Revised 12070
Code. 12071

(B) The director of health shall establish a unit within the 12072
department of health to provide advice and technical assistance 12073
and to conduct on-site visits to nursing facilities for the 12074
purpose of improving resident outcomes. The director shall assign 12075
to the unit employees who have training or experience in 12076
conducting or supervising surveys, but employees assigned to the 12077
unit shall not conduct surveys. The director shall adopt rules in 12078
accordance with Chapter 119. of the Revised Code to implement this 12079
section and shall consult with interested parties in developing 12080
the rules. Technical assistance reports are not public records 12081
under section 149.43 of the Revised Code and shall not be 12082
distributed to any person outside the unit except: 12083

(1) The nursing facility that is provided with the technical 12084
assistance; 12085

(2) Persons charged with inspecting nursing facilities under 12086
section 3721.02 of the Revised Code or with conducting surveys or 12087
reviews of nursing facilities under section 3721.022 of the 12088
Revised Code whenever any such person finds that there is serious 12089
harm to resident health or safety that is more than isolated at 12090
the nursing facility. 12091

The provisions of this section and rules adopted under this 12092
section do not affect the department's authority to administer and 12093

enforce other sections of this chapter. 12094

(C) On or before the last day of December each year, the 12095
director shall submit a report to the governor and the general 12096
assembly describing the unit's activities that year and its 12097
effectiveness in improving resident outcomes. 12098

Sec. 3721.071. The buildings in which a home is housed shall 12099
be equipped with both an automatic fire extinguishing system and 12100
fire alarm system. Such systems shall conform to standards set 12101
forth in the regulations of the board of building standards and 12102
the state fire marshal. 12103

The time for compliance with the requirements imposed by this 12104
section shall be January 1, 1975, except that the date for 12105
compliance with the automatic fire extinguishing requirements is 12106
extended to January 1, 1976, provided the buildings of the home 12107
are otherwise in compliance with fire safety laws and regulations 12108
and: 12109

(A) The home within thirty days after August 4, 1975, files a 12110
written plan with the state fire marshal's office that: 12111

(1) Outlines the interim safety procedures which shall be 12112
carried out to reduce the possibility of a fire; 12113

(2) Provides evidence that the home has entered into an 12114
agreement for a fire safety inspection to be conducted not less 12115
than monthly by a qualified independent safety engineer consultant 12116
or a township, municipal, or other legally constituted fire 12117
department, or by a township or municipal fire prevention officer; 12118

(3) Provides verification that the home has entered into a 12119
valid contract for the installation of an automatic fire 12120
extinguishing system or fire alarm system, or both, as required to 12121
comply with this section; 12122

(4) Includes a statement regarding the expected date for the 12123

completion of the fire extinguishing system or fire alarm system, 12124
or both. 12125

(B) Inspections by a qualified independent safety engineer 12126
consultant or a township, municipal, or other legally constituted 12127
fire department, or by a township or municipal fire prevention 12128
officer are initiated no later than sixty days after August 4, 12129
1975, and are conducted no less than monthly thereafter, and 12130
reports of the consultant, fire department, or fire prevention 12131
officer identifying existing hazards and recommended corrective 12132
actions are submitted to the state fire marshal, the division of 12133
industrial compliance in the department of commerce, and the 12134
department of health. 12135

It is the express intent of the general assembly that the 12136
department of ~~job and family services~~ health care administration 12137
shall terminate medicaid payments ~~under Title XIX of the "Social~~ 12138
~~Security Act," 49 Stat. 620 (1935), 42 U.S.C. 301, as amended,~~ to 12139
those homes which do not comply with the requirements of this 12140
section for the submission of a written fire safety plan and the 12141
deadline for entering into contracts for the installation of 12142
systems. 12143

Sec. 3721.08. (A) As used in this section, "real and present 12144
danger" means imminent danger of serious physical or 12145
life-threatening harm to one or more occupants of a home. 12146

(B) The director of health may petition the court of common 12147
pleas of the county in which the home is located for an order 12148
enjoining any person from operating a home without a license or 12149
enjoining a county home or district home that has had its license 12150
revoked from continuing to operate. The court shall have 12151
jurisdiction to grant such injunctive relief upon a showing that 12152
the respondent named in the petition is operating a home without a 12153
license or that the county home or district home named in the 12154

petition is operating despite the revocation of its license. The 12155
court shall have jurisdiction to grant such injunctive relief 12156
against the operation of a home without a valid license regardless 12157
of whether the home meets essential licensing requirements. 12158

(C) Unless the department of ~~job and family services~~ health 12159
care administration or contracting agency has taken action under 12160
section ~~5111.51~~ 5164.67 of the Revised Code to appoint a temporary 12161
manager or seek injunctive relief, if, in the judgment of the 12162
director of health, real and present danger exists at any home, 12163
the director may petition the court of common pleas of the county 12164
in which the home is located for such injunctive relief as is 12165
necessary to close the home, transfer one or more occupants to 12166
other homes or other appropriate care settings, or otherwise 12167
eliminate the real and present danger. The court shall have the 12168
jurisdiction to grant such injunctive relief upon a showing that 12169
there is real and present danger. 12170

(D)(1) If the director determines that real and present 12171
danger exists at a home and elects not to immediately seek 12172
injunctive relief under division (C) of this section, the director 12173
may give written notice of proposed action to the home. The notice 12174
shall specify all of the following: 12175

(a) The nature of the conditions giving rise to the real and 12176
present danger; 12177

(b) The measures that the director determines the home must 12178
take to respond to the conditions; 12179

(c) The date on which the director intends to seek injunctive 12180
relief under division (C) of this section if the director 12181
determines that real and present danger exists at the home. 12182

(2) If the home notifies the director, within the time 12183
specified pursuant to division (D)(1)(c) of this section, that it 12184
believes the conditions giving rise to the real and present danger 12185

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, 12217
the salary of a special master and any costs incurred by a special 12218
master shall be the obligation of the home. 12219

(2) No special master shall enter into any employment 12220
contract on behalf of a home, or purchase with the home's funds 12221
any capital goods totaling more than ten thousand dollars, unless 12222
the special master has obtained approval for the contract or 12223
purchase from the home's operator or the court. 12224

(G) If the director takes action under division (C), (D), or 12225
(E) of this section, the director may also appoint employees of 12226
the department of health to conduct on-site monitoring of the 12227
home. Appointment of monitors is not subject to appeal under 12228
Chapter 119. or any other section of the Revised Code. No employee 12229
of a home for which monitors are appointed, no person employed by 12230
the home within the previous two years, and no person who 12231
currently has a consulting contract with the department or a home, 12232
shall be appointed under this division. Every monitor shall have 12233
the professional qualifications necessary to monitor correction of 12234
the conditions that give rise to or, in the director's judgment, 12235
will give rise to real and present danger. The number of monitors 12236
present at a home at any given time shall not exceed one for every 12237
fifty residents, or fraction thereof. 12238

(H) On finding that the real and present danger for which 12239
injunctive relief was granted under division (C) of this section 12240
has been eliminated and that the home's operator has demonstrated 12241
the capacity to prevent the real and present danger from 12242
recurring, the court shall terminate its jurisdiction over the 12243
home and return control and management of the home to the 12244
operator. If the real and present danger cannot be eliminated 12245
practicably within a reasonable time following appointment of a 12246
special master, the court may order the special master to close 12247
the home and transfer all residents to other homes or other 12248

appropriate care settings. 12249

(I) The director of health shall give notice of proposed 12250
action under divisions (D) and (E) of this section to both of the 12251
following: 12252

(1) The home's administrator; 12253

(2) If the home is operated by an organization described in 12254
subsection 501(c)(3) and tax exempt under subsection 501(a) of the 12255
"Internal Revenue Code of 1986," 100 Stat. 2085, 26 U.S.C.A. 1, as 12256
amended, the board of trustees of the organization; or, if the 12257
home is not operated by such an organization, the owner of the 12258
home. 12259

Notices shall be delivered by certified mail or hand 12260
delivery. If notices are mailed, they shall be addressed to the 12261
persons specified in divisions (I)(1) and (2) of this section, as 12262
indicated in the department of health's records. If they are hand 12263
delivered, they shall be delivered to persons who would reasonably 12264
appear to the average prudent person to have authority to accept 12265
them. 12266

(J) If ownership of a home is assigned or transferred to a 12267
different person, the new owner is responsible and liable for 12268
compliance with any notice of proposed action or order issued 12269
under this section prior to the effective date of the assignment 12270
or transfer. 12271

Sec. 3721.10. As used in sections 3721.10 to 3721.18 of the 12272
Revised Code: 12273

(A) "Home" means all of the following: 12274

(1) A home as defined in section 3721.01 of the Revised Code; 12275

(2) Any facility or part of a facility not defined as a home 12276
under section 3721.01 of the Revised Code that is certified as a 12277
skilled nursing facility ~~under Title XVIII of the "Social Security~~ 12278

~~Act," 79 Stat. 286 (1965), 42 U.S.C.A. 1395 and 1396, as amended,~~ 12279
~~for the medicare program~~ or as a nursing facility ~~as defined in~~ 12280
~~section 5111.20 of the Revised Code~~ for the medicaid program; 12281

(3) A county home or district home operated pursuant to 12282
Chapter 5155. of the Revised Code. 12283

(B) "Resident" means a resident or a patient of a home. 12284

(C) "Administrator" means all of the following: 12285

(1) With respect to a home as defined in section 3721.01 of 12286
the Revised Code, a nursing home administrator as defined in 12287
section 4751.01 of the Revised Code; 12288

(2) With respect to a facility or part of a facility not 12289
defined as a home in section 3721.01 of the Revised Code that is 12290
authorized to provide skilled nursing facility or nursing facility 12291
services, the administrator of the facility or part of a facility; 12292

(3) With respect to a county home or district home, the 12293
superintendent appointed under Chapter 5155. of the Revised Code. 12294

(D) "Sponsor" means an adult relative, friend, or guardian of 12295
a resident who has an interest or responsibility in the resident's 12296
welfare. 12297

(E) "Residents' rights advocate" means: 12298

(1) An employee or representative of any state or local 12299
government entity that has a responsibility regarding residents 12300
and that has registered with the department of health under 12301
division (B) of section 3701.07 of the Revised Code; 12302

(2) An employee or representative of any private nonprofit 12303
corporation or association that qualifies for tax-exempt status 12304
under section 501(a) of the "Internal Revenue Code of 1986," 100 12305
Stat. 2085, 26 U.S.C.A. 1, as amended, and that has registered 12306
with the department of health under division (B) of section 12307
3701.07 of the Revised Code and whose purposes include educating 12308

and counseling residents, assisting residents in resolving 12309
problems and complaints concerning their care and treatment, and 12310
assisting them in securing adequate services to meet their needs; 12311

(3) A member of the general assembly. 12312

(F) "Physical restraint" means, but is not limited to, any 12313
article, device, or garment that interferes with the free movement 12314
of the resident and that the resident is unable to remove easily, 12315
a geriatric chair, or a locked room door. 12316

(G) "Chemical restraint" means any medication bearing the 12317
American hospital formulary service therapeutic class 4.00, 12318
28:16:08, 28:24:08, or 28:24:92 that alters the functioning of the 12319
central nervous system in a manner that limits physical and 12320
cognitive functioning to the degree that the resident cannot 12321
attain the resident's highest practicable physical, mental, and 12322
psychosocial well-being. 12323

(H) "Ancillary service" means, but is not limited to, 12324
podiatry, dental, hearing, vision, physical therapy, occupational 12325
therapy, speech therapy, and psychological and social services. 12326

(I) "Facility" means a facility, or part of a facility, 12327
certified as a nursing facility or skilled nursing facility under 12328
~~Title XVIII or Title XIX of the "Social Security Act."~~ the 12329
medicare or medicaid programs. "Facility" does not include an 12330
intermediate care facility for the mentally retarded, as defined 12331
in section ~~5111.20~~ 5164.01 of the Revised Code. 12332

~~(J) "Medicare" means the program established by Title XVIII~~ 12333
~~of the "Social Security Act."~~ 12334

~~(K) "Medicaid" means the program established by Title XIX of~~ 12335
~~the "Social Security Act" and Chapter 5111. of the Revised Code.~~ 12336

Sec. 3721.12. (A) The administrator of a home shall: 12337

(1) With the advice of residents, their sponsors, or both, 12338

establish and review at least annually, written policies regarding 12339
the applicability and implementation of residents' rights under 12340
sections 3721.10 to 3721.17 of the Revised Code, the 12341
responsibilities of residents regarding the rights, and the home's 12342
grievance procedure established under division (A)(2) of this 12343
section. The administrator is responsible for the development of, 12344
and adherence to, procedures implementing the policies. 12345

(2) Establish a grievance committee for review of complaints 12346
by residents. The grievance committee shall be comprised of the 12347
home's staff and residents, sponsors, or outside representatives 12348
in a ratio of not more than one staff member to every two 12349
residents, sponsors, or outside representatives. 12350

(3) Furnish to each resident and sponsor prior to or at the 12351
time of admission, and to each member of the home's staff, at 12352
least one of each of the following: 12353

(a) A copy of the rights established under sections 3721.10 12354
to 3721.17 of the Revised Code; 12355

(b) A written explanation of the provisions of sections 12356
3721.16 to 3721.162 of the Revised Code; 12357

(c) A copy of the home's policies and procedures established 12358
under this section; 12359

(d) A copy of the home's rules; 12360

(e) A copy of the addresses and telephone numbers of the 12361
board of health of the health district of the county in which the 12362
home is located, the county department of job and family services 12363
of the county in which the home is located, the state departments 12364
of health and job and family services, the state and local offices 12365
of the department of aging, and any Ohio nursing home ombudsperson 12366
program. 12367

(B) Written acknowledgment of the receipt of copies of the 12368

materials listed in this section shall be made part of the 12369
resident's record and the staff member's personnel record. 12370

(C) The administrator shall post all of the following 12371
prominently within the home: 12372

(1) A copy of the rights of residents as listed in division 12373
(A) of section 3721.13 of the Revised Code; 12374

(2) A copy of the home's rules and its policies and 12375
procedures regarding the rights and responsibilities of residents; 12376

(3) A notice that a copy of this chapter, rules of the 12377
department of health applicable to the home, and federal 12378
regulations adopted under the medicare and medicaid programs, and 12379
the materials required to be available in the home under section 12380
3721.021 of the Revised Code, are available for inspection in the 12381
home at reasonable hours; 12382

(4) A list of residents' rights advocates; 12383

(5) A notice that the following are available in a place 12384
readily accessible to residents: 12385

(a) If the home is licensed under section 3721.02 of the 12386
Revised Code, a copy of the most recent licensure inspection 12387
report prepared for the home under that section; 12388

(b) If the home is a facility, a copy of the most recent 12389
statement of deficiencies issued to the home under section ~~5111.42~~ 12390
5164.58 of the Revised Code. 12391

(D) The administrator of a home may, with the advice of 12392
residents, their sponsors, or both, establish written policies 12393
regarding the applicability and administration of any additional 12394
residents' rights beyond those set forth in sections 3721.10 to 12395
3721.17 of the Revised Code, and the responsibilities of residents 12396
regarding the rights. Policies established under this division 12397
shall be reviewed, and procedures developed and adhered to as in 12398

division (A)(1) of this section. 12399

Sec. 3721.121. (A) As used in this section: 12400

(1) "Adult day-care program" means a program operated 12401
pursuant to rules adopted by the public health council under 12402
section 3721.04 of the Revised Code and provided by and on the 12403
same site as homes licensed under this chapter. 12404

(2) "Applicant" means a person who is under final 12405
consideration for employment with a home or adult day-care program 12406
in a full-time, part-time, or temporary position that involves 12407
providing direct care to an older adult. "Applicant" does not 12408
include a person who provides direct care as a volunteer without 12409
receiving or expecting to receive any form of remuneration other 12410
than reimbursement for actual expenses. 12411

(3) "Criminal records check" and "older adult" have the same 12412
meanings as in section 109.572 of the Revised Code. 12413

(4) "Home" means a home as defined in section 3721.10 of the 12414
Revised Code. 12415

(B)(1) Except as provided in division (I) of this section, 12416
the chief administrator of a home or adult day-care program shall 12417
request that the superintendent of the bureau of criminal 12418
identification and investigation conduct a criminal records check 12419
with respect to each applicant. If an applicant for whom a 12420
criminal records check request is required under this division 12421
does not present proof of having been a resident of this state for 12422
the five-year period immediately prior to the date the criminal 12423
records check is requested or provide evidence that within that 12424
five-year period the superintendent has requested information 12425
about the applicant from the federal bureau of investigation in a 12426
criminal records check, the chief administrator shall request that 12427
the superintendent obtain information from the federal bureau of 12428

investigation as part of the criminal records check of the 12429
applicant. Even if an applicant for whom a criminal records check 12430
request is required under this division presents proof of having 12431
been a resident of this state for the five-year period, the chief 12432
administrator may request that the superintendent include 12433
information from the federal bureau of investigation in the 12434
criminal records check. 12435

(2) A person required by division (B)(1) of this section to 12436
request a criminal records check shall do both of the following: 12437

(a) Provide to each applicant for whom a criminal records 12438
check request is required under that division a copy of the form 12439
prescribed pursuant to division (C)(1) of section 109.572 of the 12440
Revised Code and a standard fingerprint impression sheet 12441
prescribed pursuant to division (C)(2) of that section, and obtain 12442
the completed form and impression sheet from the applicant; 12443

(b) Forward the completed form and impression sheet to the 12444
superintendent of the bureau of criminal identification and 12445
investigation. 12446

(3) An applicant provided the form and fingerprint impression 12447
sheet under division (B)(2)(a) of this section who fails to 12448
complete the form or provide fingerprint impressions shall not be 12449
employed in any position for which a criminal records check is 12450
required by this section. 12451

(C)(1) Except as provided in rules adopted by the director of 12452
health in accordance with division (F) of this section and subject 12453
to division (C)(2) of this section, no home or adult day-care 12454
program shall employ a person in a position that involves 12455
providing direct care to an older adult if the person has been 12456
convicted of or pleaded guilty to any of the following: 12457

(a) A violation of section 2903.01, 2903.02, 2903.03, 12458
2903.04, 2903.11, 2903.12, 2903.13, 2903.16, 2903.21, 2903.34, 12459

2905.01, 2905.02, 2905.11, 2905.12, 2907.02, 2907.03, 2907.05, 12460
2907.06, 2907.07, 2907.08, 2907.09, 2907.12, 2907.25, 2907.31, 12461
2907.32, 2907.321, 2907.322, 2907.323, 2911.01, 2911.02, 2911.11, 12462
2911.12, 2911.13, 2913.02, 2913.03, 2913.04, 2913.11, 2913.21, 12463
2913.31, 2913.40, 2913.43, 2913.47, 2913.51, 2919.25, 2921.36, 12464
2923.12, 2923.13, 2923.161, 2925.02, 2925.03, 2925.11, 2925.13, 12465
2925.22, 2925.23, or 3716.11 of the Revised Code. 12466

(b) A violation of an existing or former law of this state, 12467
any other state, or the United States that is substantially 12468
equivalent to any of the offenses listed in division (C)(1)(a) of 12469
this section. 12470

(2)(a) A home or an adult day-care program may employ 12471
conditionally an applicant for whom a criminal records check 12472
request is required under division (B) of this section prior to 12473
obtaining the results of a criminal records check regarding the 12474
individual, provided that the home or program shall request a 12475
criminal records check regarding the individual in accordance with 12476
division (B)(1) of this section not later than five business days 12477
after the individual begins conditional employment. In the 12478
circumstances described in division (I)(2) of this section, a home 12479
or adult day-care program may employ conditionally an applicant 12480
who has been referred to the home or adult day-care program by an 12481
employment service that supplies full-time, part-time, or 12482
temporary staff for positions involving the direct care of older 12483
adults and for whom, pursuant to that division, a criminal records 12484
check is not required under division (B) of this section. 12485

(b) A home or adult day-care program that employs an 12486
individual conditionally under authority of division (C)(2)(a) of 12487
this section shall terminate the individual's employment if the 12488
results of the criminal records check requested under division (B) 12489
of this section or described in division (I)(2) of this section, 12490
other than the results of any request for information from the 12491

federal bureau of investigation, are not obtained within the 12492
period ending thirty days after the date the request is made. 12493
Regardless of when the results of the criminal records check are 12494
obtained, if the results indicate that the individual has been 12495
convicted of or pleaded guilty to any of the offenses listed or 12496
described in division (C)(1) of this section, the home or program 12497
shall terminate the individual's employment unless the home or 12498
program chooses to employ the individual pursuant to division (F) 12499
of this section. Termination of employment under this division 12500
shall be considered just cause for discharge for purposes of 12501
division (D)(2) of section 4141.29 of the Revised Code if the 12502
individual makes any attempt to deceive the home or program about 12503
the individual's criminal record. 12504

(D)(1) Each home or adult day-care program shall pay to the 12505
bureau of criminal identification and investigation the fee 12506
prescribed pursuant to division (C)(3) of section 109.572 of the 12507
Revised Code for each criminal records check conducted pursuant to 12508
a request made under division (B) of this section. 12509

(2) A home or adult day-care program may charge an applicant 12510
a fee not exceeding the amount the home or program pays under 12511
division (D)(1) of this section. A home or program may collect a 12512
fee only if both of the following apply: 12513

(a) The home or program notifies the person at the time of 12514
initial application for employment of the amount of the fee and 12515
that, unless the fee is paid, the person will not be considered 12516
for employment; 12517

(b) ~~The medical assistance~~ medicaid ~~program established under~~ 12518
~~Chapter 5111. of the Revised Code~~ does not reimburse the home or 12519
program the fee it pays under division (D)(1) of this section. 12520

(E) The report of any criminal records check conducted 12521
pursuant to a request made under this section is not a public 12522

record for the purposes of section 149.43 of the Revised Code and 12523
shall not be made available to any person other than the 12524
following: 12525

(1) The individual who is the subject of the criminal records 12526
check or the individual's representative; 12527

(2) The chief administrator of the home or program requesting 12528
the criminal records check or the administrator's representative; 12529

(3) The administrator of any other facility, agency, or 12530
program that provides direct care to older adults that is owned or 12531
operated by the same entity that owns or operates the home or 12532
program; 12533

(4) A court, hearing officer, or other necessary individual 12534
involved in a case dealing with a denial of employment of the 12535
applicant or dealing with employment or unemployment benefits of 12536
the applicant; 12537

(5) Any person to whom the report is provided pursuant to, 12538
and in accordance with, division (I)(1) or (2) of this section; 12539

(6) The board of nursing for purposes of accepting and 12540
processing an application for a medication aide certificate issued 12541
under Chapter 4723. of the Revised Code. 12542

(F) In accordance with section 3721.11 of the Revised Code, 12543
the director of health shall adopt rules to implement this 12544
section. The rules shall specify circumstances under which a home 12545
or adult day-care program may employ a person who has been 12546
convicted of or pleaded guilty to an offense listed or described 12547
in division (C)(1) of this section but meets personal character 12548
standards set by the director. 12549

(G) The chief administrator of a home or adult day-care 12550
program shall inform each individual, at the time of initial 12551
application for a position that involves providing direct care to 12552

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 12584
supplies full-time, part-time, or temporary staff for positions 12585
involving the direct care of older adults and both of the 12586
following apply: 12587

(a) The chief administrator receives from the employment 12588
service or the applicant a report of the results of a criminal 12589
records check regarding the applicant that has been conducted by 12590
the superintendent within the one-year period immediately 12591
preceding the applicant's referral; 12592

(b) The report of the criminal records check demonstrates 12593
that the person has not been convicted of or pleaded guilty to an 12594
offense listed or described in division (C)(1) of this section, or 12595
the report demonstrates that the person has been convicted of or 12596
pleaded guilty to one or more of those offenses, but the home or 12597
adult day-care program chooses to employ the individual pursuant 12598
to division (F) of this section. 12599

(2) The chief administrator of a home or adult day-care 12600
program is not required to request that the superintendent of the 12601
bureau of criminal identification and investigation conduct a 12602
criminal records check of an applicant and may employ the 12603
applicant conditionally as described in this division, if the 12604
applicant has been referred to the home or program by an 12605
employment service that supplies full-time, part-time, or 12606
temporary staff for positions involving the direct care of older 12607
adults and if the chief administrator receives from the employment 12608
service or the applicant a letter from the employment service that 12609
is on the letterhead of the employment service, dated, and signed 12610
by a supervisor or another designated official of the employment 12611
service and that states that the employment service has requested 12612
the superintendent to conduct a criminal records check regarding 12613
the applicant, that the requested criminal records check will 12614
include a determination of whether the applicant has been 12615

convicted of or pleaded guilty to any offense listed or described 12616
in division (C)(1) of this section, that, as of the date set forth 12617
on the letter, the employment service had not received the results 12618
of the criminal records check, and that, when the employment 12619
service receives the results of the criminal records check, it 12620
promptly will send a copy of the results to the home or adult 12621
day-care program. If a home or adult day-care program employs an 12622
applicant conditionally in accordance with this division, the 12623
employment service, upon its receipt of the results of the 12624
criminal records check, promptly shall send a copy of the results 12625
to the home or adult day-care program, and division (C)(2)(b) of 12626
this section applies regarding the conditional employment. 12627

Sec. 3721.13. (A) The rights of residents of a home shall 12628
include, but are not limited to, the following: 12629

(1) The right to a safe and clean living environment pursuant 12630
to the medicare and medicaid programs and applicable state laws 12631
and regulations prescribed by the public health council; 12632

(2) The right to be free from physical, verbal, mental, and 12633
emotional abuse and to be treated at all times with courtesy, 12634
respect, and full recognition of dignity and individuality; 12635

(3) Upon admission and thereafter, the right to adequate and 12636
appropriate medical treatment and nursing care and to other 12637
ancillary services that comprise necessary and appropriate care 12638
consistent with the program for which the resident contracted. 12639
This care shall be provided without regard to considerations such 12640
as race, color, religion, national origin, age, or source of 12641
payment for care. 12642

(4) The right to have all reasonable requests and inquiries 12643
responded to promptly; 12644

(5) The right to have clothes and bed sheets changed as the 12645

need arises, to ensure the resident's comfort or sanitation; 12646

(6) The right to obtain from the home, upon request, the name 12647
and any specialty of any physician or other person responsible for 12648
the resident's care or for the coordination of care; 12649

(7) The right, upon request, to be assigned, within the 12650
capacity of the home to make the assignment, to the staff 12651
physician of the resident's choice, and the right, in accordance 12652
with the rules and written policies and procedures of the home, to 12653
select as the attending physician a physician who is not on the 12654
staff of the home. If the cost of a physician's services is to be 12655
met under a federally supported program, the physician shall meet 12656
the federal laws and regulations governing such services. 12657

(8) The right to participate in decisions that affect the 12658
resident's life, including the right to communicate with the 12659
physician and employees of the home in planning the resident's 12660
treatment or care and to obtain from the attending physician 12661
complete and current information concerning medical condition, 12662
prognosis, and treatment plan, in terms the resident can 12663
reasonably be expected to understand; the right of access to all 12664
information in the resident's medical record; and the right to 12665
give or withhold informed consent for treatment after the 12666
consequences of that choice have been carefully explained. When 12667
the attending physician finds that it is not medically advisable 12668
to give the information to the resident, the information shall be 12669
made available to the resident's sponsor on the resident's behalf, 12670
if the sponsor has a legal interest or is authorized by the 12671
resident to receive the information. The home is not liable for a 12672
violation of this division if the violation is found to be the 12673
result of an act or omission on the part of a physician selected 12674
by the resident who is not otherwise affiliated with the home. 12675

(9) The right to withhold payment for physician visitation if 12676
the physician did not visit the resident; 12677

(10) The right to confidential treatment of personal and 12678
medical records, and the right to approve or refuse the release of 12679
these records to any individual outside the home, except in case 12680
of transfer to another home, hospital, or health care system, as 12681
required by law or rule, or as required by a third-party payment 12682
contract; 12683

(11) The right to privacy during medical examination or 12684
treatment and in the care of personal or bodily needs; 12685

(12) The right to refuse, without jeopardizing access to 12686
appropriate medical care, to serve as a medical research subject; 12687

(13) The right to be free from physical or chemical 12688
restraints or prolonged isolation except to the minimum extent 12689
necessary to protect the resident from injury to self, others, or 12690
to property and except as authorized in writing by the attending 12691
physician for a specified and limited period of time and 12692
documented in the resident's medical record. Prior to authorizing 12693
the use of a physical or chemical restraint on any resident, the 12694
attending physician shall make a personal examination of the 12695
resident and an individualized determination of the need to use 12696
the restraint on that resident. 12697

Physical or chemical restraints or isolation may be used in 12698
an emergency situation without authorization of the attending 12699
physician only to protect the resident from injury to self or 12700
others. Use of the physical or chemical restraints or isolation 12701
shall not be continued for more than twelve hours after the onset 12702
of the emergency without personal examination and authorization by 12703
the attending physician. The attending physician or a staff 12704
physician may authorize continued use of physical or chemical 12705
restraints for a period not to exceed thirty days, and at the end 12706
of this period and any subsequent period may extend the 12707
authorization for an additional period of not more than thirty 12708
days. The use of physical or chemical restraints shall not be 12709

continued without a personal examination of the resident and the 12710
written authorization of the attending physician stating the 12711
reasons for continuing the restraint. 12712

If physical or chemical restraints are used under this 12713
division, the home shall ensure that the restrained resident 12714
receives a proper diet. In no event shall physical or chemical 12715
restraints or isolation be used for punishment, incentive, or 12716
convenience. 12717

(14) The right to the pharmacist of the resident's choice and 12718
the right to receive pharmaceutical supplies and services at 12719
reasonable prices not exceeding applicable and normally accepted 12720
prices for comparably packaged pharmaceutical supplies and 12721
services within the community; 12722

(15) The right to exercise all civil rights, unless the 12723
resident has been adjudicated incompetent pursuant to Chapter 12724
2111. of the Revised Code and has not been restored to legal 12725
capacity, as well as the right to the cooperation of the home's 12726
administrator in making arrangements for the exercise of the right 12727
to vote; 12728

(16) The right of access to opportunities that enable the 12729
resident, at the resident's own expense or at the expense of a 12730
third-party payer, to achieve the resident's fullest potential, 12731
including educational, vocational, social, recreational, and 12732
habilitation programs; 12733

(17) The right to consume a reasonable amount of alcoholic 12734
beverages at the resident's own expense, unless not medically 12735
advisable as documented in the resident's medical record by the 12736
attending physician or unless contradictory to written admission 12737
policies; 12738

(18) The right to use tobacco at the resident's own expense 12739
under the home's safety rules and under applicable laws and rules 12740

of the state, unless not medically advisable as documented in the 12741
resident's medical record by the attending physician or unless 12742
contradictory to written admission policies; 12743

(19) The right to retire and rise in accordance with the 12744
resident's reasonable requests, if the resident does not disturb 12745
others or the posted meal schedules and upon the home's request 12746
remains in a supervised area, unless not medically advisable as 12747
documented by the attending physician; 12748

(20) The right to observe religious obligations and 12749
participate in religious activities; the right to maintain 12750
individual and cultural identity; and the right to meet with and 12751
participate in activities of social and community groups at the 12752
resident's or the group's initiative; 12753

(21) The right upon reasonable request to private and 12754
unrestricted communications with the resident's family, social 12755
worker, and any other person, unless not medically advisable as 12756
documented in the resident's medical record by the attending 12757
physician, except that communications with public officials or 12758
with the resident's attorney or physician shall not be restricted. 12759
Private and unrestricted communications shall include, but are not 12760
limited to, the right to: 12761

(a) Receive, send, and mail sealed, unopened correspondence; 12762

(b) Reasonable access to a telephone for private 12763
communications; 12764

(c) Private visits at any reasonable hour. 12765

(22) The right to assured privacy for visits by the spouse, 12766
or if both are residents of the same home, the right to share a 12767
room within the capacity of the home, unless not medically 12768
advisable as documented in the resident's medical record by the 12769
attending physician; 12770

(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; 12802

(ii) A listing of all deposits and withdrawals transacted, 12803
which shall be substantiated by receipts which shall be available 12804
for inspection and copying by the resident or sponsor. 12805

(28) The right of the resident to be allowed unrestricted 12806
access to the resident's property on deposit at reasonable hours, 12807
unless requests for access to property on deposit are so 12808
persistent, continuous, and unreasonable that they constitute a 12809
nuisance; 12810

(29) The right to receive reasonable notice before the 12811
resident's room or roommate is changed, including an explanation 12812
of the reason for either change. 12813

(30) The right not to be transferred or discharged from the 12814
home unless the transfer is necessary because of one of the 12815
following: 12816

(a) The welfare and needs of the resident cannot be met in 12817
the home. 12818

(b) The resident's health has improved sufficiently so that 12819
the resident no longer needs the services provided by the home. 12820

(c) The safety of individuals in the home is endangered. 12821

(d) The health of individuals in the home would otherwise be 12822
endangered. 12823

(e) The resident has failed, after reasonable and appropriate 12824
notice, to pay or to have the medicare or medicaid program pay on 12825
the resident's behalf, for the care provided by the home. A 12826
resident shall not be considered to have failed to have the 12827
resident's care paid for if the resident has applied for medicaid, 12828
unless both of the following are the case: 12829

(i) The resident's application, or a substantially similar 12830
previous application, has been denied by the county department of 12831

job and family services. 12832

(ii) If the resident appealed the denial pursuant to division 12833
(C) of section ~~5101.35~~ 5160.34 of the Revised Code, the director 12834
of job and family services has upheld the denial. 12835

(f) The home's license has been revoked, the home is being 12836
closed pursuant to section 3721.08, sections ~~5111.35~~ 5164.50 to 12837
~~5111.62~~ 5164.78, or section 5155.31 of the Revised Code, or the 12838
home otherwise ceases to operate. 12839

(g) The resident is a recipient of medicaid, and the home's 12840
participation in the medicaid program is involuntarily terminated 12841
or denied. 12842

(h) The resident is a beneficiary under the medicare program, 12843
and the home's participation in the medicare program is 12844
involuntarily terminated or denied. 12845

(31) The right to voice grievances and recommend changes in 12846
policies and services to the home's staff, to employees of the 12847
department of health, or to other persons not associated with the 12848
operation of the home, of the resident's choice, free from 12849
restraint, interference, coercion, discrimination, or reprisal. 12850
This right includes access to a residents' rights advocate, and 12851
the right to be a member of, to be active in, and to associate 12852
with persons who are active in organizations of relatives and 12853
friends of nursing home residents and other organizations engaged 12854
in assisting residents. 12855

(32) The right to have any significant change in the 12856
resident's health status reported to the resident's sponsor. As 12857
soon as such a change is known to the home's staff, the home shall 12858
make a reasonable effort to notify the sponsor within twelve 12859
hours. 12860

(B) A sponsor may act on a resident's behalf to assure that 12861
the home does not deny the residents' rights under sections 12862

3721.10 to 3721.17 of the Revised Code. 12863

(C) Any attempted waiver of the rights listed in division (A) 12864
of this section is void. 12865

Sec. 3721.15. (A) Authorization from a resident or a sponsor 12866
with a power of attorney for a home to manage the resident's 12867
financial affairs shall be in writing and shall be attested to by 12868
a witness who is not connected in any manner whatsoever with the 12869
home or its administrator. The home shall maintain accounts 12870
pursuant to division (A)(27) of section 3721.13 of the Revised 12871
Code. Upon the resident's transfer, discharge, or death, the 12872
account shall be closed and a final accounting made. All remaining 12873
funds shall be returned to the resident or resident's sponsor, 12874
except in the case of death, when all remaining funds shall be 12875
transferred or used in accordance with section ~~5111.113~~ 5162.37 of 12876
the Revised Code. 12877

(B) A home that manages a resident's financial affairs shall 12878
deposit the resident's funds in excess of one hundred dollars, and 12879
may deposit the resident's funds that are one hundred dollars or 12880
less, in an interest-bearing account separate from any of the 12881
home's operating accounts. Interest earned on the resident's funds 12882
shall be credited to the resident's account. A resident's funds 12883
that are one hundred dollars or less and have not been deposited 12884
in an interest-bearing account may be deposited in a 12885
noninterest-bearing account or petty cash fund. 12886

(C) Each resident whose financial affairs are managed by a 12887
home shall be promptly notified by the home when the total of the 12888
amount of funds in the resident's accounts and the petty cash fund 12889
plus other nonexempt resources reaches two hundred dollars less 12890
than the maximum amount permitted a recipient of medicaid. The 12891
notice shall include an explanation of the potential effect on the 12892
resident's eligibility for medicaid if the amount in the 12893

resident's accounts and the petty cash fund, plus the value of 12894
other nonexempt resources, exceeds the maximum assets a medicaid 12895
recipient may retain. 12896

(D) Each home that manages the financial affairs of residents 12897
shall purchase a surety bond or otherwise provide assurance 12898
satisfactory to the director of health, or, in the case of a home 12899
that participates in the medicaid program, to the director of ~~job~~ 12900
~~and family services~~ health care administration, to assure the 12901
security of all residents' funds managed by the home. 12902

Sec. 3721.16. For each resident of a home, notice of a 12903
proposed transfer or discharge shall be in accordance with this 12904
section. 12905

(A)(1) The administrator of a home shall notify a resident in 12906
writing, and the resident's sponsor in writing by certified mail, 12907
return receipt requested, in advance of any proposed transfer or 12908
discharge from the home. The administrator shall send a copy of 12909
the notice to the state department of health. The notice shall be 12910
provided at least thirty days in advance of the proposed transfer 12911
or discharge, unless any of the following applies: 12912

(a) The resident's health has improved sufficiently to allow 12913
a more immediate discharge or transfer to a less skilled level of 12914
care; 12915

(b) The resident has resided in the home less than thirty 12916
days; 12917

(c) An emergency arises in which the safety of individuals in 12918
the home is endangered; 12919

(d) An emergency arises in which the health of individuals in 12920
the home would otherwise be endangered; 12921

(e) An emergency arises in which the resident's urgent 12922
medical needs necessitate a more immediate transfer or discharge. 12923

In any of the circumstances described in divisions (A)(1)(a) 12924
to (e) of this section, the notice shall be provided as many days 12925
in advance of the proposed transfer or discharge as is 12926
practicable. 12927

(2) The notice required under division (A)(1) of this section 12928
shall include all of the following: 12929

(a) The reasons for the proposed transfer or discharge; 12930

(b) The proposed date the resident is to be transferred or 12931
discharged; 12932

(c) The proposed location to which the resident is to be 12933
transferred or discharged; 12934

(d) Notice of the right of the resident and the resident's 12935
sponsor to an impartial hearing at the home on the proposed 12936
transfer or discharge, and of the manner in which and the time 12937
within which the resident or sponsor may request a hearing 12938
pursuant to section 3721.161 of the Revised Code; 12939

(e) A statement that the resident will not be transferred or 12940
discharged before the date specified in the notice unless the home 12941
and the resident or, if the resident is not competent to make a 12942
decision, the home and the resident's sponsor, agree to an earlier 12943
date; 12944

(f) The address of the legal services office of the 12945
department of health; 12946

(g) The name, address, and telephone number of a 12947
representative of the state long-term care ombudsperson program 12948
and, if the resident or patient has a developmental disability or 12949
mental illness, the name, address, and telephone number of the 12950
Ohio legal rights service. 12951

(B) No home shall transfer or discharge a resident before the 12952
date specified in the notice required by division (A) of this 12953

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 12984
resident and in writing by certified mail, return receipt 12985
requested, to the resident's sponsor, specifying the number of 12986
days, if any, during which the resident will be permitted under 12987
the medicaid program to return and resume residence in the home 12988
and specifying the medicaid program's coverage of the days during 12989
which the resident is absent from the home. An individual who is 12990
absent from a home for more than the number of days specified in 12991
the notice and continues to require the services provided by the 12992
facility shall be given priority for the first available bed in a 12993
semi-private room. 12994

Sec. 3721.17. (A) Any resident who believes that the 12995
resident's rights under sections 3721.10 to 3721.17 of the Revised 12996
Code have been violated may file a grievance under procedures 12997
adopted pursuant to division (A)(2) of section 3721.12 of the 12998
Revised Code. 12999

When the grievance committee determines a violation of 13000
sections 3721.10 to 3721.17 of the Revised Code has occurred, it 13001
shall notify the administrator of the home. If the violation 13002
cannot be corrected within ten days, or if ten days have elapsed 13003
without correction of the violation, the grievance committee shall 13004
refer the matter to the department of health. 13005

(B) Any person who believes that a resident's rights under 13006
sections 3721.10 to 3721.17 of the Revised Code have been violated 13007
may report or cause reports to be made of the information directly 13008
to the department of health. No person who files a report is 13009
liable for civil damages resulting from the report. 13010

(C)(1) Within thirty days of receiving a complaint under this 13011
section, the department of health shall investigate any complaint 13012
referred to it by a home's grievance committee and any complaint 13013
from any source that alleges that the home provided substantially 13014

less than adequate care or treatment, or substantially unsafe 13015
conditions, or, within seven days of receiving a complaint, refer 13016
it to the attorney general, if the attorney general agrees to 13017
investigate within thirty days. 13018

(2) Within thirty days of receiving a complaint under this 13019
section, the department of health may investigate any alleged 13020
violation of sections 3721.10 to 3721.17 of the Revised Code, or 13021
of rules, policies, or procedures adopted pursuant to those 13022
sections, not covered by division (C)(1) of this section, or it 13023
may, within seven days of receiving a complaint, refer the 13024
complaint to the grievance committee at the home where the alleged 13025
violation occurred, or to the attorney general if the attorney 13026
general agrees to investigate within thirty days. 13027

(D) If, after an investigation, the department of health 13028
finds probable cause to believe that a violation of sections 13029
3721.10 to 3721.17 of the Revised Code, or of rules, policies, or 13030
procedures adopted pursuant to those sections, has occurred at a 13031
home that is certified under the medicare or medicaid program, it 13032
shall cite one or more findings or deficiencies under sections 13033
~~5111.35~~ 5164.50 to ~~5111.62~~ 5164.78 of the Revised Code. If the 13034
home is not so certified, the department shall hold an 13035
adjudicative hearing within thirty days under Chapter 119. of the 13036
Revised Code. 13037

(E) Upon a finding at an adjudicative hearing under division 13038
(D) of this section that a violation of sections 3721.10 to 13039
3721.17 of the Revised Code, or of rules, policies, or procedures 13040
adopted pursuant thereto, has occurred, the department of health 13041
shall make an order for compliance, set a reasonable time for 13042
compliance, and assess a fine pursuant to division (F) of this 13043
section. The fine shall be paid to the general revenue fund only 13044
if compliance with the order is not shown to have been made within 13045
the reasonable time set in the order. The department of health may 13046

issue an order prohibiting the continuation of any violation of 13047
sections 3721.10 to 3721.17 of the Revised Code. 13048

Findings at the hearings conducted under this section may be 13049
appealed pursuant to Chapter 119. of the Revised Code, except that 13050
an appeal may be made to the court of common pleas of the county 13051
in which the home is located. 13052

The department of health shall initiate proceedings in court 13053
to collect any fine assessed under this section that is unpaid 13054
thirty days after the violator's final appeal is exhausted. 13055

(F) Any home found, pursuant to an adjudication hearing under 13056
division (D) of this section, to have violated sections 3721.10 to 13057
3721.17 of the Revised Code, or rules, policies, or procedures 13058
adopted pursuant to those sections may be fined not less than one 13059
hundred nor more than five hundred dollars for a first offense. 13060
For each subsequent offense, the home may be fined not less than 13061
two hundred nor more than one thousand dollars. 13062

A violation of sections 3721.10 to 3721.17 of the Revised 13063
Code is a separate offense for each day of the violation and for 13064
each resident who claims the violation. 13065

(G) No home or employee of a home shall retaliate against any 13066
person who: 13067

(1) Exercises any right set forth in sections 3721.10 to 13068
3721.17 of the Revised Code, including, but not limited to, filing 13069
a complaint with the home's grievance committee or reporting an 13070
alleged violation to the department of health; 13071

(2) Appears as a witness in any hearing conducted under this 13072
section or section 3721.162 of the Revised Code; 13073

(3) Files a civil action alleging a violation of sections 13074
3721.10 to 3721.17 of the Revised Code, or notifies a county 13075
prosecuting attorney or the attorney general of a possible 13076

violation of sections 3721.10 to 3721.17 of the Revised Code. 13077

If, under the procedures outlined in this section, a home or 13078
its employee is found to have retaliated, the violator may be 13079
fined up to one thousand dollars. 13080

(H) When legal action is indicated, any evidence of criminal 13081
activity found in an investigation under division (C) of this 13082
section shall be given to the prosecuting attorney in the county 13083
in which the home is located for investigation. 13084

(I)(1)(a) Any resident whose rights under sections 3721.10 to 13085
3721.17 of the Revised Code are violated has a cause of action 13086
against any person or home committing the violation. 13087

(b) An action under division (I)(1)(a) of this section may be 13088
commenced by the resident or by the resident's legal guardian or 13089
other legally authorized representative on behalf of the resident 13090
or the resident's estate. If the resident or the resident's legal 13091
guardian or other legally authorized representative is unable to 13092
commence an action under that division on behalf of the resident, 13093
the following persons in the following order of priority have the 13094
right to and may commence an action under that division on behalf 13095
of the resident or the resident's estate: 13096

(i) The resident's spouse; 13097

(ii) The resident's parent or adult child; 13098

(iii) The resident's guardian if the resident is a minor 13099
child; 13100

(iv) The resident's brother or sister; 13101

(v) The resident's niece, nephew, aunt, or uncle. 13102

(c) Notwithstanding any law as to priority of persons 13103
entitled to commence an action, if more than one eligible person 13104
within the same level of priority seeks to commence an action on 13105
behalf of a resident or the resident's estate, the court shall 13106

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. 13138

(3) Division (I)(2) (b) of this section shall be considered 13139
to be purely remedial in operation and shall be applied in a 13140
remedial manner in any civil action in which this section is 13141
relevant, whether the action is pending in court or commenced on 13142
or after July 9, 1998. 13143

(4) Within thirty days after the filing of a complaint in an 13144
action for damages brought against a home under division (I)(1)(a) 13145
of this section by or on behalf of a resident or former resident 13146
of the home, the plaintiff or plaintiff's counsel shall send 13147
written notice of the filing of the complaint to the department of 13148
job and family services if the department has a right of recovery 13149
under section ~~5101.58~~ 5160.38 of the Revised Code against the 13150
liability of the home for the cost of medical services and care 13151
arising out of injury, disease, or disability of the resident or 13152
former resident. 13153

Sec. 3721.19. (A) As used in this section: 13154

(1) "Home" and "residential care facility" have the same 13155
meanings as in section 3721.01 of the Revised Code; 13156

(2) "Sponsor" and "residents' rights advocate" have the same 13157
meanings as in section 3721.10 of the Revised Code. 13158

A home licensed under this chapter that is not a party to a 13159
provider agreement, as defined in section ~~5111.20~~ 5164.01 of the 13160
Revised Code, shall provide each prospective resident, before 13161
admission, with the following information, orally and in a 13162
separate written notice on which is printed in a conspicuous 13163
manner: "This home is not a participant in the ~~medical assistance~~ 13164
medicaid program administered by the Ohio department of ~~job and~~ 13165
~~family services~~ health care administration. Consequently, you may 13166
be discharged from this home if you are unable to pay for the 13167

services provided by this home." 13168

If the prospective resident has a sponsor whose identity is 13169
made known to the home, the home shall also inform the sponsor, 13170
before admission of the resident, of the home's status relative to 13171
the ~~medical assistance~~ medicaid program. Written ~~acknowledgement~~ 13172
acknowledgment of the receipt of the information shall be provided 13173
by the resident and, if the prospective resident has a sponsor who 13174
has been identified to the home, by the sponsor. The written 13175
~~acknowledgement~~ acknowledgment shall be made part of the 13176
resident's record by the home. 13177

No home shall terminate its status as a provider under the 13178
medicaid program unless it has complied with section ~~5111.66~~ 13179
5164.83 of the Revised Code and, at least ninety days prior to 13180
such termination, provided written notice to the residents of the 13181
home and their sponsors of such action. This requirement shall not 13182
apply in cases where the department of ~~job and family services~~ 13183
health care administration terminates a home's provider agreement 13184
or provider status. 13185

(B) A home licensed under this chapter as a residential care 13186
facility shall provide notice to each prospective resident or the 13187
individual's sponsor of the services offered by the facility and 13188
the types of skilled nursing care that the facility may provide. A 13189
residential care facility that, pursuant to section 3721.012 of 13190
the Revised Code, has a policy of entering into risk agreements 13191
with residents or their sponsors shall provide each prospective 13192
resident or the individual's sponsor a written explanation of the 13193
policy and the provisions that may be contained in a risk 13194
agreement. At the time the information is provided, the facility 13195
shall obtain a statement signed by the individual receiving the 13196
information acknowledging that the individual received the 13197
information. The facility shall maintain on file the individual's 13198
signed statement. 13199

(C) A resident has a cause of action against a home for 13200
breach of any duty imposed by this section. The action may be 13201
commenced by the resident, or on the resident's behalf by the 13202
resident's sponsor or a residents' rights advocate, by the filing 13203
of a civil action in the court of common pleas of the county in 13204
which the home is located, or in the court of common pleas of 13205
Franklin county. 13206

If the court finds that a breach of any duty imposed by this 13207
section has occurred, the court shall enjoin the home from 13208
discharging the resident from the home until arrangements 13209
satisfactory to the court are made for the orderly transfer of the 13210
resident to another mode of health care including, but not limited 13211
to, another home, and may award the resident and a person or 13212
public agency that brings an action on behalf of a resident 13213
reasonable attorney's fees. If a home discharges a resident to 13214
whom or to whose sponsor information concerning its status 13215
relative to the ~~medical assistance~~ medicaid program was not 13216
provided as required under this section, the court shall grant any 13217
appropriate relief including, but not limited to, actual damages, 13218
reasonable attorney's fees, and costs. 13219

Sec. 3721.21. As used in sections 3721.21 to 3721.34 of the 13220
Revised Code: 13221

(A) "Long-term care facility" means either of the following: 13222

(1) A nursing home as defined in section 3721.01 of the 13223
Revised Code, other than a nursing home or part of a nursing home 13224
certified as an intermediate care facility for the mentally 13225
retarded under ~~Title XIX of the "Social Security Act," 49 Stat.~~ 13226
~~620 (1935), 42 U.S.C.A. 301, as amended~~ medicaid program; 13227

(2) A facility or part of a facility that is certified as a 13228
skilled nursing facility or a nursing facility under ~~Title XVIII~~ 13229
~~or XIX of the "Social Security Act~~ medicare program and medicaid 13230

<u>program.</u> "	13231
(B) "Residential care facility" has the same meaning as in section 3721.01 of the Revised Code.	13232 13233
(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.	13234 13235 13236 13237 13238 13239
(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.	13240 13241 13242 13243 13244 13245 13246
(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.	13247 13248 13249 13250
(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.	13251 13252 13253
(G) "Physical restraint" has the same meaning as in section 3721.10 of the Revised Code.	13254 13255
(H) "Chemical restraint" has the same meaning as in section 3721.10 of the Revised Code.	13256 13257
(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	13258 13259 13260

adopt in accordance with Chapter 119. of the Revised Code. 13261

(J) "Personal care services" has the same meaning as in 13262
section 3721.01 of the Revised Code. 13263

(K)(1) Except as provided in division (K)(2) of this section, 13264
"nurse aide" means an individual who provides nursing and 13265
nursing-related services to residents in a long-term care 13266
facility, either as a member of the staff of the facility for 13267
monetary compensation or as a volunteer without monetary 13268
compensation. 13269

(2) "Nurse aide" does not include either of the following: 13270

(a) A licensed health professional practicing within the 13271
scope of the professional's license; 13272

(b) An individual providing nursing and nursing-related 13273
services in a religious nonmedical health care institution, if the 13274
individual has been trained in the principles of nonmedical care 13275
and is recognized by the institution as being competent in the 13276
administration of care within the religious tenets practiced by 13277
the residents of the institution. 13278

(L) "Licensed health professional" means all of the 13279
following: 13280

(1) An occupational therapist or occupational therapy 13281
assistant licensed under Chapter 4755. of the Revised Code; 13282

(2) A physical therapist or physical therapy assistant 13283
licensed under Chapter 4755. of the Revised Code; 13284

(3) A physician authorized under Chapter 4731. of the Revised 13285
Code to practice medicine and surgery, osteopathic medicine and 13286
surgery, or podiatry; 13287

(4) A physician assistant authorized under Chapter 4730. of 13288
the Revised Code to practice as a physician assistant; 13289

(5) A registered nurse or licensed practical nurse licensed 13290

under Chapter 4723. of the Revised Code;	13291
(6) A social worker or independent social worker licensed	13292
under Chapter 4757. of the Revised Code or a social work assistant	13293
registered under that chapter;	13294
(7) A speech-language pathologist or audiologist licensed	13295
under Chapter 4753. of the Revised Code;	13296
(8) A dentist or dental hygienist licensed under Chapter	13297
4715. of the Revised Code;	13298
(9) An optometrist licensed under Chapter 4725. of the	13299
Revised Code;	13300
(10) A pharmacist licensed under Chapter 4729. of the Revised	13301
Code;	13302
(11) A psychologist licensed under Chapter 4732. of the	13303
Revised Code;	13304
(12) A chiropractor licensed under Chapter 4734. of the	13305
Revised Code;	13306
(13) A nursing home administrator licensed or temporarily	13307
licensed under Chapter 4751. of the Revised Code;	13308
(14) A professional counselor or professional clinical	13309
counselor licensed under Chapter 4757. of the Revised Code.	13310
(M) "Religious nonmedical health care institution" means an	13311
institution that meets or exceeds the conditions to receive	13312
payment under the medicare program established under Title XVIII	13313
of the "Social Security Act" for inpatient hospital services or	13314
post-hospital extended care services furnished to an individual in	13315
a religious nonmedical health care institution, as defined in	13316
section 1861(ss)(1) of the "Social Security Act," 79 Stat. 286	13317
(1965), 42 U.S.C. 1395x(ss)(1), as amended.	13318
(N) "Competency evaluation program" means a program through	13319
which the competency of a nurse aide to provide nursing and	13320

nursing-related services is evaluated. 13321

(O) "Training and competency evaluation program" means a 13322
program of nurse aide training and evaluation of competency to 13323
provide nursing and nursing-related services. 13324

Sec. 3721.28. (A)(1) Each nurse aide used by a long-term care 13325
facility on a full-time, temporary, per diem, or other basis on 13326
July 1, 1989, shall be provided by the facility a competency 13327
evaluation program approved by the director of health under 13328
division (A) of section 3721.31 of the Revised Code or conducted 13329
by ~~him~~ the director under division (C) of that section. Each 13330
long-term care facility using a nurse aide on July 1, 1989, shall 13331
provide the nurse aide the preparation necessary to complete the 13332
competency evaluation program by January 1, 1990. 13333

(2) Each nurse aide used by a long-term care facility on a 13334
full-time, temporary, per diem, or other basis on January 1, 1990, 13335
who either was not used by the facility on July 1, 1989, or was 13336
used by the facility on July 1, 1989, but had not successfully 13337
completed a competency evaluation program by January 1, 1990, 13338
shall be provided by the facility a competency evaluation program 13339
approved by the director under division (A) of section 3721.31 of 13340
the Revised Code or conducted by ~~him~~ the director under division 13341
(C) of that section. Each long-term care facility using a nurse 13342
aide described in division (A)(2) of this section shall provide 13343
the nurse aide the preparation necessary to complete the 13344
competency evaluation program by October 1, 1990, and shall assist 13345
the nurse aide in registering for the program. 13346

(B) Effective June 1, 1990, no long-term care facility shall 13347
use an individual as a nurse aide for more than four months unless 13348
the individual is competent to provide the services ~~he~~ the 13349
individual is to provide, the facility has received from the nurse 13350
aide registry established under section 3721.32 of the Revised 13351

Code the information concerning the individual provided through 13352
the registry, and one of the following is the case: 13353

(1) The individual was used by a facility as a nurse aide on 13354
a full-time, temporary, per diem, or other basis at any time 13355
during the period commencing July 1, 1989, and ending January 1, 13356
1990, and successfully completed, not later than October 1, 1990, 13357
a competency evaluation program approved by the director under 13358
division (A) of section 3721.31 of the Revised Code or conducted 13359
by ~~him~~ the director under division (C) of that section. 13360

(2) The individual has successfully completed a training and 13361
competency evaluation program approved by the director under 13362
division (A) of section 3721.31 of the Revised Code or conducted 13363
by ~~him~~ the director under division (C) of that section or has met 13364
the conditions specified in division (F) of this section and, in 13365
addition, if the training and competency evaluation program or the 13366
training, instruction, or education the individual completed in 13367
meeting the conditions specified in division (F) of this section 13368
was conducted by or in a long-term care facility, or if the 13369
director pursuant to division (E) of section 3721.31 of the 13370
Revised Code so requires, the individual has successfully 13371
completed a competency evaluation program conducted by the 13372
director. 13373

(3) Prior to July 1, 1989, if the long-term care facility is 13374
certified as a skilled nursing facility or a nursing facility 13375
under ~~Title XVIII or XIX of the "Social Security Act," 49 Stat.~~ 13376
~~620 (1935), 42 U.S.C.A. 301, as amended~~ medicare program or 13377
medicaid program, or prior to January 1, 1990, if the facility is 13378
not so certified, the individual completed a program that the 13379
director determines included a competency evaluation component no 13380
less stringent than the competency evaluation programs approved by 13381
~~him~~ the director under division (A) of section 3721.31 of the 13382
Revised Code or conducted by ~~him~~ the director under division (C) 13383

of that section, and was otherwise comparable to the training and 13384
competency evaluation programs being approved by the director 13385
under division (A) of that section. 13386

(4) The individual is listed in a nurse aide registry 13387
maintained by another state and that state certifies that its 13388
program for training and evaluation of competency of nurse aides 13389
complies with ~~Titles XVIII and XIX of the "Social Security Act"~~ 13390
medicare program and medicaid program and regulations adopted 13391
thereunder. 13392

(5) Prior to July 1, 1989, the individual was found competent 13393
to serve as a nurse aide after the completion of a course of nurse 13394
aide training of at least one hundred hours' duration. 13395

(6) The individual is enrolled in a prelicensure program of 13396
nursing education approved by the board of nursing or by an agency 13397
of another state that regulates nursing education, has provided 13398
the long-term care facility with a certificate from the program 13399
indicating that the individual has successfully completed the 13400
courses that teach basic nursing skills including infection 13401
control, safety and emergency procedures, and personal care, and 13402
has successfully completed a competency evaluation program 13403
conducted by the director under division (C) of section 3721.31 of 13404
the Revised Code. 13405

(7) The individual has the equivalent of twelve months or 13406
more of full-time employment in the preceding five years as a 13407
hospital aide or orderly and has successfully completed a 13408
competency evaluation program conducted by the director under 13409
division (C) of section 3721.31 of the Revised Code. 13410

(C) Effective June 1, 1990, no long-term care facility shall 13411
continue for longer than four months to use as a nurse aide an 13412
individual who previously met the requirements of division (B) of 13413
this section but since most recently doing so has not performed 13414

nursing and nursing-related services for monetary compensation for 13415
twenty-four consecutive months, unless the individual successfully 13416
completes additional training and competency evaluation by 13417
complying with divisions (C)(1) and (2) of this section: 13418

(1) Doing one of the following: 13419

(a) Successfully completing a training and competency 13420
evaluation program approved by the director under division (A) of 13421
section 3721.31 of the Revised Code or conducted by ~~him~~ the 13422
director under division (C) of that section; 13423

(b) Successfully completing a training and competency 13424
evaluation program described in division (B)(4) of this section; 13425

(c) Meeting the requirements specified in division (B)(6) or 13426
(7) of this section. 13427

(2) If the training and competency evaluation program 13428
completed under division (C)(1)(a) of this section was conducted 13429
by or in a long-term care facility, or if the director pursuant to 13430
division (E) of section 3721.31 of the Revised Code so requires, 13431
successfully completing a competency evaluation program conducted 13432
by the director. 13433

(D)(1) The four-month periods provided for in divisions (B) 13434
and (C) of this section include any time, on or after June 1, 13435
1990, that an individual is used as a nurse aide on a full-time, 13436
temporary, per diem, or any other basis by the facility or any 13437
other long-term care facility. 13438

(2) During the four-month period provided for in division (B) 13439
of this section, during which a long-term care facility may, 13440
subject to division (E) of this section, use as a nurse aide an 13441
individual who does not have the qualifications specified in 13442
divisions (B)(1) to (7) of this section, a facility shall require 13443
the individual to comply with divisions (D)(2)(a) and (b) of this 13444
section: 13445

(a) Participate in one of the following: 13446

(i) If the individual has successfully completed a training 13447
and competency evaluation program approved by the director under 13448
division (A) of section 3721.31 of the Revised Code, and the 13449
program was conducted by or in a long-term care facility, or the 13450
director pursuant to division (E) of section 3721.31 of the 13451
Revised Code so requires, a competency evaluation program 13452
conducted by the director; 13453

(ii) If the individual is enrolled in a prelicensure program 13454
of nursing education described in division (B)(6) of this section 13455
and has completed or is working toward completion of the courses 13456
described in that division, or the individual has the experience 13457
described in division (B)(7) of this section, a competency 13458
evaluation program conducted by the director; 13459

(iii) A training and competency evaluation program approved 13460
by the director under division (A) of section 3721.31 of the 13461
Revised Code or conducted by ~~him~~ the director under division (C) 13462
of that section. 13463

(b) If the individual participates in or has successfully 13464
completed a training and competency evaluation program under 13465
division (D)(2)(a)(iii) of this section that is conducted by or in 13466
a long-term care facility, or the director pursuant to division 13467
(E) of section 3721.31 of the Revised Code so requires, ~~participate~~ 13468
participate in a competency evaluation program conducted by the 13469
director. 13470

(3) During the four-month period provided for in division (C) 13471
of this section, during which a long-term care facility may, 13472
subject to division (E) of this section, use as a nurse aide an 13473
individual who does not have the qualifications specified in 13474
divisions (C)(1) and (2) of this section, a facility shall require 13475
the individual to comply with divisions (D)(3)(a) and (b) of this 13476

section:	13477
(a) Participate in one of the following:	13478
(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;	13479 13480 13481 13482 13483 13484
(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;	13485 13486 13487 13488 13489 13490
(iii) A training and competency evaluation program approved or conducted by the director.	13491 13492
(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.	13493 13494 13495 13496 13497 13498 13499
(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:	13500 13501 13502 13503 13504
(1) The individual has completed the number of hours of training that he must complete <u>be completed</u> prior to providing services to residents as prescribed by rules that shall be adopted	13505 13506 13507

by the director in accordance with Chapter 119. of the Revised Code; 13508
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(2) The individual is under the personal supervision of a registered or licensed practical nurse licensed under Chapter 4723. of the Revised Code. 13510
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(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: 13513
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(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; 13518
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(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. 13522
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(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. 13527
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(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." 13533
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Sec. 3721.32. (A) The director of health shall establish a 13538
state nurse aide registry listing all individuals who have done 13539
any of the following: 13540

(1) Were used by a long-term care facility as nurse aides on 13541
a full-time, temporary, per diem, or other basis at any time 13542
during the period commencing July 1, 1989, and ending January 1, 13543
1990, and successfully completed, not later than October 1, 1990, 13544
a competency evaluation program approved by the director under 13545
division (A) of section 3721.31 of the Revised Code or conducted 13546
by the director under division (C) of that section; 13547

(2) Successfully completed a training and competency 13548
evaluation program approved by the director under division (A) of 13549
section 3721.31 of the Revised Code or met the conditions 13550
specified in division (F) of section 3721.28 of the Revised Code, 13551
and, if the training and competency evaluation program or the 13552
training, instruction, or education the individual completed in 13553
meeting the conditions specified in division (F) of section 13554
3721.28 of the Revised Code was conducted in or by a long-term 13555
care facility, or if the director so required pursuant to division 13556
(E) of section 3721.31 of the Revised Code, has successfully 13557
completed a competency evaluation program conducted by the 13558
director; 13559

(3) Successfully completed a training and competency 13560
evaluation program conducted by the director under division (C) of 13561
section 3721.31 of the Revised Code; 13562

(4) Successfully completed, prior to July 1, 1989, a program 13563
that the director has determined under division (B)(3) of section 13564
3721.28 of the Revised Code included a competency evaluation 13565
component no less stringent than the competency evaluation 13566
programs approved or conducted by the director under section 13567
3721.31 of the Revised Code, and was otherwise comparable to the 13568

training and competency evaluation program being approved by the 13569
director under section 3721.31 of the Revised Code; 13570

(5) Are listed in a nurse aide registry maintained by another 13571
state that certifies that its program for training and evaluation 13572
of competency of nurse aides complies with ~~Titles XVIII and XIX of~~ 13573
the ~~"Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301,~~ 13574
~~as amended~~ medicare program and medicaid program, or regulations 13575
adopted thereunder; 13576

(6) Were found competent, as provided in division (B)(5) of 13577
section 3721.28 of the Revised Code, prior to July 1, 1989, after 13578
the completion of a course of nurse aide training of at least one 13579
hundred hours' duration; 13580

(7) Are enrolled in a prelicensure program of nursing 13581
education approved by the board of nursing or by an agency of 13582
another state that regulates nursing education, have provided the 13583
long-term care facility with a certificate from the program 13584
indicating that the individual has successfully completed the 13585
courses that teach basic nursing skills including infection 13586
control, safety and emergency procedures, and personal care, and 13587
have successfully completed a competency evaluation program 13588
conducted by the director under division (A) of section 3721.31 of 13589
the Revised Code; 13590

(8) Have the equivalent of twelve months or more of full-time 13591
employment in the five years preceding listing in the registry as 13592
a hospital aide or orderly and have successfully completed a 13593
competency evaluation program conducted by the director under 13594
division (C) of section 3721.31 of the Revised Code. 13595

(B) The registry shall include both of the following: 13596

(1) The statement required by section 3721.23 of the Revised 13597
Code detailing findings by the director under that section 13598
regarding alleged abuse or neglect of a resident or 13599

misappropriation of resident property; 13600

(2) Any statement provided by an individual under section 13601
3721.23 of the Revised Code disputing the director's findings. 13602

Whenever an inquiry is received as to the information 13603
contained in the registry concerning an individual about whom a 13604
statement required by section 3721.23 of the Revised Code is 13605
included in the registry, the director shall disclose the 13606
statement or a summary of the statement together with any 13607
statement provided by the individual under section 3721.23 or a 13608
clear and accurate summary of that statement. 13609

(C) The director may by rule specify additional information 13610
that must be provided the registry by long-term care facilities 13611
and persons or government agencies conducting approved competency 13612
evaluation programs and training and competency evaluation 13613
programs. 13614

(D) Information contained in the registry is a public record 13615
for the purposes of section 149.43 of the Revised Code, and is 13616
subject to inspection and copying under section 1347.08 of the 13617
Revised Code. 13618

Sec. 3722.10. (A) The public health council shall have the 13619
exclusive authority to adopt and shall adopt rules in accordance 13620
with Chapter 119. of the Revised Code governing the licensing and 13621
operation of adult care facilities. The rules shall specify: 13622

(1) Procedures for the issuance, renewal, and revocation of 13623
licenses and temporary licenses, for the granting and denial of 13624
waivers, and for the issuance and termination of orders of 13625
suspension of admission pursuant to section 3722.07 of the Revised 13626
Code; 13627

(2) The qualifications required for owners, managers, and 13628
employees of adult care facilities, including character, training, 13629

education, experience, and financial resources and the number of 13630
staff members required in a facility; 13631

(3) Adequate space, equipment, safety, and sanitation 13632
standards for the premises of adult care facilities, and fire 13633
protection standards for adult family homes as required by section 13634
3722.041 of the Revised Code; 13635

(4) The personal, social, dietary, and recreational services 13636
to be provided to each resident of adult care facilities; 13637

(5) Rights of residents of adult care facilities, in addition 13638
to the rights enumerated under section 3722.12 of the Revised 13639
Code, and procedures to protect and enforce the rights of these 13640
residents; 13641

(6) Provisions for keeping records of residents and for 13642
maintaining the confidentiality of the records as required by 13643
division (B) of section 3722.12 of the Revised Code. The 13644
provisions for maintaining the confidentiality of records shall, 13645
at the minimum, meet the requirements for maintaining the 13646
confidentiality of records under ~~Title XIX of the Social Security~~ 13647
~~Act, 49 Stat. 620, 42 U.S.C. 301, as amended~~ medicaid program, and 13648
regulations promulgated thereunder. 13649

(7) Measures to be taken by adult care facilities relative to 13650
residents' medication, including policies and procedures 13651
concerning medication, storage of medication in a locked area, and 13652
disposal of medication and assistance with self-administration of 13653
medication, if the facility provides assistance; 13654

(8) Requirements for initial and periodic health assessments 13655
of prospective and current adult care facility residents by 13656
physicians or other health professionals to ensure that they do 13657
not require a level of care beyond that which is provided by the 13658
adult care facility, including assessment of their capacity to 13659
self-administer the medications prescribed for them; 13660

(9) Requirements relating to preparation of special diets;	13661
(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;	13662 13663 13664
(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;	13665 13666 13667 13668 13669 13670 13671
(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:	13672 13673 13674
(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:	13675 13676 13677 13678 13679 13680 13681
(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.	13682 13683 13684 13685 13686 13687
(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;	13688 13689 13690 13691

(iii) Any other process regarding referrals and effective arrangements for ongoing mental health services.	13692 13693
(b) Specify the date an owner or manager must begin to follow the procedures established by division (A)(12)(a) of this section.	13694 13695
(13) Any other rules necessary for the administration and enforcement of this chapter.	13696 13697
(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.	13698 13699 13700 13701 13702 13703
(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.	13704 13705 13706
(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.	13707 13708 13709
(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.	13710 13711 13712 13713 13714
Sec. 3722.16. (A) No person shall:	13715
(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;	13716 13717 13718
(2) Admit to an adult care facility more residents than the number authorized in the facility's license;	13719 13720

(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; 13751

(3) The individual to whom the skilled nursing care is 13752
provided is suffering from a short-term illness; 13753

(4) If the skilled nursing care is to be provided by the 13754
nursing staff of a nursing home, all of the following are the 13755
case: 13756

(a) The adult care facility evaluates the individual 13757
receiving the skilled nursing care at least once every seven days 13758
to determine whether the individual should be transferred to a 13759
nursing home; 13760

(b) The adult care facility meets at all times staffing 13761
requirements established by rules adopted under section 3722.10 of 13762
the Revised Code; 13763

(c) The nursing home does not include the cost of providing 13764
skilled nursing care to the adult care facility residents in a 13765
cost report filed under section ~~5111.26~~ 5164.37 of the Revised 13766
Code; 13767

(d) The nursing home meets at all times the nursing home 13768
licensure staffing ratios established by rules adopted under 13769
section 3721.04 of the Revised Code; 13770

(e) The nursing home staff providing skilled nursing care to 13771
adult care facility residents are registered nurses or licensed 13772
practical nurses licensed under Chapter 4723. of the Revised Code 13773
and meet the personnel qualifications for nursing home staff 13774
established by rules adopted under section 3721.04 of the Revised 13775
Code; 13776

(f) The skilled nursing care is provided in accordance with 13777
rules established for nursing homes under section 3721.04 of the 13778
Revised Code; 13779

(g) The nursing home meets the skilled nursing care needs of 13780

the adult care facility residents; 13781

(h) Using the nursing home's nursing staff does not prevent 13782
the nursing home or adult care facility from meeting the needs of 13783
the nursing home and adult care facility residents in a quality 13784
and timely manner. 13785

Notwithstanding section 3721.01 of the Revised Code, an adult 13786
care facility in which residents receive skilled nursing care as 13787
described in division (B) of this section is not a nursing home. 13788
No adult care facility shall provide skilled nursing care. 13789

(C) A home health agency or hospice care program that 13790
provides skilled nursing care pursuant to division (B) of this 13791
section may not be associated with the adult care facility unless 13792
the facility is part of a home for the aged as defined in section 13793
5701.13 of the Revised Code or the adult care facility is owned 13794
and operated by the same person and located on the same site as a 13795
nursing home licensed under Chapter 3721. of the Revised Code that 13796
is associated with the home health agency or hospice care program. 13797
In addition, the following requirements shall be met: 13798

(1) The adult care facility shall evaluate the individual 13799
receiving the skilled nursing care not less than once every seven 13800
days to determine whether the individual should be transferred to 13801
a nursing home; 13802

(2) If the costs of providing the skilled nursing care are 13803
included in a cost report filed pursuant to section ~~5111.26~~ 13804
5164.37 of the Revised Code by the nursing home that is part of 13805
the same home for the aged, the home health agency or hospice care 13806
program shall not seek reimbursement for the care under the 13807
~~medical assistance~~ medicaid program ~~established under Chapter~~ 13808
~~5111. of the Revised Code.~~ 13809

(D)(1) No person knowingly shall place or recommend placement 13810
of any person in an adult care facility that is operating without 13811

a license. 13812

(2) No employee of a unit of local or state government, board 13813
of alcohol, drug addiction, and mental health services, mental 13814
health agency, or PASSPORT administrative agency shall place or 13815
recommend placement of any person in an adult care facility if the 13816
employee knows that the facility cannot meet the needs of the 13817
potential resident. 13818

(3) No person who has reason to believe that an adult care 13819
facility is operating without a license shall fail to report this 13820
information to the director of health. 13821

(E) In accordance with Chapter 119. of the Revised Code, the 13822
public health council shall adopt rules that define a short-term 13823
illness for purposes of division (B)(3) of this section and 13824
specify, consistent with rules pertaining to home health care 13825
adopted by the director of ~~job and family services~~ health care 13826
administration under the ~~medical assistance~~ medicaid program 13827
~~established under Chapter 5111. of the Revised Code and Title XIX~~ 13828
~~of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C. 301,~~ 13829
~~as amended,~~ what constitutes a part-time, intermittent basis for 13830
purposes of division (B)(1) of this section. 13831

Sec. 3727.02. (A) No person and no political subdivision, 13832
agency, or instrumentality of this state shall operate a hospital 13833
unless it is certified under ~~Title XVIII of the "Social Security~~ 13834
~~Act," 49 Stat. 620 (1935), 42 U.S.C. 301, as amended~~ medicare 13835
program, or is accredited by the joint commission on accreditation 13836
of hospitals or the American osteopathic association. 13837

(B) No person and no political subdivision, agency, or 13838
instrumentality of this state shall hold out as a hospital any 13839
health facility that is not certified or accredited as required in 13840
division (A) of this section. 13841

Sec. 3742.30. Each child at risk of lead poisoning shall 13842
undergo a blood lead screening test to determine whether the child 13843
has lead poisoning. The at-risk children shall undergo the test at 13844
times determined by rules the public health council shall adopt in 13845
accordance with Chapter 119. of the Revised Code that are 13846
consistent with the guidelines established by the centers for 13847
disease control and prevention in the public health service of the 13848
United States department of health and human services. The rules 13849
shall specify which children are at risk of lead poisoning. 13850

Neither this section nor the rules adopted under it affect 13851
the coverage of blood lead screening tests by any publicly funded 13852
health program, including the medicaid program ~~established by~~ 13853
~~Chapter 5111. of the Revised Code.~~ Neither this section nor the 13854
rules adopted under it apply to a child if a parent of the child 13855
objects to the test on the grounds that the test conflicts with 13856
the parent's religious tenets and practices. 13857

Sec. 3742.51. (A) There is hereby created in the state 13858
treasury the lead poisoning prevention fund. The fund shall 13859
include all moneys appropriated to the department of health for 13860
the administration and enforcement of sections 3742.31 to 3742.50 13861
of the Revised Code and the rules adopted under those sections. 13862
Any grants, contributions, or other moneys collected by the 13863
department for purposes of preventing lead poisoning shall be 13864
deposited in the state treasury to the credit of the fund. 13865

(B) Moneys in the fund shall be used solely for the purposes 13866
of the child lead poisoning prevention program established under 13867
section 3742.31 of the Revised Code, including providing financial 13868
assistance to individuals who are unable to pay for the following: 13869

(1) Costs associated with obtaining lead tests and lead 13870
poisoning treatment for children under six years of age who are 13871

not covered by private medical insurance or are underinsured, are 13872
not eligible for the medicaid program established under Chapter 13873
~~5111. of the Revised Code~~ or any other government health program, 13874
and do not have access to another source of funds to cover the 13875
cost of lead tests and any indicated treatments; 13876

(2) Costs associated with having lead abatement performed or 13877
having the preventive treatments specified in section 3742.41 of 13878
the Revised Code performed. 13879

Sec. 3793.07. ~~(A) As used in this section:~~ 13880

~~(1) "Medicare program" means the program established under 13881
Title XVIII of the "Social Security Act," 49 Stat. 620 (1935), 42 13882
U.S.C. 301, as amended;~~ 13883

~~(2) "Medicaid program" means the program established under 13884
Title XIX of the "Social Security Act."~~ 13885

~~(B)~~(A) Except as provided in division ~~(D)~~(C) of this section, 13886
the department of alcohol and drug addiction services shall 13887
establish and administer a process for the certification or 13888
credentialing of chemical dependency counselors and alcohol and 13889
other drug prevention specialists for the purpose of qualifying 13890
their services for reimbursement under the medicare or medicaid 13891
program. The process shall be made available to any individual who 13892
is a member of the profession of drug abuse counseling or chemical 13893
dependency counseling or any individual who is an alcohol and 13894
other drug prevention specialist. Nothing in this section shall be 13895
construed as requiring such certification or credentials for 13896
services that are not reimbursed by medicare or medicaid. 13897

The department shall cease to administer its process for the 13898
certification or credentialing of chemical dependency counselors 13899
and alcohol and other drug prevention specialists under this 13900
section at the earlier of the following: 13901

(1) The date, which shall be specified in an agreement 13902
between the department and chemical dependency professionals 13903
board, on which the board is to assume, under Chapter 4758. of the 13904
Revised Code, the department's certification duties; 13905

(2) Two years after ~~the effective date of this amendment~~ 13906
December 23, 2002. 13907

~~(C)~~(B) The department shall adopt rules in accordance with 13908
Chapter 119. of the Revised Code establishing standards and 13909
procedures for the certification or credentialing process. The 13910
rules shall include the following: 13911

(1) Eligibility requirements; 13912

(2) Application procedures; 13913

(3) Minimum educational and clinical training requirements 13914
that must be met for initial certification or credentialing; 13915

(4) Continuing education and training requirements for 13916
certified or credentialed individuals; 13917

(5) Application and renewal fees that do not exceed the cost 13918
incurred by the department in implementing and administering the 13919
process; 13920

(6) Administration or approval of examinations; 13921

(7) Investigation of complaints and alleged violations of 13922
this section; 13923

(8) Maintenance of the confidentiality of the department's 13924
investigative records; 13925

(9) Disciplinary actions, including application denial and 13926
suspension or revocation of certification or credentials; 13927

(10) Any other rules the department considers necessary to 13928
establish or administer the certification or credentialing 13929
process. 13930

~~(D)~~(C)(1) Except as provided in division ~~(D)~~(C)(2) of this 13931
section, the department shall not issue an initial certificate or 13932
credential to practice as a chemical dependency counselor I, but 13933
may renew such a certificate or credential issued prior to ~~the~~ 13934
~~effective date of this amendment~~ December 23, 2002, or pursuant to 13935
division ~~(D)~~(C)(2) of this section until the department ceases to 13936
administer the certification and credentialing process under this 13937
section. 13938

(2) The department may issue an initial certificate or 13939
credential to practice as a chemical dependency counselor I to an 13940
individual if the individual submitted the application for 13941
certification or credentials to the department prior to ~~the~~ 13942
~~effective date of this amendment~~ December 23, 2002. 13943

~~(E)~~(D) The department shall investigate alleged violations of 13944
this section or the rules adopted under it. As part of its 13945
investigation, the department may issue subpoenas, examine 13946
witnesses, and administer oaths. The department shall ensure that 13947
all records it holds pertaining to an investigation remain 13948
confidential. 13949

~~(F)~~(E) With respect to hearings conducted by the department 13950
as part of the certification or credentialing process, both of the 13951
following apply: 13952

(1) An individual whose application for certification or 13953
credentials issued under this section has been denied by the 13954
department may request a hearing in accordance with Chapter 119. 13955
of the Revised Code and the rules adopted under this section. 13956

(2) The department may appoint a referee or hearing examiner 13957
to conduct the proceedings and make recommendations to the 13958
department as appropriate. 13959

~~(G)~~(F) The department shall maintain a record of all fees 13960
collected under this section. All fees collected shall be paid 13961

into the state treasury to the credit of the credentialing fund, 13962
which is hereby created. Money credited to the fund shall be used 13963
solely to pay the costs of establishing and administering the 13964
process for certification or credentialing of chemical dependency 13965
professionals under this section. 13966

Money credited to the credentialing fund under this section 13967
shall be transferred to the occupational licensing and regulatory 13968
fund created under section 4743.05 of the Revised Code at the 13969
earlier of the following: 13970

(1) The date, which shall be specified in an agreement 13971
between the department and chemical dependency professionals 13972
board, on which the board is to assume, under Chapter 4758. of the 13973
Revised Code, the department's certification duties; 13974

(2) Two years after ~~the effective date of this amendment~~ 13975
December 23, 2002. 13976

~~(H)~~(G) Certifications made and credentials issued by the Ohio 13977
credentialing board for chemical dependency professionals prior to 13978
the date the department establishes its certification or 13979
credentialing process under this section shall continue to be 13980
accepted by the department until, with respect to any particular 13981
individual, one of the following occurs: 13982

(1) The individual's certification or credentials from the 13983
board have expired. 13984

(2) The individual's certification or credentials from the 13985
board would be suspended or revoked by the department if the 13986
certification or credentials had been issued by the department 13987
under this section. 13988

Sec. 3901.3814. Sections 3901.38 and 3901.381 to 3901.3813 of 13989
the Revised Code do not apply to the following: 13990

(A) Policies offering coverage that is regulated under 13991

Chapters 3935. and 3937. of the Revised Code; 13992

(B) An employer's self-insurance plan and any of its 13993
administrators, as defined in section 3959.01 of the Revised Code, 13994
to the extent that federal law supersedes, preempts, prohibits, or 13995
otherwise precludes the application of any provisions of those 13996
sections to the plan and its administrators; 13997

(C) A third-party payer for coverage provided under the 13998
medicare advantage program operated under ~~Title XVIII of the~~ 13999
~~"Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as~~ 14000
~~amended the medicare program;~~ 14001

(D) A third-party payer for coverage provided under the 14002
medicaid program ~~operated under Title XIX of the "Social Security~~ 14003
~~Act,"~~ except that if a federal waiver applied for under section 14004
~~5111.178~~ 5165.16 of the Revised Code is granted or the director of 14005
~~job and family services~~ health care administration determines that 14006
this provision can be implemented without a waiver, sections 14007
3901.38 and 3901.381 to 3901.3813 of the Revised Code apply to 14008
claims submitted electronically or non-electronically that are 14009
made with respect to coverage of medicaid recipients by health 14010
insuring corporations licensed under Chapter 1751. of the Revised 14011
Code, instead of the prompt payment requirements of 42 C.F.R. 14012
447.46; 14013

(E) A third-party payer for coverage provided under the 14014
tricare program offered by the United States department of 14015
defense. 14016

Sec. 3903.14. (A) The superintendent of insurance as 14017
rehabilitator may appoint one or more special deputies, who shall 14018
have all the powers and responsibilities of the rehabilitator 14019
granted under this section, and the superintendent may employ such 14020
clerks and assistants as considered necessary. The compensation of 14021
the special deputies, clerks, and assistants and all expenses of 14022

taking possession of the insurer and of conducting the proceedings 14023
shall be fixed by the superintendent, with the approval of the 14024
court and shall be paid out of the funds or assets of the insurer. 14025
The persons appointed under this section shall serve at the 14026
pleasure of the superintendent. In the event that the property of 14027
the insurer does not contain sufficient cash or liquid assets to 14028
defray the costs incurred, the superintendent may advance the 14029
costs so incurred out of any appropriation for the maintenance of 14030
the department of insurance. Any amounts so advanced for expenses 14031
of administration shall be repaid to the superintendent for the 14032
use of the department out of the first available money of the 14033
insurer. 14034

(B) The rehabilitator may take such action as the 14035
rehabilitator considers necessary or appropriate to reform and 14036
revitalize the insurer. The rehabilitator shall have all the 14037
powers of the directors, officers, and managers, whose authority 14038
shall be suspended, except as they are redelegated by the 14039
rehabilitator. The rehabilitator shall have full power to direct 14040
and manage, to hire and discharge employees subject to any 14041
contract rights they may have, and to deal with the property and 14042
business of the insurer. 14043

(C) If it appears to the rehabilitator that there has been 14044
criminal or tortious conduct, or breach of any contractual or 14045
fiduciary obligation detrimental to the insurer by any officer, 14046
manager, agent, director, trustee, broker, employee, or other 14047
person, the rehabilitator may pursue all appropriate legal 14048
remedies on behalf of the insurer. 14049

(D) If the rehabilitator determines that reorganization, 14050
consolidation, conversion, reinsurance, merger, or other 14051
transformation of the insurer is appropriate, the rehabilitator 14052
shall prepare a plan to effect such changes. Upon application of 14053
the rehabilitator for approval of the plan, and after such notice 14054

and hearings as the court may prescribe, the court may either 14055
approve or disapprove the plan proposed, or may modify it and 14056
approve it as modified. Any plan approved under this section shall 14057
be, in the judgment of the court, fair and equitable to all 14058
parties concerned. If the plan is approved, the rehabilitator 14059
shall carry out the plan. In the case of a life insurer, the plan 14060
proposed may include the imposition of liens upon the policies of 14061
the company, if all rights of shareholders are first relinquished. 14062
A plan for a life insurer may also propose imposition of a 14063
moratorium upon loan and cash surrender rights under policies, for 14064
such period and to such an extent as may be necessary. 14065

(E) In the case of a medicaid health insuring corporation 14066
that has posted a bond or deposited securities in accordance with 14067
section 1751.271 of the Revised Code, the plan proposed under 14068
division (D) of this section may include the use of the proceeds 14069
of the bond or securities to first pay the claims of contracted 14070
providers for covered health care services provided to medicaid 14071
recipients, then next to pay other claimants with any remaining 14072
funds, consistent with the priorities set forth in sections 14073
3903.421 and 3903.42 of the Revised Code. 14074

(F) The rehabilitator shall have the power under sections 14075
3903.26 and 3903.27 of the Revised Code to avoid fraudulent 14076
transfers. 14077

(G) As used in this section: 14078

(1) "Contracted provider" means a provider with a contract 14079
with a medicaid health insuring corporation to provide covered 14080
health care services to medicaid recipients. 14081

(2) "Medicaid recipient" means a person eligible for 14082
~~assistance under the medicaid program operated pursuant to Chapter~~ 14083
~~5111. of the Revised Code.~~ 14084

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 Code⁷. 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 14115
transferred and that the beneficiary has been designated pursuant 14116
to the viatical settlement contract; 14117

(g) That entering into a viatical settlement contract may 14118
cause other rights or benefits, including conversion rights and 14119
waiver of premium benefits that may exist under the policy or 14120
certificate, to be forfeited by the viator and that assistance 14121
should be sought from a financial advisor. 14122

(2) The viatical settlement provider or viatical settlement 14123
broker shall provide the disclosures under division (A)(1) of this 14124
section in a separate document that is signed by the viator and 14125
the viatical settlement provider or viatical settlement broker. 14126

(3) Disclosure to a viator under division (A)(1) of this 14127
section shall include distribution of a brochure describing the 14128
process of viatical settlements. The viatical settlement provider 14129
or viatical settlement broker shall use the NAIC's form for the 14130
brochure unless one is developed by the superintendent. 14131

(4) The disclosure document under division (A)(1) of this 14132
section shall contain the following language: 14133

"All medical, financial, or personal information solicited or 14134
obtained by a viatical settlement provider or viatical settlement 14135
broker about an insured, including the insured's identity or the 14136
identity of family members, a spouse, or a significant other may 14137
be disclosed as necessary to effect the viatical settlement 14138
between the viator and the viatical settlement provider. If you 14139
are asked to provide this information, you will be asked to 14140
consent to the disclosure. The information may be provided to 14141
someone who buys the policy or provides funds for the purchase. 14142
You may be asked to renew your permission to share information 14143
every two years." 14144

(B)(1) A viatical settlement provider shall disclose at least 14145

the following to a viator prior to the date the viatical settlement contract is signed by all the necessary parties: 14146
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(a) The affiliation, if any, between the viatical settlement provider and the issuer of the insurance policy or certificate to be viaticated; 14148
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(b) The name, address, and telephone number of the viatical settlement provider; 14151
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(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. 14153
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(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; 14158
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(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. 14166
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(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. 14172
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(2) The viatical settlement provider or viatical settlement 14176

broker shall conspicuously display the disclosures under division 14177
(B)(1) of this section in a separate document signed by the viator 14178
and the viatical settlement provider or viatical settlement 14179
broker. 14180

(C) If the provider transfers ownership or changes the 14181
beneficiary of the insurance policy or certificate, the provider 14182
shall communicate the change in ownership or beneficiary to the 14183
insured within twenty days after the change. 14184

Sec. 3923.122. (A) Every policy of group sickness and 14185
accident insurance providing hospital, surgical, or medical 14186
expense coverage for other than specific diseases or accidents 14187
only, and delivered, issued for delivery, or renewed in this state 14188
on or after January 1, 1976, shall include a provision giving each 14189
insured the option to convert to the following: 14190

(1) In the case of an individual who is not a federally 14191
eligible individual, any of the individual policies of hospital, 14192
surgical, or medical expense insurance then being issued by the 14193
insurer with benefit limits not to exceed those in effect under 14194
the group policy; 14195

(2) In the case of a federally eligible individual, a basic 14196
or standard plan established by the board of directors of the Ohio 14197
health reinsurance program or plans substantially similar to the 14198
basic and standard plan in benefit design and scope of covered 14199
services. For purposes of division (A)(2) of this section, the 14200
superintendent of insurance shall determine whether a plan is 14201
substantially similar to the basic or standard plan in benefit 14202
design and scope of covered services. 14203

(B) An option for conversion to an individual policy shall be 14204
available without evidence of insurability to every insured, 14205
including any person eligible under division (D) of this section, 14206
who terminates employment or membership in the group holding the 14207

policy after having been continuously insured thereunder for at least one year. 14208
14209

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: 14210
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14216

(1) The effective date of the converted policy; 14217

(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. 14218
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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. 14226
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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. 14229
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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. 14232
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(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: 14235
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14237

(1) Title XVIII of the Social Security Act, as amended or superseded <u>The medicare program</u> ;	14238 14239
(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;	14240 14241 14242
(3) Any policy that duplicates coverage offered under division (C)(1) of this section;	14243 14244
(4) Any other group sickness and accident insurance providing hospital, surgical, or medical expense coverage for other than specific diseases or accidents only.	14245 14246 14247
(D) The option for conversion shall be available:	14248
(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;	14249 14250 14251
(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;	14252 14253 14254
(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.	14255 14256 14257 14258 14259
Persons possessing the option for conversion pursuant to this division shall be considered members for the purposes of division (H) of this section.	14260 14261 14262
(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 <u>medicare program</u> , the employee may elect, in lieu of the continuance of group insurance, to have the same conversion	14263 14264 14265 14266 14267

rights as would apply had the employee's insurance terminated at 14268
retirement by reason of termination of employment. 14269

(F) If the insurer and the group policyholder agree upon one 14270
or more additional plans of benefits to be available for converted 14271
policies, the applicant for the converted policy may elect such a 14272
plan in lieu of a converted policy. 14273

(G) The converted policy may contain provisions for avoiding 14274
duplication of benefits provided pursuant to divisions (C)(1), 14275
(2), (3), and (4) of this section or provided under any other 14276
insured or noninsured plan or program. 14277

(H) If an employee or member becomes entitled to obtain a 14278
converted policy pursuant to this section, and if the employee or 14279
member has not received notice of the conversion privilege at 14280
least fifteen days prior to the expiration of the thirty-one-day 14281
conversion period provided in division (B) of this section, then 14282
the employee or member has an additional period within which to 14283
exercise the privilege. This additional period shall expire 14284
fifteen days after the employee or member receives notice, but in 14285
no event shall the period extend beyond sixty days after the 14286
expiration of the thirty-one-day conversion period. 14287

Written notice presented to the employee or member, or mailed 14288
by the policyholder to the last known address of the employee or 14289
member as indicated on its records, constitutes notice for the 14290
purpose of this division. In the case of a person who is eligible 14291
for a converted policy under division (D)(2) or (D)(3) of this 14292
section, a policyholder shall not be responsible for presenting or 14293
mailing such notice, unless such policyholder has actual knowledge 14294
of the person's eligibility for a converted policy. 14295

If an additional period is allowed by an employee or member 14296
for the exercise of a conversion privilege, and if written 14297
application for the converted policy, accompanied by at least the 14298

first quarterly premium, is made after the expiration of the 14299
thirty-one-day conversion period, but within the additional period 14300
allowed an employee or member in accordance with this division, 14301
the effective date of the converted policy shall be the date of 14302
application. 14303

(I) The converted policy may provide that any hospital, 14304
surgical, or medical expense benefits otherwise payable with 14305
respect to any person may be reduced by the amount of any such 14306
benefits payable under the group policy for the same loss after 14307
termination of coverage. 14308

(J) The converted policy may contain: 14309

(1) Any exclusion, reduction, or limitation contained in the 14310
group policy or customarily used in individual policies issued by 14311
the insurer; 14312

(2) Any provision permitted in this section; 14313

(3) Any other provision not prohibited by law. 14314

Any provision required or permitted in this section may be 14315
made a part of any converted policy by means of an endorsement or 14316
rider. 14317

(K) The time limit specified in a converted policy for 14318
certain defenses with respect to any person who was covered by a 14319
group policy shall commence on the effective date of such person's 14320
coverage under the group policy. 14321

(L) No insurer shall use deterioration of health as the basis 14322
for refusing to renew a converted policy. 14323

(M) No insurer shall use age as the basis for refusing to 14324
renew a converted policy. 14325

(N) A converted policy made available pursuant to this 14326
section shall, if delivery of the policy is to be made in this 14327
state, comply with this section. If delivery of a converted policy 14328

is to be made in another state, it may be on a form offered by the 14329
insurer in the jurisdiction where the delivery is to be made and 14330
which provides benefits substantially in compliance with those 14331
required in a policy delivered in this state. 14332

(O) As used in this section, "federally eligible individual" 14333
means an eligible individual as defined in 45 C.F.R. 148.103. 14334

Sec. 3923.27. No policy of sickness and accident insurance 14335
delivered, issued for delivery, or renewed in this state after 14336
August 26, 1976, including both individual and group policies, 14337
that provides hospitalization coverage for mental illness shall 14338
exclude such coverage for the reason that the insured is 14339
hospitalized in an institution or facility receiving tax support 14340
from the state, any municipal corporation, county, or joint county 14341
board, whether such institution or facility is deemed charitable 14342
or otherwise, provided the institution or facility or portion 14343
thereof is fully accredited by the joint commission on 14344
accreditation of hospitals or certified under ~~Titles XVIII and XIX~~ 14345
~~of the "Social Security Act of 1935," 79 Stat. 291, 42 U.S.C.A.~~ 14346
~~1395, as amended~~ medicare program and medicaid program. The 14347
insurance coverage shall provide payment amounting to the lesser 14348
of either the full amount of the statutory charge for the cost of 14349
the services pursuant to section 5121.33 of the Revised Code or 14350
the benefits payable for the services under the applicable 14351
insurance policy. Insurance benefits for the coverage shall be 14352
paid so long as patients and their liable relatives retain their 14353
statutory liability pursuant to section 5121.33 of the Revised 14354
Code. Only that portion or per cent of the benefits shall be 14355
payable that has been assigned, or ordered to be paid, to the 14356
state or other appropriate provider for services rendered by the 14357
institution or facility. 14358

Sec. 3923.281. (A) As used in this section: 14359

(1) "Biologically based mental illness" means schizophrenia, 14360
schizoaffective disorder, major depressive disorder, bipolar 14361
disorder, paranoia and other psychotic disorders, 14362
obsessive-compulsive disorder, and panic disorder, as these terms 14363
are defined in the most recent edition of the diagnostic and 14364
statistical manual of mental disorders published by the American 14365
psychiatric association. 14366

(2) "Policy of sickness and accident insurance" has the same 14367
meaning as in section 3923.01 of the Revised Code, but excludes 14368
any hospital indemnity, medicare supplement, long-term care, 14369
disability income, one-time-limited-duration policy of not longer 14370
than six months, supplemental benefit, or other policy that 14371
provides coverage for specific diseases or accidents only; any 14372
policy that provides coverage for workers' compensation claims 14373
compensable pursuant to Chapters 4121. and 4123. of the Revised 14374
Code; and any policy that provides coverage to beneficiaries 14375
enrolled in ~~Title XIX of the "Social Security Act," 49 Stat. 620~~ 14376
~~(1935), 42 U.S.C.A. 301, as amended, known as the medical~~ 14377
~~assistance program or medicaid, as provided by the Ohio department~~ 14378
~~of job and family services under Chapter 5111. of the Revised Code~~ 14379
program. 14380

(B) Notwithstanding section 3901.71 of the Revised Code, and 14381
subject to division (E) of this section, every group policy of 14382
sickness and accident insurance shall provide benefits for the 14383
diagnosis and treatment of biologically based mental illnesses on 14384
the same terms and conditions as, and shall provide benefits no 14385
less extensive than, those provided under the policy of sickness 14386
and accident insurance for the treatment and diagnosis of all 14387
other physical diseases and disorders, if both of the following 14388
apply: 14389

(1) The biologically based mental illness is clinically 14390
diagnosed by a physician authorized under Chapter 4731. of the 14391

Revised Code to practice medicine and surgery or osteopathic 14392
medicine and surgery; a psychologist licensed under Chapter 4732. 14393
of the Revised Code; a professional clinical counselor, 14394
professional counselor, or independent social worker licensed 14395
under Chapter 4757. of the Revised Code; or a clinical nurse 14396
specialist licensed under Chapter 4723. of the Revised Code whose 14397
nursing specialty is mental health. 14398

(2) The prescribed treatment is not experimental or 14399
investigational, having proven its clinical effectiveness in 14400
accordance with generally accepted medical standards. 14401

(C) Division (B) of this section applies to all coverages and 14402
terms and conditions of the policy of sickness and accident 14403
insurance, including, but not limited to, coverage of inpatient 14404
hospital services, outpatient services, and medication; maximum 14405
lifetime benefits; copayments; and individual and family 14406
deductibles. 14407

(D) Nothing in this section shall be construed as prohibiting 14408
a sickness and accident insurance company from taking any of the 14409
following actions: 14410

(1) Negotiating separately with mental health care providers 14411
with regard to reimbursement rates and the delivery of health care 14412
services; 14413

(2) Offering policies that provide benefits solely for the 14414
diagnosis and treatment of biologically based mental illnesses; 14415

(3) Managing the provision of benefits for the diagnosis or 14416
treatment of biologically based mental illnesses through the use 14417
of pre-admission screening, by requiring beneficiaries to obtain 14418
authorization prior to treatment, or through the use of any other 14419
mechanism designed to limit coverage to that treatment determined 14420
to be necessary; 14421

(4) Enforcing the terms and conditions of a policy of 14422

sickness and accident insurance. 14423

(E) An insurer that offers a group policy of sickness and 14424
accident insurance is not required to provide benefits for the 14425
diagnosis and treatment of biologically based mental illnesses 14426
pursuant to division (B) of this section if all of the following 14427
apply: 14428

(1) The insurer submits documentation certified by an 14429
independent member of the American academy of actuaries to the 14430
superintendent of insurance showing that incurred claims for 14431
diagnostic and treatment services for biologically based mental 14432
illnesses for a period of at least six months independently caused 14433
the insurer's costs for claims and administrative expenses for the 14434
coverage of all other physical diseases and disorders to increase 14435
by more than one per cent per year. 14436

(2) The insurer submits a signed letter from an independent 14437
member of the American academy of actuaries to the superintendent 14438
of insurance opining that the increase described in division 14439
(E)(1) of this section could reasonably justify an increase of 14440
more than one per cent in the annual premiums or rates charged by 14441
the insurer for the coverage of all other physical diseases and 14442
disorders. 14443

(3) The superintendent of insurance makes the following 14444
determinations from the documentation and opinion submitted 14445
pursuant to divisions (E)(1) and (2) of this section: 14446

(a) Incurred claims for diagnostic and treatment services for 14447
biologically based mental illnesses for a period of at least six 14448
months independently caused the insurer's costs for claims and 14449
administrative expenses for the coverage of all other physical 14450
diseases and disorders to increase by more than one per cent per 14451
year. 14452

(b) The increase in costs reasonably justifies an increase of 14453

more than one per cent in the annual premiums or rates charged by 14454
the insurer for the coverage of all other physical diseases and 14455
disorders. 14456

Any determination made by the superintendent under this 14457
division is subject to Chapter 119. of the Revised Code. 14458

Sec. 3923.33. As used in section 3923.33 and sections 14459
3923.331 to 3923.339 of the Revised Code: 14460

(A) "Applicant" means: 14461

(1) In the case of an individual medicare supplement policy, 14462
the person who seeks to contract for insurance benefits; and 14463

(2) In the case of a group medicare supplement policy, the 14464
proposed certificate holder. 14465

(B) "Certificate" means, for purposes of section 3923.33 and 14466
sections 3923.331 to 3923.339 of the Revised Code, any certificate 14467
delivered or issued for delivery in this state under a group 14468
medicare supplement policy. 14469

(C) "Certificate form" means the form on which the 14470
certificate is delivered or issued for delivery by the issuer. 14471

(D) "Direct response insurance policy" means a medicare 14472
supplement policy or certificate marketed without the direct 14473
involvement of an insurance agent. 14474

(E) "Issuer" includes insurance companies, fraternal benefit 14475
societies, health insuring corporations, and any other entities 14476
delivering or issuing for delivery in this state medicare 14477
supplement policies or certificates. 14478

(F) ~~"Medicare" means the "Health Insurance for the Aged Act,"~~ 14479
~~Title XVIII of the Social Security Amendments of 1965, 79 Stat.~~ 14480
~~291, 42 U.S.C.A. 1395, as then constituted or later amended.~~ 14481

~~(G)~~ "Medicare supplement policy" means a group or individual 14482

policy of sickness and accident insurance or a subscriber contract 14483
of health insuring corporations or any other issuers, other than a 14484
policy issued pursuant to a contract under section 1876 of the 14485
"Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A., 1395mm, 14486
as amended, or an issued policy under any demonstration project 14487
specified in 42 U.S.C.A. 1395ss(g)(1), which is advertised, 14488
marketed, or designed primarily as a supplement to reimbursements 14489
under medicare for the hospital, medical, or surgical expenses of 14490
persons eligible for medicare. 14491

~~(H)~~(G) "Policy form" means the form on which the policy is 14492
delivered or issued for delivery by the issuer. 14493

Sec. 3923.38. (A) As used in this section: 14494

(1) "Group policy" includes any group sickness and accident 14495
policy or contract delivered, issued for delivery, or renewed in 14496
this state on or after June 28, 1984, and any private or public 14497
employer self-insurance plan or other plan that provides, or 14498
provides payment for, health care benefits for employees resident 14499
in this state other than through an insurer or health insuring 14500
corporation, to which both of the following apply: 14501

(a) The policy insures employees for hospital, surgical, or 14502
major medical insurance on an expense incurred or service basis, 14503
other than for specified diseases or for accidental injuries only. 14504

(b) The policy is in effect and covers an eligible employee 14505
at the time the employee's employment is terminated. 14506

(2) "Eligible employee" includes only an employee to whom all 14507
of the following apply: 14508

(a) The employee has been continuously insured under a group 14509
policy or under the policy and any prior similar group coverage 14510
replaced by the policy, during the entire three-month period 14511
preceding the termination of the employee's employment. 14512

(b) The employee is entitled, at the time of the termination 14513
of the employee's employment, to unemployment compensation 14514
benefits under Chapter 4141. of the Revised Code. 14515

(c) The employee is not, and does not become, covered by or 14516
eligible for coverage by medicare ~~under Title XVIII of the Social~~ 14517
~~Security Act, as amended.~~ 14518

(d) The employee is not, and does not become, covered by or 14519
eligible for coverage by any other insured or uninsured 14520
arrangement that provides hospital, surgical, or medical coverage 14521
for individuals in a group and under which the person was not 14522
covered immediately prior to such termination. A person eligible 14523
for continuation of coverage under this section, who is also 14524
eligible for coverage under section 3923.123 of the Revised Code, 14525
may elect either coverage, but not both. A person who elects 14526
continuation of coverage may elect any coverage available under 14527
section 3923.123 of the Revised Code upon the termination of the 14528
continuation of coverage. 14529

(3) "Group rate" means, in the case of an employer 14530
self-insurance or other health benefits plan, the average monthly 14531
cost per employee, over a period of at least twelve months, of the 14532
operation of the plan that would represent a group insurance rate 14533
if the same coverage had been provided under a group sickness and 14534
accident insurance policy. 14535

(B) A group policy shall provide that any eligible employee 14536
may continue the employee's hospital, surgical, and medical 14537
insurance under the policy, for the employee and the employee's 14538
eligible dependents, for a period of six months after the date 14539
that the insurance coverage would otherwise terminate by reason of 14540
the termination of the employee's employment. Each certificate of 14541
coverage, or other notice of coverage, issued to employees under 14542
the policy shall include a notice of the employee's privilege of 14543
continuation. 14544

(C) All of the following apply to the continuation of 14545
coverage required under division (B) of this section: 14546

(1) Continuation need not include dental, vision care, 14547
prescription drug benefits, or any other benefits provided under 14548
the policy in addition to its hospital, surgical, or major medical 14549
benefits. 14550

(2) The employer shall notify the employee of the right of 14551
continuation at the time the employer notifies the employee of the 14552
termination of employment. The notice shall inform the employee of 14553
the amount of contribution required by the employer under division 14554
(C)(4) of this section. 14555

(3) The employee shall file a written election of 14556
continuation with the employer and pay the employer the first 14557
contribution required under division (C)(4) of this section. The 14558
request and payment must be received by the employer no later than 14559
the earlier of any of the following dates: 14560

(a) Thirty-one days after the date on which the employee's 14561
coverage would otherwise terminate; 14562

(b) Ten days after the date on which the employee's coverage 14563
would otherwise terminate, if the employer has notified the 14564
employee of the right of continuation prior to such date; 14565

(c) Ten days after the employer notifies the employee of the 14566
right of continuation, if the notice is given after the date on 14567
which the employee's coverage would otherwise terminate. 14568

(4) The employee must pay to the employer, on a monthly 14569
basis, in advance, the amount of contribution required by the 14570
employer. The amount required shall not exceed the group rate for 14571
the insurance being continued under the policy on the due date of 14572
each payment. 14573

(5) The employee's privilege to continue coverage and the 14574

coverage under any continuation ceases if any of the following	14575
occurs:	14576
(a) The employee ceases to be an eligible employee under	14577
division (A)(2)(c) or (d) of this section;	14578
(b) A period of six months expires after the date that the	14579
employee's insurance under the policy would otherwise have	14580
terminated because of the termination of employment;	14581
(c) The employee fails to make a timely payment of a required	14582
contribution, in which event the coverage shall cease at the end	14583
of the coverage for which contributions were made;	14584
(d) The policy is terminated, or the employer terminates	14585
participation under the policy, unless the employer replaces the	14586
coverage by similar coverage under another group policy or other	14587
group health arrangement.	14588
If the employer replaces the policy with similar group health	14589
coverage, all of the following apply:	14590
(i) The member shall be covered under the replacement	14591
coverage, for the balance of the period that the member would have	14592
remained covered under the terminated coverage if it had not been	14593
terminated.	14594
(ii) The minimum level of benefits under the replacement	14595
coverage shall be the applicable level of benefits of the policy	14596
replaced reduced by any benefits payable under the policy	14597
replaced.	14598
(iii) The policy replaced shall continue to provide benefits	14599
to the extent of its accrued liabilities and extensions of	14600
benefits as if the replacement had not occurred.	14601
(D) This section does not apply to an employer's	14602
self-insurance plan if federal law supersedes, preempts,	14603
prohibits, or otherwise precludes its application to such plans.	14604

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; 14633
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(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; 14635
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(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; 14639
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(G) Comply with other requirements established in rules adopted under this section. 14643
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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. 14645
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Sec. 3923.58. (A) As used in sections 3923.58 and 3923.59 of the Revised Code: 14652
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(1) "Health benefit plan" and "MEWA" have the same meanings as in section 3924.01 of the Revised Code. 14654
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(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. 14656
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(3) "Pre-existing conditions provision" means a policy provision that excludes or limits coverage for charges or expenses 14661
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incurred during a specified period following the insured's 14663
effective date of coverage as to a condition which, during a 14664
specified period immediately preceding the effective date of 14665
coverage, had manifested itself in such a manner as would cause an 14666
ordinarily prudent person to seek medical advice, diagnosis, care, 14667
or treatment or for which medical advice, diagnosis, care, or 14668
treatment was recommended or received, or a pregnancy existing on 14669
the effective date of coverage. 14670

(B) Beginning in January of each year, insurers in the 14671
business of issuing individual policies of sickness and accident 14672
insurance as contemplated by section 3923.021 of the Revised Code, 14673
except individual policies issued pursuant to section 3923.122 of 14674
the Revised Code, shall accept applicants for open enrollment 14675
coverage, as set forth in this division, in the order in which 14676
they apply for coverage and subject to the limitation set forth in 14677
division (G) of this section. Insurers shall accept for coverage 14678
pursuant to this section individuals to whom both of the following 14679
conditions apply: 14680

(1) The individual is not applying for coverage as an 14681
employee of an employer, as a member of an association, or as a 14682
member of any other group. 14683

(2) The individual is not covered, and is not eligible for 14684
coverage, under any other private or public health benefits 14685
arrangement, including the medicare program ~~established under~~ 14686
~~Title XVIII of the "Social Security Act," 49 Stat. 620 (1935), 42~~ 14687
~~U.S.C.A. 301, as amended,~~ or any other act of congress or law of 14688
this or any other state of the United States that provides 14689
benefits comparable to the benefits provided under this section, 14690
any medicare supplement policy, or any continuation of coverage 14691
policy under state or federal law. 14692

(C) An insurer shall offer to any individual accepted under 14693
this section the Ohio health care basic and standard plans 14694

established by the board of directors of the Ohio health 14695
reinsurance program under division (A) of section 3924.10 of the 14696
Revised Code or health benefit plans that are substantially 14697
similar to the Ohio health care basic and standard plans in 14698
benefit plan design and scope of covered services. 14699

An insurer may offer other health benefit plans in addition 14700
to, but not in lieu of, the plans required to be offered under 14701
this division. A basic health benefit plan shall provide, at a 14702
minimum, the coverage provided by the Ohio health care basic plan 14703
or any health benefit plan that is substantially similar to the 14704
Ohio health care basic plan in benefit plan design and scope of 14705
covered services. A standard health benefit plan shall provide, at 14706
a minimum, the coverage provided by the Ohio health care standard 14707
plan or any health benefit plan that is substantially similar to 14708
the Ohio health care standard plan in benefit plan design and 14709
scope of covered services. 14710

For purposes of this division, the superintendent of 14711
insurance shall determine whether a health benefit plan is 14712
substantially similar to the Ohio health care basic and standard 14713
plans in benefit plan design and scope of covered services. 14714

(D) Health benefit plans issued under this section may 14715
establish pre-existing conditions provisions that exclude or limit 14716
coverage for a period of up to twelve months following the 14717
individual's effective date of coverage and that may relate only 14718
to conditions during the six months immediately preceding the 14719
effective date of coverage. 14720

(E) Premiums charged to individuals under this section may 14721
not exceed an amount that is two and one-half times the highest 14722
rate charged any other individual to which the insurer is 14723
currently accepting new business, and for which similar copayments 14724
and deductibles are applied. 14725

(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 14758
requirements of division (B) or (G) of this section. The actions 14759
of the superintendent under this division shall be effective for a 14760
period of not more than one year. At the expiration of such time, 14761
a new showing of need for a waiver or modification by the insurer 14762
shall be made before a new waiver or modification is issued or 14763
imposed. 14764

(J) No hospital, health care facility, or health care 14765
practitioner, and no person who employs any health care 14766
practitioner, shall balance bill any individual or dependent of an 14767
individual for any health care supplies or services provided to 14768
the individual or dependent who is insured under a policy issued 14769
under this section. The hospital, health care facility, or health 14770
care practitioner, or any person that employs the health care 14771
practitioner, shall accept payments made to it by the insurer 14772
under the terms of the policy or contract insuring or covering 14773
such individual as payment in full for such health care supplies 14774
or services. 14775

As used in this division, "hospital" has the same meaning as 14776
in section 3727.01 of the Revised Code; "health care practitioner" 14777
has the same meaning as in section 4769.01 of the Revised Code; 14778
and "balance bill" means charging or collecting an amount in 14779
excess of the amount reimbursable or payable under the policy or 14780
health care service contract issued to an individual under this 14781
section for such health care supply or service. "Balance bill" 14782
does not include charging for or collecting copayments or 14783
deductibles required by the policy or contract. 14784

(K) An insurer shall pay an agent a commission in the amount 14785
of five per cent of the premium charged for initial placement or 14786
for otherwise securing the issuance of a policy or contract issued 14787
to an individual under this section, and four per cent of the 14788
premium charged for the renewal of such a policy or contract. The 14789

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; 14820
automobile medical payment insurance; or insurance under which 14821
benefits are payable with or without regard to fault and which is 14822
statutorily required to be contained in any liability insurance 14823
policy or equivalent self-insurance. 14824

(b) Coverage provided under the medicaid, ~~as defined in~~ 14825
~~section 5111.01 of the Revised Code~~ program. 14826

(c) Coverage provided under an employer's self-insurance plan 14827
or by any of its administrators, as defined in section 3959.01 of 14828
the Revised Code, to the extent that federal law supersedes, 14829
preempts, prohibits, or otherwise precludes the application of 14830
this section to the plan and its administrators. 14831

(B) A standardized identification card or an electronic 14832
technology issued or required to be used as provided in division 14833
(A)(1) of this section shall contain uniform prescription drug 14834
information in accordance with either division (B)(1) or (2) of 14835
this section. 14836

(1) The standardized identification card or the electronic 14837
technology shall be in a format and contain information fields 14838
approved by the national council for prescription drug programs or 14839
a successor organization, as specified in the council's or 14840
successor organization's pharmacy identification card 14841
implementation guide in effect on the first day of October most 14842
immediately preceding the issuance or required use of the 14843
standardized identification card or the electronic technology. 14844

(2) If the insurer or person under contract with the insurer 14845
to issue a standardized identification card or an electronic 14846
technology requires the information for the submission and routing 14847
of a claim, the standardized identification card or the electronic 14848
technology shall contain any of the following information: 14849

(a) The insurer's name; 14850

(b) The insured's name, group number, and identification number; 14851
14852

(c) A telephone number to inquire about pharmacy-related issues; 14853
14854

(d) The issuer's international identification number, labeled as "ANSI BIN" or "RxBIN"; 14855
14856

(e) The processor's control number, labeled as "RxPCN"; 14857

(f) The insured's pharmacy benefits group number if different from the insured's medical group number, labeled as "RxGrp." 14858
14859

(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. 14860
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(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. 14868
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(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. 14874
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(2) An insurer or person under contract with the insurer is 14881
not required under division (E)(1) of this section to issue a new 14882
card or electronic technology to an insured more than once during 14883
a twelve-month period. 14884

(F) Nothing in this section shall be construed as requiring 14885
an insurer to produce more than one standardized identification 14886
card or one electronic technology for use by insureds accessing 14887
health care benefits provided under a policy of sickness and 14888
accident insurance. 14889

Sec. 3923.70. Consistent with the Rules of Evidence, a 14890
written decision or opinion prepared by an independent review 14891
organization under section 3923.67 or 3923.68 of the Revised Code 14892
shall be admissible in any civil action related to the coverage 14893
decision that was the subject of the decision or opinion. The 14894
independent review organization's decision or opinion shall be 14895
presumed to be a scientifically valid and accurate description of 14896
the state of medical knowledge at the time it was written. 14897

Consistent with the Rules of Evidence, any party to a civil 14898
action related to an insurer's decision involving an 14899
investigational or experimental drug, device, or treatment may 14900
introduce into evidence any applicable medicare reimbursement 14901
standards established under ~~Title XVIII of the "Social Security~~ 14902
~~Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended~~ medicare 14903
program. 14904

Sec. 3923.79. Consistent with the Rules of Evidence, a 14905
written decision or opinion prepared by an independent review 14906
organization under section 3923.76 or 3923.77 of the Revised Code 14907
shall be admissible in any civil action related to the coverage 14908
decision that was the subject of the decision or opinion. The 14909
independent review organization's decision or opinion shall be 14910

presumed to be a scientifically valid and accurate description of 14911
the state of medical knowledge at the time it was written. 14912

Consistent with the Rules of Evidence, any party to a civil 14913
action related to a plan's decision involving an investigational 14914
or experimental drug, device, or treatment may introduce into 14915
evidence any applicable medicare reimbursement standards 14916
established under ~~Title XVIII of the "Social Security Act," 49~~ 14917
~~Stat. 620 (1935), 42 U.S.C.A. 301, as amended~~ medicare program. 14918

Sec. 3923.83. (A)(1) This section applies to both of the 14919
following: 14920

(a) A public employee benefit plan that issues or requires 14921
the use of a standardized identification card or an electronic 14922
technology for submission and routing of prescription drug claims 14923
pursuant to a policy, contract, or agreement for health care 14924
services; 14925

(b) A person or entity that a public employee benefit plan 14926
contracts with to issue a standardized identification card or an 14927
electronic technology described in division (A)(1)(a) of this 14928
section. 14929

(2) Notwithstanding division (A)(1) of this section, this 14930
section does not apply to the issuance or required use of a 14931
standardized identification card or an electronic technology for 14932
the submission and routing of prescription drug claims in 14933
connection with either of the following: 14934

(a) Any individual or group policy of insurance covering only 14935
accident, credit, dental, disability income, long-term care, 14936
hospital indemnity, medicare supplement, medicare, tricare, 14937
specified disease, or vision care; coverage under a 14938
one-time-limited-duration policy of not longer than six months; 14939
coverage issued as a supplement to liability insurance; insurance 14940

arising out of workers' compensation or similar law; automobile 14941
medical payment insurance; or insurance under which benefits are 14942
payable with or without regard to fault and which is statutorily 14943
required to be contained in any liability insurance policy or 14944
equivalent self-insurance. 14945

(b) Coverage provided under the medicaid, ~~as defined in~~ 14946
~~section 5111.01 of the Revised Code~~ program. 14947

(B) A standardized identification card or an electronic 14948
technology issued or required to be used as provided in division 14949
(A)(1) of this section shall contain uniform prescription drug 14950
information in accordance with either division (B)(1) or (2) of 14951
this section. 14952

(1) The standardized identification card or the electronic 14953
technology shall be in a format and contain information fields 14954
approved by the national council for prescription drug programs or 14955
a successor organization, as specified in the council's or 14956
successor organization's pharmacy identification card 14957
implementation guide in effect on the first day of October most 14958
immediately preceding the issuance or required use of the 14959
standardized identification card or the electronic technology. 14960

(2) If the public employee benefit plan or person under 14961
contract with the plan to issue a standardized identification card 14962
or an electronic technology requires the information for the 14963
submission and routing of a claim, the standardized identification 14964
card or the electronic technology shall contain any of the 14965
following information: 14966

(a) The plan's name; 14967

(b) The insured's name, group number, and identification 14968
number; 14969

(c) A telephone number to inquire about pharmacy-related 14970
issues; 14971

(d) The issuer's international identification number, labeled 14972
as "ANSI BIN" or "RxBIN"; 14973

(e) The processor's control number, labeled as "RxPCN"; 14974

(f) The insured's pharmacy benefits group number if different 14975
from the insured's medical group number, labeled as "RxGrp." 14976

(C) If the standardized identification card or the electronic 14977
technology issued or required to be used as provided in division 14978
(A)(1) of this section is also used for submission and routing of 14979
nonpharmacy claims, the designation "Rx" is required to be 14980
included as part of the labels identified in divisions (B)(2)(d) 14981
and (e) of this section if the issuer's international 14982
identification number or the processor's control number is 14983
different for medical and pharmacy claims. 14984

(D)(1) Except as provided in division (D)(2) of this section, 14985
if there is a change in the information contained in the 14986
standardized identification card or the electronic technology 14987
issued to an insured, the public employee benefit plan or person 14988
under contract with the plan to issue a standardized 14989
identification card or electronic technology shall issue a new 14990
card or electronic technology to the insured. 14991

(2) A public employee benefit plan or person under contract 14992
with the plan is not required under division (D)(1) of this 14993
section to issue a new card or electronic technology to an insured 14994
more than once during a twelve-month period. 14995

~~(F)~~(E) Nothing in this section shall be construed as 14996
requiring a public employee benefit plan to produce more than one 14997
standardized identification card or one electronic technology for 14998
use by insureds accessing health care benefits provided under a 14999
health benefit plan. 15000

Sec. 3924.41. (A) As used in sections 3924.41 and 3924.42 of 15001

the Revised Code, "health insurer" means any sickness and accident 15002
insurer or health insuring corporation. "Health insurer" also 15003
includes any group health plan as defined in section 607 of the 15004
federal "Employee Retirement Income Security Act of 1974," 88 15005
Stat. 832, 29 U.S.C.A. 1167. 15006

(B) Notwithstanding any other provision of the Revised Code, 15007
no health insurer shall take into consideration the availability 15008
of, or eligibility for, ~~medical assistance~~ the medicaid program in 15009
this state ~~under Chapter 5111. of the Revised Code~~ or in any other 15010
state ~~pursuant to Title XIX of the "Social Security Act," 49 Stat.~~ 15011
~~620 (1935), 42 U.S.C.A. 301, as amended,~~ when determining an 15012
individual's eligibility for coverage or when making payments to 15013
or on behalf of an enrollee, subscriber, policyholder, or 15014
certificate holder. 15015

Sec. 3924.42. No health insurer shall impose requirements on 15016
the department of ~~job and family services~~ health care 15017
administration, when it has been assigned the rights of an 15018
individual who is eligible for ~~medical assistance under Chapter~~ 15019
~~5111. of the Revised Code~~ the medicaid program and who is covered 15020
under a health care policy, contract, or plan issued by the health 15021
insurer, that are different from the requirements applicable to an 15022
agent or assignee of any other individual so covered. 15023

Sec. 4123.27. Information contained in the annual statement 15024
provided for in section 4123.26 of the Revised Code, and such 15025
other information as may be furnished to the bureau of workers' 15026
compensation by employers in pursuance of that section, is for the 15027
exclusive use and information of the bureau in the discharge of 15028
its official duties, and shall not be open to the public nor be 15029
used in any court in any action or proceeding pending therein 15030
unless the bureau is a party to the action or proceeding; but the 15031
information contained in the statement may be tabulated and 15032

published by the bureau in statistical form for the use and 15033
information of other state departments and the public. No person 15034
in the employ of the bureau, except those who are authorized by 15035
the administrator of workers' compensation, shall divulge any 15036
information secured by the person while in the employ of the 15037
bureau in respect to the transactions, property, claim files, 15038
records, or papers of the bureau or in respect to the business or 15039
mechanical, chemical, or other industrial process of any company, 15040
firm, corporation, person, association, partnership, or public 15041
utility to any person other than the administrator or to the 15042
superior of such employee of the bureau. 15043

Notwithstanding the restrictions imposed by this section, the 15044
governor, select or standing committees of the general assembly, 15045
the auditor of state, the attorney general, or their designees, 15046
pursuant to the authority granted in this chapter and Chapter 15047
4121. of the Revised Code, may examine any records, claim files, 15048
or papers in possession of the industrial commission or the 15049
bureau. They also are bound by the privilege that attaches to 15050
these papers. 15051

The administrator shall report to the director of job and 15052
family services or to the county director of job and family 15053
services the name, address, and social security number or other 15054
identification number of any person receiving workers' 15055
compensation whose name or social security number or other 15056
identification number is the same as that of a person required by 15057
a court or child support enforcement agency to provide support 15058
payments to a recipient or participant of public assistance, and 15059
whose name is submitted to the administrator by the director under 15060
section 5101.36 of the Revised Code. The administrator shall 15061
report to the director of health care administration or to the 15062
county director of job and family services the name, address, and 15063
social security number or other identification number of any 15064

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 15097
first provided under Chapter 5107. of the Revised Code, 15098
prevention, retention, and contingency benefits and services 15099
provided under Chapter 5108. of the Revised Code, disability 15100
financial assistance provided under Chapter 5115. of the Revised 15101
Code, or the disability medical assistance ~~provided under Chapter~~ 15102
~~5115. of the Revised Code~~ program. 15103~~

Sec. 4141.162. (A) The director of job and family services, 15104
in collaboration with the director of health care administration, 15105
shall establish an income and eligibility verification system that 15106
complies with section 1137 of the "Social Security Act." The 15107
programs included in the system are all of the following: 15108

(1) Unemployment compensation pursuant to section 3304 of the 15109
"Internal Revenue Code of 1954"; 15110

(2) The state programs funded in part under part A of Title 15111
IV of the "Social Security Act" and administered under Chapters 15112
5107. and 5108. of the Revised Code; 15113

(3) Medicaid ~~pursuant to Title XIX of the "Social Security~~ 15114
~~Act";~~ 15115

(4) Food stamps pursuant to the "Food Stamp Act of 1977," 91 15116
Stat. 958, 7 U.S.C.A. 2011, as amended; 15117

(5) Any Ohio program under a plan approved under Title I, X, 15118
XIV, or XVI of the "Social Security Act." 15119

Wage information provided by employers to the director shall 15120
be furnished to the income and eligibility verification system. 15121
Such information shall be used by the director to determine 15122
eligibility of individuals for unemployment compensation benefits 15123
and the amount of those benefits and used by the agencies that 15124
administer the programs identified in divisions (A)(2) to (5) of 15125
this section to determine or verify eligibility for or the amount 15126

of benefits under those programs. 15127

The director shall fully implement the use of wage 15128
information to determine eligibility for and the amount of 15129
unemployment compensation benefits by September 30, 1988. 15130

Information furnished under the system shall also be made 15131
available to the appropriate state or local child support 15132
enforcement agency for the purposes of an approved plan under 15133
Title IV-D of the "Social Security Act" and to the appropriate 15134
federal agency for the purposes of Titles II and XVI of the 15135
"Social Security Act." 15136

(B) The director shall adopt rules as necessary under which 15137
the department of job and family services and other state agencies 15138
that the director determines must participate in order to ensure 15139
compliance with section 1137 of the "Social Security Act" exchange 15140
information with each other or authorized federal agencies about 15141
individuals who are applicants for or recipients of benefits under 15142
any of the programs enumerated in division (A) of this section. 15143
The rules shall extend to all of the following: 15144

(1) A requirement for standardized formats and procedures for 15145
a participating agency to request and receive information about an 15146
individual, which information shall include the individual's 15147
social security number; 15148

(2) A requirement that all applicants for and recipients of 15149
benefits under any program enumerated in division (A) of this 15150
section be notified at the time of application, and periodically 15151
thereafter, that information available through the system may be 15152
shared with agencies that administer other benefit programs and 15153
utilized in establishing or verifying eligibility or benefit 15154
amounts under the other programs enumerated in division (A) of 15155
this section; 15156

(3) A requirement that information is made available only to 15157

the extent necessary to assist in the valid administrative needs 15158
of the program receiving the information and is targeted for use 15159
in ways which are most likely to be productive in identifying and 15160
preventing ineligibility and incorrect payments; 15161

(4) A requirement that information is adequately protected 15162
against unauthorized disclosures for purposes other than to 15163
establish or verify eligibility or benefit amounts under the 15164
programs enumerated in division (A) of this section; 15165

(5) A requirement that a program providing information is 15166
reimbursed by the program using the information for the actual 15167
costs of furnishing the information and that the director be 15168
reimbursed by the participating programs for any actual costs 15169
incurred in operating the system; 15170

(6) Requirements for any other matters necessary to ensure 15171
the effective, efficient, and timely exchange of necessary 15172
information or that the director determines must be addressed in 15173
order to ensure compliance with the requirements of section 1137 15174
of the "Social Security Act." 15175

(C) Each participating agency shall furnish to the income and 15176
eligibility verification system established in division (A) of 15177
this section that information, which the director, by rule, 15178
determines is necessary in order to comply with section 1137 of 15179
the "Social Security Act." 15180

(D) Notwithstanding the information disclosure requirements 15181
of this section and section 4141.21 and division (A) of section 15182
4141.284 of the Revised Code, the director shall administer those 15183
provisions of law so as to comply with section 1137 of the "Social 15184
Security Act." 15185

(E) Requirements in section 4141.21 of the Revised Code with 15186
respect to confidentiality of information obtained in the 15187
administration of Chapter 4141. of the Revised Code and any 15188

sanctions imposed for improper disclosure of such information 15189
shall apply to the redisclosure of information disclosed under 15190
this section. 15191

Sec. 4719.01. (A) As used in sections 4719.01 to 4719.18 of 15192
the Revised Code: 15193

(1) "Affiliate" means a business entity that is owned by, 15194
operated by, controlled by, or under common control with another 15195
business entity. 15196

(2) "Communication" means a written or oral notification or 15197
advertisement that meets both of the following criteria, as 15198
applicable: 15199

(a) The notification or advertisement is transmitted by or on 15200
behalf of the seller of goods or services and by or through any 15201
printed, audio, video, cinematic, telephonic, or electronic means. 15202

(b) In the case of a notification or advertisement other than 15203
by telephone, either of the following conditions is met: 15204

(i) The notification or advertisement is followed by a 15205
telephone call from a telephone solicitor or salesperson. 15206

(ii) The notification or advertisement invites a response by 15207
telephone, and, during the course of that response, a telephone 15208
solicitor or salesperson attempts to make or makes a sale of goods 15209
or services. As used in division (A)(2)(b)(ii) of this section, 15210
"invites a response by telephone" excludes the mere listing or 15211
inclusion of a telephone number in a notification or 15212
advertisement. 15213

(3) "Gift, award, or prize" means anything of value that is 15214
offered or purportedly offered, or given or purportedly given by 15215
chance, at no cost to the receiver and with no obligation to 15216
purchase goods or services. As used in this division, "chance" 15217
includes a situation in which a person is guaranteed to receive an 15218

item and, at the time of the offer or purported offer, the 15219
telephone solicitor does not identify the specific item that the 15220
person will receive. 15221

(4) "Goods or services" means any real property or any 15222
tangible or intangible personal property, or services of any kind 15223
provided or offered to a person. "Goods or services" includes, but 15224
is not limited to, advertising; labor performed for the benefit of 15225
a person; personal property intended to be attached to or 15226
installed in any real property, regardless of whether it is so 15227
attached or installed; timeshare estates or licenses; and extended 15228
service contracts. 15229

(5) "Purchaser" means a person that is solicited to become or 15230
does become financially obligated as a result of a telephone 15231
solicitation. 15232

(6) "Salesperson" means an individual who is employed, 15233
appointed, or authorized by a telephone solicitor to make 15234
telephone solicitations but does not mean any of the following: 15235

(a) An individual who comes within one of the exemptions in 15236
division (B) of this section; 15237

(b) An individual employed, appointed, or authorized by a 15238
person who comes within one of the exemptions in division (B) of 15239
this section; 15240

(c) An individual under a written contract with a person who 15241
comes within one of the exemptions in division (B) of this 15242
section, if liability for all transactions with purchasers is 15243
assumed by the person so exempted. 15244

(7) "Telephone solicitation" means a communication to a 15245
person that meets both of the following criteria: 15246

(a) The communication is initiated by or on behalf of a 15247
telephone solicitor or by a salesperson. 15248

(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 15280
another person to collect the payment of any money, this exemption 15281
does not apply. 15282

(4) A licensed securities, commodities, or investment broker, 15283
dealer, investment advisor, or associated person when making a 15284
telephone solicitation within the scope of the person's license. 15285
As used in division (B)(4) of this section, "licensed securities, 15286
commodities, or investment broker, dealer, investment advisor, or 15287
associated person" means a person subject to licensure or 15288
registration as such by the securities and exchange commission; 15289
the National Association of Securities Dealers or other 15290
self-regulatory organization, as defined by 15 U.S.C.A. 78c; by 15291
the division of securities under Chapter 1707. of the Revised 15292
Code; or by an official or agency of any other state of the United 15293
States. 15294

(5)(a) A person primarily engaged in soliciting the sale of a 15295
newspaper of general circulation; 15296

(b) As used in division (B)(5)(a) of this section, "newspaper 15297
of general circulation" includes, but is not limited to, both of 15298
the following: 15299

(i) A newspaper that is a daily law journal designated as an 15300
official publisher of court calendars pursuant to section 2701.09 15301
of the Revised Code; 15302

(ii) A newspaper or publication that has at least twenty-five 15303
per cent editorial, non-advertising content, exclusive of inserts, 15304
measured relative to total publication space, and an audited 15305
circulation to at least fifty per cent of the households in the 15306
newspaper's retail trade zone as defined by the audit. 15307

(6)(a) An issuer, or its subsidiary, that has a class of 15308
securities to which all of the following apply: 15309

(i) The class of securities is subject to section 12 of the 15310

"Securities Exchange Act of 1934," 15 U.S.C.A. 781, and is 15311
registered or is exempt from registration under 15 U.S.C.A. 15312
781(g)(2)(A), (B), (C), (E), (F), (G), or (H); 15313

(ii) The class of securities is listed on the New York stock 15314
exchange, the American stock exchange, or the NASDAQ national 15315
market system; 15316

(iii) The class of securities is a reported security as 15317
defined in 17 C.F.R. 240.11Aa3-1(a)(4). 15318

(b) An issuer, or its subsidiary, that formerly had a class 15319
of securities that met the criteria set forth in division 15320
(B)(6)(a) of this section if the issuer, or its subsidiary, has a 15321
net worth in excess of one hundred million dollars, files or its 15322
parent files with the securities and exchange commission an S.E.C. 15323
form 10-K, and has continued in substantially the same business 15324
since it had a class of securities that met the criteria in 15325
division (B)(6)(a) of this section. As used in division (B)(6)(b) 15326
of this section, "issuer" and "subsidiary" include the successor 15327
to an issuer or subsidiary. 15328

(7) A person soliciting a transaction regulated by the 15329
commodity futures trading commission, if the person is registered 15330
or temporarily registered for that activity with the commission 15331
under 7 U.S.C.A. 1 et. seq. and the registration or temporary 15332
registration has not expired or been suspended or revoked; 15333

(8) A person soliciting the sale of any book, record, audio 15334
tape, compact disc, or video, if the person allows the purchaser 15335
to review the merchandise for at least seven days and provides a 15336
full refund within thirty days to a purchaser who returns the 15337
merchandise or if the person solicits the sale on behalf of a 15338
membership club operating in compliance with regulations adopted 15339
by the federal trade commission in 16 C.F.R. 425; 15340

(9) A supervised financial institution or its subsidiary. As 15341

used in division (B)(9) of this section, "supervised financial 15342
institution" means a bank, trust company, savings and loan 15343
association, savings bank, credit union, industrial loan company, 15344
consumer finance lender, commercial finance lender, or institution 15345
described in section 2(c)(2)(F) of the "Bank Holding Company Act 15346
of 1956," 12 U.S.C.A. 1841(c)(2)(F), as amended, supervised by an 15347
official or agency of the United States, this state, or any other 15348
state of the United States; or a licensee or registrant under 15349
sections 1321.01 to 1321.19, 1321.51 to 1321.60, or 1321.71 to 15350
1321.83 of the Revised Code. 15351

(10)(a) An insurance company, association, or other 15352
organization that is licensed or authorized to conduct business in 15353
this state by the superintendent of insurance pursuant to Title 15354
XXXIX of the Revised Code or Chapter 1751. of the Revised Code, 15355
when soliciting within the scope of its license or authorization. 15356

(b) A licensed insurance broker, agent, or solicitor when 15357
soliciting within the scope of the person's license. As used in 15358
division (B)(10)(b) of this section, "licensed insurance broker, 15359
agent, or solicitor" means any person licensed as an insurance 15360
broker, agent, or solicitor by the superintendent of insurance 15361
pursuant to Title XXXIX of the Revised Code. 15362

(11) A person soliciting the sale of services provided by a 15363
cable television system operating under authority of a 15364
governmental franchise or permit; 15365

(12) A person soliciting a business-to-business sale under 15366
which any of the following conditions are met: 15367

(a) The telephone solicitor has been operating continuously 15368
for at least three years under the same business name under which 15369
it solicits purchasers, and at least fifty-one per cent of its 15370
gross dollar volume of sales consists of repeat sales to existing 15371
customers to whom it has made sales under the same business name. 15372

(b) The purchaser business intends to resell the goods purchased.	15373 15374
(c) The purchaser business intends to use the goods or services purchased in a recycling, reuse, manufacturing, or remanufacturing process.	15375 15376 15377
(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.	15378 15379 15380 15381 15382 15383 15384 15385
(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:	15386 15387 15388
(a) It includes all of the following:	15389
(i) The business address of the seller;	15390
(ii) A written description or illustration of each good or service offered for sale;	15391 15392
(iii) A clear and conspicuous disclosure of the sale price of each good or service; shipping, handling, and other charges; and return policy;	15393 15394 15395
(b) One of the following applies:	15396
(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;	15397 15398 15399 15400
(ii) The catalog includes at least ten pages of written material or an equivalent amount of material in electronic form on	15401 15402

the internet or an on-line computer service, the person does not 15403
solicit customers by telephone but solely receives telephone calls 15404
made in response to the catalog, and during the calls the person 15405
takes orders but does not engage in further solicitation of the 15406
purchaser. As used in division (B)(13)(b)(ii) of this section, 15407
"further solicitation" does not include providing the purchaser 15408
with information about, or attempting to sell, any other item in 15409
the catalog that prompted the purchaser's call or in a 15410
substantially similar catalog issued by the seller. 15411

(14) A political subdivision or instrumentality of the United 15412
States, this state, or any state of the United States; 15413

(15) A college or university or any other public or private 15414
institution of higher education in this state; 15415

(16) A public utility as defined in section 4905.02 of the 15416
Revised Code or a retail natural gas supplier as defined in 15417
section 4929.01 of the Revised Code, if the utility or supplier is 15418
subject to regulation by the public utilities commission, or the 15419
affiliate of the utility or supplier; 15420

(17) A person that solicits sales through a television 15421
program or advertisement that is presented in the same market area 15422
no fewer than twenty days per month or offers for sale no fewer 15423
than ten distinct items of goods or services; and offers to the 15424
purchaser an unconditional right to return any good or service 15425
purchased within a period of at least seven days and to receive a 15426
full refund within thirty days after the purchaser returns the 15427
good or cancels the service; 15428

(18)(a) A person that, for at least one year, has been 15429
operating a retail business under the same name as that used in 15430
connection with telephone solicitation and both of the following 15431
occur on a continuing basis: 15432

(i) The person either displays goods and offers them for 15433

retail sale at the person's business premises or offers services 15434
for sale and provides them at the person's business premises. 15435

(ii) At least fifty-one per cent of the person's gross dollar 15436
volume of retail sales involves purchases of goods or services at 15437
the person's business premises. 15438

(b) An affiliate of a person that meets the requirements in 15439
division (B)(18)(a) of this section if the affiliate meets all of 15440
the following requirements: 15441

(i) The affiliate has operated a retail business for a period 15442
of less than one year; 15443

(ii) The affiliate either displays goods and offers them for 15444
retail sale at the affiliate's business premises or offers 15445
services for sale and provides them at the affiliate's business 15446
premises; 15447

(iii) At least fifty-one per cent of the affiliate's gross 15448
dollar volume of retail sales involves purchases of goods or 15449
services at the affiliate's business premises. 15450

(c) A person that, for a period of less than one year, has 15451
been operating a retail business in this state under the same name 15452
as that used in connection with telephone solicitation, as long as 15453
all of the following requirements are met: 15454

(i) The person either displays goods and offers them for 15455
retail sale at the person's business premises or offers services 15456
for sale and provides them at the person's business premises; 15457

(ii) The goods or services that are the subject of telephone 15458
solicitation are sold at the person's business premises, and at 15459
least sixty-five per cent of the person's gross dollar volume of 15460
retail sales involves purchases of goods or services at the 15461
person's business premises; 15462

(iii) The person conducts all telephone solicitation 15463

activities according to sections 310.3, 310.4, and 310.5 of the 15464
telemarketing sales rule adopted by the federal trade commission 15465
in 16 C.F.R. part 310. 15466

(19) A person who performs telephone solicitation sales 15467
services on behalf of other persons and to whom one of the 15468
following applies: 15469

(a) The person has operated under the same ownership, 15470
control, and business name for at least five years, and the person 15471
receives at least seventy-five per cent of its gross revenues from 15472
written telephone solicitation contracts with persons who come 15473
within one of the exemptions in division (B) of this section. 15474

(b) The person is an affiliate of one or more exempt persons 15475
and makes telephone solicitations on behalf of only the exempt 15476
persons of which it is an affiliate. 15477

(c) The person makes telephone solicitations on behalf of 15478
only exempt persons, the person and each exempt person on whose 15479
behalf telephone solicitations are made have entered into a 15480
written contract that specifies the manner in which the telephone 15481
solicitations are to be conducted and that at a minimum requires 15482
compliance with the telemarketing sales rule adopted by the 15483
federal trade commission in 16 C.F.R. part 310, and the person 15484
conducts the telephone solicitations in the manner specified in 15485
the written contract. 15486

(d) The person performs telephone solicitation for religious 15487
or political purposes, a charitable organization, a fund-raising 15488
council, or a professional solicitor in compliance with the 15489
registration and reporting requirements of Chapter 1716. of the 15490
Revised Code; and meets all of the following requirements: 15491

(i) The person has operated under the same ownership, 15492
control, and business name for at least five years, and the person 15493
receives at least fifty-one per cent of its gross revenues from 15494

written telephone solicitation contracts with persons who come	15495
within the exemption in division (B)(2) of this section;	15496
(ii) The person does not conduct a prize promotion or offer	15497
the sale of an investment opportunity;	15498
(iii) The person conducts all telephone solicitation	15499
activities according to sections 310.3, 310.4, and 310.5 of the	15500
telemarketing sales rules adopted by the federal trade commission	15501
in 16 C.F.R. part 310.	15502
(20) A person that is a licensed real estate salesperson or	15503
broker under Chapter 4735. of the Revised Code when soliciting	15504
within the scope of the person's license;	15505
(21)(a) Either of the following:	15506
(i) A publisher that solicits the sale of the publisher's	15507
periodical or magazine of general, paid circulation, or a person	15508
that solicits a sale of that nature on behalf of a publisher under	15509
a written agreement directly between the publisher and the person.	15510
(ii) A publisher that solicits the sale of the publisher's	15511
periodical or magazine of general, paid circulation, or a person	15512
that solicits a sale of that nature as authorized by a publisher	15513
under a written agreement directly with a publisher's	15514
clearinghouse provided the person is a resident of Ohio for more	15515
than three years and initiates all telephone solicitations from	15516
Ohio and the person conducts the solicitation and sale in	15517
compliance with 16 C.F.R. part 310, as adopted by the federal	15518
trade commission.	15519
(b) As used in division (B)(21) of this section, "periodical	15520
or magazine of general, paid circulation" excludes a periodical or	15521
magazine circulated only as part of a membership package or given	15522
as a free gift or prize from the publisher or person.	15523
(22) A person that solicits the sale of food, as defined in	15524

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 15555
according to sections 310.3, 310.4, and 310.5 of the telemarketing 15556
sales rules adopted by the federal trade commission in 16 C.F.R. 15557
part 310; 15558

(e) Neither the person nor any of its principals has been 15559
convicted of, pleaded guilty to, or has entered a plea of no 15560
contest for a felony or a theft offense as defined in sections 15561
2901.02 and 2913.01 of the Revised Code or similar law of another 15562
state or of the United States; 15563

(f) Neither the person nor any of its principals has had 15564
entered against them an injunction or a final judgment or order, 15565
including an agreed judgment or order, an assurance of voluntary 15566
compliance, or any similar instrument, in any civil or 15567
administrative action involving engaging in a pattern of corrupt 15568
practices, fraud, theft, embezzlement, fraudulent conversion, or 15569
misappropriation of property; the use of any untrue, deceptive, or 15570
misleading representation; or the use of any unfair, unlawful, 15571
deceptive, or unconscionable trade act or practice. 15572

(26) An institution defined as a home health agency in 15573
section 3701.881 of the Revised Code, that conducts all telephone 15574
solicitation activities according to sections 310.3, 310.4, and 15575
310.5 of the telemarketing sales rules adopted by the federal 15576
trade commission in 16 C.F.R. part 310, and engages in telephone 15577
solicitation only within the scope of the institution's 15578
certification, accreditation, contract with the department of 15579
aging, or status as a home health agency; and that meets one of 15580
the following requirements: 15581

(a) The institution is certified as a provider of home health 15582
services under ~~Title XVIII of the Social Security Act, 49 Stat.~~ 15583
~~620, 42 U.S.C. 301, as amended~~ medicare program; 15584

(b) The institution is accredited by either the joint 15585

commission on accreditation of health care organizations or the 15586
community health accreditation program; 15587

(c) The institution is providing passport services under the 15588
direction of the Ohio department of aging under section 173.40 of 15589
the Revised Code; 15590

(d) An affiliate of an institution that meets the 15591
requirements of division (B)(26)(a), (b), or (c) of this section 15592
when offering for sale substantially the same goods and services 15593
as those that are offered by the institution that meets the 15594
requirements of division (B)(26)(a), (b), or (c) of this section. 15595

(27) A person licensed to provide a hospice care program by 15596
the department of health pursuant to section 3712.04 of the 15597
Revised Code when conducting telephone solicitations within the 15598
scope of the person's license and according to sections 310.3, 15599
310.4, and 310.5 of the telemarketing sales rules adopted by the 15600
federal trade commission in 16 C.F.R. part 310. 15601

Sec. 4723.063. (A) As used in this section: 15602

(1) "Health care facility" means: 15603

(a) A hospital registered under section 3701.07 of the 15604
Revised Code; 15605

(b) A nursing home licensed under section 3721.02 of the 15606
Revised Code, or by a political subdivision certified under 15607
section 3721.09 of the Revised Code; 15608

(c) A county home or a county nursing home as defined in 15609
section 5155.31 of the Revised Code that is certified under ~~Title~~ 15610
~~XVIII or XIX of the "Social Security Act," 49 Stat. 620 (1935), 42~~ 15611
~~U.S.C. 301, amended~~ medicare program or medicaid program; 15612

(d) A freestanding dialysis center; 15613

(e) A freestanding inpatient rehabilitation facility; 15614

(f) An ambulatory surgical facility;	15615
(g) A freestanding cardiac catheterization facility;	15616
(h) A freestanding birthing center;	15617
(i) A freestanding or mobile diagnostic imaging center;	15618
(j) A freestanding radiation therapy center.	15619
(2) "Nurse education program" means a prelicensure nurse	15620
education program approved by the board of nursing under section	15621
4723.06 of the Revised Code or a postlicensure nurse education	15622
program approved by the board of regents under section 3333.04 of	15623
the Revised Code.	15624
(B) The state board of nursing shall establish and administer	15625
the nurse education grant program. Under the program, the board	15626
shall award grants to nurse education programs that have	15627
partnerships with other education programs, community health	15628
agencies, or health care facilities. Grant recipients shall use	15629
the money to fund partnerships to increase the nurse education	15630
program's enrollment capacity. Methods of increasing a program's	15631
enrollment capacity may include hiring faculty and preceptors,	15632
purchasing educational equipment and materials, and other actions	15633
acceptable to the board. Grant money shall not be used to	15634
construct or renovate buildings. Partnerships may be developed	15635
between one or more nurse education programs and one or more	15636
health care facilities.	15637
In awarding grants, the board shall give preference to	15638
partnerships between nurse education programs and hospitals,	15639
nursing homes, and county homes or county nursing homes, but may	15640
also award grants to fund partnerships between nurse education	15641
programs and other health care facilities.	15642
(C) The board shall adopt rules in accordance with Chapter	15643
119. of the Revised Code establishing the following:	15644

(1) Eligibility requirements for receipt of a grant;	15645
(2) Grant application forms and procedures;	15646
(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;	15647 15648 15649 15650
(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;	15651 15652 15653
(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;	15654 15655 15656
(6) The percentage of available grants to be awarded to licensed practical nurse education programs, registered nurse education programs, and graduate programs;	15657 15658 15659
(7) Any other matters incidental to the operation of the program.	15660 15661
(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.	15662 15663 15664 15665 15666 15667 15668 15669 15670
(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	15671 15672 15673 15674

quarter and the amount equal to that number times ten dollars. 15675

(F) Notwithstanding the requirements of section 4743.05 of 15676
the Revised Code, from January 1, 2004, until December 31, 2013, 15677
at the end of each quarter, the director of budget and management 15678
shall transfer from the occupational licensing and regulatory fund 15679
to the nurse education grant program fund the amount certified 15680
under division (E) of this section. 15681

Sec. 4723.17. (A) The board of nursing may authorize a 15682
licensed practical nurse to administer to an adult intravenous 15683
therapy authorized by an individual who is authorized to practice 15684
in this state and is acting within the course of the individual's 15685
professional practice, if the licensed practical nurse has a 15686
current, valid license issued under this chapter that includes 15687
authorization to administer medications and one of the following 15688
is the case: 15689

(1) The nurse has successfully completed, within a practical 15690
nurse prelicensure education program approved by the board or by 15691
another jurisdiction's agency that regulates the practice of 15692
nursing, a course of study that prepares the nurse to safely 15693
perform the intravenous therapy procedures the board may authorize 15694
under this section. To meet this requirement, the course of study 15695
must include all of the following: 15696

(a) Both didactic and clinical components; 15697

(b) Curriculum requirements established in rules the board of 15698
nursing shall adopt in accordance with Chapter 119. of the Revised 15699
Code; 15700

(c) Standards that require the nurse to perform a successful 15701
demonstration of the intravenous procedures, including all skills 15702
needed to perform them safely. 15703

(2) The nurse has successfully completed a minimum of forty 15704

hours of training that includes all of the following: 15705

(a) The curriculum established by rules adopted by the board 15706
and in effect on January 1, 1999; 15707

(b) Training in the anatomy and physiology of the 15708
cardiovascular system, signs and symptoms of local and systemic 15709
complications in the administration of fluids and antibiotic 15710
additives, and guidelines for management of these complications; 15711

(c) Any other training or instruction the board considers 15712
appropriate. 15713

(d) A testing component that requires the nurse to perform a 15714
successful demonstration of the intravenous procedures, including 15715
all skills needed to perform them safely. 15716

(B) Except as provided in section 4723.171 of the Revised 15717
Code, a licensed practical nurse may perform intravenous therapy 15718
only if authorized by the board pursuant to division (A) of this 15719
section and only if it is performed in accordance with this 15720
section. 15721

A licensed practical nurse authorized by the board to perform 15722
intravenous therapy may perform an intravenous therapy procedure 15723
only at the direction of one of the following: 15724

(1) A licensed physician, dentist, optometrist, or podiatrist 15725
who, except as provided in division (C)(2) of this section, is 15726
present and readily available at the facility where the 15727
intravenous therapy procedure is performed; 15728

(2) A registered nurse in accordance with division (C) of 15729
this section. 15730

(C)(1) Except as provided in division (C)(2) of this section 15731
and section 4723.171 of the Revised Code, when a licensed 15732
practical nurse authorized by the board to perform intravenous 15733
therapy performs an intravenous therapy procedure at the direction 15734

of a registered nurse, the registered nurse or another registered 15735
nurse shall be readily available at the site where the intravenous 15736
therapy is performed, and before the licensed practical nurse 15737
initiates the intravenous therapy, the registered nurse shall 15738
personally perform an on-site assessment of the individual who is 15739
to receive the intravenous therapy. 15740

(2) When a licensed practical nurse authorized by the board 15741
to perform intravenous therapy performs an intravenous therapy 15742
procedure in a home as defined in section 3721.10 of the Revised 15743
Code, or in an intermediate care facility for the mentally 15744
retarded as defined in section ~~5111.20~~ 5164.01 of the Revised 15745
Code, at the direction of a registered nurse or licensed 15746
physician, dentist, optometrist, or podiatrist, a registered nurse 15747
shall be on the premises of the home or facility or accessible by 15748
some form of telecommunication. 15749

(D) No licensed practical nurse shall perform any of the 15750
following intravenous therapy procedures: 15751

(1) Initiating or maintaining any of the following: 15752

(a) Blood or blood components; 15753

(b) Solutions for total parenteral nutrition; 15754

(c) Any cancer therapeutic medication including, but not 15755
limited to, cancer chemotherapy or an anti-neoplastic agent; 15756

(d) Solutions administered through any central venous line or 15757
arterial line or any other line that does not terminate in a 15758
peripheral vein, except that a licensed practical nurse authorized 15759
by the board to perform intravenous therapy may maintain the 15760
solutions specified in division (D)(6)(a) of this section that are 15761
being administered through a central venous line or peripherally 15762
inserted central catheter; 15763

(e) Any investigational or experimental medication. 15764

(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; 15765
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(3) Discontinuing a central venous, arterial, or any other line that does not terminate in a peripheral vein; 15770
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(4) Initiating or discontinuing a peripherally inserted central catheter; 15772
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(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; 15774
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(6) Administering medication via the intravenous route, including all of the following activities: 15778
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(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: 15780
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(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. 15784
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(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. 15788
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(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 15792
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intravenous piggyback infusion containing an antibiotic additive;	15795
(c) Injecting medication via a direct intravenous route,	15796
except that a licensed practical nurse authorized by the board to	15797
perform intravenous therapy may inject heparin or normal saline to	15798
flush an intermittent infusion device or heparin lock including,	15799
but not limited to, bolus or push.	15800
(7) Aspirating any intravenous line to maintain patency;	15801
(8) Changing tubing on any line including, but not limited	15802
to, an arterial line or a central venous line, except that a	15803
licensed practical nurse authorized by the board to perform	15804
intravenous therapy may change tubing on an intravenous line that	15805
terminates in a peripheral vein;	15806
(9) Programming or setting any function of a patient	15807
controlled infusion pump.	15808
(E) Notwithstanding division (D) of this section, at the	15809
direction of a physician or a registered nurse, a licensed	15810
practical nurse authorized by the board to perform intravenous	15811
therapy may perform the following activities for the purpose of	15812
performing dialysis:	15813
(1) The routine administration and regulation of saline	15814
solution for the purpose of maintaining an established fluid plan;	15815
(2) The administration of a heparin dose intravenously;	15816
(3) The administration of a heparin dose peripherally via a	15817
fistula needle;	15818
(4) The loading and activation of a constant infusion pump or	15819
the intermittent injection of a dose of medication prescribed by a	15820
licensed physician for dialysis.	15821
(F) No person shall employ or direct a licensed practical	15822
nurse to perform an intravenous therapy procedure without first	15823
verifying that the licensed practical nurse is authorized by the	15824

board to perform intravenous therapy. 15825

(G) The board shall issue an intravenous therapy card to the 15826
licensed practical nurses authorized pursuant to division (A) of 15827
this section to perform intravenous therapy. A fee for issuing the 15828
card shall not be charged under section 4723.08 of the Revised 15829
Code if the licensed practical nurse receives the card by meeting 15830
the requirements of division (A)(1) of this section. The board 15831
shall maintain a registry of the names of licensed practical 15832
nurses who hold intravenous therapy cards. 15833

Sec. 4723.63. (A) In consultation with the medication aide 15834
advisory council established under section 4723.62 of the Revised 15835
Code, the board of nursing shall conduct a pilot program for the 15836
use of medication aides in nursing homes and residential care 15837
facilities. The board shall conduct the pilot program in a manner 15838
consistent with human protection and other ethical concerns 15839
typically associated with research studies involving live 15840
subjects. The pilot program shall be commenced not later than May 15841
1, 2006, and shall be conducted until July 1, 2007. 15842

During the period the pilot program is conducted, a nursing 15843
home or residential care facility participating in the pilot 15844
program may use one or more medication aides to administer 15845
prescription medications to its residents, subject to both of the 15846
following conditions: 15847

(1) Each individual used as a medication aide must hold a 15848
current, valid medication aide certificate issued by the board of 15849
nursing under this chapter. 15850

(2) The nursing home or residential care facility shall 15851
ensure that the requirements of section 4723.67 of the Revised 15852
Code are met. 15853

(B) The board, in consultation with the medication aide 15854

advisory council, shall do all of the following not later than 15855
February 1, 2006: 15856

(1) Design the pilot program; 15857

(2) Establish standards to govern medication aides and the 15858
nursing homes and residential care facilities participating in the 15859
pilot program, including standards for the training of medication 15860
aides and the staff of participating nursing homes and residential 15861
care facilities; 15862

(3) Establish standards to protect the health and safety of 15863
the residents of the nursing homes and residential care facilities 15864
participating in the program; 15865

(4) Implement a process for selecting the nursing homes and 15866
residential care facilities to participate in the program. 15867

(C)(1) A nursing home or residential care facility may 15868
volunteer to participate in the pilot program by submitting an 15869
application to the board on a form prescribed and provided by the 15870
board. From among the applicants, the board shall select eighty 15871
nursing homes and forty residential care facilities to participate 15872
in the pilot program. 15873

(2) To be eligible to participate, a nursing home or 15874
residential care facility shall agree to observe the standards 15875
established by the board for the use of medication aides. A 15876
nursing home is eligible to participate only if the department of 15877
health has found in the two most recent surveys or inspections of 15878
the home that the home is free from deficiencies related to the 15879
administration of medication. A residential care facility is 15880
eligible to participate only if the department has found that the 15881
facility is free from deficiencies related to the provision of 15882
skilled nursing care or the administration of medication. 15883

(D) As a condition of participation in the pilot program, a 15884
nursing home and residential care facility selected by the board 15885

shall pay the participation fee established in rules adopted under 15886
section 4723.69 of the Revised Code. The participation fee is not 15887
reimbursable under the medicaid program ~~established under Chapter~~ 15888
~~5111. of the Revised Code.~~ 15889

(E) On receipt of evidence found credible by the board that 15890
continued participation by a nursing home or residential care 15891
facility poses an imminent danger, risk of serious harm, or 15892
jeopardy to a resident of the home or facility, the board may 15893
terminate the authority of the home or facility to participate in 15894
the pilot program. 15895

(F)(1) With the assistance of the medication aide advisory 15896
council, the board shall conduct an evaluation of the pilot 15897
program. In conducting the evaluation, the board shall do all of 15898
the following: 15899

(a) Assess whether medication aides are able to administer 15900
prescription medications safely to nursing home and residential 15901
care facility residents; 15902

(b) Determine the financial implications of using medication 15903
aides in nursing homes and residential care facilities; 15904

(c) Consider any other issue the board or council considers 15905
relevant to the evaluation. 15906

(2) Not later than March 1, 2007, the board shall prepare a 15907
report of its findings and recommendations derived from the 15908
evaluation of the pilot program. The board shall submit the report 15909
to the governor, president and minority leader of the senate, 15910
speaker and minority leader of the house of representatives, and 15911
director of health. 15912

Sec. 4731.151. (A) Naprapaths who received a certificate to 15913
practice from the board prior to March 2, 1992, may continue to 15914
practice naprapathy, as defined in rules adopted by the board. 15915

Such naprapaths shall practice in accordance with rules adopted by the board. 15916
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(B)(1) As used in this division: 15918

(a) "Mechanotherapy" means all of the following: 15919

(i) Examining patients by verbal inquiry; 15920

(ii) Examination of the musculoskeletal system by hand; 15921

(iii) Visual inspection and observation; 15922

(iv) Diagnosing a patient's condition only as to whether the patient has a disorder of the musculoskeletal system; 15923
15924

(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. 15925
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(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. 15934
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(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. 15938
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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 15943
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hygienic and nutritional care of the patients. Roentgen rays shall 15946
be used by a mechanotherapist only for diagnostic purposes. 15947

(3) A person who holds a certificate to practice 15948
mechanotherapy and completed educational requirements in 15949
mechanotherapy on or before November 3, 1985, is entitled to use 15950
the title "doctor of mechanotherapy" and is a "physician" who 15951
performs "medical services" for the purposes of Chapters 4121. and 15952
4123. of the Revised Code and the medicaid program ~~established~~ 15953
~~under section 5111.01 of the Revised Code~~, and shall receive 15954
payment or reimbursement as provided under those chapters and that 15955
~~section program~~. 15956

Sec. 4731.65. As used in sections 4731.65 to 4731.71 of the 15957
Revised Code: 15958

(A)(1) "Clinical laboratory services" means either of the 15959
following: 15960

(a) Any examination of materials derived from the human body 15961
for the purpose of providing information for the diagnosis, 15962
prevention, or treatment of any disease or impairment or for the 15963
assessment of health; 15964

(b) Procedures to determine, measure, or otherwise describe 15965
the presence or absence of various substances or organisms in the 15966
body. 15967

(2) "Clinical laboratory services" does not include the mere 15968
collection or preparation of specimens. 15969

(B) "Designated health services" means any of the following: 15970

(1) Clinical laboratory services; 15971

(2) Home health care services; 15972

(3) Outpatient prescription drugs. 15973

(C) "Fair market value" means the value in arms-length 15974

transactions, consistent with general market value and: 15975

(1) With respect to rentals or leases, the value of rental 15976
property for general commercial purposes, not taking into account 15977
its intended use; 15978

(2) With respect to a lease of space, not adjusted to reflect 15979
the additional value the prospective lessee or lessor would 15980
attribute to the proximity or convenience to the lessor if the 15981
lessor is a potential source of referrals to the lessee. 15982

(D) "Governmental health care program" means any program 15983
providing health care benefits that is administered by the federal 15984
government, this state, or a political subdivision of this state, 15985
including the medicare program ~~established under Title XVIII of~~ 15986
~~the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301,~~ 15987
~~as amended,~~ health care coverage for public employees, health care 15988
benefits administered by the bureau of workers' compensation, the 15989
~~medical assistance~~ medicaid program ~~established under Chapter~~ 15990
~~5111. of the Revised Code,~~ and the disability medical assistance 15991
program ~~established under Chapter 5115. of the Revised Code.~~ 15992

(E)(1) "Group practice" means a group of two or more holders 15993
of certificates under this chapter legally organized as a 15994
partnership, professional corporation or association, limited 15995
liability company, foundation, nonprofit corporation, faculty 15996
practice plan, or similar group practice entity, including an 15997
organization comprised of a nonprofit medical clinic that 15998
contracts with a professional corporation or association of 15999
physicians to provide medical services exclusively to patients of 16000
the clinic in order to comply with section 1701.03 of the Revised 16001
Code and including a corporation, limited liability company, 16002
partnership, or professional association described in division (B) 16003
of section 4731.226 of the Revised Code formed for the purpose of 16004
providing a combination of the professional services of 16005
optometrists who are licensed, certificated, or otherwise legally 16006

authorized to practice optometry under Chapter 4725. of the 16007
Revised Code, chiropractors who are licensed, certificated, or 16008
otherwise legally authorized to practice chiropractic under 16009
Chapter 4734. of the Revised Code, psychologists who are licensed, 16010
certificated, or otherwise legally authorized to practice 16011
psychology under Chapter 4732. of the Revised Code, registered or 16012
licensed practical nurses who are licensed, certificated, or 16013
otherwise legally authorized to practice nursing under Chapter 16014
4723. of the Revised Code, pharmacists who are licensed, 16015
certificated, or otherwise legally authorized to practice pharmacy 16016
under Chapter 4729. of the Revised Code, physical therapists who 16017
are licensed, certificated, or otherwise legally authorized to 16018
practice physical therapy under sections 4755.40 to 4755.56 of the 16019
Revised Code, occupational therapists who are licensed, 16020
certificated, or otherwise legally authorized to practice 16021
occupational therapy under sections 4755.04 to 4755.13 of the 16022
Revised Code, mechanotherapists who are licensed, certificated, or 16023
otherwise legally authorized to practice mechanotherapy under 16024
section 4731.151 of the Revised Code, and doctors of medicine and 16025
surgery, osteopathic medicine and surgery, or podiatric medicine 16026
and surgery who are licensed, certificated, or otherwise legally 16027
authorized for their respective practices under this chapter, to 16028
which all of the following apply: 16029

(a) Each physician who is a member of the group practice 16030
provides substantially the full range of services that the 16031
physician routinely provides, including medical care, 16032
consultation, diagnosis, or treatment, through the joint use of 16033
shared office space, facilities, equipment, and personnel. 16034

(b) Substantially all of the services of the members of the 16035
group are provided through the group and are billed in the name of 16036
the group and amounts so received are treated as receipts of the 16037
group. 16038

(c) The overhead expenses of and the income from the practice 16039
are distributed in accordance with methods previously determined 16040
by members of the group. 16041

(d) The group practice meets any other requirements that the 16042
state medical board applies in rules adopted under section 4731.70 16043
of the Revised Code. 16044

(2) In the case of a faculty practice plan associated with a 16045
hospital with a medical residency training program in which 16046
physician members may provide a variety of specialty services and 16047
provide professional services both within and outside the group, 16048
as well as perform other tasks such as research, the criteria in 16049
division (E)(1) of this section apply only with respect to 16050
services rendered within the faculty practice plan. 16051

(F) "Home health care services" and "immediate family" have 16052
the same meanings as in the rules adopted under section 4731.70 of 16053
the Revised Code. 16054

(G) "Hospital" has the same meaning as in section 3727.01 of 16055
the Revised Code. 16056

(H) A "referral" includes both of the following: 16057

(1) A request by a holder of a certificate under this chapter 16058
for an item or service, including a request for a consultation 16059
with another physician and any test or procedure ordered by or to 16060
be performed by or under the supervision of the other physician; 16061

(2) A request for or establishment of a plan of care by a 16062
certificate holder that includes the provision of designated 16063
health services. 16064

(I) "Third-party payer" has the same meaning as in section 16065
3901.38 of the Revised Code. 16066

Sec. 4731.71. The auditor of state may implement procedures 16067
to detect violations of section 4731.66 or 4731.69 of the Revised 16068

Code within governmental health care programs administered by the 16069
state. The auditor of state shall report any violation of either 16070
section to the state medical board and shall certify to the 16071
attorney general in accordance with section 131.02 of the Revised 16072
Code the amount of any refund owed to a state-administered 16073
governmental health care program under section 4731.69 of the 16074
Revised Code as a result of a violation. If a refund is owed to 16075
the ~~medical assistance~~ medicaid program ~~established under Chapter~~ 16076
~~5111. of the Revised Code~~ or the disability medical assistance 16077
program ~~established under Chapter 5115. of the Revised Code~~, the 16078
auditor of state also shall report the amount to the department of 16079
commerce. 16080

The state medical board also may implement procedures to 16081
detect violations of section 4731.66 or 4731.69 of the Revised 16082
Code. 16083

Sec. 4752.02. (A) Except as provided in division (B) of this 16084
section, no person shall provide home medical equipment services 16085
or claim to the public to be a home medical equipment services 16086
provider unless either of the following is the case: 16087

(1) The person holds a valid license issued under this 16088
chapter; 16089

(2) The person holds a valid certificate of registration 16090
issued under this chapter. 16091

(B) Division (A) of this section does not apply to any of the 16092
following: 16093

(1) A health care practitioner, as defined in section 4769.01 16094
of the Revised Code, who does not sell or rent home medical 16095
equipment; 16096

(2) A hospital that provides home medical equipment services 16097
only as an integral part of patient care and does not provide the 16098

services through a separate entity that has its own medicare or	16099
medicaid provider number;	16100
(3) A manufacturer or wholesale distributor of home medical	16101
equipment that does not sell directly to the public;	16102
(4) A hospice care program, as defined by section 3712.01 of	16103
the Revised Code, that does not sell or rent home medical	16104
equipment;	16105
(5) A home, as defined by section 3721.01 of the Revised	16106
Code;	16107
(6) A home health agency that is certified under Title XVIII	16108
of the "Social Security Act," 79 Stat. 286 (1965), 42 U.S.C. 1395,	16109
<u>medicare program</u> as a provider of home health services and does	16110
not sell or rent home medical equipment;	16111
(7) An individual who holds a current, valid license issued	16112
under Chapter 4741. of the Revised Code to practice veterinary	16113
medicine;	16114
(8) An individual who holds a current, valid license issued	16115
under Chapter 4779. of the Revised Code to practice orthotics,	16116
prosthetics, or pedorthics;	16117
(9) A pharmacy licensed under Chapter 4729. of the Revised	16118
Code that either does not sell or rent home medical equipment or	16119
receives total payments of less than ten thousand dollars per year	16120
from selling or renting home medical equipment;	16121
(10) A home dialysis equipment provider regulated by federal	16122
law.	16123
Sec. 4752.09. (A) The Ohio respiratory care board may, in	16124
accordance with Chapter 119. of the Revised Code, suspend or	16125
revoke a license issued under this chapter or discipline a license	16126
holder by imposing a fine of not more than five thousand dollars	16127
or taking other disciplinary action on any of the following	16128

grounds:	16129
(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;	16130 16131 16132
(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;	16133 16134 16135
(3) Making a material misstatement in furnishing information to the board;	16136 16137
(4) Professional incompetence;	16138
(5) Being guilty of negligence or gross misconduct in providing home medical equipment services;	16139 16140
(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;	16141 16142 16143 16144
(7) Failing, within sixty days, to provide information in response to a written request by the board;	16145 16146
(8) Engaging in conduct likely to deceive, defraud, or harm the public;	16147 16148
(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;	16149 16150 16151
(10) Directly or indirectly giving to or receiving from any person a fee, commission, rebate, or other form of compensation for services not rendered;	16152 16153 16154
(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;	16155 16156 16157 16158

(12) Failing to comply with federal rules issued pursuant to 16159
the medicare program ~~established under Title XVIII of the "Social~~ 16160
~~Security Act," 49 Stat. 620(1935), 42 U.S.C. 1395, as amended,~~ 16161
relating to operations, financial transactions, and general 16162
business practices of home medical services providers. 16163

(B) The respiratory care board immediately may suspend a 16164
license without a hearing if it determines that there is evidence 16165
that the license holder is subject to actions under this section 16166
and that there is clear and convincing evidence that continued 16167
operation by the license holder presents an immediate and serious 16168
harm to the public. The president and executive director of the 16169
board shall make a preliminary determination and describe, by 16170
telephone conference or any other method of communication, the 16171
evidence on which they made their determination to the other 16172
members of the board. The board may by resolution designate 16173
another board member to act in place of the president of the board 16174
or another employee to act in the place of the executive director, 16175
in the event that the board president or executive director is 16176
unavailable or unable to act. On review of the evidence, the board 16177
may by a vote of not less than seven of its members, suspend a 16178
license without a prior hearing. The board may vote on the 16179
suspension by way of a telephone conference call. 16180

Immediately following the decision to suspend a license under 16181
this division, the board shall issue a written order of suspension 16182
and cause it to be delivered in accordance with section 119.07 of 16183
the Revised Code. The order shall not be subject to suspension by 16184
the court during the pendency of any appeal filed under section 16185
119.12 of the Revised Code. If the license holder requests an 16186
adjudication hearing, the date set for the hearing shall be within 16187
fifteen days but not earlier than seven days after the license 16188
holder requests the hearing, unless another date is agreed to by 16189
the license holder and the board. The suspension shall remain in 16190

effect, unless reversed by the board, until a final adjudication 16191
order issued by the board pursuant to this section and Chapter 16192
119. of the Revised Code becomes effective. The board shall issue 16193
its final adjudication order not later than ninety days after 16194
completion of the hearing. The board's failure to issue the order 16195
by that day shall cause the summary suspension to end, but shall 16196
not affect the validity of any subsequent final adjudication 16197
order. 16198

Sec. 4753.071. A person who is required to meet the 16199
supervised professional experience requirement of division (F) of 16200
section 4753.06 of the Revised Code shall submit to the board of 16201
speech-language pathology and audiology an application for a 16202
conditional license. The application shall include a plan for the 16203
content of the supervised professional experience on a form the 16204
board shall prescribe. The board shall issue the conditional 16205
license to the applicant if the applicant meets the requirements 16206
of section 4753.06 of the Revised Code, other than the requirement 16207
to have obtained the supervised professional experience, and pays 16208
to the board the appropriate fee for a conditional license. An 16209
applicant may not begin employment until the conditional license 16210
has been issued. 16211

A conditional license authorizes an individual to practice 16212
speech-language pathology or audiology while completing the 16213
supervised professional experience as required by division (F) of 16214
section 4753.06 of the Revised Code. A person holding a 16215
conditional license may practice speech-language pathology or 16216
audiology while working under the supervision of a person fully 16217
licensed in accordance with this chapter. A conditional license is 16218
valid for eighteen months unless suspended or revoked pursuant to 16219
section 3123.47 or 4753.10 of the Revised Code. 16220

A person holding a conditional license may perform services 16221

for which reimbursement will be sought under the medicare program 16222
~~established under Title XVIII of the "Social Security Act," 79~~ 16223
~~Stat. 286 (1965), 42 U.S.C. 1395, as amended,~~ or the medicaid 16224
program ~~established under Chapter 5111. of the Revised Code~~ but 16225
all requests for reimbursement for such services shall be made by 16226
the person who supervises the person performing the services. 16227

Sec. 4755.481. (A) If a physical therapist evaluates and 16228
treats a patient without the prescription of, or the referral of 16229
the patient by, a person who is licensed to practice medicine and 16230
surgery, chiropractic, dentistry, osteopathic medicine and 16231
surgery, podiatric medicine and surgery, or nursing as a certified 16232
registered nurse anesthetist, clinical nurse specialist, certified 16233
nurse-midwife, or certified nurse practitioner, all of the 16234
following apply: 16235

(1) The physical therapist shall, upon consent of the 16236
patient, inform the patient's physician, chiropractor, dentist, 16237
podiatrist, certified registered nurse anesthetist, clinical nurse 16238
specialist, certified nurse-midwife, or certified nurse 16239
practitioner of the evaluation not later than five business days 16240
after the evaluation is made. 16241

(2) If the physical therapist determines, based on reasonable 16242
evidence, that no substantial progress has been made with respect 16243
to that patient during the thirty-day period immediately following 16244
the date of the patient's initial visit with the physical 16245
therapist, the physical therapist shall consult with or refer the 16246
patient to a licensed physician, chiropractor, dentist, 16247
podiatrist, certified registered nurse anesthetist, clinical nurse 16248
specialist, certified nurse-midwife, or certified nurse 16249
practitioner, unless either of the following applies: 16250

(a) The evaluation, treatment, or services are being provided 16251
for fitness, wellness, or prevention purposes. 16252

(b) The patient previously was diagnosed with chronic, 16253
neuromuscular, or developmental conditions and the evaluation, 16254
treatment, or services are being provided for problems or symptoms 16255
associated with one or more of those previously diagnosed 16256
conditions. 16257

(3) If the physical therapist determines that orthotic 16258
devices are necessary to treat the patient, the physical therapist 16259
shall be limited to the application of the following orthotic 16260
devices: 16261

(a) Upper extremity adaptive equipment used to facilitate the 16262
activities of daily living; 16263

(b) Finger splints; 16264

(c) Wrist splints; 16265

(d) Prefabricated elastic or fabric abdominal supports with 16266
or without metal or plastic reinforcing stays and other 16267
prefabricated soft goods requiring minimal fitting; 16268

(e) Nontherapeutic accommodative inlays; 16269

(f) Shoes that are not manufactured or modified for a 16270
particular individual; 16271

(g) Prefabricated foot care products; 16272

(h) Custom foot orthotics; 16273

(i) Durable medical equipment. 16274

(4) If, at any time, the physical therapist has reason to 16275
believe that the patient has symptoms or conditions that require 16276
treatment or services beyond the scope of practice of a physical 16277
therapist, the physical therapist shall refer the patient to a 16278
licensed health care practitioner acting within the practitioner's 16279
scope of practice. 16280

(B) Nothing in sections 4755.40 to 4755.56 of the Revised 16281

Code shall be construed to require reimbursement under any health 16282
insuring corporation policy, contract, or agreement, any sickness 16283
and accident insurance policy, the ~~medical assistance~~ medicaid 16284
program ~~as defined in section 5111.01 of the Revised Code~~, or the 16285
health partnership program or qualified health plans established 16286
pursuant to sections 4121.44 to 4121.442 of the Revised Code, for 16287
any physical therapy service rendered without the prescription of, 16288
or the referral of the patient by, a licensed physician, 16289
chiropractor, dentist, podiatrist, certified registered nurse 16290
anesthetist, clinical nurse specialist, certified nurse-midwife, 16291
or certified nurse practitioner. 16292

(C) For purposes of this section, "business day" means any 16293
calendar day that is not a Saturday, Sunday, or legal holiday. 16294
"Legal holiday" has the same meaning as in section 1.14 of the 16295
Revised Code. 16296

Sec. 4758.02. (A) Effective two years after the date the 16297
department of alcohol and drug addiction services ceases to 16298
administer its certification and credentialing process under 16299
section 3793.07 of the Revised Code as specified in division 16300
(~~B~~)(A) of that section and except as provided in sections 4758.03 16301
and 4758.04 of the Revised Code, no person shall do any of the 16302
following: 16303

(1) Engage in or represent to the public that the person 16304
engages in chemical dependency counseling for a fee, salary, or 16305
other consideration unless the person holds a valid independent 16306
chemical dependency counselor license, chemical dependency 16307
counselor III license, chemical dependency counselor II license, 16308
chemical dependency counselor I certificate, or chemical 16309
dependency counselor assistant certificate issued under this 16310
chapter; 16311

(2) Use the title "licensed independent chemical dependency 16312

counselor," "LICDC," "licensed chemical dependency counselor III," 16313
"LCDC III," "licensed chemical dependency counselor II," "LCDC 16314
II," "certified chemical dependency counselor I," "CCDC I," 16315
"chemical dependency counselor assistant," "CDCA," or any other 16316
title or description incorporating the word "chemical dependency 16317
counselor" or any other initials used to identify persons acting 16318
in those capacities unless currently authorized under this chapter 16319
to act in the capacity indicated by the title or initials; 16320

(3) Represent to the public that the person is a registered 16321
applicant unless the person holds a valid registered applicant 16322
certificate issued under this chapter; 16323

(4) Use the title "certified prevention specialist II," "CPS 16324
II," "certified prevention specialist I," "CPS I," "registered 16325
applicant," or any other title, description, or initials used to 16326
identify persons acting in those capacities unless currently 16327
authorized under this chapter to act in the capacity indicated by 16328
the title or initials. 16329

(B) Effective six years after ~~the effective date of this~~ 16330
~~section~~ December 23, 2002, no person shall engage in or represent 16331
to the public that the person engages in chemical dependency 16332
counseling as a chemical dependency counselor I. 16333

Sec. 4758.04. After the date the department of alcohol and 16334
drug addiction services ceases to administer its certification and 16335
credentialing process under section 3793.07 of the Revised Code as 16336
specified in division ~~(B)~~(A) of that section, an individual who 16337
holds, on ~~the effective date of this section~~ December 23, 2002, a 16338
valid certificate or credentials that are accepted under section 16339
3793.07 of the Revised Code as authority to practice as a chemical 16340
dependency counselor or alcohol and other drug prevention 16341
specialist may apply to the chemical dependency professionals 16342
board for the board to delay the expiration date of the 16343

individual's certificate or credentials. If the board determines 16344
that there is good cause for delaying the expiration date, the 16345
board may delay the expiration date until a date the board 16346
specifies. The date the board specifies shall not be later than 16347
the date that is three years after the effective date of the 16348
board's initial rules adopted under section 4758.20 of the Revised 16349
Code. 16350

An individual who has the expiration date of the individual's 16351
certificate or credentials delayed under this section may perform 16352
services within the scope, standards, and ethics of the 16353
certificate or credentials until the date of the delayed 16354
expiration date. 16355

Sec. 4761.01. As used in this chapter: 16356

(A) "Respiratory care" means rendering or offering to render 16357
to individuals, groups, organizations, or the public any service 16358
involving the evaluation of cardiopulmonary function, the 16359
treatment of cardiopulmonary impairment, the assessment of 16360
treatment effectiveness, and the care of patients with 16361
deficiencies and abnormalities associated with the cardiopulmonary 16362
system. The practice of respiratory care includes: 16363

(1) Obtaining, analyzing, testing, measuring, and monitoring 16364
blood and gas samples in the determination of cardiopulmonary 16365
parameters and related physiologic data, including flows, 16366
pressures, and volumes, and the use of equipment employed for this 16367
purpose; 16368

(2) Administering, monitoring, recording the results of, and 16369
instructing in the use of medical gases, aerosols, and 16370
bronchopulmonary hygiene techniques, including drainage, 16371
aspiration, and sampling, and applying, maintaining, and 16372
instructing in the use of artificial airways, ventilators, and 16373
other life support equipment employed in the treatment of 16374

cardiopulmonary impairment and provided in collaboration with 16375
other licensed health care professionals responsible for providing 16376
care; 16377

(3) Performing cardiopulmonary resuscitation and respiratory 16378
rehabilitation techniques; 16379

(4) Administering medications for the testing or treatment of 16380
cardiopulmonary impairment. 16381

(B) "Respiratory care professional" means a person who is 16382
licensed under this chapter to practice the full range of 16383
respiratory care services as defined in division (A) of this 16384
section. 16385

(C) "Physician" means an individual authorized under Chapter 16386
4731. of the Revised Code to practice medicine and surgery or 16387
osteopathic medicine and surgery. 16388

(D) "Registered nurse" means an individual licensed under 16389
Chapter 4723. of the Revised Code to engage in the practice of 16390
nursing as a registered nurse. 16391

(E) "Hospital" means a facility that meets the operating 16392
standards of section 3727.02 of the Revised Code. 16393

(F) "Nursing facility" has the same meaning as in section 16394
~~5111.20~~ 5164.01 of the Revised Code. 16395

Sec. 4761.03. The Ohio respiratory care board shall regulate 16396
the practice of respiratory care in this state and the persons to 16397
whom the board issues licenses and limited permits under this 16398
chapter and shall license and register home medical equipment 16399
services providers under Chapter 4752. of the Revised Code ~~under~~ 16400
~~this chapter~~. Rules adopted under this chapter that deal with the 16401
provision of respiratory care in a hospital, other than rules 16402
regulating the issuance of licenses or limited permits, shall be 16403
consistent with the conditions for participation under medicare, 16404

~~Title XVIII of the "Social Security Act," 79 Stat. 286 (1965), 42~~ 16405
~~U.S.C.A. 1395, as amended,~~ and with the respiratory care 16406
accreditation standards of the joint commission on accreditation 16407
of healthcare organizations or the American osteopathic 16408
association. 16409

The board shall: 16410

(A) Adopt, and may rescind or amend, rules in accordance with 16411
Chapter 119. of the Revised Code to carry out the purposes of this 16412
chapter, including rules prescribing: 16413

(1) The form and manner for filing applications for licensure 16414
and renewal, limited permits, and limited permit extensions under 16415
sections 4761.05 and 4761.06 of the Revised Code; 16416

(2) The form, scoring, and scheduling of examinations and 16417
reexaminations for licensure and license renewal; 16418

(3) Standards for the approval of educational programs 16419
required to qualify for licensure and continuing education 16420
programs required for license renewal; 16421

(4) Continuing education courses and the number of hour 16422
requirements necessary for license renewal, in accordance with 16423
section 4761.06 of the Revised Code; 16424

(5) Procedures for the issuance and renewal of licenses and 16425
limited permits, including the duties that may be fulfilled by the 16426
board's executive director and other board employees; 16427

(6) Procedures for the denial, suspension, permanent 16428
revocation, refusal to renew, and reinstatement of licenses and 16429
limited permits, the conduct of hearings, and the imposition of 16430
fines for engaging in conduct that is grounds for such action and 16431
hearings under section 4761.09 of the Revised Code; 16432

(7) Standards of ethical conduct for the practice of 16433
respiratory care; 16434

(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; 16435
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16437

(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; 16438
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16440

(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. 16441
16442
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(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; 16444
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(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; 16448
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(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. 16451
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(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 16456
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audit records during normal business hours at the place of 16466
business of a licensee or person who is the subject of a complaint 16467
filed with the board or at any place where the records are kept. 16468

Except when required by court order, the board and its 16469
employees shall not disclose confidential information obtained 16470
during an investigation or identifying information about any 16471
person who files a complaint with the board. 16472

The board may hear testimony in matters relating to the 16473
duties imposed upon it and issue subpoenas pursuant to an 16474
investigation. The president and secretary of the board may 16475
administer oaths. 16476

(F) Conduct hearings, keep records of its proceedings, and do 16477
all such other things as are necessary and proper to carry out and 16478
enforce the provisions of this chapter; 16479

(G) Maintain, publish, and make available upon request, for a 16480
fee not to exceed the actual cost of printing and mailing: 16481

(1) The requirements for the issuance of licenses and limited 16482
permits under this chapter and rules adopted by the board; 16483

(2) A current register of every person licensed to practice 16484
respiratory care in this state, to include the addresses of the 16485
person's last known place of business and residence, the effective 16486
date and identification number of the license, the name and 16487
location of the institution that granted the person's degree or 16488
certificate of completion of respiratory care educational 16489
requirements, and the date the degree or certificate was issued; 16490

(3) A list of the names and locations of the institutions 16491
that each year granted degrees or certificates of completion in 16492
respiratory care; 16493

(4) After the administration of each examination, a list of 16494
persons who passed the examination. 16495

(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	16526
dispensing optician licensed under Chapter 4725. of the Revised Code;	16527 16528
(5) A pharmacist licensed under Chapter 4729. of the Revised Code;	16529 16530
(6) A physician authorized under Chapter 4731. of the Revised Code to practice medicine and surgery, osteopathic medicine and surgery, or podiatry;	16531 16532 16533
(7) A physician assistant authorized under Chapter 4730. of the Revised Code to practice as a physician assistant;	16534 16535
(8) A practitioner of a limited branch of medicine issued a certificate under Chapter 4731. of the Revised Code;	16536 16537
(9) A psychologist licensed under Chapter 4732. of the Revised Code;	16538 16539
(10) A chiropractor licensed under Chapter 4734. of the Revised Code;	16540 16541
(11) A hearing aid dealer or fitter licensed under Chapter 4747. of the Revised Code;	16542 16543
(12) A speech-language pathologist or audiologist licensed under Chapter 4753. of the Revised Code;	16544 16545
(13) An occupational therapist or occupational therapy assistant licensed under Chapter 4755. of the Revised Code;	16546 16547
(14) A physical therapist or physical therapy assistant licensed under Chapter 4755. of the Revised Code;	16548 16549
(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;	16550 16551 16552 16553
(16) A dietitian licensed under Chapter 4759. of the Revised	16554

Code;	16555
(17) A respiratory care professional licensed under Chapter 4761. of the Revised Code;	16556 16557
(18) An emergency medical technician-basic, emergency medical technician-intermediate, or emergency medical technician-paramedic certified under Chapter 4765. of the Revised Code.	16558 16559 16560
Sec. 5101.07. There is hereby created in the state treasury the <u>ODJFS</u> 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:	16561 16562 16563 16564 16565 16566 16567
(A) The department's costs for computer projects;	16568
(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.	16569 16570 16571
Sec. 5101.071. There is hereby created in the state treasury the <u>ODJFS</u> 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:	16572 16573 16574 16575 16576
(A) The department of job and family services' costs for computer projects;	16577 16578
(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.	16579 16580 16581
Sec. 5101.11. This section does not apply to contracts	16582

~~entered into under section 5111.90 or 5111.91 of the Revised Code.~~ 16583

(A) As used in this section: 16584

(1) "Entity" includes an agency, board, commission, or 16585
department of the state or a political subdivision of the state; a 16586
private, nonprofit entity; a school district; a private school; or 16587
a public or private institution of higher education. 16588

(2) "Federal financial participation" means the federal 16589
government's share of expenditures made by an entity in 16590
implementing a program administered by the department of job and 16591
family services. 16592

(B) At the request of any public entity having authority to 16593
implement a program administered by the department of job and 16594
family services or any private entity under contract with a public 16595
entity to implement a program administered by the department, the 16596
department may seek to obtain federal financial participation for 16597
costs incurred by the entity. Federal financial participation may 16598
be sought from programs operated pursuant to Title IV-A, and Title 16599
IV-E, ~~and Title XIX~~ of the "Social Security Act," 49 Stat. 620 16600
(1935), 42 U.S.C. 301, as amended; the "Food Stamp Act of 1964," 16601
78 Stat. 703, 7 U.S.C. 2011, as amended; and any other statute or 16602
regulation under which federal financial participation may be 16603
available, except that federal financial participation may be 16604
sought only for expenditures made with funds for which federal 16605
financial participation is available under federal law. 16606

(C) All funds collected by the department of job and family 16607
services pursuant to division (B) of this section shall be 16608
distributed to the entities that incurred the costs, except for 16609
any amounts retained by the department pursuant to division (D)(3) 16610
of this section. 16611

(D) In distributing federal financial participation pursuant 16612
to this section, the department may either enter into an agreement 16613

with the entity that is to receive the funds or distribute the 16614
funds in accordance with rules adopted under division (F) of this 16615
section. If the department decides to enter into an agreement to 16616
distribute the funds, the agreement may include terms that do any 16617
of the following: 16618

(1) Provide for the whole or partial reimbursement of any 16619
cost incurred by the entity in implementing the program; 16620

(2) In the event that federal financial participation is 16621
disallowed or otherwise unavailable for any expenditure, require 16622
the department of job and family services or the entity, whichever 16623
party caused the disallowance or unavailability of federal 16624
financial participation, to assume responsibility for the 16625
expenditures; 16626

(3) Permit the department to retain not more than five per 16627
cent of the amount of the federal financial participation to be 16628
distributed to the entity; 16629

(4) Require the public entity to certify the availability of 16630
sufficient unencumbered funds to match the federal financial 16631
participation it receives under this section; 16632

(5) Establish the length of the agreement, which may be for a 16633
fixed or a continuing period of time; 16634

(6) Establish any other requirements determined by the 16635
department to be necessary for the efficient administration of the 16636
agreement. 16637

(E) An entity that receives federal financial participation 16638
pursuant to this section for a program aiding children and their 16639
families shall establish a process for collaborative planning with 16640
the department of job and family services for the use of the funds 16641
to improve and expand the program. 16642

(F) The director of job and family services shall adopt rules 16643

as necessary to implement this section, including rules for the 16644
distribution of federal financial participation pursuant to this 16645
section. The rules shall be adopted in accordance with Chapter 16646
119. of the Revised Code. The director may adopt or amend any 16647
statewide plan required by the federal government for a program 16648
administered by the department, as necessary to implement this 16649
section. 16650

(G) Federal financial participation received pursuant to this 16651
section shall not be included in any calculation made under 16652
section 5101.16 or 5101.161 of the Revised Code. 16653

Sec. 5101.16. (A) As used in this section and sections 16654
5101.161 and 5101.162 of the Revised Code: 16655

(1) "Disability financial assistance" means the financial 16656
assistance program established under Chapter 5115. of the Revised 16657
Code. 16658

~~(2) "Disability medical assistance" means the medical 16659
assistance program established under Chapter 5115. of the Revised 16660
Code. 16661~~

~~(3) "Food stamps" means the program administered by the 16662
department of job and family services pursuant to section 5101.54 16663
of the Revised Code. 16664~~

~~(4) "Medicaid" means the medical assistance program 16665
established by Chapter 5111. of the Revised Code, excluding 16666
transportation services provided under that chapter. 16667~~

~~(5)~~(3) "Ohio works first" means the program established by 16668
Chapter 5107. of the Revised Code. 16669

~~(6)~~(4) "Prevention, retention, and contingency" means the 16670
program established by Chapter 5108. of the Revised Code. 16671

~~(7)~~(5) "Public assistance expenditures" means expenditures 16672
for all of the following: 16673

(a) Ohio works first;	16674
(b) County administration of Ohio works first;	16675
(c) Prevention, retention, and contingency;	16676
(d) County administration of prevention, retention, and contingency;	16677 16678
(e) Disability financial assistance;	16679
(f) Disability medical assistance;	16680
(g) County administration of disability financial assistance;	16681
(h) County administration of disability medical assistance;	16682
(i) <u>(g)</u> County administration of food stamps;	16683
(j) County administration of medicaid.	16684
(8) <u>(6)</u> "Public medical assistance expenditures" has the same <u>meaning as in section 5160.26 of the Revised Code.</u>	16685 16686
<u>(7)</u> "Title IV-A program" has the same meaning as in section 5101.80 of the Revised Code.	16687 16688
(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:	16689 16690 16691 16692 16693 16694
(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 these programs <u>disability financial assistance</u> during the state fiscal year ending in the previous calendar year that the department of job and family services determines are allowable.	16695 16696 16697 16698 16699 16700
(2) The amount that is ten per cent, or other percentage determined under division (D) of this section, of the county's	16701 16702

total expenditures for county administration of food stamps ~~and~~ 16703
~~medicaid~~ during the state fiscal year ending in the previous 16704
calendar year that the department determines are allowable, less 16705
the amount of federal reimbursement credited to the county under 16706
division (E) of this section for the state fiscal year ending in 16707
the previous calendar year; 16708

(3) A percentage of the actual amount of the county share of 16709
program and administrative expenditures during federal fiscal year 16710
1994 for assistance and services, other than child care, provided 16711
under ~~Titles former Title IV-A and IV-F~~ of the "Social Security 16712
Act," 49 Stat. ~~620~~ 627 (1935), 42 U.S.C. ~~301~~ 601, and former Title 16713
IV-F of the "Social Security Act," 102 Stat. 2360 (1988), 42 16714
U.S.C. 681, as those titles existed prior to the enactment of the 16715
"Personal Responsibility and Work Opportunity Reconciliation Act 16716
of 1996," 110 Stat. 2105. The department of job and family 16717
services shall determine the actual amount of the county share 16718
from expenditure reports submitted to the United States department 16719
of health and human services. The percentage shall be the 16720
percentage established in rules adopted under division (F) of this 16721
section. 16722

(C)(1) If a county's share of public assistance expenditures 16723
determined under division (B) of this section and the county's 16724
share of public medical assistance expenditures determined under 16725
division (B) of section 5160.26 of the Revised Code for a state 16726
fiscal year exceeds one hundred ten per cent of the county's share 16727
for those expenditures for the immediately preceding state fiscal 16728
year, the department of job and family services shall reduce the 16729
county's share for expenditures under divisions (B)(1) and (2) of 16730
this section so that the total of the county's share for public 16731
assistance expenditures under division (B) of this section and 16732
public medical assistance expenditures equals one hundred ten per 16733
cent of the county's share of those expenditures for the 16734

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 16767
an annual income of less than three thousand dollars for the state 16768
and for each county by multiplying the most recent estimate of 16769
such families published by the department of development, by a 16770
fraction, the numerator of which is the estimate of average annual 16771
personal income published by the bureau of economic analysis of 16772
the United States department of commerce for the year on which the 16773
census estimate is based and the denominator of which is the most 16774
recent such estimate published by the bureau. 16775

(3) If the per capita tax duplicate of a county is less than 16776
the per capita tax duplicate of the state as a whole and the 16777
percentage of families in the county with an annual income of less 16778
than three thousand dollars is greater than the percentage of such 16779
families in the state, the percentage to be used for the purpose 16780
of division (B)(2) of this section shall be determined as follows: 16781

(a) Multiply ten by the fraction determined under division 16782
(D)(1) of this section; 16783

(b) Multiply the product determined under division (D)(3)(a) 16784
of this section by the fraction determined under division (D)(2) 16785
of this section. 16786

(4) The department of job and family services shall 16787
determine, for each county, the percentage to be used for the 16788
purpose of division (B)(2) of this section not later than the 16789
first day of July of the year preceding the state fiscal year for 16790
which the percentage is used. 16791

(E) The department of job and family services shall credit to 16792
a county the amount of federal reimbursement the department 16793
receives from the United States ~~departments~~ department of 16794
agriculture ~~and health and human services~~ for the county's 16795
expenditures for administration of food stamps ~~and medicaid~~ that 16796
the department determines are allowable administrative 16797

expenditures. 16798

(F)(1) The director of job and family services shall adopt 16799
rules in accordance with section 111.15 of the Revised Code to 16800
establish all of the following: 16801

(a) The method the department is to use to change a county's 16802
share of public assistance expenditures determined under division 16803
(B) of this section as provided in division (C) of this section; 16804

(b) The allocation methodology and formula the department 16805
will use to determine the amount of funds to credit to a county 16806
under this section; 16807

(c) The method the department will use to change the payment 16808
of the county share of public assistance expenditures from a 16809
calendar-year basis to a state fiscal year basis; 16810

(d) The percentage to be used for the purpose of division 16811
(B)(3) of this section, which shall, except as provided in section 16812
5101.163 of the Revised Code, meet both of the following 16813
requirements: 16814

(i) The percentage shall not be less than seventy-five per 16815
cent nor more than eighty-two per cent; 16816

(ii) The percentage shall not exceed the percentage that the 16817
state's qualified state expenditures is of the state's historic 16818
state expenditures as those terms are defined in 42 U.S.C. 16819
609(a)(7). 16820

(e) Other procedures and requirements necessary to implement 16821
this section. 16822

(2) The director of job and family services may amend the 16823
rule adopted under division (F)(1)(d) of this section to modify 16824
the percentage on determination that the amount the general 16825
assembly appropriates for Title IV-A programs makes the 16826
modification necessary. The rule shall be adopted and amended as 16827

if an internal management rule and in consultation with the 16828
director of budget and management. 16829

Sec. 5101.162. Subject to available federal funds and 16830
appropriations made by the general assembly, the department of job 16831
and family services may, at its sole discretion, use available 16832
federal funds to reimburse county expenditures for county 16833
administration of food stamps ~~or medicaid~~ even though the county 16834
expenditures meet or exceed the maximum allowable reimbursement 16835
amount established by rules adopted under section 5101.161 of the 16836
Revised Code if the board of county commissioners has entered into 16837
a fiscal agreement with the director of job and family services 16838
under section 5101.21 of the Revised Code. The director may adopt 16839
internal management rules in accordance with section 111.15 of the 16840
Revised Code to implement this section. 16841

Sec. 5101.18. ~~(A)~~ When the director of job and family 16842
services adopts rules under section 5107.05 regarding income 16843
requirements for the Ohio works first program and under section 16844
5115.03 of the Revised Code regarding income and resource 16845
requirements for the disability financial assistance program, the 16846
director shall determine what payments shall be regarded or 16847
disregarded. In making this determination, the director shall 16848
consider: 16849

~~(1)~~(A) The source of the payment; 16850

~~(2)~~(B) The amount of the payment; 16851

~~(3)~~(C) The purpose for which the payment was made; 16852

~~(4)~~(D) Whether regarding the payment as income would be in 16853
the public interest; 16854

~~(5)~~(E) Whether treating the payment as income would be 16855
detrimental to any of the programs administered in whole or in 16856
part by the department of job and family services or department of 16857

health care administration and whether such determination would 16858
jeopardize the receipt of any federal grant or payment by the 16859
state or any receipt of aid under Chapter 5107. of the Revised 16860
Code. 16861

~~(B) Any recipient of aid under Title XVI of the "Social 16862
Security Act," 49 Stat. 620 (1935), 42 U.S.C. 301, as amended, 16863
whose money payment is discontinued as the result of a general 16864
increase in old age, survivors, and disability insurance benefits 16865
under such act, shall remain a recipient for the purpose of 16866
receiving medical assistance through the medical assistance 16867
program established under section 5111.01 of the Revised Code. 16868~~

Sec. 5101.181. ~~(A) As used in this section and section 16869
5101.182 of the Revised Code, "public assistance" includes, in 16870
addition to Ohio works first, all of the following: 16871~~

~~(1) Prevention, retention, and contingency; 16872~~

~~(2) Medicaid; 16873~~

~~(3) Disability financial assistance; 16874~~

~~(4) Disability medical assistance; 16875~~

~~(5) General assistance provided prior to July 17, 1995, under 16876
former Chapter 5113. of the Revised Code. 16877~~

~~(B) As part of the procedure for the determination of 16878
overpayment to a recipient of public assistance under Chapter 16879
5107., 5108., 5111., or 5115. of the Revised Code, the director of 16880
job and family services shall furnish quarterly the name and 16881
social security number of each individual who receives public 16882
assistance to the director of administrative services, the 16883
administrator of the bureau of workers' compensation, and each of 16884
the state's retirement boards. Within fourteen days after 16885
receiving the name and social security number of an individual who 16886
receives public assistance, the director of administrative 16887~~

services, administrator, or board shall inform the auditor of 16888
state as to whether such individual is receiving wages or 16889
benefits, the amount of any wages or benefits being received, the 16890
social security number, and the address of the individual. The 16891
director of administrative services, administrator, boards, and 16892
any agent or employee of those officials and boards shall comply 16893
with the rules ~~of the director of job and family services adopted~~ 16894
under section 5101.30 of the Revised Code restricting the 16895
disclosure of information regarding recipients of public 16896
assistance. Any person who violates this provision shall 16897
thereafter be disqualified from acting as an agent or employee or 16898
in any other capacity under appointment or employment of any state 16899
board, commission, or agency. 16900

~~(C) The auditor of state may enter into a reciprocal 16901
agreement with the director of job and family services or 16902
comparable officer of any other state for the exchange of names, 16903
current or most recent addresses, or social security numbers of 16904
persons receiving public assistance under Title IV A or under 16905
Title XIX of the "Social Security Act," 49 Stat. 620 (1935), 42 16906
U.S.C. 301, as amended. 16907~~

~~(D)(1) The auditor of state shall retain, for not less than 16908
two years, at least one copy of all information received under 16909
this section and sections 145.27, 742.41, 3307.20, 3309.22, 16910
4123.27, 5101.182, and 5505.04 of the Revised Code. The auditor 16911
shall review the information to determine whether overpayments 16912
were made to recipients of public assistance under Chapters 5107., 16913
5108., 5111., and 5115. of the Revised Code. The auditor of state 16914
shall initiate action leading to prosecution, where warranted, of 16915
recipients who received overpayments by forwarding the name of 16916
each recipient who received overpayment, together with other 16917
pertinent information, to the director of job and family services 16918
and the attorney general, to the district director of job and 16919~~

~~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.~~ 16920
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~~(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.~~ 16924
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~~(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.~~ 16938
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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 16941
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individual income tax return, separate or joint, as provided by 16951
section 5747.08 of the Revised Code, for either or both of the two 16952
taxable years preceding the year in which the director furnished 16953
the names and social security numbers to the commissioner. If the 16954
individual did so file, at the same time the commissioner shall 16955
also inform the auditor of state of the amount of the federal 16956
adjusted gross income as reported on such returns and of the 16957
addresses on such returns. The commissioner shall also advise the 16958
auditor of state whether such returns were filed on a joint basis, 16959
as provided in section 5747.08 of the Revised Code, in which case 16960
the federal adjusted gross income as reported may be that of the 16961
individual or the individual's spouse. 16962
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If the auditor of state determines that further investigation 16964
is needed, the auditor of state may request the commissioner to 16965
determine whether the individual filed income tax returns for any 16966
previous taxable years in which the individual received public 16967
assistance and for which the tax department retains income tax 16968
returns. Within fourteen days of receipt of the request, the 16969
commissioner shall inform the auditor of state whether the 16970
individual filed an individual income tax return for the taxable 16971
years in question, of the amount of the federal adjusted gross 16972
income as reported on such returns, of the addresses on such 16973
returns, and whether the returns were filed on a joint or separate 16974
basis. 16975

If the auditor of state determines that further investigation 16976
is needed of a recipient of public assistance who filed an Ohio 16977
individual income tax return, the auditor of state may request a 16978
certified copy of the Ohio individual income tax return or returns 16979
of that person for the taxable years described above, together 16980
with any other documents the commissioner has concerning the 16981
return or returns. Within fourteen days of receipt of such a 16982

request in writing, the commissioner shall forward the returns and 16983
documents to the auditor of state. 16984

The director of job and family services, district director of 16985
job and family services, county director of job and family 16986
services, county prosecutor, attorney general, auditor of state, 16987
or any agent or employee of those officials having access to any 16988
information or documents furnished by the commissioner pursuant to 16989
this section shall not divulge or use any such information except 16990
for the purpose of determining overpayment of public assistance, 16991
or for an audit, investigation, or prosecution, or in accordance 16992
with a proper judicial order. Any person who violates this 16993
provision shall thereafter be disqualified from acting as an agent 16994
or employee or in any other capacity under appointment or 16995
employment of any state or county board, commission, or agency. 16996

Sec. 5101.184. (A) The director of job and family services 16997
shall work with the tax commissioner to collect overpayments of 16998
assistance under Chapter 5107., ~~5111.7~~, or 5115., former Chapter 16999
5113., or section 5101.54 of the Revised Code from refunds of 17000
state income taxes for taxable year 1992 and thereafter that are 17001
payable to the recipients of such overpayments. 17002

Any overpayment of assistance, whether obtained by fraud or 17003
misrepresentation, as the result of an error by the recipient or 17004
by the agency making the payment, or in any other manner, may be 17005
collected under this section. Any reduction under section 5747.12 17006
or 5747.121 of the Revised Code to an income tax refund shall be 17007
made before a reduction under this section. No reduction shall be 17008
made under this section if the amount of the refund is less than 17009
twenty-five dollars after any reduction under section 5747.12 of 17010
the Revised Code. A reduction under this section shall be made 17011
before any part of the refund is contributed under section 17012
5747.113 of the Revised Code, or is credited under section 5747.12 17013

of the Revised Code against tax due in any subsequent year. 17014

The director and the tax commissioner, by rules adopted in 17015
accordance with Chapter 119. of the Revised Code, shall establish 17016
procedures to implement this division. The procedures shall 17017
provide for notice to a recipient of assistance and an opportunity 17018
for the recipient to be heard before the recipient's income tax 17019
refund is reduced. 17020

(B) The director of job and family services may enter into 17021
agreements with the federal government to collect overpayments of 17022
assistance from refunds of federal income taxes that are payable 17023
to recipients of the overpayments. 17024

Sec. 5101.21. (A) As used in ~~this section,~~ "county sections 17025
5101.21 to 5101.25 of the Revised Code: 17026

(1) "County signer" means all of the following: 17027

~~(1)(a)~~ A board of county commissioners; 17028

~~(2)(b)~~ A county children services board appointed under 17029
section 5153.03 of the Revised Code if required by division (B) of 17030
this section to enter into a fiscal agreement; 17031

~~(3)(c)~~ A county elected official that is a child support 17032
enforcement agency if required by division (B) of this section to 17033
enter into a fiscal agreement. 17034

"ODJFS family services duty" means a family services duty 17035
associated with a program that the department of job and family 17036
services supervises the administration of on the state level. 17037

(B) The director of job and family services may enter into 17038
one or more written fiscal agreements with boards of county 17039
commissioners under which financial assistance is awarded for 17040
ODJFS family services duties included in the agreements. Boards of 17041
county commissioners shall select which ODJFS family services 17042
duties to include in a fiscal agreement. If a board of county 17043

commissioners elects to include ODJFS family services duties of a 17044
public children services agency and a county children services 17045
board appointed under section 5153.03 of the Revised Code serves 17046
as the county's public children services agency, the board of 17047
county commissioners and county children services board shall 17048
jointly enter into the fiscal agreement with the director. If a 17049
board of county commissioners elects to include ODJFS family 17050
services duties of a child support enforcement agency and the 17051
entity designated under former section 2301.35 of the Revised Code 17052
prior to October 1, 1997, or designated under section 307.981 of 17053
the Revised Code as the county's child support enforcement agency 17054
is an elected official of the county, the board of county 17055
commissioners and county elected official shall jointly enter into 17056
the fiscal agreement with the director. A fiscal agreement shall 17057
do all of the following: 17058

(1) Specify the ODJFS family services duties included in the 17059
agreement and the private and government entities designated under 17060
section 307.981 of the Revised Code to serve as the county family 17061
services agencies performing the ODJFS family services duties; 17062

(2) Provide for the department of job and family services to 17063
award financial assistance for the ODJFS family services duties 17064
included in the agreement in accordance with a methodology for 17065
determining the amount of the award established by rules adopted 17066
under division (D) of this section; 17067

(3) Specify the form of the award of financial assistance 17068
which may be an allocation, cash draw, reimbursement, property, 17069
or, to the extent authorized by an appropriation made by the 17070
general assembly and to the extent practicable and not in conflict 17071
with a federal or state law, a consolidated funding allocation for 17072
two or more ODJFS family services duties included in the 17073
agreement; 17074

(4) Provide that the award of financial assistance is subject 17075

to the availability of federal funds and appropriations made by 17076
the general assembly; 17077

(5) Specify annual financial, administrative, or other 17078
incentive awards, if any, to be provided in accordance with 17079
section 5101.23 of the Revised Code; 17080

(6) Include the assurance of each county signer that the 17081
county signer will do all of the following: 17082

(a) Ensure that the financial assistance awarded under the 17083
agreement is used, and the ODJFS family services duties included 17084
in the agreement are performed, in accordance with requirements 17085
for the duties established by the department, a federal or state 17086
law, or any of the following that concern the ODJFS family 17087
services duties included in the fiscal agreement and are published 17088
under section 5101.212 of the Revised Code: state plans for 17089
receipt of federal financial participation, grant agreements 17090
between the department and a federal agency, and executive orders 17091
issued by the governor; 17092

(b) Ensure that the board and county family services agencies 17093
utilize a financial management system and other accountability 17094
mechanisms for the financial assistance awarded under the 17095
agreement that meet requirements the department establishes; 17096

(c) Require the county family services agencies to do both of 17097
the following: 17098

(i) Monitor all private and government entities that receive 17099
a payment from financial assistance awarded under the agreement to 17100
ensure that each entity uses the payment in accordance with 17101
requirements for the ODJFS family services duties included in the 17102
agreement; 17103

(ii) Take action to recover payments that are not used in 17104
accordance with the requirements for the ODJFS family services 17105
duties included in the agreement. 17106

(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 17138
conditions of the agreement that the director and each county 17139
signer agree are erroneous; 17140

(12) Except as provided in rules adopted under division (D) 17141
of this section, begin on the first day of July of an odd-numbered 17142
year and end on the last day of June of the next odd-numbered 17143
year. 17144

(C) The department shall make payments authorized by a fiscal 17145
agreement on vouchers it prepares and may include any funds 17146
appropriated or allocated to it for carrying out ODJFS family 17147
services duties included in the agreement, including funds for 17148
personal services and maintenance. 17149

(D)(1) The director shall adopt rules in accordance with 17150
section 111.15 of the Revised Code governing fiscal agreements. 17151
The director shall adopt the rules as if they were internal 17152
management rules. Before adopting the rules, the director shall 17153
give the public an opportunity to review and comment on the 17154
proposed rules. The rules shall establish methodologies to be used 17155
to determine the amount of financial assistance to be awarded 17156
under the agreements. The rules also shall establish terms and 17157
conditions under which an agreement may be entered into after the 17158
first day of July of an odd-numbered year. The rules may do any or 17159
all of the following: 17160

(a) Govern the establishment of allocations; 17161

(b) Specify allowable uses of financial assistance awarded 17162
under the agreements; 17163

(c) Establish reporting, cash management, audit, and other 17164
requirements the director determines are necessary to provide 17165
accountability for the use of financial assistance awarded under 17166
the agreements and determine compliance with requirements 17167
established by the department, a federal or state law, or any of 17168

the following that concern the ODJFS family services duties 17169
included in the agreements and are published under section 17170
5101.212 of the Revised Code: state plans for receipt of federal 17171
financial participation, grant agreements between the department 17172
and a federal entity, and executive orders issued by the governor. 17173

(2) A requirement of a fiscal agreement established by a rule 17174
adopted under this division is applicable to a fiscal agreement 17175
without having to be restated in the fiscal agreement. 17176

Sec. 5101.212. The department of job and family services 17177
shall publish in a manner accessible to the public all of the 17178
following that concern ODJFS family services duties included in 17179
fiscal agreements entered into under section 5101.21 of the 17180
Revised Code: state plans for receipt of federal financial 17181
participation, grant agreements between the department and a 17182
federal agency, and executive orders issued by the governor. The 17183
department may publish the materials electronically or otherwise. 17184

Sec. 5101.213. (A) Except as provided in section 5101.211 of 17185
the Revised Code, if a fiscal agreement under section 5101.21 of 17186
the Revised Code between the director of job and family services 17187
and a board of county commissioners is not in effect, all of the 17188
following apply: 17189

(1) The department of job and family services shall award to 17190
the county the board serves financial assistance for ODJFS family 17191
services duties in accordance with a methodology for determining 17192
the amount of the award established by rules adopted under 17193
division (B) of this section. 17194

(2) The financial assistance may be provided in the form of 17195
allocations, cash draws, reimbursements, and property but may not 17196
be made in the form of a consolidated funding allocation. 17197

(3) The award of the financial assistance is subject to the 17198

availability of federal funds and appropriations made by the 17199
general assembly. 17200

(4) The county family services agencies performing the ODJFS 17201
family services duties for which the financial assistance is 17202
awarded shall do all of the following: 17203

(a) Use the financial assistance, and perform the ODJFS 17204
family services duties, in accordance with requirements for the 17205
duties established by the department, a federal or state law, or 17206
any of the following that concern the duties: state plans for 17207
receipt of federal financial participation, grant agreements 17208
between the department and a federal agency, and executive orders 17209
issued by the governor; 17210

(b) Utilize a financial management system and other 17211
accountability mechanisms for the financial assistance that meet 17212
requirements the department establishes; 17213

(c) Monitor all private and government entities that receive 17214
a payment from the financial assistance to ensure that each entity 17215
uses the payment in accordance with requirements for the ODJFS 17216
family services duties and take action to recover payments that 17217
are not used in accordance with the requirements for the ODJFS 17218
family services duties; 17219

(d) Promptly reimburse the department the amount that 17220
represents the amount an agency is responsible for, pursuant to 17221
action the department takes under division (C) of section 5101.24 17222
of the Revised Code, of funds the department pays to any entity 17223
because of an adverse audit finding, adverse quality control 17224
finding, final disallowance of federal financial participation, or 17225
other sanction or penalty; 17226

(e) Take prompt corrective action, including paying amounts 17227
resulting from an adverse finding, sanction, or penalty, if the 17228
department, auditor of state, federal agency, or other entity 17229

authorized by federal or state law to determine compliance with 17230
requirements for a an ODJFS family services duty determines 17231
compliance has not been achieved. 17232

(B) The director shall adopt rules in accordance with section 17233
111.15 of the Revised Code as necessary to implement this section. 17234
The director shall adopt the rules as if they were internal 17235
management rules. Before adopting the rules, the director shall 17236
give the public an opportunity to review and comment on the 17237
proposed rules. The rules shall establish methodologies to be used 17238
to determine the amount of financial assistance to be awarded and 17239
may do any or all of the following: 17240

(1) Govern the establishment of funding allocations; 17241

(2) Specify allowable uses of financial assistance the 17242
department awards under this section; 17243

(3) Establish reporting, cash management, audit, and other 17244
requirements the director determines are necessary to provide 17245
accountability for the use of the financial assistance and 17246
determine compliance with requirements established by the 17247
department, a federal or state law, or any of the following that 17248
concern the ODJFS family services duties for which the financial 17249
assistance is awarded: state plans for receipt of federal 17250
financial participation, grant agreements between the department 17251
and a federal entity, and executive orders issued by the governor. 17252

Sec. 5101.214. The director of job and family services may 17253
enter into a written agreement with one or more state agencies, as 17254
defined in section 117.01 of the Revised Code, and state 17255
universities and colleges to assist in the coordination, 17256
provision, or enhancement of the ODJFS family services duties of a 17257
county family services agency or the workforce development 17258
activities of a workforce development agency. The director also 17259
may enter into written agreements or contracts with, or issue 17260

grants to, private and government entities under which funds are 17261
provided for the enhancement or innovation of ODJFS family 17262
services duties or workforce development activities on the state 17263
or local level. 17264

The director may adopt internal management rules in 17265
accordance with section 111.15 of the Revised Code to implement 17266
this section. 17267

Sec. 5101.216. The director of job and family services may 17268
enter into one or more written operational agreements with boards 17269
of county commissioners to do one or more of the following 17270
regarding ODJFS family services duties: 17271

(A) Provide for the director to amend or rescind a rule the 17272
director previously adopted; 17273

(B) Provide for the director to modify procedures or 17274
establish alternative procedures to accommodate special 17275
circumstances in a county; 17276

(C) Provide for the director and board to jointly identify 17277
operational problems of mutual concern and develop a joint plan to 17278
address the problems; 17279

(D) Establish a framework for the director and board to 17280
modify the use of existing resources in a manner that is 17281
beneficial to the department of job and family services and the 17282
county that the board serves and improves ODJFS family services 17283
duties for the recipients of the services. 17284

Sec. 5101.22. The department of job and family services may 17285
establish performance and other administrative standards for the 17286
administration and outcomes of ODJFS family services duties and 17287
determine at intervals the department decides the degree to which 17288
a county family services agency complies with a performance or 17289
other administrative standard. The department may use statistical 17290

sampling, performance audits, case reviews, or other methods it 17291
determines necessary and appropriate to determine compliance with 17292
performance and administrative standards. 17293

Sec. 5101.221. (A) Except as provided by division (C) of this 17294
section, if the department of job and family services determines 17295
that a county family services agency has failed to comply with a 17296
performance or other administrative standard established under 17297
section 5101.22 of the Revised Code or by federal law for the 17298
administration or outcome of a an ODJFS family services duty, the 17299
department shall require the agency to develop, submit to the 17300
department for approval, and comply with a corrective action plan. 17301
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(B) If a county family services agency fails to develop, 17303
submit to the department, or comply with a corrective action plan 17304
under division (A) of this section, or the department disapproves 17305
the agency's corrective action plan, the department may require 17306
the agency to develop, submit to the department for approval, and 17307
comply with a corrective action plan that requires the agency to 17308
commit existing resources to the plan. 17309

(C) The department may not require a county family services 17310
agency to take action under this section for failure to comply 17311
with a performance or other administrative standard established 17312
for an incentive awarded by the department. Instead, the 17313
department may require a county family services agency that fails 17314
to comply with that kind of performance or other administrative 17315
standard to take action in accordance with rules adopted by the 17316
department governing the standard. 17317

(D) At the request of a county family services agency, the 17318
department shall assist the agency with the development of a 17319
corrective action plan under this section and provide the agency 17320
technical assistance in the implementation of the plan. 17321

Sec. 5101.23. Subject to the availability of funds, the 17322
department of job and family services may provide annual 17323
financial, administrative, or other incentive awards to county 17324
family services agencies and workforce development agencies. A 17325
county family services agency or workforce development agency may 17326
spend funds provided as a financial incentive award only for the 17327
purpose for which the funds are appropriated. The department may 17328
adopt internal management rules in accordance with section 111.15 17329
of the Revised Code to establish the amounts of awards, 17330
methodology for distributing the awards, types of awards, and 17331
standards for administration by the department. 17332

There is hereby created in the state treasury the social 17333
services incentive fund. The director of job and family services 17334
may request that the director of budget and management transfer 17335
funds in the Title IV-A reserve fund created under section 5101.82 17336
of the Revised Code and other funds appropriated for ODJFS family 17337
services duties or workforce investment activities into the fund. 17338
If the director of budget and management determines that the funds 17339
identified by the director of job and family services are 17340
available and appropriate for transfer, the director of budget and 17341
management shall make the transfer. Money in the fund shall be 17342
used to provide incentive awards under this section. 17343

Sec. 5101.24. (A) As used in this section, "responsible 17344
entity" means a board of county commissioners or a county family 17345
services agency, whichever the director of job and family services 17346
determines is appropriate to take action against under division 17347
(C) of this section. 17348

(B) Regardless of whether a an ODJFS family services duty is 17349
performed by a county family services agency, private or 17350
government entity pursuant to a contract entered into under 17351
section 307.982 of the Revised Code or division (C)(2) of section 17352

5153.16 of the Revised Code, or private or government provider of 17353
a an ODJFS family service duty, the department of job and family 17354
services may take action under division (C) of this section 17355
against the responsible entity if the department determines any of 17356
the following are the case: 17357

(1) A requirement of a fiscal agreement entered into under 17358
section 5101.21 of the Revised Code that includes the ODJFS family 17359
services duty, including a requirement for fiscal agreements 17360
established by rules adopted under that section, is not complied 17361
with; 17362

(2) A county family services agency fails to develop, submit 17363
to the department, or comply with a corrective action plan under 17364
division (B) of section 5101.221 of the Revised Code, or the 17365
department disapproves the agency's corrective action plan 17366
developed under division (B) of section 5101.221 of the Revised 17367
Code; 17368

(3) A requirement for the ODJFS family services duty 17369
established by the department or any of the following is not 17370
complied with: a federal or state law, state plan for receipt of 17371
federal financial participation, grant agreement between the 17372
department and a federal agency, or executive order issued by the 17373
governor; 17374

(4) The responsible entity is solely or partially 17375
responsible, as determined by the director of job and family 17376
services, for an adverse audit finding, adverse quality control 17377
finding, final disallowance of federal financial participation, or 17378
other sanction or penalty regarding the ODJFS family services 17379
duty. 17380

(C) The department may take one or more of the following 17381
actions against the responsible entity when authorized by division 17382
(B)(1), (2), (3), or (4) of this section: 17383

(1) Require the responsible entity to comply with a 17384
corrective action plan pursuant to a time schedule specified by 17385
the department. The corrective action plan shall be established or 17386
approved by the department and shall not require a county family 17387
services agency to commit resources to the plan. 17388

(2) Require the responsible entity to comply with a 17389
corrective action plan pursuant to a time schedule specified by 17390
the department. The corrective action plan shall be established or 17391
approved by the department and require a county family services 17392
agency to commit to the plan existing resources identified by the 17393
agency. 17394

(3) Require the responsible entity to do one of the 17395
following: 17396

(a) Share with the department a final disallowance of federal 17397
financial participation or other sanction or penalty; 17398

(b) Reimburse the department the final amount the department 17399
pays to the federal government or another entity that represents 17400
the amount the responsible entity is responsible for of an adverse 17401
audit finding, adverse quality control finding, final disallowance 17402
of federal financial participation, or other sanction or penalty 17403
issued by the federal government, auditor of state, or other 17404
entity; 17405

(c) Pay the federal government or another entity the final 17406
amount that represents the amount the responsible entity is 17407
responsible for of an adverse audit finding, adverse quality 17408
control finding, final disallowance of federal financial 17409
participation, or other sanction or penalty issued by the federal 17410
government, auditor of state, or other entity; 17411

(d) Pay the department the final amount that represents the 17412
amount the responsible entity is responsible for of an adverse 17413
audit finding or adverse quality control finding. 17414

(4) Impose an administrative sanction issued by the 17415
department against the responsible entity. A sanction may be 17416
increased if the department has previously taken action against 17417
the responsible entity under this division. 17418

(5) Perform, or contract with a government or private entity 17419
for the entity to perform, the ODJFS family services duty until 17420
the department is satisfied that the responsible entity ensures 17421
that the duty will be performed satisfactorily. If the department 17422
performs or contracts with an entity to perform a an ODJFS family 17423
services duty under division (C)(5) of this section, the 17424
department may do either or both of the following: 17425

(a) Spend funds in the county treasury appropriated by the 17426
board of county commissioners for the duty; 17427

(b) Withhold funds allocated or reimbursements due to the 17428
responsible entity for the duty and spend the funds for the duty. 17429

(6) Request that the attorney general bring mandamus 17430
proceedings to compel the responsible entity to take or cease the 17431
action that causes division (B)(1), (2), (3), or (4) of this 17432
section to apply. The attorney general shall bring mandamus 17433
proceedings in the Franklin county court of appeals at the 17434
department's request. 17435

(7) If the department takes action under this division 17436
because of division (B)(3) of this section, temporarily withhold 17437
funds allocated or reimbursement due to the responsible entity 17438
until the department determines that the responsible entity is in 17439
compliance with the requirement. The department shall release the 17440
funds when the department determines that compliance has been 17441
achieved. 17442

(D) If the department proposes to take action against the 17443
responsible entity under division (C) of this section, the 17444
department shall notify the responsible entity and county auditor. 17445

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 17476
division (C)(1) of this section for fifteen calendar days 17477
following the day it receives the request or extended period of 17478
time provided for in division (D)(5) of this section to allow a 17479
representative of the department and a representative of the 17480
responsible entity an informal opportunity to resolve any dispute 17481
during that fifteen-day or extended period. 17482

(4) In the case of a proposed action under division (C)(2), 17483
(3), (4), (5), or (7) of this section, the responsible entity 17484
shall have thirty calendar days after the department mails the 17485
notice to the responsible entity to send a written request to the 17486
department for an administrative review. If it receives such a 17487
request within the required time, the department shall postpone 17488
taking action under division (C)(2), (3), (4), (5), or (7) of this 17489
section for thirty calendar days following the day it receives the 17490
request or extended period of time provided for in division (D)(5) 17491
of this section to allow a representative of the department and a 17492
representative of the responsible entity an informal opportunity 17493
to resolve any dispute during that thirty-day or extended period. 17494

(5) If the informal opportunity provided in division (D)(3) 17495
or (4) of this section does not result in a written resolution to 17496
the dispute within the fifteen- or thirty-day period, the director 17497
of job and family services and representative of the responsible 17498
entity may enter into a written agreement extending the time 17499
period for attempting an informal resolution of the dispute under 17500
division (D)(3) or (4) of this section. 17501

(6) In the case of a proposed action under division (C)(3) of 17502
this section, the responsible entity may not include in its 17503
request disputes over a finding, final disallowance of federal 17504
financial participation, or other sanction or penalty issued by 17505
the federal government, auditor of state, or entity other than the 17506
department. 17507

(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 17540
disapprove the recommendations. If the director modifies or 17541
disapproves the recommendations, the director shall state the 17542
reasons for the modification or disapproval and the actions to be 17543
taken against the responsible entity. 17544

(10) The director's approval, modification, or disapproval 17545
under division (D)(9) of this section shall be final and binding 17546
on the responsible entity and shall not be subject to further 17547
departmental review. 17548

(E) The responsible entity is not entitled to an 17549
administrative review under division (D) of this section for any 17550
of the following: 17551

(1) An action taken under division (C)(6) of this section; 17552

(2) An action taken under section 5101.242 of the Revised 17553
Code; 17554

(3) An action taken under division (C)(3) of this section if 17555
the federal government, auditor of state, or entity other than the 17556
department has identified the county family services agency as 17557
being solely or partially responsible for an adverse audit 17558
finding, adverse quality control finding, final disallowance of 17559
federal financial participation, or other sanction or penalty; 17560

(4) An adjustment to an allocation, cash draw, advance, or 17561
reimbursement to a county family services agency that the 17562
department determines necessary for budgetary reasons; 17563

(5) Withholding of a cash draw or reimbursement due to 17564
noncompliance with a reporting requirement established in rules 17565
adopted under section 5101.243 of the Revised Code. 17566

(F) This section does not apply to other actions the 17567
department takes against the responsible entity pursuant to 17568
authority granted by another state law unless the other state law 17569

requires the department to take the action in accordance with this 17570
section. 17571

(G) The director of job and family services may adopt rules 17572
in accordance with Chapter 119. of the Revised Code as necessary 17573
to implement this section. 17574

Sec. 5101.243. The director of job and family services may 17575
adopt rules in accordance with section 111.15 of the Revised Code 17576
establishing reporting requirements for ODJFS family services 17577
duties and workforce development activities. If the director 17578
adopts the rules, the director shall adopt the rules as if they 17579
were internal management rules and, before adopting the rules, 17580
give the public an opportunity to review and comment on the 17581
proposed rules. 17582

Sec. 5101.25. The department of ~~human~~ job and family 17583
services, in consultation with county representatives, shall 17584
develop annual training goals and model training curriculum 17585
regarding ODJFS family services duties for employees of county 17586
family services agencies and identify a variety of state funded 17587
training opportunities to meet the proposed goals. 17588

Sec. 5101.26. As used in this section and in sections 5101.27 17589
to 5101.30 of the Revised Code: 17590

(A) "County agency" means a county department of job and 17591
family services or a public children services agency. 17592

(B) "Fugitive felon" means an individual who is fleeing to 17593
avoid prosecution, or custody or confinement after conviction, 17594
under the laws of the place from which the individual is fleeing, 17595
for a crime or an attempt to commit a crime that is a felony under 17596
the laws of the place from which the individual is fleeing or, in 17597
the case of New Jersey, a high misdemeanor, regardless of whether 17598

the individual has departed from the individual's usual place of residence. 17599
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(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. 17601
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(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. 17607
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(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. 17615
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(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. 17623
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(G) "Public assistance recipient" means an applicant for or 17629

recipient or former recipient of public assistance. 17630

Sec. 5101.27. (A) Except as permitted by this section, 17631
section 5101.28 or 5101.29 of the Revised Code, or the rules 17632
adopted under division (A) of section 5101.30 of the Revised Code, 17633
or required by federal law, no person or government entity shall 17634
solicit, disclose, receive, use, or knowingly permit, or 17635
participate in the use of any information regarding a public 17636
assistance recipient for any purpose not directly connected with 17637
the administration of a public assistance program. 17638

(B) To the extent permitted by federal law, the department of 17639
job and family services and county agencies shall do all of the 17640
following: 17641

(1) Release information regarding a public assistance 17642
recipient for purposes directly connected to the administration of 17643
the program to a government entity responsible for administering 17644
that public assistance program; 17645

(2) Provide information regarding a public assistance 17646
recipient to a law enforcement agency for the purpose of any 17647
investigation, prosecution, or criminal or civil proceeding 17648
relating to the administration of that public assistance program; 17649

(3) Provide, for purposes directly connected to the 17650
administration of a program that assists needy individuals with 17651
the costs of public utility services, information regarding a 17652
recipient of financial assistance provided under a program 17653
administered by the department or a county agency pursuant to 17654
Chapter 5107. or 5108. of the Revised Code or sections 5115.01 to 17655
5115.07 of the Revised Code to an entity administering the public 17656
utility services program. 17657

(C) To the extent permitted by federal law and section 17658
1347.08 of the Revised Code, the department and county agencies 17659

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 17690
connected to the administration of or provision of medical 17691
assistance provided under a ~~public assistance~~ government-funded 17692
program; 17693

(2) The information is released to persons or government 17694
entities that are subject to standards of confidentiality and 17695
safeguarding information substantially comparable to those 17696
established for medical assistance provided under a ~~public~~ 17697
~~assistance~~ government-funded program; 17698

(3) The department or county agency has obtained an 17699
authorization consistent with section 5101.271 of the Revised 17700
Code. 17701

(G) Information concerning the receipt of medical assistance 17702
provided under a ~~public assistance~~ government-funded program may 17703
be released only if the release complies with this section and 17704
rules adopted by the department pursuant to section 5101.30 of the 17705
Revised Code or, if more restrictive, the Health Insurance 17706
Portability and Accountability Act of 1996, Pub. L. No. 104-191, 17707
110 Stat. 1955, 42 U.S.C. 1320d, et seq., as amended, and 17708
regulations adopted by the United States department of health and 17709
human services to implement the act. 17710

(H) The department of job and family services may adopt rules 17711
defining "authorized representative" for purposes of division 17712
(C)(2) of this section. 17713

Sec. 5101.35. (A) As used in this section: 17714

(1) "Agency" means the following entities that administer a 17715
family services program: 17716

(a) The department of job and family services; 17717

(b) A county department of job and family services; 17718

(c) A public children services agency; 17719

(d) A private or government entity administering, in whole or 17720
in part, a family services program for or on behalf of the 17721
department of job and family services or a county department of 17722
job and family services or public children services agency. 17723

(2) "Appellant" means an applicant, participant, former 17724
participant, recipient, or former recipient of a family services 17725
program who is entitled by federal or state law to a hearing 17726
regarding a decision or order of the agency that administers the 17727
program. 17728

(3) "Family services program" means assistance provided under 17729
a Title IV-A program as defined in section 5101.80 of the Revised 17730
Code or under Chapter 5104., ~~5111.~~ or 5115. or section ~~173.35~~ 17731
5160.80, 5101.141, 5101.46, 5101.461, 5101.54, 5153.163, or 17732
5153.165 of the Revised Code, other than assistance provided under 17733
section 5101.46 of the Revised Code by the department of mental 17734
health, the department of mental retardation and developmental 17735
disabilities, a board of alcohol, drug addiction, and mental 17736
health services, or a county board of mental retardation and 17737
developmental disabilities. 17738

(B) Except as provided by ~~divisions~~ division (G) ~~and (H)~~ of 17739
this section, an appellant who appeals under federal or state law 17740
a decision or order of an agency administering a family services 17741
program shall, at the appellant's request, be granted a state 17742
hearing by the department of job and family services. This state 17743
hearing shall be conducted in accordance with rules adopted under 17744
this section. The state hearing shall be recorded, but neither the 17745
recording nor a transcript of the recording shall be part of the 17746
official record of the proceeding. A state hearing decision is 17747
binding upon the agency and department, unless it is reversed or 17748
modified on appeal to the director of job and family services or a 17749
court of common pleas. 17750

(C) Except as provided by division (G) of this section, an 17751

appellant who disagrees with a state hearing decision may make an 17752
administrative appeal to the director of job and family services 17753
in accordance with rules adopted under this section. This 17754
administrative appeal does not require a hearing, but the director 17755
or the director's designee shall review the state hearing decision 17756
and previous administrative action and may affirm, modify, remand, 17757
or reverse the state hearing decision. Any person designated to 17758
make an administrative appeal decision on behalf of the director 17759
shall have been admitted to the practice of law in this state. An 17760
administrative appeal decision is the final decision of the 17761
department and is binding upon the department and agency, unless 17762
it is reversed or modified on appeal to the court of common pleas. 17763

(D) An agency shall comply with a decision issued pursuant to 17764
division (B) or (C) of this section within the time limits 17765
established by rules adopted under this section. If a county 17766
department of job and family services or a public children 17767
services agency fails to comply within these time limits, the 17768
department may take action pursuant to section 5101.24 of the 17769
Revised Code. If another agency fails to comply within the time 17770
limits, the department may force compliance by withholding funds 17771
due the agency or imposing another sanction established by rules 17772
adopted under this section. 17773

(E) An appellant who disagrees with an administrative appeal 17774
decision of the director of job and family services or the 17775
director's designee issued under division (C) of this section may 17776
appeal from the decision to the court of common pleas pursuant to 17777
section 119.12 of the Revised Code. The appeal shall be governed 17778
by section 119.12 of the Revised Code except that: 17779

(1) The person may appeal to the court of common pleas of the 17780
county in which the person resides, or to the court of common 17781
pleas of Franklin county if the person does not reside in this 17782
state. 17783

(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 17815
division (B) or (C) of this section; 17816

(4) Sanctions that may be applied against an agency under 17817
division (D) of this section. 17818

(G) The department of job and family services may adopt rules 17819
in accordance with Chapter 119. of the Revised Code establishing 17820
an appeals process for an appellant who appeals a decision or 17821
order regarding a Title IV-A program identified under division 17822
(A)(4)(c), (d), (e), or (f) of section 5101.80 of the Revised Code 17823
that is different from the appeals process established by this 17824
section. The different appeals process may include having a state 17825
agency that administers the Title IV-A program pursuant to an 17826
interagency agreement entered into under section 5101.801 of the 17827
Revised Code administer the appeals process. 17828

~~(H) If an appellant receiving medicaid through a health 17829
insuring corporation that holds a certificate of authority under 17830
Chapter 1751. of the Revised Code is appealing a denial of 17831
medicaid services based on lack of medical necessity or other 17832
clinical issues regarding coverage by the health insuring 17833
corporation, the person hearing the appeal may order an 17834
independent medical review if that person determines that a review 17835
is necessary. The review shall be performed by a health care 17836
professional with appropriate clinical expertise in treating the 17837
recipient's condition or disease. The department shall pay the 17838
costs associated with the review. 17839~~

~~A review ordered under this division shall be part of the 17840
record of the hearing and shall be given appropriate evidentiary 17841
consideration by the person hearing the appeal. 17842~~

~~(I) The requirements of Chapter 119. of the Revised Code 17843
apply to a state hearing or administrative appeal under this 17844
section only to the extent, if any, specifically provided by rules 17845~~

adopted under this section. 17846

Sec. 5101.36. Any application for public assistance gives a 17847
right of subrogation to the department of job and family services 17848
for any workers' compensation benefits payable to a person who is 17849
subject to a support order, as defined in section 3119.01 of the 17850
Revised Code, on behalf of the applicant, to the extent of any 17851
public assistance payments made on the applicant's behalf. If the 17852
director of job and family services, in consultation with a child 17853
support enforcement agency and the administrator of the bureau of 17854
workers' compensation, determines that a person responsible for 17855
support payments to a recipient of public assistance is receiving 17856
workers' compensation, the director shall notify the administrator 17857
of the amount of the benefit to be paid to the department of job 17858
and family services. 17859

For purposes of this section, "public assistance" means 17860
~~medical assistance provided through the medical assistance program~~ 17861
~~established under section 5111.01 of the Revised Code;~~ Ohio works 17862
first provided under Chapter 5107. of the Revised Code; 17863
prevention, retention, and contingency benefits and services 17864
provided under Chapter 5108. of the Revised Code; or disability 17865
financial assistance provided under Chapter 5115. of the Revised 17866
Code; ~~or disability medical assistance provided under Chapter~~ 17867
~~5115. of the Revised Code.~~ 17868

Sec. 5101.47. (A) Except as provided in division (B) of this 17869
section, the director of job and family services may accept 17870
applications, determine eligibility, redetermine eligibility, and 17871
perform related administrative activities for one or more of the 17872
following: 17873

(1) ~~The medicaid program established by Chapter 5111. of the~~ 17874
~~Revised Code;~~ 17875

(2) The children's health insurance program parts I and II provided for under sections 5101.50 and 5101.51 of the Revised Code;	17876
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(3) Publicly funded child care provided under Chapter 5104. of the Revised Code;	17879
	17880
(4)(2) The food stamp program administered by the department of job and family services pursuant to section 5101.54 of the Revised Code;	17881
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(5)(3) Other programs the director determines are supportive of children, adults, or families;	17884
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(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.	17886
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(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.	17891
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(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:	17896
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(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.	17901
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(2) The director is subject to federal statutes and	17905

regulations and state statutes and rules that require, permit, or 17906
prohibit an action regarding accepting applications, determining 17907
or redetermining eligibility, and performing related 17908
administrative activities for the program. 17909

(D) The director may adopt rules as necessary to implement 17910
this section. 17911

Sec. 5101.97. (A)(1) Not later than the last day of each July 17912
and January, the department of job and family services shall 17913
complete a report on the characteristics of the individuals who 17914
participate in or receive services through the programs operated 17915
by the department and the outcomes of the individuals' 17916
participation in or receipt of services through the programs. The 17917
reports shall be for the six-month periods ending on the last days 17918
of June and December and shall include information on the 17919
following: 17920

(a) Work activities, developmental activities, and 17921
alternative work activities established under sections 5107.40 to 17922
5107.69 of the Revised Code; 17923

(b) Programs of publicly funded child care, as defined in 17924
section 5104.01 of the Revised Code; 17925

(c) Child support enforcement programs; 17926

~~(d) Births to recipients of the medical assistance program 17927
established under Chapter 5111. of the Revised Code. 17928~~

(2) The department shall submit the reports required under 17929
division (A)(1) of this section to the speaker and minority leader 17930
of the house of representatives, the president and minority leader 17931
of the senate, the legislative budget officer, the director of 17932
budget and management, and each board of county commissioners. The 17933
department shall provide copies of the reports to any person or 17934
government entity on request. 17935

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 17967
guardian of such children; provided, that any organization, 17968
society, association, school, agency, child guidance center, 17969
detention or rehabilitation facility, or children's clinic 17970
licensed, regulated, approved, operated under the direction of, or 17971
otherwise certified by the department of education, a local board 17972
of education, the department of youth services, the department of 17973
mental health, or the department of mental retardation and 17974
developmental disabilities, or any individual who provides care 17975
for only a single-family group, placed there by their parents or 17976
other relative having custody, shall not be considered as being 17977
within the purview of these sections. 17978

(B) "Family foster home" means a foster home that is not a 17979
specialized foster home. 17980

(C) "Foster caregiver" means a person holding a valid foster 17981
home certificate issued under section 5103.03 of the Revised Code. 17982

(D) "Foster home" means a private residence in which children 17983
are received apart from their parents, guardian, or legal 17984
custodian, by an individual reimbursed for providing the children 17985
nonsecure care, supervision, or training twenty-four hours a day. 17986
"Foster home" does not include care provided for a child in the 17987
home of a person other than the child's parent, guardian, or legal 17988
custodian while the parent, guardian, or legal custodian is 17989
temporarily away. Family foster homes and specialized foster homes 17990
are types of foster homes. 17991

(E) "Medically fragile foster home" means a foster home that 17992
provides specialized medical services designed to meet the needs 17993
of children with intensive health care needs who meet all of the 17994
following criteria: 17995

(1) Under rules adopted by the ~~department~~ director of ~~job and~~ 17996
~~family services~~ health care administration governing payment under 17997

Chapter 5111. of the Revised Code <u>the medicaid program</u> for	17998
long-term care services, the children require a skilled level of	17999
care.	18000
(2) The children require the services of a doctor of medicine	18001
or osteopathic medicine at least once a week due to the	18002
instability of their medical conditions.	18003
(3) The children require the services of a registered nurse	18004
on a daily basis.	18005
(4) The children are at risk of institutionalization in a	18006
hospital, skilled nursing facility, or intermediate care facility	18007
for the mentally retarded.	18008
(F) "Recommending agency" means a public children services	18009
agency, private child placing agency, or private noncustodial	18010
agency that recommends that the department of job and family	18011
services take any of the following actions under section 5103.03	18012
of the Revised Code regarding a foster home:	18013
(1) Issue a certificate;	18014
(2) Deny a certificate;	18015
(3) Renew a certificate;	18016
(4) Deny renewal of a certificate;	18017
(5) Revoke a certificate.	18018
(G) "Specialized foster home" means a medically fragile	18019
foster home or a treatment foster home.	18020
(H) "Treatment foster home" means a foster home that	18021
incorporates special rehabilitative services designed to treat the	18022
specific needs of the children received in the foster home and	18023
that receives and cares for children who are emotionally or	18024
behaviorally disturbed, chemically dependent, mentally retarded,	18025
developmentally disabled, or who otherwise have exceptional needs.	18026

Sec. 5107.10. (A) As used in this section:	18027
(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.	18028 18029 18030
(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.	18031 18032 18033 18034
(3) "Gross income" means gross earned income and gross unearned income.	18035 18036
(4) "Initial eligibility threshold" means the higher of the following:	18037 18038
(a) Fifty per cent of the federal poverty guidelines;	18039
(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 <u>September 29, 2005</u> .	18040 18041 18042 18043
(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.	18044 18045 18046 18047 18048 18049 18050 18051 18052
(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	18053 18054 18055 18056

be provided in accordance with the self-sufficiency contract 18057
entered into under section 5107.14 of the Revised Code. 18058

(C) To be eligible to participate in Ohio works first, an 18059
assistance group must meet all of the following requirements: 18060

(1) The assistance group, except as provided in division (E) 18061
of this section, must include at least one of the following: 18062

(a) A minor child who, except as provided in section 5107.24 18063
of the Revised Code, resides with a parent, or specified relative 18064
caring for the child, or, to the extent permitted by Title IV-A 18065
and federal regulations adopted until Title IV-A, resides with a 18066
guardian or custodian caring for the child; 18067

(b) A parent residing with and caring for the parent's minor 18068
child who receives benefits under the supplemental security income 18069
~~under Title XVI of the "Social Security Act," 86 Stat. 1475~~ 18070
~~(1972), 42 U.S.C.A. 1383, as amended,~~ program or federal, state, 18071
or local adoption assistance; 18072

(c) A specified relative residing with and caring for a minor 18073
child who is related to the specified relative in a manner that 18074
makes the specified relative a specified relative and receives 18075
supplemental security income or federal, state, or local foster 18076
care or adoption assistance; 18077

(d) A woman at least six months pregnant. 18078

(2) The assistance group must meet the income requirements 18079
established by division (D) of this section. 18080

(3) No member of the assistance group may be involved in a 18081
strike. 18082

(4) The assistance group must satisfy the requirements for 18083
Ohio works first established by this chapter and sections ~~5101.58~~ 18084
5160.37, ~~5101.59~~ 5160.38, and 5101.83 of the Revised Code. 18085

(5) The assistance group must meet requirements for Ohio 18086

works first established by rules adopted under section 5107.05 of 18087
the Revised Code. 18088

(D)(1) Except as provided in division (D)(4) of this section, 18089
to determine whether an assistance group is initially eligible to 18090
participate in Ohio works first, a county department of job and 18091
family services shall do the following: 18092

(a) Determine whether the assistance group's gross income 18093
exceeds the initial eligibility threshold. In making this 18094
determination, the county department shall disregard amounts that 18095
federal statutes or regulations and sections 5101.17 and 5117.10 18096
of the Revised Code require be disregarded. The assistance group 18097
is ineligible to participate in Ohio works first if the assistance 18098
group's gross income, less the amounts disregarded, exceeds the 18099
initial eligibility threshold. 18100

(b) If the assistance group's gross income, less the amounts 18101
disregarded pursuant to division (D)(1)(a) of this section, does 18102
not exceed the initial eligibility threshold, determine whether 18103
the assistance group's countable income is less than the payment 18104
standard. The assistance group is ineligible to participate in 18105
Ohio works first if the assistance group's countable income equals 18106
or exceeds the payment standard. 18107

(2) For the purpose of determining whether an assistance 18108
group meets the income requirement established by division 18109
(D)(1)(a) of this section, the annual revision that the United 18110
States department of health and human services makes to the 18111
federal poverty guidelines shall go into effect on the first day 18112
of July of the year for which the revision is made. 18113

(3) To determine whether an assistance group participating in 18114
Ohio works first continues to be eligible to participate, a county 18115
department of job and family services shall determine whether the 18116
assistance group's countable income continues to be less than the 18117

payment standard. In making this determination, the county 18118
department shall disregard the first two hundred fifty dollars and 18119
fifty per cent of the remainder of the assistance group's gross 18120
earned income. No amounts shall be disregarded from the assistance 18121
group's gross unearned income. The assistance group ceases to be 18122
eligible to participate in Ohio works first if its countable 18123
income, less the amounts disregarded, equals or exceeds the 18124
payment standard. 18125

(4) If an assistance group reapplies to participate in Ohio 18126
works first not more than four months after ceasing to 18127
participate, a county department of job and family services shall 18128
use the income requirement established by division (D)(3) of this 18129
section to determine eligibility for resumed participation rather 18130
than the income requirement established by division (D)(1) of this 18131
section. 18132

(E)(1) An assistance group may continue to participate in 18133
Ohio works first even though a public children services agency 18134
removes the assistance group's minor children from the assistance 18135
group's home due to abuse, neglect, or dependency if the agency 18136
does both of the following: 18137

(a) Notifies the county department of job and family services 18138
at the time the agency removes the children that it believes the 18139
children will be able to return to the assistance group within six 18140
months; 18141

(b) Informs the county department at the end of each of the 18142
first five months after the agency removes the children that the 18143
parent, guardian, custodian, or specified relative of the children 18144
is cooperating with the case plans prepared for the children under 18145
section 2151.412 of the Revised Code and that the agency is making 18146
reasonable efforts to return the children to the assistance group. 18147

(2) An assistance group may continue to participate in Ohio 18148

works first pursuant to division (E)(1) of this section for not 18149
more than six payment months. This division does not affect the 18150
eligibility of an assistance group that includes a woman at least 18151
six months pregnant. 18152

Sec. 5107.14. An assistance group is ineligible to 18153
participate in Ohio works first unless the minor head of household 18154
or each adult member of the assistance group, not later than 18155
thirty days after applying for or undergoing a redetermination of 18156
eligibility for the program, enters into a written 18157
self-sufficiency contract with the county department of job and 18158
family services. The contract shall set forth the rights and 18159
responsibilities of the assistance group as applicants for and 18160
participants of the program, including work responsibilities 18161
established under sections 5107.40 to 5107.69 of the Revised Code 18162
and other requirements designed to assist the assistance group in 18163
achieving self sufficiency and personal responsibility. The county 18164
department shall provide without charge a copy of the contract to 18165
each assistance group member who signs it. 18166

Each self-sufficiency contract shall include, based on 18167
appraisals conducted under section 5107.41 of the Revised Code and 18168
assessments conducted under section 5107.70 of the Revised Code, 18169
the following: 18170

(A) The assistance group's plan, developed under section 18171
5107.41 of the Revised Code, to achieve the goal of self 18172
sufficiency and personal responsibility through unsubsidized 18173
employment within the time limit for participating in Ohio works 18174
first established by section 5107.18 of the Revised Code; 18175

(B) Work activities, developmental activities, and 18176
alternative work activities to which members of the assistance 18177
group are assigned under sections 5107.40 to 5107.69 of the 18178
Revised Code; 18179

(C) The responsibility of a caretaker member of the 18180
assistance group to cooperate in establishing a minor child's 18181
paternity and establishing, modifying, and enforcing a support 18182
order for the child in accordance with section 5107.22 of the 18183
Revised Code; 18184

(D) Other responsibilities that members of the assistance 18185
group must satisfy to participate in Ohio works first and the 18186
consequences for failure or refusal to satisfy the 18187
responsibilities; 18188

(E) An agreement that the assistance group will comply with 18189
the conditions of participating in Ohio works first established by 18190
this chapter and sections ~~5101.58, 5101.59~~ 5160.37, 5160.38, and 18191
5101.83 of the Revised Code; 18192

(F) Assistance and services the county department will 18193
provide to the assistance group; 18194

(G) Assistance and services the child support enforcement 18195
agency and public children services agency will provide to the 18196
assistance group pursuant to a plan of cooperation entered into 18197
under section 307.983 of the Revised Code; 18198

(H) Other provisions designed to assist the assistance group 18199
in achieving self sufficiency and personal responsibility; 18200

(I) Procedures for assessing whether responsibilities are 18201
being satisfied and whether the contract should be amended; 18202

(J) Procedures for amending the contract. 18203

Sec. 5107.16. (A) If a member of an assistance group fails or 18204
refuses, without good cause, to comply in full with a provision of 18205
a self-sufficiency contract entered into under section 5107.14 of 18206
the Revised Code, a county department of job and family services 18207
shall sanction the assistance group as follows: 18208

(1) For a first failure or refusal, the county department 18209

shall deny or terminate the assistance group's eligibility to 18210
participate in Ohio works first for one payment month or until the 18211
failure or refusal ceases, whichever is longer; 18212

(2) For a second failure or refusal, the county department 18213
shall deny or terminate the assistance group's eligibility to 18214
participate in Ohio works first for three payment months or until 18215
the failure or refusal ceases, whichever is longer; 18216

(3) For a third or subsequent failure or refusal, the county 18217
department shall deny or terminate the assistance group's 18218
eligibility to participate in Ohio works first for six payment 18219
months or until the failure or refusal ceases, whichever is 18220
longer. 18221

(B) Each county department of job and family services shall 18222
establish standards for the determination of good cause for 18223
failure or refusal to comply in full with a provision of a 18224
self-sufficiency contract. 18225

(1) In the case of a failure or refusal to participate in a 18226
work activity, developmental activity, or alternative work 18227
activity under sections 5107.40 to 5107.69 of the Revised Code, 18228
good cause shall include, except as provided in division (B)(2) of 18229
this section, the following: 18230

(a) Failure of the county department to place the member in 18231
an activity; 18232

(b) Failure of the county department to provide for the 18233
assistance group to receive support services the county department 18234
determines under section 5107.66 of the Revised Code to be 18235
necessary. In determining whether good cause exists, a county 18236
department shall determine that day care is a necessary support 18237
service if a single custodial parent caring for a minor child 18238
under age six proves a demonstrated inability, as determined by 18239
the county department, to obtain needed child care for one or more 18240

of the following reasons: 18241

(i) Unavailability of appropriate child care within a 18242
reasonable distance from the parent's home or work site; 18243

(ii) Unavailability or unsuitability of informal child care 18244
by a relative or under other arrangements; 18245

(iii) Unavailability of appropriate and affordable formal 18246
child care arrangements. 18247

(2) Good cause does not exist if the member of the assistance 18248
group is placed in a work activity established under section 18249
5107.58 of the Revised Code and exhausts the support services 18250
available for that activity. 18251

(C) When a state hearing under division (B) of section 18252
5101.35 of the Revised Code or an administrative appeal under 18253
division (C) of that section is held regarding a sanction under 18254
this section, the hearing officer, director of job and family 18255
services, or director's designee shall base the decision in the 18256
hearing or appeal on the county department's standards of good 18257
cause for failure or refusal to comply in full with a provision of 18258
a self-sufficiency contract, if the county department provides the 18259
hearing officer, director, or director's designee a copy of the 18260
county department's good cause standards. 18261

(D) After sanctioning an assistance group under division (A) 18262
of this section, a county department of job and family services 18263
shall continue to work with the assistance group to provide the 18264
member of the assistance group who caused the sanction an 18265
opportunity to demonstrate to the county department a willingness 18266
to cease the failure or refusal to comply with the 18267
self-sufficiency contract. 18268

(E) An adult eligible for ~~medical assistance~~ the medicaid 18269
program pursuant to division (A)(1)(a) of section ~~5111.01~~ 5162.01 18270
of the Revised Code who is sanctioned under division (A)(3) of 18271

this section for a failure or refusal, without good cause, to 18272
comply in full with a provision of a self-sufficiency contract 18273
related to work responsibilities under sections 5107.40 to 5107.69 18274
of the Revised Code loses eligibility for ~~medical assistance~~ the 18275
medicaid program unless the adult is otherwise eligible for 18276
~~medical assistance~~ the medicaid program pursuant to another 18277
division of section ~~5111.01~~ 5162.01 of the Revised Code. 18278

(F) An assistance group that would be participating in Ohio 18279
works first if not for a sanction under this section shall 18280
continue to be eligible for all of the following: 18281

(1) Publicly funded child care in accordance with division 18282
(A)(3) of section 5104.30 of the Revised Code; 18283

(2) Support services in accordance with section 5107.66 of 18284
the Revised Code; 18285

(3) To the extent permitted by the "Fair Labor Standards Act 18286
of 1938," 52 Stat. 1060, 29 U.S.C.A. 201, as amended, to 18287
participate in work activities, developmental activities, and 18288
alternative work activities in accordance with sections 5107.40 to 18289
5107.69 of the Revised Code. 18290

Sec. 5107.20. As used in this section, "support" means child 18291
support, spousal support, and support for a spouse or a former 18292
spouse. 18293

Participation in Ohio works first constitutes an assignment 18294
to the department of job and family services of any rights members 18295
of an assistance group have to support from any other person, 18296
excluding medical support assigned pursuant to section ~~5101.59~~ 18297
5160.37 of the Revised Code. The rights to support assigned to the 18298
department pursuant to this section constitute an obligation of 18299
the person who is responsible for providing the support to the 18300
state for the amount of cash assistance provided to the assistance 18301

group. 18302

The office of child support in the department of job and 18303
family services shall collect and distribute support payments owed 18304
to Ohio works first participants, whether assigned to the 18305
department or unassigned, in accordance with 42 U.S.C. 654 B and 18306
657 and regulations adopted under those statutes, state statutes, 18307
and rules adopted under section 5107.05 of the Revised Code. 18308

Upon implementation of centralized collection and 18309
disbursement under Chapter 3121. of the Revised Code, in 18310
accordance with 42 U.S.C. 654 B and 657 and regulations adopted 18311
under those statutes, the department shall deposit support 18312
payments it receives pursuant to this section into the state 18313
treasury to the credit of the child support collections fund or 18314
the child support administrative fund, both of which are hereby 18315
created. Money credited to the funds shall be used to make cash 18316
assistance payments under Ohio works first. 18317

Sec. 5107.26. (A) As used in this section: 18318

(1) "Transitional child care" means publicly funded child 18319
care provided under division (A)(3) of section 5104.34 of the 18320
Revised Code. 18321

(2) "Transitional medicaid" means the medical assistance 18322
provided under the medicaid program pursuant to section ~~5111.0115~~ 18323
5162.09 of the Revised Code. 18324

(B) Except as provided in division (C) of this section, each 18325
member of an assistance group participating in Ohio works first is 18326
ineligible to participate in the program for six payment months if 18327
a county department of job and family services determines that a 18328
member of the assistance group terminated the member's employment 18329
and each person who, on the day prior to the day a recipient 18330
begins to receive transitional child care or transitional 18331

medicaid, was a member of the recipient's assistance group is 18332
ineligible to participate in Ohio works first for six payment 18333
months if a county department determines that the recipient 18334
terminated the recipient's employment. 18335

(C) No assistance group member shall lose or be denied 18336
eligibility to participate in Ohio works first pursuant to 18337
division (B) of this section if the termination of employment was 18338
because an assistance group member or recipient of transitional 18339
child care or transitional medicaid secured comparable or better 18340
employment or the county department of job and family services 18341
certifies that the member or recipient terminated the employment 18342
with just cause. 18343

Just cause includes the following: 18344

(1) Discrimination by an employer based on age, race, sex, 18345
color, handicap, religious beliefs, or national origin; 18346

(2) Work demands or conditions that render continued 18347
employment unreasonable, such as working without being paid on 18348
schedule; 18349

(3) Employment that has become unsuitable due to any of the 18350
following: 18351

(a) The wage is less than the federal minimum wage; 18352

(b) The work is at a site subject to a strike or lockout, 18353
unless the strike has been enjoined under section 208 of the 18354
"Labor-Management Relations Act," 61 Stat. 155 (1947), 29 U.S.C.A. 18355
178, as amended, an injunction has been issued under section 10 of 18356
the "Railway Labor Act," 44 Stat. 586 (1926), 45 U.S.C.A. 160, as 18357
amended, or an injunction has been issued under section 4117.16 of 18358
the Revised Code; 18359

(c) The documented degree of risk to the member or 18360
recipient's health and safety is unreasonable; 18361

(d) The member or recipient is physically or mentally unfit 18362
to perform the employment, as documented by medical evidence or by 18363
reliable information from other sources. 18364

(4) Documented illness of the member or recipient or of 18365
another assistance group member of the member or recipient 18366
requiring the presence of the member or recipient; 18367

(5) A documented household emergency; 18368

(6) Lack of adequate child care for children of the member or 18369
recipient who are under six years of age. 18370

Sec. 5115.02. (A) An individual is not eligible for 18371
disability financial assistance under this chapter if any of the 18372
following apply: 18373

(1) The individual is eligible to participate in the Ohio 18374
works first program established under Chapter 5107. of the Revised 18375
Code; eligible ~~to receive for the~~ supplemental security income 18376
~~provided pursuant to Title XVI of the "Social Security Act," 86~~ 18377
~~Stat. 1475 (1972), 42 U.S.C. 1383, as amended~~ program; or eligible 18378
to participate in or receive assistance through another state or 18379
federal program that provides financial assistance similar to 18380
disability financial assistance, as determined by the director of 18381
job and family services; 18382

(2) The individual is ineligible to participate in the Ohio 18383
works first program because of any of the following: 18384

(a) The time limit established by section 5107.18 of the 18385
Revised Code; 18386

(b) Failure to comply with an application or verification 18387
procedure; 18388

(c) The fraud control provisions of section 5101.83 of the 18389
Revised Code or the fraud control program established pursuant to 18390
45 C.F.R. 235.112, as in effect July 1, 1996; 18391

(d) The self-sufficiency contract provisions of sections 5107.14 and 5107.16 of the Revised Code;	18392 18393
(e) The minor parent provisions of section 5107.24 of the Revised Code;	18394 18395
(f) The provisions of section 5107.26 of the Revised Code regarding termination of employment without just cause.	18396 18397
(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;	18398 18399 18400
(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;	18401 18402 18403 18404 18405 18406
(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;	18407 18408 18409 18410
(6) The individual reside <u>resides</u> in a county home, city infirmary, jail, or public institution;	18411 18412
(7) The individual is a fugitive felon as defined in section 5101.26 of the Revised Code;	18413 18414
(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.	18415 18416 18417
(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.	18418 18419 18420
(2) Ineligibility under division (A)(2)(c) or (d) of this	18421

section applies as follows: 18422

(a) In the case of an individual who is under eighteen years 18423
of age, the individual is ineligible only if the individual caused 18424
the assistance group to be ineligible to participate in the Ohio 18425
works first program or resides with an individual eighteen years 18426
of age or older who was a member of the same ineligible assistance 18427
group. 18428

(b) In the case of an individual who is eighteen years of age 18429
or older, the individual is ineligible regardless of whether the 18430
individual caused the assistance group to be ineligible to 18431
participate in the Ohio works first program. 18432

Sec. 5115.20. (A) The department of job and family services 18433
shall establish a disability advocacy program and each county 18434
department of job and family services shall establish a disability 18435
advocacy program unit or join with other county departments of job 18436
and family services to establish a joint county disability 18437
advocacy program unit. Through the program the department and 18438
county departments shall cooperate in efforts to assist applicants 18439
for and recipients of assistance under the disability financial 18440
assistance program and the disability medical assistance program, 18441
who might be eligible for benefits under the supplemental security 18442
income ~~benefits under Title XVI of the "Social Security Act," 86~~ 18443
~~Stat. 1475 (1972), 42 U.S.C.A. 1383, as amended~~ program, in 18444
applying for those benefits. The department of health care 18445
administration shall assist the department of job and family 18446
services and county departments with the program. 18447

As part of their disability advocacy programs, the state 18448
department and county departments may enter into contracts for the 18449
services of persons and government entities that in the judgment 18450
of the department or county department have demonstrated expertise 18451
in representing persons seeking supplemental security income 18452

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."~~ 18516

~~(D)~~ The director of job and family services shall adopt rules 18517
in accordance with section 111.15 of the Revised Code for the 18518
effective administration of the disability advocacy program. The 18519
rules shall include all of the following: 18520

(1) Methods to be used in collecting information from and 18521
disseminating it to county departments, including the following: 18522

(a) The number of individuals in the county who are disabled 18523
recipients of disability financial assistance or disability 18524
medical assistance; 18525

(b) The final decision made either by the social security 18526
administration or by a court for each application or 18527
reconsideration in which an individual was assisted pursuant to 18528
this section. 18529

(2) The type and process of training to be provided by the 18530
department of job and family services to the employees of the 18531
county department of job and family services who perform duties 18532
under this section and section 329.043 of the Revised Code; 18533

(3) Requirements for the written authorization required by 18534
division ~~(C)(5)(E)~~ of ~~this~~ section 329.043 of the Revised Code. 18535

~~(E)~~~~(D)~~ The department of job and family services shall 18536
provide basic and continuing training to employees of the county 18537
department of job and family services who perform duties under 18538
this section and section 329.043 of the Revised Code. Training 18539
shall include but not be limited to all processes necessary to 18540
obtain federal disability benefits, and methods of advocacy. 18541

~~(F)~~ The department shall establish a disability determination 18542
unit and develop guidelines for expediting reviews of applications 18543
for medical assistance under Chapter 5111. of the Revised Code for 18544
persons who have been referred to the unit under division ~~(C)(4)~~ 18545

~~of this section. The department shall make determinations of~~ 18546
~~eligibility for medical assistance for any such person within the~~ 18547
~~time prescribed by federal regulations.~~ 18548

~~(G)~~(E) The department of job and family services may, under 18549
rules the director of job and family services adopts in accordance 18550
with section 111.15 of the Revised Code, pay a portion of the 18551
federal reimbursement described in division ~~(C)(5)~~(E) of ~~this~~ 18552
section 329.043 of the Revised Code to persons or government 18553
entities that assist or represent assistance recipients in 18554
reconsiderations and appeals of social security administration 18555
decisions denying them supplemental security income benefits. 18556

~~(H)~~(F) The director of job and family services shall conduct 18557
investigations to determine whether disability advocacy programs 18558
are being administered in compliance with the Revised Code and the 18559
rules adopted by the director pursuant to this section. 18560

Sec. 5115.22. (A) If a recipient of disability financial 18561
assistance ~~or disability medical assistance~~, or an individual 18562
whose income and resources are included in determining the 18563
recipient's eligibility for the assistance, becomes possessed of 18564
resources or income in excess of the amount allowed to retain 18565
eligibility, or if other changes occur that affect the recipient's 18566
eligibility or need for assistance, the recipient shall notify the 18567
state or county department of job and family services within the 18568
time limits specified in rules adopted by the director of job and 18569
family services in accordance with section 111.15 of the Revised 18570
Code. Failure of a recipient to report possession of excess 18571
resources or income or a change affecting eligibility or need 18572
within those time limits shall be considered prima-facie evidence 18573
of intent to defraud under section 5115.23 of the Revised Code. 18574

(B) As a condition of eligibility for disability financial 18575
assistance ~~or disability medical assistance~~, and as a means of 18576

preventing or reducing the provision of assistance at public 18577
expense, each applicant for or recipient of the assistance shall 18578
make reasonable efforts to secure support from persons responsible 18579
for the applicant's or recipient's support, and from other 18580
sources, including any federal program designed to provide 18581
assistance to individuals with disabilities. The state or county 18582
department of job and family services may provide assistance to 18583
the applicant or recipient in securing other forms of financial 18584
assistance. 18585

Sec. 5115.23. As used in this section, "erroneous payments" 18586
means disability financial assistance payments ~~or disability~~ 18587
~~medical assistance payments~~ made to persons who are not entitled 18588
to receive them, including payments made as a result of 18589
misrepresentation or fraud, and payments made due to an error by 18590
the recipient or by the county department of job and family 18591
services that made the payment. 18592

The department of job and family services shall adopt rules 18593
in accordance with section 111.15 of the Revised Code specifying 18594
the circumstances under which action is to be taken under this 18595
section to recover erroneous payments. The department, or a county 18596
department of job and family services at the request of the 18597
department, shall take action to recover erroneous payments in the 18598
circumstances specified in the rules. The department or county 18599
department may institute a civil action to recover erroneous 18600
payments. 18601

Whenever disability financial assistance ~~or disability~~ 18602
~~medical assistance~~ has been furnished to a recipient for whose 18603
support another person is responsible, the other person shall, in 18604
addition to the liability otherwise imposed, as a consequence of 18605
failure to support the recipient, be liable for all assistance 18606
furnished the recipient. The value of the assistance so furnished 18607

may be recovered in a civil action brought by the county 18608
department of job and family services. 18609

Each county department of job and family services shall 18610
retain fifty per cent of the erroneous payments it recovers under 18611
this section. The department of job and family services shall 18612
receive the remaining fifty per cent. 18613

Sec. 5117.10. (A) On or before the fifteenth day of January, 18614
the director of development shall pay each applicant determined 18615
eligible for a payment under divisions (A) and (B) of section 18616
5117.07 of the Revised Code one hundred twenty-five dollars. 18617

(B) The director may withhold from any payment to which a 18618
person would otherwise be entitled under division (A) of this 18619
section any amount that the director determines was erroneously 18620
received by such person in a preceding year under this or the 18621
program established under Am. Sub. H.B. 230, as amended by Am. 18622
H.B. 937, Am. Sub. H.B. 1073, Am. Sub. S.B. 493, and Am. Sub. S.B. 18623
523 of the 112th general assembly, provided the director has 18624
employed all other legal methods reasonably available to obtain 18625
reimbursement for the erroneous payment or credit prior to the 18626
commencement of the current program year. 18627

(C) Payments made under this section and credits granted 18628
under section 5117.09 of the Revised Code shall not be considered 18629
income for the purpose of determining eligibility or the level of 18630
benefits or assistance under section 329.042 or Chapters 5107.7 18631
~~5111.7~~ and 5115. of the Revised Code; the medicaid program; the 18632
disability medical assistance program; supplemental security 18633
income payments ~~under Title XVI of the "Social Security Act," 49~~ 18634
~~Stat. 620 (1935), 42 U.S.C. 301, as amended;~~ or any other program 18635
under which eligibility or the level of benefits or assistance is 18636
based upon need measured by income. 18637

Sec. 5119.04. The department of mental health and any 18638
institutions under its supervision or jurisdiction shall, where 18639
applicable, be in substantial compliance with standards set forth 18640
for psychiatric facilities by the joint commission on 18641
accreditation of healthcare organizations or ~~medical assistance~~ 18642
medicaid standards ~~under Title XIX of the "Social Security Act,"~~ 18643
~~49 Stat. 620 (1935), 42 U.S.C. 301, as amended,~~ or other 18644
applicable standards, except that the department and any 18645
institution under its supervision or jurisdiction shall be in 18646
substantial compliance with standards for physical facilities and 18647
equipment by July 1, 1989. The requirements of this section do not 18648
apply to any facility designated by the director of mental health 18649
for use as a psychiatric rehabilitation center. 18650

The requirements of this section are in addition to any other 18651
requirements established by the Revised Code and nothing in this 18652
section shall be construed to limit any rights, privileges, 18653
protections, or immunities which may exist under the constitution 18654
and laws of the United States or this state. 18655

Sec. 5119.061. (A) As used in this section, "mentally ill 18656
individual" and "specialized services" have the same meanings as 18657
in section ~~5111.202~~ 5119.061 of the Revised Code. 18658

(B)(1) Except as provided in division (B)(2) of this section 18659
and rules adopted under division (E)(3) of this section, for 18660
purposes of section ~~5111.202~~ 5119.061 of the Revised Code, the 18661
department of mental health shall determine in accordance with 18662
~~section 1919(e)(7) of the "Social Security Act," 49 Stat. 620~~ 18663
~~(1935), 42 U.S.C.A. 301, as amended,~~ 1396r(e)(7) and regulations 18664
adopted under ~~section 1919(f)(8)(A) of that act~~ 42 U.S.C. 18665
1396r(f)(8)(A) whether, because of the individual's physical and 18666
mental condition, a mentally ill individual seeking admission to a 18667
nursing facility requires the level of services provided by a 18668

nursing facility and, if the individual requires that level of 18669
services, whether the individual requires specialized services for 18670
mental illness. The determination required by this division shall 18671
be based on an independent physical and mental evaluation 18672
performed by a person or entity other than the department. 18673

(2) A determination under this division is not required for 18674
any of the following: 18675

(a) An individual seeking readmission to a nursing facility 18676
after having been transferred from a nursing facility to a 18677
hospital for care; 18678

(b) An individual who meets all of the following conditions: 18679

(i) The individual is admitted to the nursing facility 18680
directly from a hospital after receiving inpatient care at the 18681
hospital; 18682

(ii) The individual requires nursing facility services for 18683
the condition for which care in the hospital was received; 18684

(iii) The individual's attending physician has certified, 18685
before admission to the nursing facility, that the individual is 18686
likely to require less than thirty days of nursing facility 18687
services. 18688

(c) An individual transferred from one nursing facility to 18689
another nursing facility, with or without an intervening hospital 18690
stay. 18691

(C) Except as provided in rules adopted under division (F)(3) 18692
of this section, the department of mental health shall review and 18693
determine for each resident of a nursing facility who is mentally 18694
ill, whether the resident, because of the resident's physical and 18695
mental condition, requires the level of services provided by a 18696
nursing facility and whether the resident requires specialized 18697
services for mental illness. The review and determination shall be 18698

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 18730
months before the date of the review and determination under 18731
division (C) of this section, if the resident is determined not to 18732
require the level of services provided by a nursing facility, but 18733
is determined to require specialized services for mental illness, 18734
or if the resident is determined to require neither the level of 18735
services provided by a nursing facility nor specialized services 18736
for mental illness, the department shall act in accordance with 18737
its alternative disposition plan approved by the United States 18738
department of health and human services under section 18739
1919(e)(7)(E) of the "Social Security Act." 18740

(3) In the case of an individual who is determined under 18741
division (B) or (C) of this section to require both the level of 18742
services provided by a nursing facility and specialized services 18743
for mental illness, the department of mental health shall provide 18744
or arrange for the provision of the specialized services needed by 18745
the individual or resident while residing in a nursing facility. 18746

(E) The department of mental health shall adopt rules in 18747
accordance with Chapter 119. of the Revised Code that do all of 18748
the following: 18749

(1) Establish criteria to be used in making the 18750
determinations required by divisions (B) and (C) of this section. 18751
The criteria shall not exceed the criteria established by 18752
regulations adopted by the United States department of health and 18753
human services under section 1919(f)(8)(A) of the "Social Security 18754
Act." 18755

(2) Specify information to be provided by the individual or 18756
nursing facility resident being assessed; 18757

(3) Specify any circumstances, in addition to circumstances 18758
listed in division (B) of this section, under which determinations 18759
under divisions (B) and (C) of this section are not required to be 18760

made. 18761

Sec. 5119.16. As used in this section, "free clinic" has the 18762
same meaning as in section 2305.2341 of the Revised Code. 18763

(A) The department of mental health is hereby designated to 18764
provide certain goods and services for the department of mental 18765
health, the department of mental retardation and developmental 18766
disabilities, the department of rehabilitation and correction, the 18767
department of youth services, and other state, county, or 18768
municipal agencies requesting ~~such~~ those goods and services when 18769
the department of mental health determines that it is in the 18770
public interest, and considers it advisable, to provide ~~these~~ 18771
those goods and services. The department of mental health also may 18772
provide goods and services to agencies operated by the United 18773
States government and to public or private nonprofit agencies, 18774
other than free clinics, that are funded in whole or in part by 18775
the state if the public or private nonprofit agencies are 18776
designated for participation in this program by the director of 18777
mental health for community mental health agencies, the director 18778
of mental retardation and developmental disabilities for community 18779
mental retardation and developmental disabilities agencies, the 18780
director of rehabilitation and correction for community 18781
rehabilitation and correction agencies, or the director of youth 18782
services for community youth services agencies. 18783

Designated community agencies shall receive goods and 18784
services through the department of mental health only in those 18785
cases where the designating state agency certifies that providing 18786
~~such~~ the goods and services to the agency will conserve public 18787
resources to the benefit of the public and where the provision of 18788
~~such~~ the goods and services is considered feasible by the 18789
department of mental health. 18790

(B) The department of mental health may permit free clinics 18791

to purchase certain goods and services to the extent the purchases 18792
fall within the exemption to the Robinson-Patman Act, 15 U.S.C. 13 18793
et seq., applicable to ~~non-profit~~ nonprofit institutions, in 15 18794
U.S.C. 13c, as amended. 18795

(C) The goods and services to be provided by the department 18796
of mental health under divisions (A) and (B) of this section may 18797
include all of the following: 18798

(1) Procurement, storage, processing, and distribution of 18799
food and professional consultation on food operations; 18800

(2) Procurement, storage, and distribution of medical and 18801
laboratory supplies, dental supplies, medical records, forms, 18802
optical supplies, and sundries, subject to section 5120.135 of the 18803
Revised Code; 18804

(3) Procurement, storage, repackaging, distribution, and 18805
dispensing of drugs, the provision of professional pharmacy 18806
consultation, and drug information services; 18807

(4) Other goods and services as may be agreed to. 18808

(D) ~~The~~ Subject to section 5160.75 of the Revised Code, the 18809
department of mental health shall provide the goods and services 18810
designated in division (C) of this section to its institutions and 18811
to state-operated community-based mental health services. 18812

(E) After consultation with and advice from the director of 18813
mental retardation and developmental disabilities, the director of 18814
rehabilitation and correction, and the director of youth services 18815
and subject to section 5160.75 of the Revised Code, the department 18816
of mental health shall provide the goods and services designated 18817
in division (C) of this section to the department of mental 18818
retardation and developmental disabilities, the department of 18819
rehabilitation and correction, and the department of youth 18820
services. 18821

(F) The cost of administration of this section shall be 18822
determined by the department of mental health and paid by the 18823
agencies or free clinics receiving the goods and services to the 18824
department for deposit in the state treasury to the credit of the 18825
mental health fund, which is hereby created. The fund shall be 18826
used to pay the cost of administration of this section to the 18827
department. 18828

(G) If the goods or services designated in division (C) of 18829
this section are not provided in a satisfactory manner by the 18830
department of mental health to the agencies described in division 18831
(A) of this section, the director of mental retardation and 18832
developmental disabilities, the director of rehabilitation and 18833
correction, the director of youth services, or the managing 18834
officer of a department of mental health institution shall attempt 18835
to resolve unsatisfactory service with the director of mental 18836
health. If, after ~~such~~ the attempt, the provision of goods or 18837
services continues to be unsatisfactory, the director or officer 18838
shall notify the director of mental health. If, within thirty days 18839
of ~~such~~ that notice the department of mental health does not 18840
provide the specified goods and services in a satisfactory manner, 18841
the director of mental retardation and developmental disabilities, 18842
the director of rehabilitation and correction, the director of 18843
youth services, or the managing officer of the department of 18844
mental health institution shall notify the director of mental 18845
health of the director's or managing officer's intent to cease 18846
purchasing goods and services from the department. Following a 18847
sixty-day cancellation period from the date of ~~such~~ that notice 18848
and subject to section 5160.75 of the Revised Code, the department 18849
of mental retardation, department of rehabilitation and 18850
correction, department of youth services, or the department of 18851
mental health institution may obtain the goods and services from a 18852
source other than the department of mental health, if the 18853
department certifies to the department of administrative services 18854

that the requirements of this division have been met. 18855

(H) Whenever a state agency fails to make a payment for goods 18856
and services provided under this section within thirty-one days 18857
after the date the payment was due, the office of budget and 18858
management may transfer moneys from the state agency to the 18859
department of mental health. The amount transferred shall not 18860
exceed the amount of overdue payments. Prior to making a transfer 18861
under this division, the office of budget and management shall 18862
apply any credits the state agency has accumulated in payments for 18863
goods and services provided under this section. 18864

(I) Purchases of goods and services under this section are 18865
not subject to section 307.86 of the Revised Code. 18866

(J) The department shall not perform any acts described in 18867
division (A)(3) of this section for state departments or other 18868
state agencies covered by the operation of section 5160.75 of the 18869
Revised Code. 18870

Sec. 5119.351. The department of mental health may pay an 18871
amount for personal use to each individual residing in a state 18872
institution as described in section 5119.02 of the Revised Code 18873
who would be eligible for supplemental security income benefits at 18874
the reduced rate established by ~~Title XVI of the "Social Security 18875
Act," 49 Stat. 620 (1935), 42 U.S.C.A. 1382, as amended the 18876
supplemental security income program, if the state medicaid plan 18877
~~for providing medical assistance under section 5111.01 of the 18878
Revised Code~~ included reimbursement of services provided in such 18879
institutions. The amount paid by the department shall not exceed 18880
the reduced supplemental security income benefit rate established 18881
by ~~Title XVI of the "Social Security Act~~ the program." 18882~~

Sec. 5119.61. Any provision in this chapter that refers to a 18883
board of alcohol, drug addiction, and mental health services also 18884

refers to the community mental health board in an alcohol, drug 18885
addiction, and mental health service district that has a community 18886
mental health board. 18887

The director of mental health with respect to all facilities 18888
and programs established and operated under Chapter 340. of the 18889
Revised Code for mentally ill and emotionally disturbed persons, 18890
shall do all of the following: 18891

(A) Adopt rules pursuant to Chapter 119. of the Revised Code 18892
that may be necessary to carry out the purposes of Chapter 340. 18893
and sections 5119.61 to 5119.63 of the Revised Code. 18894

(1) The rules shall include all of the following: 18895

(a) Rules governing a community mental health agency's 18896
services under section 340.091 of the Revised Code to an 18897
individual referred to the agency under division (C)(2) of section 18898
~~173.35~~ 5160.80 of the Revised Code; 18899

(b) For the purpose of division (A)(16) of section 340.03 of 18900
the Revised Code, rules governing the duties of mental health 18901
agencies and boards of alcohol, drug addiction, and mental health 18902
services under section 3722.18 of the Revised Code regarding 18903
referrals of individuals with mental illness or severe mental 18904
disability to adult care facilities and effective arrangements for 18905
ongoing mental health services for the individuals. The rules 18906
shall do at least the following: 18907

(i) Provide for agencies and boards to participate fully in 18908
the procedures owners and managers of adult care facilities must 18909
follow under division (A)(2) of section 3722.18 of the Revised 18910
Code; 18911

(ii) Specify the manner in which boards are accountable for 18912
ensuring that ongoing mental health services are effectively 18913
arranged for individuals with mental illness or severe mental 18914
disability who are referred by the board or mental health agency 18915

under contract with the board to an adult care facility. 18916

(c) Rules governing a board of alcohol, drug addiction, and 18917
mental health services when making a report to the director of 18918
health under section 3722.17 of the Revised Code regarding the 18919
quality of care and services provided by an adult care facility to 18920
a person with mental illness or a severe mental disability. 18921

(2) Rules may be adopted to govern the method of paying a 18922
community mental health facility, as defined in section ~~5111.023~~ 18923
5163.20 of the Revised Code, for providing services listed in 18924
division (B) of that section. Such rules must be consistent with 18925
the contract entered into between the departments of ~~job and~~ 18926
~~family services~~ health care administration and mental health under 18927
section ~~5111.91~~ 5161.05 of the Revised Code and include 18928
requirements ensuring appropriate service utilization. 18929

(B) Review and evaluate, and, taking into account the 18930
findings and recommendations of the board of alcohol, drug 18931
addiction, and mental health services of the district served by 18932
the program and the requirements and priorities of the state 18933
mental health plan, including the needs of residents of the 18934
district now residing in state mental institutions, approve and 18935
allocate funds to support community programs, and make 18936
recommendations for needed improvements to boards of alcohol, drug 18937
addiction, and mental health services; 18938

(C) Withhold state and federal funds for any program, in 18939
whole or in part, from a board of alcohol, drug addiction, and 18940
mental health services in the event of failure of that program to 18941
comply with Chapter 340. or section 5119.61, 5119.611, 5119.612, 18942
or 5119.62 of the Revised Code or rules of the department of 18943
mental health. The director shall identify the areas of 18944
noncompliance and the action necessary to achieve compliance. The 18945
director shall offer technical assistance to the board to achieve 18946
compliance. The director shall give the board a reasonable time 18947

within which to comply or to present its position that it is in 18948
compliance. Before withholding funds, a hearing shall be conducted 18949
to determine if there are continuing violations and that either 18950
assistance is rejected or the board is unable to achieve 18951
compliance. Subsequent to the hearing process, if it is determined 18952
that compliance has not been achieved, the director may allocate 18953
all or part of the withheld funds to a public or private agency to 18954
provide the services not in compliance until the time that there 18955
is compliance. The director shall establish rules pursuant to 18956
Chapter 119. of the Revised Code to implement this division. 18957

(D) Withhold state or federal funds from a board of alcohol, 18958
drug addiction, and mental health services that denies available 18959
service on the basis of religion, race, color, creed, sex, 18960
national origin, age, disability as defined in section 4112.01 of 18961
the Revised Code, developmental disability, or the inability to 18962
pay; 18963

(E) Provide consultative services to community mental health 18964
agencies with the knowledge and cooperation of the board of 18965
alcohol, drug addiction, and mental health services; 18966

(F) Provide to boards of alcohol, drug addiction, and mental 18967
health services state or federal funds, in addition to those 18968
allocated under section 5119.62 of the Revised Code, for special 18969
programs or projects the director considers necessary but for 18970
which local funds are not available; 18971

(G) Establish criteria by which a board of alcohol, drug 18972
addiction, and mental health services reviews and evaluates the 18973
quality, effectiveness, and efficiency of services provided 18974
through its community mental health plan. The criteria shall 18975
include requirements ensuring appropriate service utilization. The 18976
department shall assess a board's evaluation of services and the 18977
compliance of each board with this section, Chapter 340. or 18978
section 5119.62 of the Revised Code, and other state or federal 18979

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. 19011

(I) Review each board's community mental health plan 19012
submitted pursuant to section 340.03 of the Revised Code and 19013
approve or disapprove it in whole or in part. Periodically, in 19014
consultation with representatives of boards and after considering 19015
the recommendations of the medical director, the director shall 19016
issue criteria for determining when a plan is complete, criteria 19017
for plan approval or disapproval, and provisions for conditional 19018
approval. The factors that the director considers may include, but 19019
are not limited to, the following: 19020

(1) The mental health needs of all persons residing within 19021
the board's service district, especially severely mentally 19022
disabled children, adolescents, and adults; 19023

(2) The demonstrated quality, effectiveness, efficiency, and 19024
cultural relevance of the services provided in each service 19025
district, the extent to which any services are duplicative of 19026
other available services, and whether the services meet the needs 19027
identified above; 19028

(3) The adequacy of the board's accounting for the 19029
expenditure of funds. 19030

If the director disapproves all or part of any plan, the 19031
director shall provide the board an opportunity to present its 19032
position. The director shall inform the board of the reasons for 19033
the disapproval and of the criteria that must be met before the 19034
plan may be approved. The director shall give the board a 19035
reasonable time within which to meet the criteria, and shall offer 19036
technical assistance to the board to help it meet the criteria. 19037

If the approval of a plan remains in dispute thirty days 19038
prior to the conclusion of the fiscal year in which the board's 19039
current plan is scheduled to expire, the board or the director may 19040
request that the dispute be submitted to a mutually agreed upon 19041

third-party mediator with the cost to be shared by the board and 19042
the department. The mediator shall issue to the board and the 19043
department recommendations for resolution of the dispute. Prior to 19044
the conclusion of the fiscal year in which the current plan is 19045
scheduled to expire, the director, taking into consideration the 19046
recommendations of the mediator, shall make a final determination 19047
and approve or disapprove the plan, in whole or in part. 19048

Sec. 5120.65. (A) The department of rehabilitation and 19049
correction may establish in one or more of the institutions for 19050
women operated by the department a prison nursery program under 19051
which eligible inmates and children born to them while in the 19052
custody of the department may reside together in the institution. 19053
If the department establishes a prison nursery program in one or 19054
more institutions under this section, sections 5120.651 to 19055
5120.657 of the Revised Code apply regarding the program. If the 19056
department establishes a prison nursery program and an inmate 19057
participates in the program, neither the inmate's participation in 19058
the program nor any provision of sections 5120.65 to 5120.657 of 19059
the Revised Code affects, modifies, or interferes with the 19060
inmate's custodial rights of the child or establishes legal 19061
custody of the child with the department. 19062

(B) As used in sections 5120.651 to 5120.657 of the Revised 19063
Code: 19064

(1) "Prison nursery program" means the prison nursery program 19065
established by the department of rehabilitation and correction 19066
under this section, if one is so established. 19067

(2) "Public assistance" ~~has the same meaning as in section~~ 19068
~~5101.58 of the Revised Code~~ means all of the following: 19069

(a) Medicaid; 19070

(b) Disability medical assistance; 19071

<u>(c) The Ohio works first program established under Chapter</u>	19072
<u>5107. of the Revised Code;</u>	19073
<u>(d) Disability financial assistance established under Chapter</u>	19074
<u>5115. of the Revised Code.</u>	19075
(3) "Support" means amounts to be paid under a support order.	19076
(4) "Support order" has the same meaning as in section	19077
3119.01 of the Revised Code.	19078
Sec. 5120.652. To participate in the prison nursery program,	19079
each eligible inmate selected by the department shall do all the	19080
following:	19081
(A) Agree in writing to do all the following:	19082
(1) Comply with any program, educational, counseling, and	19083
other requirements established for the program by the department	19084
of rehabilitation and correction;	19085
(2) If eligible, have the child participate in the medicaid	19086
program or a health insurance program;	19087
(3) Accept the normal risks of childrearing;	19088
(4) Abide by any court decisions regarding the allocation of	19089
parental rights and responsibilities with respect to the child.	19090
(B) Assign to the department any rights to support from any	19091
other person, excluding support assigned pursuant to section	19092
5107.20 of the Revised Code and medical support assigned pursuant	19093
to section 5101.59 <u>5160.37</u> of the Revised Code;	19094
(C) Specify with whom the child is to be placed in the event	19095
the inmate's participation in the program is terminated for a	19096
reason other than release from imprisonment.	19097
Sec. 5121.04. (A) The department of mental retardation and	19098
developmental disabilities shall investigate the financial	19099

condition of the residents in institutions, residents whose care 19100
or treatment is being paid for in a private facility or home under 19101
the control of the department, and of the relatives named in 19102
section 5121.06 of the Revised Code as liable for the support of 19103
such residents, in order to determine the ability of any resident 19104
or liable relatives to pay for the support of the resident and to 19105
provide suitable clothing as required by the superintendent of the 19106
institution. 19107

(B) The department shall follow the provisions of this 19108
division in determining the ability to pay of a resident or the 19109
resident's liable relatives and the amount to be charged such 19110
resident or liable relatives. 19111

(1) Subject to divisions (B)(10) and (11) of this section, a 19112
resident without dependents shall be liable for the full 19113
applicable cost. A resident without dependents who has a gross 19114
annual income equal to or exceeding the sum of the full applicable 19115
cost, plus fifty dollars per month, regardless of the source of 19116
such income, shall pay currently the full amount of the applicable 19117
cost; if the resident's gross annual income is less than such sum, 19118
not more than fifty dollars per month shall be kept for personal 19119
use by or on behalf of the resident, except as permitted in the 19120
state medicaid plan ~~for providing medical assistance under Title~~ 19121
~~XIX of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.~~ 19122
~~301, as amended,~~ and the balance shall be paid currently on the 19123
resident's support. Subject to divisions (B)(10) and (11) of this 19124
section, the estate of a resident without dependents shall pay 19125
currently any remaining difference between the applicable cost and 19126
the amounts prescribed in this section, or shall execute an 19127
agreement with the department for payment to be made at some 19128
future date under terms suitable to the department. However, no 19129
security interest, mortgage, or lien shall be taken, granted, or 19130
charged against any principal residence of a resident without 19131

dependents under an agreement or otherwise to secure support 19132
payments, and no foreclosure actions shall be taken on security 19133
interests, mortgages, or liens taken, granted, or charged against 19134
principal residences of residents prior to October 7, 1977. 19135

(2) The ability to pay of a resident with dependents, or of a 19136
liable relative of a resident either with or without dependents, 19137
shall be determined in accordance with the resident's or liable 19138
relative's income or other assets, the needs of others who are 19139
dependent on such income and other assets for support, and, if 19140
applicable, divisions (B)(10) and (11) of this section. 19141

For the first thirty days of care and treatment of each 19142
admission, but in no event for more than thirty days in any 19143
calendar year, the resident with dependents or the liable relative 19144
of a resident either with or without dependents shall be charged 19145
an amount equal to the percentage of the average applicable cost 19146
determined in accordance with the schedule of adjusted gross 19147
annual income contained after this paragraph. After such first 19148
thirty days of care and treatment, such resident or such liable 19149
relative shall be charged an amount equal to the percentage of a 19150
base support rate of four dollars per day for residents, as 19151
determined in accordance with the schedule of gross annual income 19152
contained after this paragraph, or in accordance with division 19153
(B)(5) of this section. Beginning January 1, 1978, the department 19154
shall increase the base rate when the consumer price index average 19155
is more than 4.0 for the preceding calendar year by not more than 19156
the average for such calendar year. 19157

Adjusted Gross Annual 19158

Income of Resident 19159

or Liable Relative (FN a) Number of Dependents (FN b) 19160

8 or 19161

1 2 3 4 5 6 7 more 19162

Rate of Support (In Percentages) 19163

\$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
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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
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(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
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(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; 19195

(d) The services of a housekeeper, costing in excess of fifty 19196
dollars per month, are required if the person who normally keeps 19197
house for minor children is the resident. 19198

(5) If with respect to any resident with dependents there is 19199
chargeable under division (B)(2) of this section less than fifty 19200
per cent of the applicable cost or, if the base support rate was 19201
used, less than fifty per cent of the amount determined by use of 19202
the base support rate, and if with respect to such resident there 19203
is a liable relative who has an estate having a value in excess of 19204
fifteen thousand dollars or if such resident has a dependent and 19205
an estate having a value in excess of fifteen thousand dollars, 19206
there shall be paid with respect to such resident a total of fifty 19207
per cent of the applicable cost or the base support rate amount, 19208
as the case may be, on a current basis or there shall be executed 19209
with respect to such resident an agreement with the department for 19210
payment to be made at some future date under terms suitable to the 19211
department. 19212

(6) When a person has been a resident for fifteen years and 19213
the support charges for which a relative is liable have been paid 19214
for the fifteen-year period, the liable relative shall be relieved 19215
of any further support charges. 19216

(7) The department shall accept voluntary payments from 19217
residents or liable relatives whose incomes are below the minimum 19218
shown in the schedule set forth in this division. The department 19219
also shall accept voluntary payments in excess of required amounts 19220
from both liable and nonliable relatives. 19221

(8) If a resident is covered by an insurance policy, or other 19222
contract that provides for payment of expenses for care and 19223
treatment for mental retardation or other developmental disability 19224
at or from an institution or facility (including a community 19225

service unit under the jurisdiction of the department), the other 19226
provisions of this section, except divisions (B)(8), (10), and 19227
(11) of this section, and of section 5121.01 of the Revised Code 19228
shall be suspended to the extent that such insurance policy or 19229
other contract is in force, and such resident shall be charged the 19230
full amount of the applicable cost. Any insurance carrier or other 19231
third party payor providing coverage for such care and treatment 19232
shall pay for this support obligation in an amount equal to the 19233
lesser of either the applicable cost or the benefits provided 19234
under the policy or other contract. Whether or not an insured, 19235
owner of, or other person having an interest in such policy or 19236
other contract is liable for support payments under other 19237
provisions of this chapter, the insured, policy owner, or other 19238
person shall assign payment directly to the department of all 19239
assignable benefits under the policy or other contract and shall 19240
pay over to the department, within ten days of receipt, all 19241
insurance or other benefits received as reimbursement or payment 19242
for expenses incurred by the resident or for any other reason. If 19243
the insured, policy owner, or other person refuses to assign such 19244
payment to the department or refuses to pay such received 19245
reimbursements or payments over to the department within ten days 19246
of receipt, the insured's, policy owners', or other person's total 19247
liability for the services equals the applicable statutory 19248
liability for payment for the services as determined under other 19249
provisions of this chapter, plus the amounts payable under the 19250
terms of the policy or other contract. In no event shall this 19251
total liability exceed the full amount of the applicable cost. 19252
Upon its request, the department is entitled to a court order that 19253
compels the insured, owner of, or other person having an interest 19254
in the policy or other contract to comply with the assignment 19255
requirements of this division or that itself serves as a legally 19256
sufficient assignment in compliance with such requirements. 19257
Notwithstanding section 5123.89 of the Revised Code and any other 19258

law relating to confidentiality of records, the managing officer 19259
of the institution or facility where a person is or has been a 19260
resident shall disclose pertinent medical information concerning 19261
the resident to the insurance carrier or other third party payor 19262
in question, in order to effect collection from the carrier or 19263
payor of the state's claim for care and treatment under this 19264
division. For such disclosure, the managing officer is not subject 19265
to any civil or criminal liability. 19266

(9) The rate to be charged for pre-admission care, 19267
after-care, day-care, or routine consultation and treatment 19268
services shall be based upon the ability of the resident or the 19269
resident's liable relatives to pay. When it is determined by the 19270
department that a charge shall be made, such charge shall be 19271
computed as provided in divisions (B)(1) and (2) of this section. 19272

(10) If a resident with or without dependents is the 19273
beneficiary of a trust created pursuant to section 1339.51 of the 19274
Revised Code, then, notwithstanding any contrary provision of this 19275
chapter or of a rule adopted pursuant to this chapter, divisions 19276
(C) and (D) of that section shall apply in determining the assets 19277
or resources of the resident, the resident's estate, the settlor, 19278
or the settlor's estate and to claims arising under this chapter 19279
against the resident, the resident's estate, the settlor, or the 19280
settlor's estate. 19281

(11) If the department waives the liability of an individual 19282
and the individual's liable relatives pursuant to section 5123.194 19283
of the Revised Code, the liability of the individual and relative 19284
ceases in accordance with the waiver's terms. 19285

(C) The department may enter into agreements with a resident 19286
or a liable relative for support payments to be made in the 19287
future. However, no security interest, mortgage, or lien shall be 19288
taken, granted, or charged against any principal family residence 19289
of a resident with dependents or a liable relative under an 19290

agreement or otherwise to secure support payments, and no 19291
foreclosure actions shall be taken on security interests, 19292
mortgages or liens taken, granted, or charged against principal 19293
residences of residents or liable relatives prior to October 7, 19294
1977. 19295

(D) The department shall make all investigations and 19296
determinations required by this section within ninety days after a 19297
resident is admitted to an institution under the department's 19298
control and immediately shall notify by mail the persons liable of 19299
the amount to be charged. 19300

(E) All actions to enforce the collection of payments agreed 19301
upon or charged by the department shall be commenced within six 19302
years after the date of default of an agreement to pay support 19303
charges or the date such payment becomes delinquent. If a payment 19304
is made pursuant to an agreement which is in default, a new 19305
six-year period for actions to enforce the collection of payments 19306
under such agreement shall be computed from the date of such 19307
payment. For purposes of this division an agreement is in default 19308
or a payment is delinquent if a payment is not made within thirty 19309
days after it is incurred or a payment, pursuant to an agreement, 19310
is not made within thirty days after the date specified for such 19311
payment. In all actions to enforce the collection of payment for 19312
the liability for support, every court of record shall receive 19313
into evidence the proof of claim made by the state together with 19314
all debts and credits, and it shall be prima-facie evidence of the 19315
facts contained in it. 19316

Sec. 5123.01. As used in this chapter: 19317

(A) "Chief medical officer" means the licensed physician 19318
appointed by the managing officer of an institution for the 19319
mentally retarded with the approval of the director of mental 19320
retardation and developmental disabilities to provide medical 19321

treatment for residents of the institution. 19322

(B) "Chief program director" means a person with special 19323
training and experience in the diagnosis and management of the 19324
mentally retarded, certified according to division (C) of this 19325
section in at least one of the designated fields, and appointed by 19326
the managing officer of an institution for the mentally retarded 19327
with the approval of the director to provide habilitation and care 19328
for residents of the institution. 19329

(C) "Comprehensive evaluation" means a study, including a 19330
sequence of observations and examinations, of a person leading to 19331
conclusions and recommendations formulated jointly, with 19332
dissenting opinions if any, by a group of persons with special 19333
training and experience in the diagnosis and management of persons 19334
with mental retardation or a developmental disability, which group 19335
shall include individuals who are professionally qualified in the 19336
fields of medicine, psychology, and social work, together with 19337
such other specialists as the individual case may require. 19338

(D) "Education" means the process of formal training and 19339
instruction to facilitate the intellectual and emotional 19340
development of residents. 19341

(E) "Habilitation" means the process by which the staff of 19342
the institution assists the resident in acquiring and maintaining 19343
those life skills that enable the resident to cope more 19344
effectively with the demands of the resident's own person and of 19345
the resident's environment and in raising the level of the 19346
resident's physical, mental, social, and vocational efficiency. 19347
Habilitation includes but is not limited to programs of formal, 19348
structured education and training. 19349

(F) "Health officer" means any public health physician, 19350
public health nurse, or other person authorized or designated by a 19351
city or general health district. 19352

(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 19384
significantly subaverage general intellectual functioning existing 19385
concurrently with deficiencies in adaptive behavior, manifested 19386
during the developmental period. 19387

~~(O)~~(N) "Mentally retarded person subject to 19388
institutionalization by court order" means a person eighteen years 19389
of age or older who is at least moderately mentally retarded and 19390
in relation to whom, because of the person's retardation, either 19391
of the following conditions exist: 19392

(1) The person represents a very substantial risk of physical 19393
impairment or injury to self as manifested by evidence that the 19394
person is unable to provide for and is not providing for the 19395
person's most basic physical needs and that provision for those 19396
needs is not available in the community; 19397

(2) The person needs and is susceptible to significant 19398
habilitation in an institution. 19399

~~(P)~~(O) "A person who is at least moderately mentally 19400
retarded" means a person who is found, following a comprehensive 19401
evaluation, to be impaired in adaptive behavior to a moderate 19402
degree and to be functioning at the moderate level of intellectual 19403
functioning in accordance with standard measurements as recorded 19404
in the most current revision of the manual of terminology and 19405
classification in mental retardation published by the American 19406
association on mental retardation. 19407

~~(Q)~~(P) As used in this division, "substantial functional 19408
limitation," "developmental delay," and "established risk" have 19409
the meanings established pursuant to section 5123.011 of the 19410
Revised Code. 19411

"Developmental disability" means a severe, chronic disability 19412
that is characterized by all of the following: 19413

(1) It is attributable to a mental or physical impairment or 19414

a combination of mental and physical impairments, other than a 19415
mental or physical impairment solely caused by mental illness as 19416
defined in division (A) of section 5122.01 of the Revised Code. 19417

(2) It is manifested before age twenty-two. 19418

(3) It is likely to continue indefinitely. 19419

(4) It results in one of the following: 19420

(a) In the case of a person under three years of age, at 19421
least one developmental delay or an established risk; 19422

(b) In the case of a person at least three years of age but 19423
under six years of age, at least two developmental delays or an 19424
established risk; 19425

(c) In the case of a person six years of age or older, a 19426
substantial functional limitation in at least three of the 19427
following areas of major life activity, as appropriate for the 19428
person's age: self-care, receptive and expressive language, 19429
learning, mobility, self-direction, capacity for independent 19430
living, and, if the person is at least sixteen years of age, 19431
capacity for economic self-sufficiency. 19432

(5) It causes the person to need a combination and sequence 19433
of special, interdisciplinary, or other type of care, treatment, 19434
or provision of services for an extended period of time that is 19435
individually planned and coordinated for the person. 19436

~~(R)~~(O) "Developmentally disabled person" means a person with 19437
a developmental disability. 19438

~~(S)~~(R) "State institution" means an institution that is 19439
tax-supported and under the jurisdiction of the department. 19440

~~(T)~~(S) "Residence" and "legal residence" have the same 19441
meaning as "legal settlement," which is acquired by residing in 19442
Ohio for a period of one year without receiving general assistance 19443
prior to July 17, 1995, under former Chapter 5113. of the Revised 19444

Code, financial assistance under Chapter 5115. of the Revised 19445
Code, or assistance from a private agency that maintains records 19446
of assistance given. A person having a legal settlement in the 19447
state shall be considered as having legal settlement in the 19448
assistance area in which the person resides. No adult person 19449
coming into this state and having a spouse or minor children 19450
residing in another state shall obtain a legal settlement in this 19451
state as long as the spouse or minor children are receiving public 19452
assistance, care, or support at the expense of the other state or 19453
its subdivisions. For the purpose of determining the legal 19454
settlement of a person who is living in a public or private 19455
institution or in a home subject to licensing by the department of 19456
job and family services, the department of mental health, or the 19457
department of mental retardation and developmental disabilities, 19458
the residence of the person shall be considered as though the 19459
person were residing in the county in which the person was living 19460
prior to the person's entrance into the institution or home. 19461
Settlement once acquired shall continue until a person has been 19462
continuously absent from Ohio for a period of one year or has 19463
acquired a legal residence in another state. A woman who marries a 19464
man with legal settlement in any county immediately acquires the 19465
settlement of her husband. The legal settlement of a minor is that 19466
of the parents, surviving parent, sole parent, parent who is 19467
designated the residential parent and legal custodian by a court, 19468
other adult having permanent custody awarded by a court, or 19469
guardian of the person of the minor, provided that: 19470

(1) A minor female who marries shall be considered to have 19471
the legal settlement of her husband and, in the case of death of 19472
her husband or divorce, she shall not thereby lose her legal 19473
settlement obtained by the marriage. 19474

(2) A minor male who marries, establishes a home, and who has 19475
resided in this state for one year without receiving general 19476

assistance prior to July 17, 1995, under former Chapter 5113. of 19477
the Revised Code, financial assistance under Chapter 5115. of the 19478
Revised Code, or assistance from a private agency that maintains 19479
records of assistance given shall be considered to have obtained a 19480
legal settlement in this state. 19481

(3) The legal settlement of a child under eighteen years of 19482
age who is in the care or custody of a public or private child 19483
caring agency shall not change if the legal settlement of the 19484
parent changes until after the child has been in the home of the 19485
parent for a period of one year. 19486

No person, adult or minor, may establish a legal settlement 19487
in this state for the purpose of gaining admission to any state 19488
institution. 19489

~~(U)~~(T)(1) "Resident" means, subject to division (R)(2) of 19490
this section, a person who is admitted either voluntarily or 19491
involuntarily to an institution or other facility pursuant to 19492
section 2945.39, 2945.40, 2945.401, or 2945.402 of the Revised 19493
Code subsequent to a finding of not guilty by reason of insanity 19494
or incompetence to stand trial or under this chapter who is under 19495
observation or receiving habilitation and care in an institution. 19496

(2) "Resident" does not include a person admitted to an 19497
institution or other facility under section 2945.39, 2945.40, 19498
2945.401, or 2945.402 of the Revised Code to the extent that the 19499
reference in this chapter to resident, or the context in which the 19500
reference occurs, is in conflict with any provision of sections 19501
2945.37 to 2945.402 of the Revised Code. 19502

~~(V)~~(U) "Respondent" means the person whose detention, 19503
commitment, or continued commitment is being sought in any 19504
proceeding under this chapter. 19505

~~(W)~~(V) "Working day" and "court day" mean Monday, Tuesday, 19506
Wednesday, Thursday, and Friday, except when such day is a legal 19507

holiday. 19508

~~(X)~~(W) "Prosecutor" means the prosecuting attorney, village 19509
solicitor, city director of law, or similar chief legal officer 19510
who prosecuted a criminal case in which a person was found not 19511
guilty by reason of insanity, who would have had the authority to 19512
prosecute a criminal case against a person if the person had not 19513
been found incompetent to stand trial, or who prosecuted a case in 19514
which a person was found guilty. 19515

~~(Y)~~(X) "Court" means the probate division of the court of 19516
common pleas. 19517

Sec. 5123.021. (A) As used in this section, "mentally 19518
retarded individual" and "specialized services" have the same 19519
meanings as in section ~~5111.202~~ 5164.45 of the Revised Code. 19520

(B)(1) Except as provided in division (B)(2) of this section 19521
and rules adopted under division (E)(3) of this section, for 19522
purposes of section ~~5111.202~~ 5164.41 of the Revised Code, the 19523
department of mental retardation and developmental disabilities 19524
shall determine in accordance with ~~section 1919(e)(7) of the~~ 19525
~~"Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as~~ 19526
~~amended, 1396r(e)(7) and regulations adopted under section~~ 19527
~~1919(f)(8)(A) of that act~~ 42 U.S.C. 1396r(f)(8)(A) whether, 19528
because of the individual's physical and mental condition, a 19529
mentally retarded individual seeking admission to a nursing 19530
facility requires the level of services provided by a nursing 19531
facility and, if the individual requires that level of services, 19532
whether the individual requires specialized services for mental 19533
retardation. 19534

(2) A determination under this division is not required for 19535
any of the following: 19536

(a) An individual seeking readmission to a nursing facility 19537

after having been transferred from a nursing facility to a hospital for care; 19538
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(b) An individual who meets all of the following conditions: 19540

(i) The individual is admitted to the nursing facility directly from a hospital after receiving inpatient care at the hospital; 19541
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(ii) The individual requires nursing facility services for the condition for which the individual received care in the hospital; 19544
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(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. 19547
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(c) An individual transferred from one nursing facility to another nursing facility, with or without an intervening hospital stay. 19551
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(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. 19554
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(D)(1) In the case of a nursing facility resident who has 19568

continuously resided in a nursing facility for at least thirty 19569
months before the date of a review and determination under 19570
division (C) of this section, if the resident is determined not to 19571
require the level of services provided by a nursing facility, but 19572
is determined to require specialized services for mental 19573
retardation, the department, in consultation with the resident's 19574
family or legal representative and care givers, shall do all of 19575
the following: 19576

(a) Inform the resident of the institutional and 19577
noninstitutional alternatives covered under the state medicaid 19578
plan ~~for medical assistance~~; 19579

(b) Offer the resident the choice of remaining in the nursing 19580
facility or receiving covered services in an alternative 19581
institutional or noninstitutional setting; 19582

(c) Clarify the effect on eligibility for services under the 19583
state medicaid plan ~~for medical assistance~~ if the resident chooses 19584
to leave the facility, including its effect on readmission to the 19585
facility; 19586

(d) Provide for or arrange for the provision of specialized 19587
services for the resident's mental retardation in the setting 19588
chosen by the resident. 19589

(2) In the case of a nursing facility resident who has 19590
continuously resided in a nursing facility for less than thirty 19591
months before the date of the review and determination under 19592
division (C) of this section, if the resident is determined not to 19593
require the level of services provided by a nursing facility, but 19594
is determined to require specialized services for mental 19595
retardation, or if the resident is determined to require neither 19596
the level of services provided by a nursing facility nor 19597
specialized services for mental retardation, the department shall 19598
act in accordance with its alternative disposition plan approved 19599

by the United States department of health and human services under 19600
section 1919(e)(7)(E) of the "Social Security Act." 19601

(3) In the case of an individual who is determined under 19602
division (B) or (C) of this section to require both the level of 19603
services provided by a nursing facility and specialized services 19604
for mental retardation, the department of mental retardation and 19605
developmental disabilities shall provide or arrange for the 19606
provision of the specialized services needed by the individual or 19607
resident while residing in a nursing facility. 19608

(E) The department of mental retardation and developmental 19609
disabilities shall adopt rules in accordance with Chapter 119. of 19610
the Revised Code that do all of the following: 19611

(1) Establish criteria to be used in making the 19612
determinations required by divisions (B) and (C) of this section. 19613
The criteria shall not exceed the criteria established by 19614
regulations adopted by the United States department of health and 19615
human services under section 1919(f)(8)(A) of the "Social Security 19616
Act." 19617

(2) Specify information to be provided by the individual or 19618
nursing facility resident being assessed; 19619

(3) Specify any circumstances, in addition to circumstances 19620
listed in division (B) of this section, under which determinations 19621
under divisions (B) and (C) of this section are not required to be 19622
made. 19623

Sec. 5123.0412. (A) The department of mental retardation and 19624
developmental disabilities shall charge each county board of 19625
mental retardation and developmental disabilities an annual fee 19626
equal to one and one-half per cent of the total value of all 19627
medicaid paid claims for medicaid case management services and 19628
home and community-based services provided during the year to an 19629

individual eligible for services from the county board. No county 19630
board shall pass the cost of a fee charged to the county board 19631
under this section on to another provider of these services. 19632

(B) The fees collected under this section shall be deposited 19633
into the ODMR/DD administration and oversight fund and the ~~ODJFS~~ 19634
ODHCA administration and oversight fund, both of which are hereby 19635
created in the state treasury. The portion of the fees to be 19636
deposited into the ODMR/DD administration and oversight fund and 19637
the portion of the fees to be deposited into the ~~ODJFS~~ ODHCA 19638
administration and oversight fund shall be the portion specified 19639
in an interagency agreement entered into under division (C) of 19640
this section. The department of mental retardation and 19641
developmental disabilities shall use the money in the ODMR/DD 19642
administration and oversight fund and the department of ~~job and~~ 19643
~~family services~~ health care administration shall use the money in 19644
the ~~ODJFS~~ ODHCA administration and oversight fund for both of the 19645
following purposes: 19646

(1) The administrative and oversight costs of medicaid case 19647
management services and home and community-based services. The 19648
administrative and oversight costs shall include costs for staff, 19649
systems, and other resources the departments need and dedicate 19650
solely to the following duties associated with the services: 19651

- (a) Eligibility determinations; 19652
- (b) Training; 19653
- (c) Fiscal management; 19654
- (d) Claims processing; 19655
- (e) Quality assurance oversight; 19656
- (f) Other duties the departments identify. 19657

(2) Providing technical support to county boards' local 19658
administrative authority under section 5126.055 of the Revised 19659

Code for the services. 19660

(C) The departments of mental retardation and developmental 19661
disabilities and ~~job and family services~~ health care 19662
administration shall enter into an interagency agreement to do 19663
both of the following: 19664

(1) Specify which portion of the fees collected under this 19665
section is to be deposited into the ODMR/DD administration and 19666
oversight fund and which portion is to be deposited into the ~~ODJFS~~ 19667
ODHCA administration and oversight fund; 19668

(2) Provide for the departments to coordinate the staff whose 19669
costs are paid for with money in the ODMR/DD administration and 19670
oversight fund and the ~~ODJFS~~ ODHCA administration and oversight 19671
fund. 19672

(D) The departments shall submit an annual report to the 19673
director of budget and management certifying how the departments 19674
spent the money in the ODMR/DD administration and oversight fund 19675
and the ~~ODJFS~~ ODHCA administration and oversight fund for the 19676
purposes specified in division (B) of this section. 19677

Sec. 5123.171. As used in this section, "respite care" means 19678
appropriate, short-term, temporary care provided to a mentally 19679
retarded or developmentally disabled person to sustain the family 19680
structure or to meet planned or emergency needs of the family. 19681

The department of mental retardation and developmental 19682
disabilities shall provide respite care services to persons with 19683
mental retardation or a developmental disability for the purpose 19684
of promoting self-sufficiency and normalization, preventing or 19685
reducing inappropriate institutional care, and furthering the 19686
unity of the family by enabling the family to meet the special 19687
needs of a mentally retarded or developmentally disabled person. 19688

In order to be eligible for respite care services under this 19689

section, the mentally retarded or developmentally disabled person 19690
must be in need of habilitation services as defined in section 19691
5126.01 of the Revised Code. 19692

Respite care may be provided in a facility licensed under 19693
section 5123.19 of the Revised Code or certified as an 19694
intermediate care facility for the mentally retarded under ~~Title~~ 19695
~~XIX of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.~~ 19696
~~301, as amended,~~ medicaid program or certified as a respite care 19697
home under section 5126.05 of the Revised Code. 19698

The department shall develop a system for locating vacant 19699
beds that are available for respite care and for making 19700
information on vacant beds available to users of respite care 19701
services. Facilities certified as intermediate care facilities for 19702
the mentally retarded and facilities holding contracts with the 19703
department for the provision of residential services under section 19704
5123.18 of the Revised Code shall report vacant beds to the 19705
department but shall not be required to accept respite care 19706
clients. 19707

The director of mental retardation and developmental 19708
disabilities shall adopt, and may amend or rescind, rules in 19709
accordance with Chapter 119. of the Revised Code for both of the 19710
following: 19711

(A) Certification by county boards of mental retardation and 19712
developmental disabilities of respite care homes; 19713

(B) Provision of respite care services authorized by this 19714
section. Rules adopted under this division shall establish all of 19715
the following: 19716

(1) A formula for distributing funds appropriated for respite 19717
care services; 19718

(2) Standards for supervision, training and quality control 19719
in the provision of respite care services; 19720

(3) Eligibility criteria for emergency respite care services. 19721

Sec. 5123.181. The director of mental retardation and 19722
developmental disabilities and the director of ~~job and family~~ 19723
~~services~~ health care administration shall, in concert with each 19724
other, eliminate all double billings and double payments for 19725
services on behalf of persons with mental retardation or another 19726
developmental disability in intermediate care facilities. The 19727
department of mental retardation and developmental disabilities 19728
may enter into contracts with providers of services for the 19729
purpose of making payments to the providers for services rendered 19730
to eligible clients who are persons with mental retardation or a 19731
developmental disability over and above the services authorized 19732
and paid under ~~Chapter 5111. of the Revised Code~~ medicaid program. 19733
Payments authorized under this section and section 5123.18 of the 19734
Revised Code shall not be subject to audit findings ~~pursuant to~~ 19735
~~Chapter 5111. of~~ under the ~~Revised Code~~ medicaid program, unless 19736
an audit determines that payment was made to the provider for 19737
services that were not rendered in accordance with the provisions 19738
of the provider agreement entered into with the department of ~~job~~ 19739
~~and family services~~ health care administration or the department 19740
of mental retardation and developmental disabilities pursuant to 19741
this section. 19742

Sec. 5123.19. (A) As used in this section and in sections 19743
5123.191, 5123.194, 5123.196, 5123.198, and 5123.20 of the Revised 19744
Code: 19745

(1)(a) "Residential facility" means a home or facility in 19746
which a mentally retarded or developmentally disabled person 19747
resides, except the home of a relative or legal guardian in which 19748
a mentally retarded or developmentally disabled person resides, a 19749
respite care home certified under section 5126.05 of the Revised 19750
Code, a county home or district home operated pursuant to Chapter 19751

5155. of the Revised Code, or a dwelling in which the only 19752
mentally retarded or developmentally disabled residents are in an 19753
independent living arrangement or are being provided supported 19754
living. 19755

(b) "Intermediate care facility for the mentally retarded" 19756
means a residential facility that is considered an intermediate 19757
care facility for the mentally retarded for the purposes of 19758
~~Chapter 5111. of the Revised Code~~ medicaid program. 19759

(2) "Political subdivision" means a municipal corporation, 19760
county, or township. 19761

(3) "Independent living arrangement" means an arrangement in 19762
which a mentally retarded or developmentally disabled person 19763
resides in an individualized setting chosen by the person or the 19764
person's guardian, which is not dedicated principally to the 19765
provision of residential services for mentally retarded or 19766
developmentally disabled persons, and for which no financial 19767
support is received for rendering such service from any 19768
governmental agency by a provider of residential services. 19769

(4) "Supported living" has the same meaning as in section 19770
5126.01 of the Revised Code. 19771

(5) "Licensee" means the person or government agency that has 19772
applied for a license to operate a residential facility and to 19773
which the license was issued under this section. 19774

(B) Every person or government agency desiring to operate a 19775
residential facility shall apply for licensure of the facility to 19776
the director of mental retardation and developmental disabilities 19777
unless the residential facility is subject to section 3721.02, 19778
3722.04, 5103.03, or 5119.20 of the Revised Code. Notwithstanding 19779
Chapter 3721. of the Revised Code, a nursing home that is 19780
certified as an intermediate care facility for the mentally 19781
retarded under ~~Title XIX of the "Social Security Act," 79 Stat.~~ 19782

~~286 (1965), 42 U.S.C.A. 1396, as amended, medicaid program~~ shall 19783
apply for licensure of the portion of the home that is certified 19784
as an intermediate care facility for the mentally retarded. 19785

(C) Subject to section 5123.196 of the Revised Code, the 19786
director of mental retardation and developmental disabilities 19787
shall license the operation of residential facilities. An initial 19788
license shall be issued for a period that does not exceed one 19789
year, unless the director denies the license under division (D) of 19790
this section. A license shall be renewed for a period that does 19791
not exceed three years, unless the director refuses to renew the 19792
license under division (D) of this section. The director, when 19793
issuing or renewing a license, shall specify the period for which 19794
the license is being issued or renewed. A license remains valid 19795
for the length of the licensing period specified by the director, 19796
unless the license is terminated, revoked, or voluntarily 19797
surrendered. 19798

(D) If it is determined that an applicant or licensee is not 19799
in compliance with a provision of this chapter that applies to 19800
residential facilities or the rules adopted under such a 19801
provision, the director may deny issuance of a license, refuse to 19802
renew a license, terminate a license, revoke a license, issue an 19803
order for the suspension of admissions to a facility, issue an 19804
order for the placement of a monitor at a facility, issue an order 19805
for the immediate removal of residents, or take any other action 19806
the director considers necessary consistent with the director's 19807
authority under this chapter regarding residential facilities. In 19808
the director's selection and administration of the sanction to be 19809
imposed, all of the following apply: 19810

(1) The director may deny, refuse to renew, or revoke a 19811
license, if the director determines that the applicant or licensee 19812
has demonstrated a pattern of serious noncompliance or that a 19813
violation creates a substantial risk to the health and safety of 19814

residents of a residential facility. 19815

(2) The director may terminate a license if more than twelve 19816
consecutive months have elapsed since the residential facility was 19817
last occupied by a resident or a notice required by division (J) 19818
of this section is not given. 19819

(3) The director may issue an order for the suspension of 19820
admissions to a facility for any violation that may result in 19821
sanctions under division (D)(1) of this section and for any other 19822
violation specified in rules adopted under division (G)(2) of this 19823
section. If the suspension of admissions is imposed for a 19824
violation that may result in sanctions under division (D)(1) of 19825
this section, the director may impose the suspension before 19826
providing an opportunity for an adjudication under Chapter 119. of 19827
the Revised Code. The director shall lift an order for the 19828
suspension of admissions when the director determines that the 19829
violation that formed the basis for the order has been corrected. 19830

(4) The director may order the placement of a monitor at a 19831
residential facility for any violation specified in rules adopted 19832
under division (G)(2) of this section. The director shall lift the 19833
order when the director determines that the violation that formed 19834
the basis for the order has been corrected. 19835

(5) If the director determines that two or more residential 19836
facilities owned or operated by the same person or government 19837
entity are not being operated in compliance with a provision of 19838
this chapter that applies to residential facilities or the rules 19839
adopted under such a provision, and the director's findings are 19840
based on the same or a substantially similar action, practice, 19841
circumstance, or incident that creates a substantial risk to the 19842
health and safety of the residents, the director shall conduct a 19843
survey as soon as practicable at each residential facility owned 19844
or operated by that person or government entity. The director may 19845
take any action authorized by this section with respect to any 19846

facility found to be operating in violation of a provision of this 19847
chapter that applies to residential facilities or the rules 19848
adopted under such a provision. 19849

(6) When the director initiates license revocation 19850
proceedings, no opportunity for submitting a plan of correction 19851
shall be given. The director shall notify the licensee by letter 19852
of the initiation of the proceedings. The letter shall list the 19853
deficiencies of the residential facility and inform the licensee 19854
that no plan of correction will be accepted. The director shall 19855
also notify each affected resident, the resident's guardian if the 19856
resident is an adult for whom a guardian has been appointed, the 19857
resident's parent or guardian if the resident is a minor, and the 19858
county board of mental retardation and developmental disabilities. 19859

(7) Pursuant to rules which shall be adopted in accordance 19860
with Chapter 119. of the Revised Code, the director may order the 19861
immediate removal of residents from a residential facility 19862
whenever conditions at the facility present an immediate danger of 19863
physical or psychological harm to the residents. 19864

(8) In determining whether a residential facility is being 19865
operated in compliance with a provision of this chapter that 19866
applies to residential facilities or the rules adopted under such 19867
a provision, or whether conditions at a residential facility 19868
present an immediate danger of physical or psychological harm to 19869
the residents, the director may rely on information obtained by a 19870
county board of mental retardation and developmental disabilities 19871
or other governmental agencies. 19872

(9) In proceedings initiated to deny, refuse to renew, or 19873
revoke licenses, the director may deny, refuse to renew, or revoke 19874
a license regardless of whether some or all of the deficiencies 19875
that prompted the proceedings have been corrected at the time of 19876
the hearing. 19877

(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. 19910

(c) After commencing, the hearing shall continue 19911
uninterrupted, except for Saturdays, Sundays, and legal holidays, 19912
unless other interruptions are agreed to by the licensee and the 19913
director. 19914

(d) If the hearing is conducted by a hearing examiner, the 19915
hearing examiner shall file a report and recommendations not later 19916
than ten days after the close of the hearing. 19917

(e) Not later than five days after the hearing examiner files 19918
the report and recommendations, the licensee may file objections 19919
to the report and recommendations. 19920

(f) Not later than fifteen days after the hearing examiner 19921
files the report and recommendations, the director shall issue an 19922
order approving, modifying, or disapproving the report and 19923
recommendations. 19924

(g) Notwithstanding the pendency of the hearing, the director 19925
shall lift the order for the suspension of admissions when the 19926
director determines that the violation that formed the basis for 19927
the order has been corrected. 19928

(G) In accordance with Chapter 119. of the Revised Code, the 19929
director shall adopt and may amend and rescind rules for licensing 19930
and regulating the operation of residential facilities, including 19931
intermediate care facilities for the mentally retarded. The rules 19932
for intermediate care facilities for the mentally retarded may 19933
differ from those for other residential facilities. The rules 19934
shall establish and specify the following: 19935

(1) Procedures and criteria for issuing and renewing 19936
licenses, including procedures and criteria for determining the 19937
length of the licensing period that the director must specify for 19938
each license when it is issued or renewed; 19939

(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;	19940 19941 19942 19943
(3) Fees for issuing and renewing licenses;	19944
(4) Procedures for surveying residential facilities;	19945
(5) Requirements for the training of residential facility personnel;	19946 19947
(6) Classifications for the various types of residential facilities;	19948 19949
(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;	19950 19951 19952 19953
(8) The maximum number of persons who may be served in a particular type of residential facility;	19954 19955
(9) Uniform procedures for admission of persons to and transfers and discharges of persons from residential facilities;	19956 19957
(10) Other standards for the operation of residential facilities and the services provided at residential facilities;	19958 19959
(11) Procedures for waiving any provision of any rule adopted under this section.	19960 19961
(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	19962 19963 19964 19965 19966 19967 19968 19969

services provided there. 19970

In conducting surveys, the director or the director's 19971
designee shall be given access to the residential facility; all 19972
records, accounts, and any other documents related to the 19973
operation of the facility; the licensee; the residents of the 19974
facility; and all persons acting on behalf of, under the control 19975
of, or in connection with the licensee. The licensee and all 19976
persons on behalf of, under the control of, or in connection with 19977
the licensee shall cooperate with the director or the director's 19978
designee in conducting the survey. 19979

Following each survey, unless the director initiates a 19980
license revocation proceeding, the director or the director's 19981
designee shall provide the licensee with a report listing any 19982
deficiencies, specifying a timetable within which the licensee 19983
shall submit a plan of correction describing how the deficiencies 19984
will be corrected, and, when appropriate, specifying a timetable 19985
within which the licensee must correct the deficiencies. After a 19986
plan of correction is submitted, the director or the director's 19987
designee shall approve or disapprove the plan. A copy of the 19988
report and any approved plan of correction shall be provided to 19989
any person who requests it. 19990

The director shall initiate disciplinary action against any 19991
department employee who notifies or causes the notification to any 19992
unauthorized person of an unannounced survey of a residential 19993
facility by an authorized representative of the department. 19994

(I) In addition to any other information which may be 19995
required of applicants for a license pursuant to this section, the 19996
director shall require each applicant to provide a copy of an 19997
approved plan for a proposed residential facility pursuant to 19998
section 5123.042 of the Revised Code. This division does not apply 19999
to renewal of a license. 20000

(J) A licensee shall notify the owner of the building in 20001
which the licensee's residential facility is located of any 20002
significant change in the identity of the licensee or management 20003
contractor before the effective date of the change if the licensee 20004
is not the owner of the building. 20005

Pursuant to rules which shall be adopted in accordance with 20006
Chapter 119. of the Revised Code, the director may require 20007
notification to the department of any significant change in the 20008
ownership of a residential facility or in the identity of the 20009
licensee or management contractor. If the director determines that 20010
a significant change of ownership is proposed, the director shall 20011
consider the proposed change to be an application for development 20012
by a new operator pursuant to section 5123.042 of the Revised Code 20013
and shall advise the applicant within sixty days of the 20014
notification that the current license shall continue in effect or 20015
a new license will be required pursuant to this section. If the 20016
director requires a new license, the director shall permit the 20017
facility to continue to operate under the current license until 20018
the new license is issued, unless the current license is revoked, 20019
refused to be renewed, or terminated in accordance with Chapter 20020
119. of the Revised Code. 20021

(K) A county board of mental retardation and developmental 20022
disabilities, the legal rights service, and any interested person 20023
may file complaints alleging violations of statute or department 20024
rule relating to residential facilities with the department. All 20025
complaints shall be in writing and shall state the facts 20026
constituting the basis of the allegation. The department shall not 20027
reveal the source of any complaint unless the complainant agrees 20028
in writing to waive the right to confidentiality or until so 20029
ordered by a court of competent jurisdiction. 20030

The department shall adopt rules in accordance with Chapter 20031
119. of the Revised Code establishing procedures for the receipt, 20032

referral, investigation, and disposition of complaints filed with 20033
the department under this division. 20034

(L) The department shall establish procedures for the 20035
notification of interested parties of the transfer or interim care 20036
of residents from residential facilities that are closing or are 20037
losing their license. 20038

(M) Before issuing a license under this section to a 20039
residential facility that will accommodate at any time more than 20040
one mentally retarded or developmentally disabled individual, the 20041
director shall, by first class mail, notify the following: 20042

(1) If the facility will be located in a municipal 20043
corporation, the clerk of the legislative authority of the 20044
municipal corporation; 20045

(2) If the facility will be located in unincorporated 20046
territory, the clerk of the appropriate board of county 20047
commissioners and the fiscal officer of the appropriate board of 20048
township trustees. 20049

The director shall not issue the license for ten days after 20050
mailing the notice, excluding Saturdays, Sundays, and legal 20051
holidays, in order to give the notified local officials time in 20052
which to comment on the proposed issuance. 20053

Any legislative authority of a municipal corporation, board 20054
of county commissioners, or board of township trustees that 20055
receives notice under this division of the proposed issuance of a 20056
license for a residential facility may comment on it in writing to 20057
the director within ten days after the director mailed the notice, 20058
excluding Saturdays, Sundays, and legal holidays. If the director 20059
receives written comments from any notified officials within the 20060
specified time, the director shall make written findings 20061
concerning the comments and the director's decision on the 20062
issuance of the license. If the director does not receive written 20063

comments from any notified local officials within the specified 20064
time, the director shall continue the process for issuance of the 20065
license. 20066

(N) Any person may operate a licensed residential facility 20067
that provides room and board, personal care, habilitation 20068
services, and supervision in a family setting for at least six but 20069
not more than eight persons with mental retardation or a 20070
developmental disability as a permitted use in any residential 20071
district or zone, including any single-family residential district 20072
or zone, of any political subdivision. These residential 20073
facilities may be required to comply with area, height, yard, and 20074
architectural compatibility requirements that are uniformly 20075
imposed upon all single-family residences within the district or 20076
zone. 20077

(O) Any person may operate a licensed residential facility 20078
that provides room and board, personal care, habilitation 20079
services, and supervision in a family setting for at least nine 20080
but not more than sixteen persons with mental retardation or a 20081
developmental disability as a permitted use in any multiple-family 20082
residential district or zone of any political subdivision, except 20083
that a political subdivision that has enacted a zoning ordinance 20084
or resolution establishing planned unit development districts may 20085
exclude these residential facilities from those districts, and a 20086
political subdivision that has enacted a zoning ordinance or 20087
resolution may regulate these residential facilities in 20088
multiple-family residential districts or zones as a conditionally 20089
permitted use or special exception, in either case, under 20090
reasonable and specific standards and conditions set out in the 20091
zoning ordinance or resolution to: 20092

(1) Require the architectural design and site layout of the 20093
residential facility and the location, nature, and height of any 20094
walls, screens, and fences to be compatible with adjoining land 20095

uses and the residential character of the neighborhood; 20096

(2) Require compliance with yard, parking, and sign 20097
regulation; 20098

(3) Limit excessive concentration of these residential 20099
facilities. 20100

(P) This section does not prohibit a political subdivision 20101
from applying to residential facilities nondiscriminatory 20102
regulations requiring compliance with health, fire, and safety 20103
regulations and building standards and regulations. 20104

(Q) Divisions (N) and (O) of this section are not applicable 20105
to municipal corporations that had in effect on June 15, 1977, an 20106
ordinance specifically permitting in residential zones licensed 20107
residential facilities by means of permitted uses, conditional 20108
uses, or special exception, so long as such ordinance remains in 20109
effect without any substantive modification. 20110

(R)(1) The director may issue an interim license to operate a 20111
residential facility to an applicant for a license under this 20112
section if either of the following is the case: 20113

(a) The director determines that an emergency exists 20114
requiring immediate placement of persons in a residential 20115
facility, that insufficient licensed beds are available, and that 20116
the residential facility is likely to receive a permanent license 20117
under this section within thirty days after issuance of the 20118
interim license. 20119

(b) The director determines that the issuance of an interim 20120
license is necessary to meet a temporary need for a residential 20121
facility. 20122

(2) To be eligible to receive an interim license, an 20123
applicant must meet the same criteria that must be met to receive 20124
a permanent license under this section, except for any differing 20125

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. 20157

Sec. 5123.192. Notwithstanding section 5123.19 of the Revised 20158
Code, any nursing home that on June 30, 1987, contained beds that 20159
the department of health had certified prior to June 30, 1987, as 20160
intermediate care facility for the mentally retarded beds under 20161
~~Title XIX of the "Social Security Act," 49 Stat. 620 (1935), 42~~ 20162
~~U.S.C. 301, as amended,~~ medicaid program or any nursing home that 20163
on June 30, 1987, had an application pending before the department 20164
to convert intermediate care facility beds to intermediate care 20165
facility for the mentally retarded beds, shall not be required to 20166
apply for licensure under section 5123.19 of the Revised Code, 20167
shall be subject to the requirements for licensure as a nursing 20168
home and all other requirements of Chapter 3721. of the Revised 20169
Code and any rules adopted under that chapter, and shall be 20170
subject to sections 3702.51 to 3702.62 of the Revised Code and any 20171
rules adopted under those sections, unless either of the following 20172
applies: 20173

(A) The nursing home's certification or provider agreement as 20174
an intermediate care facility for the mentally retarded is subject 20175
to a final order of nonrenewal or termination with respect to 20176
which all appeal rights have been exhausted and the facility 20177
intends to apply for recertification; 20178

(B) The nursing home intends to increase its number of beds 20179
certified as intermediate care facility for the mentally retarded 20180
beds. In such a case, the nursing home shall be required to apply 20181
for licensure of the additional beds under section 5123.19 of the 20182
Revised Code. 20183

Sec. 5123.196. (A) Except as provided in division (F) of this 20184
section, the director of mental retardation and developmental 20185
disabilities shall not issue a license under section 5123.19 of 20186

the Revised Code on or after July 1, 2003, if issuance will result 20187
in there being more beds in all residential facilities licensed 20188
under that section than is permitted under division (B) of this 20189
section. 20190

(B) Except as provided in division (D) of this section, the 20191
maximum number of beds for the purpose of division (A) of this 20192
section shall not exceed ten thousand eight hundred thirty-eight 20193
minus, except as provided in division (C) of this section, both of 20194
the following: 20195

(1) The number of such beds that cease to be residential 20196
facility beds on or after July 1, 2003, because a residential 20197
facility license is revoked, terminated, or not renewed for any 20198
reason or is surrendered in accordance with section 5123.19 of the 20199
Revised Code and after the issuance of an adjudication order 20200
pursuant to Chapter 119. of the Revised Code; 20201

(2) The number of such beds for which a licensee voluntarily 20202
converts to use for supported living on or after July 1, 2003. 20203

(C) The director is not required to reduce the maximum number 20204
of beds pursuant to division (B) of this section by a bed that 20205
ceases to be a residential facility bed if the director determines 20206
that the bed is needed to provide services to an individual with 20207
mental retardation or a developmental disability who resided in 20208
the residential facility in which the bed was located unless the 20209
reason the bed ceases to be a residential facility bed is because 20210
it is converted to providing home and community-based services 20211
under the ICF/MR conversion pilot program that is authorized by a 20212
waiver sought under division (B)(1) of section ~~5111.88~~ 5163.66 of 20213
the Revised Code. 20214

(D) The director shall increase the number of beds determined 20215
under division (B) of this section if necessary to enable the 20216
operator of a residential facility to do either of the following: 20217

(1) Obtain a residential facility license as required by 20218
section ~~5111.8814~~ 5163.6614 of the Revised Code; 20219

(2) Reconvert beds to providing ICF/MR services under section 20220
~~5111.8811~~ 5163.6611 of the Revised Code. 20221

(E) The director shall maintain an up-to-date written record 20222
of the maximum number of residential facility beds provided for by 20223
division (B) of this section. 20224

(F) The director may issue an interim license under division 20225
(R) of section 5123.19 of the Revised Code and issue, pursuant to 20226
rules adopted under division (G)(11) of that section, a waiver 20227
allowing a residential facility to admit more residents than the 20228
facility is licensed to admit regardless of whether the interim 20229
license or waiver will result in there being more beds in all 20230
residential facilities licensed under that section than is 20231
permitted under division (B) of this section. 20232

Sec. 5123.198. (A) As used in this section, "date of the 20233
commitment" means the date that an individual specified in 20234
division (B) of this section begins to reside in a state-operated 20235
intermediate care facility for the mentally retarded after being 20236
committed to the facility pursuant to sections 5123.71 to 5123.76 20237
of the Revised Code. 20238

(B) Except as provided in division (C) of this section, 20239
whenever a resident of a residential facility is committed to a 20240
state-operated intermediate care facility for the mentally 20241
retarded pursuant to sections 5123.71 to 5123.76 of the Revised 20242
Code, the department of mental retardation and developmental 20243
disabilities, pursuant to an adjudication order issued in 20244
accordance with Chapter 119. of the Revised Code, shall reduce by 20245
one the number of residents for which the facility in which the 20246
resident resided is licensed. 20247

(C) The department shall not reduce under division (B) of 20248
this section the number of residents for which a residential 20249
facility is licensed if any of the following are the case: 20250

(1) The resident of the residential facility who is committed 20251
to a state-operated intermediate care facility for the mentally 20252
retarded resided in the residential facility because of the 20253
closure, on or after ~~the effective date of this section~~ June 26, 20254
2003, of another state-operated intermediate care facility for the 20255
mentally retarded; 20256

(2) The residential facility admits within ninety days of the 20257
date of the commitment an individual who resides on the date of 20258
the commitment in a state-operated intermediate care facility for 20259
the mentally retarded or another residential facility; 20260

(3) The department fails to do either of the following within 20261
ninety days of the date of the commitment: 20262

(a) Identify an individual to whom all of the following 20263
applies: 20264

(i) Resides on the date of the commitment in a state-operated 20265
intermediate care facility for the mentally retarded or another 20266
residential facility; 20267

(ii) Has indicated to the department an interest in 20268
relocating to the residential facility or has a parent or guardian 20269
who has indicated to the department an interest for the individual 20270
to relocate to the residential facility; 20271

(iii) The department determines the individual has needs that 20272
the residential facility can meet. 20273

(b) Provide the residential facility with information about 20274
the individual identified under division (C)(2)(a) of this section 20275
that the residential facility needs in order to determine whether 20276
the facility can meet the individual's needs. 20277

(4) If the department completes the actions specified in 20278
divisions (C)(3)(a) and (b) of this section not later than ninety 20279
days after the date of the commitment and except as provided in 20280
division (D) of this section, the residential facility does all of 20281
the following not later than ninety days after the date of the 20282
commitment: 20283

(a) Evaluates the information provided by the department; 20284

(b) Assesses the identified individual's needs; 20285

(c) Determines that the residential facility cannot meet the 20286
identified individual's needs. 20287

(5) If the department completes the actions specified in 20288
divisions (C)(3)(a) and (b) of this section not later than ninety 20289
days after the date of the commitment and the residential facility 20290
determines that the residential facility can meet the identified 20291
individual's needs, the individual, or a parent or guardian of the 20292
individual, refuses placement in the residential facility. 20293

(D) The department may reduce under division (B) of this 20294
section the number of residents for which a residential facility 20295
is licensed even though the residential facility completes the 20296
actions specified in division (C)(4) of this section not later 20297
than ninety days after the date of the commitment if all of the 20298
following are the case: 20299

(1) The department disagrees with the residential facility's 20300
determination that the residential facility cannot meet the 20301
identified individual's needs. 20302

(2) The department issues a written decision pursuant to the 20303
uniform procedures for admissions, transfers, and discharges 20304
established by rules adopted under division (G)(9) of section 20305
5123.19 of the Revised Code that the residential facility should 20306
admit the identified individual. 20307

(3) After the department issues the written decision 20308
specified in division (D)(2) of this section, the residential 20309
facility refuses to admit the identified individual. 20310

(E) A residential facility that admits, refuses to admit, 20311
transfers, or discharges a resident under this section shall 20312
comply with the uniform procedures for admissions, transfers, and 20313
discharges established by rules adopted under division (G)(9) of 20314
section 5123.19 of the Revised Code. 20315

(F) The department of mental retardation and developmental 20316
disabilities may notify the department of ~~job and family services~~ 20317
health care administration of any reduction under this section in 20318
the number of residents for which a residential facility that is 20319
an intermediate care facility for the mentally retarded is 20320
licensed. On receiving the notice, the department of ~~job and~~ 20321
~~family services~~ health care administration may transfer to the 20322
department of mental retardation and developmental disabilities 20323
the savings in the nonfederal share of medicaid expenditures for 20324
each fiscal year after the year of the commitment to be used for 20325
costs of the resident's care in the state-operated intermediate 20326
care facility for the mentally retarded. In determining the amount 20327
saved, the department of ~~job and family services~~ health care 20328
administration shall consider medicaid payments for the remaining 20329
residents of the facility in which the resident resided. 20330

Sec. 5123.199. (A) As used in this section: 20331

(1) "Contractor" means a person or government agency that has 20332
entered into a contract with the department of mental retardation 20333
and developmental disabilities under this section. 20334

(2) "Government agency" and "residential services" have the 20335
same meanings as in section 5123.18 of the Revised Code. 20336

(3) "Intermediate care facility for the mentally retarded" 20337

has the same meaning as in section ~~5111.20~~ 5164.01 of the Revised Code. 20338
20339

(4) "Respite care services" has the same meaning as in 20340
section 5123.171 of the Revised Code. 20341

(B) The department of mental retardation and developmental 20342
disabilities may enter into a contract with a person or government 20343
agency to do any of the following: 20344

(1) Provide residential services in an intermediate care 20345
facility for the mentally retarded to an individual who meets the 20346
criteria for admission to such a facility but is not eligible for 20347
~~assistance under Chapter 5111. of the Revised Code~~ medicaid due to 20348
unliquidated assets subject to final probate action; 20349

(2) Provide respite care services in an intermediate care 20350
facility for the mentally retarded; 20351

(3) Provide residential services in a facility for which the 20352
person or government agency has applied for, but has not received, 20353
certification and payment as an intermediate care facility for the 20354
mentally retarded if the person or government agency is making a 20355
good faith effort to bring the facility into compliance with 20356
requirements for certification and payment as an intermediate care 20357
facility for the mentally retarded. In assigning payment amounts 20358
to such contracts, the department shall take into account costs 20359
incurred in attempting to meet certification requirements. 20360

(4) Reimburse an intermediate care facility for the mentally 20361
retarded for costs not otherwise reimbursed under ~~Chapter 5111. of~~ 20362
~~the Revised Code~~ the medicaid program for clothing for individuals 20363
who are mentally retarded or developmentally disabled. 20364
Reimbursement under such contracts shall not exceed a maximum 20365
amount per individual per year specified in rules that the 20366
department shall adopt in accordance with Chapter 119. of the 20367
Revised Code. 20368

(C) The amount paid to a contractor under divisions (B)(1) to 20369
(3) of this section shall not exceed the reimbursement that would 20370
be made under ~~Chapter 5111. of the Revised Code~~ the medicaid 20371
program by the department of ~~job and family services~~ health care 20372
administration for the same goods and services. 20373

(D) The department of mental retardation and developmental 20374
disabilities shall adopt rules as necessary to implement this 20375
section, including rules establishing standards and procedures for 20376
the submission of cost reports by contractors and the department's 20377
conduct of audits and reconciliations regarding the contracts. The 20378
rules shall be adopted in accordance with Chapter 119. of the 20379
Revised Code. 20380

Sec. 5123.211. (A) As used in this section, "residential 20381
services" and "supported living" have the same meanings as in 20382
section 5126.01 of the Revised Code. 20383

(B) The department of mental retardation and developmental 20384
disabilities shall provide or arrange provision of residential 20385
services for each person who, on or after July 1, 1989, ceases to 20386
be a resident of a state institution because of closure of the 20387
institution or a reduction in the institution's population by 20388
forty per cent or more within a period of one year. The services 20389
shall be provided in the county in which the person chooses to 20390
reside and shall consist of one of the following as determined 20391
appropriate by the department in consultation with the county 20392
board of mental retardation and developmental disabilities of the 20393
county in which the services are to be provided: 20394

(1) Residential services provided pursuant to section 5123.18 20395
of the Revised Code; 20396

(2) Supported living provided pursuant to section 5123.182 of 20397
the Revised Code; 20398

(3) Residential services for which reimbursement is made 20399
under the ~~medical assistance~~ medicaid program ~~established under~~ 20400
~~section 5111.01 of the Revised Code;~~ 20401

(4) Residential services provided in a manner or setting 20402
approved by the director of mental retardation and developmental 20403
disabilities. 20404

(C) Not less than six months prior to closing a state 20405
institution or reducing a state institution's population by forty 20406
per cent or more within a period of one year, the department shall 20407
identify those counties in which individuals leaving the 20408
institution have chosen to reside and notify the county boards of 20409
mental retardation and developmental disabilities in those 20410
counties of the need to develop the services specified in division 20411
(B) of this section. The notice shall specify the number of 20412
individuals requiring services who plan to reside in the county 20413
and indicate the amount of funds the department will use to 20414
provide or arrange services for those individuals. 20415

(D) In each county in which one or more persons receive 20416
residential services pursuant to division (B) of this section, the 20417
department shall provide or arrange provision of residential 20418
services, or shall distribute moneys to the county board of mental 20419
retardation and developmental disabilities to provide or arrange 20420
provision of residential services, for an equal number of persons 20421
with mental retardation or developmental disabilities in that 20422
county who the county board has determined need residential 20423
services but are not receiving them. 20424

Sec. 5123.41. As used in this section and sections 5123.42 to 20425
5123.47 of the Revised Code: 20426

(A) "Adult services" has the same meaning as in section 20427
5126.01 of the Revised Code. 20428

(B) "Certified home and community-based services provider"	20429
means a person or government entity certified under section	20430
5123.16 of the Revised Code.	20431
(C) "Certified supported living provider" means a person or	20432
government entity certified under section 5126.431 of the Revised	20433
Code.	20434
(D) "Drug" has the same meaning as in section 4729.01 of the	20435
Revised Code.	20436
(E) "Family support services" has the same meaning as in	20437
section 5126.01 of the Revised Code.	20438
(F) "Health-related activities" means the following:	20439
(1) Taking vital signs;	20440
(2) Application of clean dressings that do not require health	20441
assessment;	20442
(3) Basic measurement of bodily intake and output;	20443
(4) Oral suctioning;	20444
(5) Use of glucometers;	20445
(6) External urinary catheter care;	20446
(7) Emptying and replacing colostomy bags;	20447
(8) Collection of specimens by noninvasive means.	20448
(G) "Licensed health professional authorized to prescribe	20449
drugs" has the same meaning as in section 4729.01 of the Revised	20450
Code.	20451
(H) "Medicaid" has the same meaning as in section 5111.01 of	20452
the Revised Code.	20453
(I) "MR/DD personnel" means the employees and the workers	20454
under contract who provide specialized services to individuals	20455
with mental retardation and developmental disabilities. "MR/DD	20456

personnel" includes those who provide the services as follows: 20457

(1) Through direct employment with the department of mental 20458
retardation and developmental disabilities or a county board of 20459
mental retardation and developmental disabilities; 20460

(2) Through an entity under contract with the department of 20461
mental retardation and developmental disabilities or a county 20462
board of mental retardation and developmental disabilities; 20463

(3) Through direct employment or by being under contract with 20464
private entities, including private entities that operate 20465
residential facilities. 20466

~~(J)~~(I) "Nursing delegation" means the process established in 20467
rules adopted by the board of nursing pursuant to Chapter 4723. of 20468
the Revised Code under which a registered nurse or licensed 20469
practical nurse acting at the direction of a registered nurse 20470
transfers the performance of a particular nursing activity or task 20471
to another person who is not otherwise authorized to perform the 20472
activity or task. 20473

~~(K)~~(J) "Prescribed medication" means a drug that is to be 20474
administered according to the instructions of a licensed health 20475
professional authorized to prescribe drugs. 20476

~~(L)~~(K) "Residential facility" means a facility licensed under 20477
section 5123.19 of the Revised Code or subject to section 5123.192 20478
of the Revised Code. 20479

~~(M)~~(L) "Specialized services" has the same meaning as in 20480
section 5123.50 of the Revised Code. 20481

~~(N)~~(M) "Tube feeding" means the provision of nutrition to an 20482
individual through a gastrostomy tube or a jejunostomy tube. 20483

Sec. 5123.71. (A)(1) Proceedings for the involuntary 20484
institutionalization of a person pursuant to sections 5123.71 to 20485
5123.76 of the Revised Code shall be commenced by the filing of an 20486

affidavit with the probate division of the court of common pleas 20487
of the county where the person resides or where the person is 20488
institutionalized, in the manner and form prescribed by the 20489
department of mental retardation and developmental disabilities 20490
either on information or actual knowledge, whichever is determined 20491
to be proper by the court. The affidavit may be filed only by a 20492
person who has custody of the individual as a parent, guardian, or 20493
service provider or by a person acting on behalf of the department 20494
or a county board of mental retardation and developmental 20495
disabilities. This section does not apply regarding the 20496
institutionalization of a person pursuant to section 2945.39, 20497
2945.40, 2945.401, or 2945.402 of the Revised Code. 20498

The affidavit shall contain an allegation setting forth the 20499
specific category or categories under division ~~(O)~~(N) of section 20500
5123.01 of the Revised Code upon which the commencement of 20501
proceedings is based and a statement of the factual ground for the 20502
belief that the person is a mentally retarded person subject to 20503
institutionalization by court order. Except as provided in 20504
division (A)(2) of this section, the affidavit shall be 20505
accompanied by both of the following: 20506

(a) A comprehensive evaluation report prepared by the 20507
person's evaluation team that includes a statement by the members 20508
of the team certifying that they have performed a comprehensive 20509
evaluation of the person and that they are of the opinion that the 20510
person is a mentally retarded person subject to 20511
institutionalization by court order; 20512

(b) An assessment report prepared by the county board of 20513
mental retardation and developmental disabilities under section 20514
5123.711 of the Revised Code specifying that the individual is in 20515
need of services on an emergency or priority basis. 20516

(2) In lieu of the comprehensive evaluation report, the 20517
affidavit may be accompanied by a written and sworn statement that 20518

the person or the guardian of a person adjudicated incompetent has 20519
refused to allow a comprehensive evaluation and county board 20520
assessment and assessment reports. Immediately after accepting an 20521
affidavit that is not accompanied by the reports of a 20522
comprehensive evaluation and county board assessment, the court 20523
shall cause a comprehensive evaluation and county board assessment 20524
of the person named in the affidavit to be performed. The 20525
evaluation shall be conducted in the least restrictive environment 20526
possible and the assessment shall be conducted in the same manner 20527
as assessments conducted under section 5123.711 of the Revised 20528
Code. The evaluation and assessment must be completed before a 20529
probable cause hearing or full hearing may be held under section 20530
5123.75 or 5123.76 of the Revised Code. 20531

A written report of the evaluation team's findings and the 20532
county board's assessment shall be filed with the court. The 20533
reports shall, consistent with the rules of evidence, be accepted 20534
as probative evidence in any proceeding under section 5123.75 or 20535
5123.76 of the Revised Code. If the counsel for the person who is 20536
evaluated or assessed is known, the court shall send to the 20537
counsel a copy of the reports as soon as possible after they are 20538
filed and prior to any proceedings under section 5123.75 or 20539
5123.76 of the Revised Code. 20540

(B) Any person who is involuntarily detained in an 20541
institution or otherwise is in custody under this chapter shall be 20542
informed of the right to do the following: 20543

(1) Immediately make a reasonable number of telephone calls 20544
or use other reasonable means to contact an attorney, a physician, 20545
or both, to contact any other person or persons to secure 20546
representation by counsel, or to obtain medical assistance, and be 20547
provided assistance in making calls if the assistance is needed 20548
and requested; 20549

(2) Retain counsel and have independent expert evaluation 20550

and, if the person is an indigent person, be represented by 20551
court-appointed counsel and have independent expert evaluation at 20552
court expense; 20553

(3) Upon request, have a hearing to determine whether there 20554
is probable cause to believe that the person is a mentally 20555
retarded person subject to institutionalization by court order. 20556

(C) No person who is being treated by spiritual means through 20557
prayer alone in accordance with a recognized religious method of 20558
healing may be ordered detained or involuntarily committed unless 20559
the court has determined that the person represents a very 20560
substantial risk of self-impairment, self-injury, or impairment or 20561
injury to others. 20562

Sec. 5123.76. (A) The full hearing shall be conducted in a 20563
manner consistent with the procedures outlined in this chapter and 20564
with due process of law. The hearing shall be held by a judge of 20565
the probate division or, upon transfer by the judge of the probate 20566
division, by another judge of the court of common pleas, or a 20567
referee designated by the judge of the probate division. Any 20568
referee designated by the judge of the probate division must be an 20569
attorney. 20570

(1) The following shall be made available to counsel for the 20571
respondent: 20572

(a) All relevant documents, information, and evidence in the 20573
custody or control of the state or prosecutor; 20574

(b) All relevant documents, information, and evidence in the 20575
custody or control of the institution, facility, or program in 20576
which the respondent currently is held or in which the respondent 20577
has been held pursuant to these proceedings; 20578

(c) With the consent of the respondent, all relevant 20579
documents, information, and evidence in the custody or control of 20580

any institution or person other than the state. 20581

(2) The respondent has the right to be represented by counsel 20582
of the respondent's choice and has the right to attend the hearing 20583
except if unusual circumstances of compelling medical necessity 20584
exist that render the respondent unable to attend and the 20585
respondent has not expressed a desire to attend. 20586

(3) If the respondent is not represented by counsel and the 20587
court determines that the conditions specified in division (A)(2) 20588
of this section justify the respondent's absence and the right to 20589
counsel has not been validly waived, the court shall appoint 20590
counsel forthwith to represent the respondent at the hearing, 20591
reserving the right to tax costs of appointed counsel to the 20592
respondent unless it is shown that the respondent is indigent. If 20593
the court appoints counsel, or if the court determines that the 20594
evidence relevant to the respondent's absence does not justify the 20595
absence, the court shall continue the case. 20596

(4) The respondent shall be informed of the right to retain 20597
counsel, to have independent expert evaluation, and, if an 20598
indigent person, to be represented by court appointed counsel and 20599
have expert independent evaluation at court expense. 20600

(5) The hearing may be closed to the public unless counsel 20601
for the respondent requests that the hearing be open to the 20602
public. 20603

(6) Unless objected to by the respondent, the respondent's 20604
counsel, or the designee of the director of mental retardation and 20605
developmental disabilities, the court, for good cause shown, may 20606
admit persons having a legitimate interest in the proceedings. 20607

(7) The affiant under section 5123.71 of the Revised Code 20608
shall be subject to subpoena by either party. 20609

(8) The court shall examine the sufficiency of all documents 20610
filed and shall inform the respondent, if present, and the 20611

respondent's counsel of the nature of the content of the documents 20612
and the reason for which the respondent is being held or for which 20613
the respondent's placement is being sought. 20614

(9) The court shall receive only relevant, competent, and 20615
material evidence. 20616

(10) The designee of the director shall present the evidence 20617
for the state. In proceedings under this chapter, the attorney 20618
general shall present the comprehensive evaluation, assessment, 20619
diagnosis, prognosis, record of habilitation and care, if any, and 20620
less restrictive habilitation plans, if any. The attorney general 20621
does not have a similar presentation responsibility in connection 20622
with a person who has been found not guilty by reason of insanity 20623
and who is the subject of a hearing under section 2945.40 of the 20624
Revised Code to determine whether the person is a mentally 20625
retarded person subject to institutionalization by court order. 20626

(11) The respondent has the right to testify and the 20627
respondent or the respondent's counsel has the right to subpoena 20628
witnesses and documents and to present and cross-examine 20629
witnesses. 20630

(12) The respondent shall not be compelled to testify and 20631
shall be so advised by the court. 20632

(13) On motion of the respondent or the respondent's counsel 20633
for good cause shown, or upon the court's own motion, the court 20634
may order a continuance of the hearing. 20635

(14) To an extent not inconsistent with this chapter, the 20636
Rules of Civil Procedure shall be applicable. 20637

(B) Unless, upon completion of the hearing, the court finds 20638
by clear and convincing evidence that the respondent named in the 20639
affidavit is a mentally retarded person subject to 20640
institutionalization by court order, it shall order the 20641
respondent's discharge forthwith. 20642

(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 20673
habilitated in a less restrictive environment that is available, 20674
the following shall occur: 20675

(1) The respondent shall be released by the director of the 20676
facility or program or by the person forthwith and referred to the 20677
court together with a report of the findings and recommendations 20678
of the facility, program, or person. 20679

(2) The director of the facility or program or the person 20680
shall notify the respondent's counsel and the designee of the 20681
director of mental retardation and developmental disabilities. 20682

(3) The court shall dismiss the case or order placement in 20683
the less restrictive environment. 20684

(G)(1) Except as provided in divisions (G)(2) and (3) of this 20685
section, any person who has been committed under this section may 20686
apply at any time during the ninety-day period for voluntary 20687
admission to an institution under section 5123.69 of the Revised 20688
Code. Upon admission of a voluntary resident, the managing officer 20689
immediately shall notify the court, the respondent's counsel, and 20690
the designee of the director in writing of that fact by mail or 20691
otherwise, and, upon receipt of the notice, the court shall 20692
dismiss the case. 20693

(2) A person who is found incompetent to stand trial or not 20694
guilty by reason of insanity and who is committed pursuant to 20695
section 2945.39, 2945.40, 2945.401, or 2945.402 of the Revised 20696
Code shall not be voluntarily admitted to an institution pursuant 20697
to division (G)(1) of this section until after the termination of 20698
the commitment, as described in division (J) of section 2945.401 20699
of the Revised Code. 20700

(H) If, at the end of any commitment period, the respondent 20701
has not already been discharged or has not requested voluntary 20702
admission status, the director of the facility or program, or the 20703

person to whose care the respondent has been committed, shall 20704
discharge the respondent forthwith, unless at least ten days 20705
before the expiration of that period the designee of the director 20706
of mental retardation and developmental disabilities or the 20707
prosecutor files an application with the court requesting 20708
continued commitment. 20709

(1) An application for continued commitment shall include a 20710
written report containing a current comprehensive evaluation and 20711
assessment, a diagnosis, a prognosis, an account of progress and 20712
past habilitation, and a description of alternative habilitation 20713
settings and plans, including a habilitation setting that is the 20714
least restrictive setting consistent with the need for 20715
habilitation. A copy of the application shall be provided to 20716
respondent's counsel. The requirements for notice under section 20717
5123.73 of the Revised Code and the provisions of divisions (A) to 20718
(E) of this section apply to all hearings on such applications. 20719

(2) A hearing on the first application for continued 20720
commitment shall be held at the expiration of the first ninety-day 20721
period. The hearing shall be mandatory and may not be waived. 20722

(3) Subsequent periods of commitment not to exceed one 20723
hundred eighty days each may be ordered by the court if the 20724
designee of the director of mental retardation and developmental 20725
disabilities files an application for continued commitment, after 20726
a hearing is held on the application or without a hearing if no 20727
hearing is requested and no hearing required under division (H)(4) 20728
of this section is waived. Upon the application of a person 20729
involuntarily committed under this section, supported by an 20730
affidavit of a licensed physician alleging that the person is no 20731
longer a mentally retarded person subject to institutionalization 20732
by court order, the court for good cause shown may hold a full 20733
hearing on the person's continued commitment prior to the 20734
expiration of any subsequent period of commitment set by the 20735

court. 20736

(4) A mandatory hearing shall be held at least every two 20737
years after the initial commitment. 20738

(5) If the court, after a hearing upon a request to continue 20739
commitment, finds that the respondent is a mentally retarded 20740
person subject to institutionalization by court order, the court 20741
may make an order pursuant to divisions (C), (D), and (E) of this 20742
section. 20743

(I) Notwithstanding the provisions of division (H) of this 20744
section, no person who is found to be a mentally retarded person 20745
subject to institutionalization by court order pursuant to 20746
division ~~(O)~~(N)(2) of section 5123.01 of the Revised Code shall be 20747
held under involuntary commitment for more than five years. 20748

(J) The managing officer admitting a person pursuant to a 20749
judicial proceeding, within ten working days of the admission, 20750
shall make a report of the admission to the department. 20751

Sec. 5126.01. As used in this chapter: 20752

(A) As used in this division, "adult" means an individual who 20753
is eighteen years of age or over and not enrolled in a program or 20754
service under Chapter 3323. of the Revised Code and an individual 20755
sixteen or seventeen years of age who is eligible for adult 20756
services under rules adopted by the director of mental retardation 20757
and developmental disabilities pursuant to Chapter 119. of the 20758
Revised Code. 20759

(1) "Adult services" means services provided to an adult 20760
outside the home, except when they are provided within the home 20761
according to an individual's assessed needs and identified in an 20762
individual service plan, that support learning and assistance in 20763
the area of self-care, sensory and motor development, 20764
socialization, daily living skills, communication, community 20765

living, social skills, or vocational skills.	20766
(2) "Adult services" includes all of the following:	20767
(a) Adult day habilitation services;	20768
(b) Adult day care;	20769
(c) Prevocational services;	20770
(d) Sheltered employment;	20771
(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;	20772 20773 20774 20775 20776 20777 20778
(f) Community employment services and supported employment services.	20779 20780
(B)(1) "Adult day habilitation services" means adult services that do the following:	20781 20782
(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;	20783 20784 20785 20786 20787 20788 20789 20790
(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.	20791 20792 20793 20794
(2) "Adult day habilitation services" includes all of the	20795

following:	20796
(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;	20797 20798 20799 20800
(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;	20801 20802 20803 20804
(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;	20805 20806 20807 20808 20809 20810 20811
(d) Recreational and leisure activities identified in the individual's service plan as therapeutic in nature or assistive in developing or maintaining social supports;	20812 20813 20814
(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;	20815 20816 20817 20818 20819
(f) Transportation necessary to access adult day habilitation services;	20820 20821
(g) Habilitation management, as described in section 5126.14 of the Revised Code.	20822 20823
(3) "Adult day habilitation services" does not include activities that are components of the provision of residential	20824 20825

services, family support services, or supported living services. 20826

(C) "Appointing authority" means the following: 20827

(1) In the case of a member of a county board of mental 20828
retardation and developmental disabilities appointed by, or to be 20829
appointed by, a board of county commissioners, the board of county 20830
commissioners; 20831

(2) In the case of a member of a county board appointed by, 20832
or to be appointed by, a senior probate judge, the senior probate 20833
judge. 20834

(D) "Community employment services" or "supported employment 20835
services" means job training and other services related to 20836
employment outside a sheltered workshop. "Community employment 20837
services" or "supported employment services" include all of the 20838
following: 20839

(1) Job training resulting in the attainment of competitive 20840
work, supported work in a typical work environment, or 20841
self-employment; 20842

(2) Supervised work experience through an employer paid to 20843
provide the supervised work experience; 20844

(3) Ongoing work in a competitive work environment at a wage 20845
commensurate with workers without disabilities; 20846

(4) Ongoing supervision by an employer paid to provide the 20847
supervision. 20848

(E) As used in this division, "substantial functional 20849
limitation," "developmental delay," and "established risk" have 20850
the meanings established pursuant to section 5123.011 of the 20851
Revised Code. 20852

"Developmental disability" means a severe, chronic disability 20853
that is characterized by all of the following: 20854

(1) It is attributable to a mental or physical impairment or 20855

a combination of mental and physical impairments, other than a 20856
mental or physical impairment solely caused by mental illness as 20857
defined in division (A) of section 5122.01 of the Revised Code; 20858

(2) It is manifested before age twenty-two; 20859

(3) It is likely to continue indefinitely; 20860

(4) It results in one of the following: 20861

(a) In the case of a person under age three, at least one 20862
developmental delay or an established risk; 20863

(b) In the case of a person at least age three but under age 20864
six, at least two developmental delays or an established risk; 20865

(c) In the case of a person age six or older, a substantial 20866
functional limitation in at least three of the following areas of 20867
major life activity, as appropriate for the person's age: 20868
self-care, receptive and expressive language, learning, mobility, 20869
self-direction, capacity for independent living, and, if the 20870
person is at least age sixteen, capacity for economic 20871
self-sufficiency. 20872

(5) It causes the person to need a combination and sequence 20873
of special, interdisciplinary, or other type of care, treatment, 20874
or provision of services for an extended period of time that is 20875
individually planned and coordinated for the person. 20876

(F) "Early childhood services" means a planned program of 20877
habilitation designed to meet the needs of individuals with mental 20878
retardation or other developmental disabilities who have not 20879
attained compulsory school age. 20880

(G)(1) "Environmental modifications" means the physical 20881
adaptations to an individual's home, specified in the individual's 20882
service plan, that are necessary to ensure the individual's 20883
health, safety, and welfare or that enable the individual to 20884
function with greater independence in the home, and without which 20885

the individual would require institutionalization. 20886

(2) "Environmental modifications" includes such adaptations 20887
as installation of ramps and grab-bars, widening of doorways, 20888
modification of bathroom facilities, and installation of 20889
specialized electric and plumbing systems necessary to accommodate 20890
the individual's medical equipment and supplies. 20891

(3) "Environmental modifications" does not include physical 20892
adaptations or improvements to the home that are of general 20893
utility or not of direct medical or remedial benefit to the 20894
individual, including such adaptations or improvements as 20895
carpeting, roof repair, and central air conditioning. 20896

(H) "Family support services" means the services provided 20897
under a family support services program operated under section 20898
5126.11 of the Revised Code. 20899

(I) "Habilitation" means the process by which the staff of 20900
the facility or agency assists an individual with mental 20901
retardation or other developmental disability in acquiring and 20902
maintaining those life skills that enable the individual to cope 20903
more effectively with the demands of the individual's own person 20904
and environment, and in raising the level of the individual's 20905
personal, physical, mental, social, and vocational efficiency. 20906
Habilitation includes, but is not limited to, programs of formal, 20907
structured education and training. 20908

(J) "Home and community-based services" means medicaid-funded 20909
home and community-based services specified in division (B)(1) of 20910
section ~~5111.87~~ 5163.65 of the Revised Code and provided under the 20911
medicaid waiver components the department of mental retardation 20912
and developmental disabilities administers pursuant to section 20913
~~5111.871~~ 5163.651 of the Revised Code. 20914

(K) "Immediate family" means parents, grandparents, brothers, 20915
sisters, spouses, sons, daughters, aunts, uncles, mothers-in-law, 20916

fathers-in-law, brothers-in-law, sisters-in-law, sons-in-law, and 20917
daughters-in-law. 20918

~~(L) "Medicaid" has the same meaning as in section 5111.01 of 20919
the Revised Code. 20920~~

~~(M)~~ "Medicaid case management services" means case management 20921
services provided to an individual with mental retardation or 20922
other developmental disability that the state medicaid plan 20923
requires. 20924

~~(N)~~(M) "Mental retardation" means a mental impairment 20925
manifested during the developmental period characterized by 20926
significantly subaverage general intellectual functioning existing 20927
concurrently with deficiencies in the effectiveness or degree with 20928
which an individual meets the standards of personal independence 20929
and social responsibility expected of the individual's age and 20930
cultural group. 20931

~~(O)~~(N) "Residential services" means services to individuals 20932
with mental retardation or other developmental disabilities to 20933
provide housing, food, clothing, habilitation, staff support, and 20934
related support services necessary for the health, safety, and 20935
welfare of the individuals and the advancement of their quality of 20936
life. "Residential services" includes program management, as 20937
described in section 5126.14 of the Revised Code. 20938

~~(P)~~(O) "Resources" means available capital and other assets, 20939
including moneys received from the federal, state, and local 20940
governments, private grants, and donations; appropriately 20941
qualified personnel; and appropriate capital facilities and 20942
equipment. 20943

~~(Q)~~(P) "Senior probate judge" means the current probate judge 20944
of a county who has served as probate judge of that county longer 20945
than any of the other current probate judges of that county. If a 20946
county has only one probate judge, "senior probate judge" means 20947

that probate judge. 20948

~~(R)~~(O) "Service and support administration" means the duties 20949
performed by a service and support administrator pursuant to 20950
section 5126.15 of the Revised Code. 20951

~~(S)~~(R)(1) "Specialized medical, adaptive, and assistive 20952
equipment, supplies, and supports" means equipment, supplies, and 20953
supports that enable an individual to increase the ability to 20954
perform activities of daily living or to perceive, control, or 20955
communicate within the environment. 20956

(2) "Specialized medical, adaptive, and assistive equipment, 20957
supplies, and supports" includes the following: 20958

(a) Eating utensils, adaptive feeding dishes, plate guards, 20959
mylatex straps, hand splints, reaches, feeder seats, adjustable 20960
pointer sticks, interpreter services, telecommunication devices 20961
for the deaf, computerized communications boards, other 20962
communication devices, support animals, veterinary care for 20963
support animals, adaptive beds, supine boards, prone boards, 20964
wedges, sand bags, sidelayers, bolsters, adaptive electrical 20965
switches, hand-held shower heads, air conditioners, humidifiers, 20966
emergency response systems, folding shopping carts, vehicle lifts, 20967
vehicle hand controls, other adaptations of vehicles for 20968
accessibility, and repair of the equipment received. 20969

(b) Nondisposable items not covered by medicaid that are 20970
intended to assist an individual in activities of daily living or 20971
instrumental activities of daily living. 20972

~~(T)~~(S) "Supportive home services" means a range of services 20973
to families of individuals with mental retardation or other 20974
developmental disabilities to develop and maintain increased 20975
acceptance and understanding of such persons, increased ability of 20976
family members to teach the person, better coordination between 20977
school and home, skills in performing specific therapeutic and 20978

management techniques, and ability to cope with specific 20979
situations. 20980

~~(U)~~(T)(1) "Supported living" means services provided for as 20981
long as twenty-four hours a day to an individual with mental 20982
retardation or other developmental disability through any public 20983
or private resources, including moneys from the individual, that 20984
enhance the individual's reputation in community life and advance 20985
the individual's quality of life by doing the following: 20986

(a) Providing the support necessary to enable an individual 20987
to live in a residence of the individual's choice, with any number 20988
of individuals who are not disabled, or with not more than three 20989
individuals with mental retardation and developmental disabilities 20990
unless the individuals are related by blood or marriage; 20991

(b) Encouraging the individual's participation in the 20992
community; 20993

(c) Promoting the individual's rights and autonomy; 20994

(d) Assisting the individual in acquiring, retaining, and 20995
improving the skills and competence necessary to live successfully 20996
in the individual's residence. 20997

(2) "Supported living" includes the provision of all of the 20998
following: 20999

(a) Housing, food, clothing, habilitation, staff support, 21000
professional services, and any related support services necessary 21001
to ensure the health, safety, and welfare of the individual 21002
receiving the services; 21003

(b) A combination of lifelong or extended-duration 21004
supervision, training, and other services essential to daily 21005
living, including assessment and evaluation and assistance with 21006
the cost of training materials, transportation, fees, and 21007
supplies; 21008

(c) Personal care services and homemaker services;	21009
(d) Household maintenance that does not include modifications to the physical structure of the residence;	21010 21011
(e) Respite care services;	21012
(f) Program management, as described in section 5126.14 of the Revised Code.	21013 21014
Sec. 5126.035. (A) As used in this section:	21015
(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.	21016 21017 21018
(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.	21019 21020 21021 21022 21023
(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:	21024 21025 21026
(1) If the provider is to provide home and community-based services or medicaid case management services, comply with all applicable statewide medicaid requirements;	21027 21028 21029
(2) Include a general operating agreement component and an individual service needs addendum.	21030 21031
(C) The general operating agreement component shall include all of the following:	21032 21033
(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;	21034 21035 21036 21037

(2) The roles and responsibilities of the provider as specified in the individual service needs addendum;	21038 21039
(3) Procedures for the county board to monitor the provider's services;	21040 21041
(4) Procedures for the county board to evaluate the quality of care and cost effectiveness of the provider's services;	21042 21043
(5) Procedures for payment of eligible claims;	21044
(6) If the provider is to provide home and community-based services or medicaid case management services, both of the following:	21045 21046 21047
(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;	21048 21049 21050
(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.	21051 21052 21053 21054
(7) Procedures for the county board to perform service utilization reviews and the implementation of required corrective actions;	21055 21056 21057
(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;	21058 21059 21060
(9) Procedures for rejecting claims for payment that are submitted after the time required by division (C)(8) of this section;	21061 21062 21063
(10) Procedures for developing, modifying, and executing initial and subsequent service plans. The procedures shall provide for the provider's participation.	21064 21065 21066
(11) Procedures for affording individuals due process	21067

protections;	21068
(12) General staffing, training, and certification	21069
requirements that are consistent with state requirements and	21070
compensation arrangements that are necessary to attract, train,	21071
and retain competent personnel to deliver the services pursuant to	21072
the individual service needs addendum;	21073
(13) Methods to be used to document services provided and	21074
procedures for submitting reports the county board requires;	21075
(14) Methods for authorizing and documenting within	21076
seventy-two hours changes to the individual service needs	21077
addendum. The methods shall allow for changes to be initially	21078
authorized verbally and subsequently in writing.	21079
(15) Procedures for modifying the individual service needs	21080
addendum in accordance with changes to the recipient's	21081
individualized service plan;	21082
(16) Procedures for terminating the individual service needs	21083
addendum within thirty days of a request made by the recipient;	21084
(17) A requirement that all parties to the contract accept	21085
the contract's terms and conditions;	21086
(18) A designated contact person and the method of contacting	21087
the designated person to respond to medical or behavioral problems	21088
and allegations of major unusual incidents or unusual incidents;	21089
(19) Procedures for ensuring the health and welfare of the	21090
recipient;	21091
(20) Procedures for ensuring fiscal accountability and the	21092
collection and reporting of programmatic data;	21093
(21) Procedures for implementing the mediation and	21094
arbitration process under section 5126.036 of the Revised Code;	21095
(22) Procedures for amending or terminating the contract,	21096
including as necessary to make the general operating agreement	21097

component consistent with any changes made to the individual	21098
service needs addendum;	21099
(23) Anything else allowable under federal and state law that	21100
the county board and provider agree to.	21101
(D) The individual service needs addendum shall be consistent	21102
with the general operating agreement component and include all of	21103
the following:	21104
(1) The name of the individual with mental retardation or	21105
other developmental disability who is to receive the services from	21106
the provider and any information about the recipient that the	21107
provider needs to be able to provide the services;	21108
(2) A clear and complete description of the services that the	21109
recipient is to receive as determined using statewide assessment	21110
tools;	21111
(3) A copy of the recipient's assessment and individualized	21112
service plan;	21113
(4) A clear and complete description of the provider's	21114
responsibilities to the recipient and county board in providing	21115
appropriate services in a coordinated manner with other providers	21116
and in a manner that contributes to and ensures the recipient's	21117
health, safety, and welfare.	21118
(E) A service contract does not negate the requirement that a	21119
provider of home and community-based services or medicaid case	21120
management services have a medicaid provider agreement with the	21121
department of job and family services <u>health care administration</u> .	21122
Sec. 5126.036. (A) As used in this section:	21123
(1) "Aggrieved party" means any of the following:	21124
(a) The party to a service contract that is aggrieved by an	21125
action the other party has taken or not taken under the service	21126

contract;	21127
(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;	21128 21129 21130 21131
(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.	21132 21133 21134 21135
(2) "Mediator/arbitrator" means either of the following:	21136
(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;	21137 21138 21139
(b) A retired judge who is selected under division (B)(4) of this section to conduct mediation and arbitration.	21140 21141
(3) "Other party" means any of the following:	21142
(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;	21143 21144 21145
(b) A county board of mental retardation and developmental disabilities that refuses to enter into a service contract with a person or government entity;	21146 21147 21148
(c) A county board of mental retardation and developmental disabilities that terminates a service contract.	21149 21150
(4) "Parties" mean either of the following:	21151
(a) A county board of mental retardation and developmental disabilities and a provider that have or had a service contract with each other;	21152 21153 21154
(b) A person or government entity that seeks a service	21155

contract with a county board of mental retardation and 21156
developmental disabilities and the county board that refuses to 21157
enter into the service contract with the person or government 21158
entity. 21159

(5) "Provider" means a person or government entity that 21160
provides services to an individual with mental retardation or 21161
other developmental disability pursuant to a service contract. 21162

(6) "Service contract" means a contract between a county 21163
board of mental retardation and developmental disabilities and a 21164
provider under which the provider is to provide services to an 21165
individual with mental retardation or other developmental 21166
disability. 21167

(B) An aggrieved party that seeks to require the other party 21168
to take or cease an action under a service contract that causes 21169
the aggrieved party to be aggrieved, a person or government entity 21170
aggrieved by the refusal of a county board of mental retardation 21171
and developmental disabilities to enter into a service contract 21172
with the person or government entity, or a person or government 21173
entity aggrieved by a county board's termination of a service 21174
contract between the person or government entity and the county 21175
board and the other party shall follow the following mediation and 21176
arbitration procedures: 21177

(1) No later than thirty days after first notifying the other 21178
party that the aggrieved party is aggrieved, the aggrieved party 21179
shall file a written notice of mediation and arbitration with the 21180
department of mental retardation and developmental disabilities 21181
and provide a copy of the written notice to the other party. The 21182
written notice shall include an explanation of why the aggrieved 21183
party is aggrieved. The department of mental retardation and 21184
developmental disabilities shall provide the department of ~~job and~~ 21185
~~family services~~ health care administration a copy of the notice. 21186

(2) In the case of parties that have a current service 21187
contract with each other and unless otherwise agreed to by both 21188
parties, the parties shall continue to operate under the contract 21189
in the manner they have been operating until the mediation and 21190
arbitration process, including an appeal under division (B)(9) of 21191
this section, if any, is completed. 21192

(3) During the thirty days following the date the aggrieved 21193
party files the written notice of mediation and arbitration under 21194
division (B)(1) of this section, the parties may attempt to 21195
resolve the conflict informally. If the parties are able to 21196
resolve the conflict informally within this time, the aggrieved 21197
party shall rescind the written notice of mediation and 21198
arbitration filed under division (B)(1) of this section. 21199

(4) No later than thirty days after the date the aggrieved 21200
party files the written notice of mediation and arbitration under 21201
division (B)(1) of this section, the parties shall mutually select 21202
an attorney at law licensed to practice law in this state to 21203
conduct the mediation and arbitration and schedule the first 21204
meeting of the mediation unless the parties informally resolve the 21205
conflict under division (B)(3) of this section. If the parties 21206
fail to select an attorney to conduct the mediation and 21207
arbitration within the required time, the parties shall request 21208
that the chief justice of the supreme court of Ohio provide the 21209
parties a list of five retired judges who are willing to perform 21210
the mediation and arbitration duties. The chief justice shall 21211
create such a list and provide it to the parties. To select the 21212
retired judge to conduct the mediation and arbitration, the 21213
parties shall take turns, beginning with the aggrieved party, 21214
striking retired judges from the list. The retired judge remaining 21215
on the list after both parties have each stricken two retired 21216
judges from the list shall perform the mediation and arbitration 21217
duties, including scheduling the first meeting of mediation if the 21218

parties are unable to agree on a date for the first meeting. 21219

(5) A stenographic record or tape recording and transcript of 21220
each mediation and arbitration meeting shall be maintained as part 21221
of the mediation and arbitration's official records. The parties 21222
shall share the cost of the mediation and arbitration, including 21223
the cost of the mediator/arbitrator's services but excluding the 21224
cost of representation. 21225

(6) The first mediation meeting shall be held no later than 21226
sixty days after the date the aggrieved party files the written 21227
notice of mediation and arbitration under division (B)(1) of this 21228
section unless the parties informally resolve the conflict under 21229
division (B)(3) of this section or the parties mutually agree to 21230
hold the first meeting at a later time. The mediation shall be 21231
conducted in the manner the parties mutually agree. If the parties 21232
are unable to agree on how the mediation is to be conducted, the 21233
mediator/arbitrator selected under division (B)(4) of this section 21234
shall determine how it is to be conducted. The rules of evidence 21235
may be used. The mediator/arbitrator shall attempt to resolve the 21236
conflict through the mediation process. The mediator/arbitrator's 21237
resolution of the conflict may be applied retroactively. 21238

(7) If the conflict is not resolved through the mediation 21239
process, the mediator/arbitrator shall arbitrate the conflict. The 21240
parties shall present evidence to the mediator/arbitrator in the 21241
manner the mediator/arbitrator requires. The mediator/arbitrator 21242
shall render a written recommendation within thirty days of the 21243
conclusion of the last arbitration meeting based on the service 21244
contract, applicable law, and the preponderance of the evidence 21245
presented during the arbitration. The mediator/arbitrator's 21246
recommendation may be applied retroactively. If the parties agree, 21247
the mediator/arbitrator may continue to attempt to resolve the 21248
conflict through mediation while the mediator/arbitrator 21249
arbitrates the conflict. 21250

(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 21314
self-harm or substantial harm to others if action is not taken 21315
within thirty days. An "emergency" may include one or more of the 21316
following situations: 21317

(1) Loss of present residence for any reason, including legal 21318
action; 21319

(2) Loss of present caretaker for any reason, including 21320
serious illness of the caretaker, change in the caretaker's 21321
status, or inability of the caretaker to perform effectively for 21322
the individual; 21323

(3) Abuse, neglect, or exploitation of the individual; 21324

(4) Health and safety conditions that pose a serious risk to 21325
the individual or others of immediate harm or death; 21326

(5) Change in the emotional or physical condition of the 21327
individual that necessitates substantial accommodation that cannot 21328
be reasonably provided by the individual's existing caretaker. 21329

(B) If a county board of mental retardation and developmental 21330
disabilities determines that available resources are not 21331
sufficient to meet the needs of all individuals who request 21332
programs and services and may be offered the programs and 21333
services, it shall establish waiting lists for services. The board 21334
may establish priorities for making placements on its waiting 21335
lists according to an individual's emergency status and shall 21336
establish priorities in accordance with divisions (D) and (E) of 21337
this section. 21338

The individuals who may be placed on a waiting list include 21339
individuals with a need for services on an emergency basis and 21340
individuals who have requested services for which resources are 21341
not available. 21342

Except for an individual who is to receive priority for 21343

services pursuant to division (D)(3) of this section, an 21344
individual who currently receives a service but would like to 21345
change to another service shall not be placed on a waiting list 21346
but shall be placed on a service substitution list. The board 21347
shall work with the individual, service providers, and all 21348
appropriate entities to facilitate the change in service as 21349
expeditiously as possible. The board may establish priorities for 21350
making placements on its service substitution lists according to 21351
an individual's emergency status. 21352

In addition to maintaining waiting lists and service 21353
substitution lists, a board shall maintain a long-term service 21354
planning registry for individuals who wish to record their 21355
intention to request in the future a service they are not 21356
currently receiving. The purpose of the registry is to enable the 21357
board to document requests and to plan appropriately. The board 21358
may not place an individual on the registry who meets the 21359
conditions for receipt of services on an emergency basis. 21360

(C) A county board shall establish a separate waiting list 21361
for each of the following categories of services, and may 21362
establish separate waiting lists within the waiting lists: 21363

(1) Early childhood services; 21364

(2) Educational programs for preschool and school age 21365
children; 21366

(3) Adult services; 21367

(4) Service and support administration; 21368

(5) Residential services and supported living; 21369

(6) Transportation services; 21370

(7) Other services determined necessary and appropriate for 21371
persons with mental retardation or a developmental disability 21372
according to their individual habilitation or service plans; 21373

(8) Family support services provided under section 5126.11 of the Revised Code. 21374
21375

(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: 21376
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(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: 21381
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(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: 21384
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(i) Is twenty-two years of age or older; 21390

(ii) Receives supported living or family support services. 21391

(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: 21392
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(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; 21397
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(ii) Receives adult services from the county board. 21400

(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 21401
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the following requirements priority for such services over any 21404
other individual on a waiting list established under division (C) 21405
of this section: 21406

(a) Does not receive residential services or supported 21407
living, either needs services in the individual's current living 21408
arrangement or will need services in a new living arrangement, and 21409
has a primary caregiver who is sixty years of age or older; 21410

(b) Is less than twenty-two years of age and has at least one 21411
of the following service needs that are unusual in scope or 21412
intensity: 21413

(i) Severe behavior problems for which a behavior support 21414
plan is needed; 21415

(ii) An emotional disorder for which anti-psychotic 21416
medication is needed; 21417

(iii) A medical condition that leaves the individual 21418
dependent on life-support medical technology; 21419

(iv) A condition affecting multiple body systems for which a 21420
combination of specialized medical, psychological, educational, or 21421
habilitation services are needed; 21422

(v) A condition the county board determines to be comparable 21423
in severity to any condition described in ~~division~~ divisions 21424
(D)(2)(b)(i) to (iv) of this section and places the individual at 21425
significant risk of institutionalization. 21426

(c) Is twenty-two years of age or older, does not receive 21427
residential services or supported living, and is determined by the 21428
county board to have intensive needs for home and community-based 21429
services on an in-home or out-of-home basis. 21430

(3) In fiscal years 2002 and 2003, give an individual who is 21431
eligible for home and community-based services, resides in an 21432
intermediate care facility for the mentally retarded or nursing 21433

facility, chooses to move to another setting with the help of home 21434
and community-based services, and has been determined by the 21435
department of mental retardation and developmental disabilities to 21436
be capable of residing in the other setting, priority over any 21437
other individual on a waiting list established under division (C) 21438
of this section for home and community-based services who does not 21439
meet these criteria. The department of mental retardation and 21440
developmental disabilities shall identify the individuals to 21441
receive priority under division (D)(3) of this section, assess the 21442
needs of the individuals, and notify the county boards that are to 21443
provide the individuals priority under division (D)(3) of this 21444
section of the individuals identified by the department and the 21445
individuals' assessed needs. 21446

(E) Except as provided in division (G) of this section and 21447
for a number of years and beginning on a date specified in rules 21448
adopted under division (K) of this section, a county board shall 21449
give an individual who is eligible for home and community-based 21450
services, resides in a nursing facility, and chooses to move to 21451
another setting with the help of home and community-based 21452
services, priority over any other individual on a waiting list 21453
established under division (C) of this section for home and 21454
community-based services who does not meet these criteria. 21455

(F) If two or more individuals on a waiting list established 21456
under division (C) of this section for home and community-based 21457
services have priority for the services pursuant to division 21458
(D)(1) or (2) or (E) of this section, a county board may use, 21459
until December 31, 2007, criteria specified in rules adopted under 21460
division (K)(2) of this section in determining the order in which 21461
the individuals with priority will be offered the services. 21462
Otherwise, the county board shall offer the home and 21463
community-based services to such individuals in the order they are 21464
placed on the waiting list. 21465

(G)(1) No individual may receive priority for services 21466
pursuant to division (D) or (E) of this section over an individual 21467
placed on a waiting list established under division (C) of this 21468
section on an emergency status. 21469

(2) No more than four hundred individuals in the state may 21470
receive priority for services during the 2006 and 2007 biennium 21471
pursuant to division (D)(2)(b) of this section. 21472

(3) No more than a total of seventy-five individuals in the 21473
state may receive priority for services during state fiscal years 21474
2002 and 2003 pursuant to division (D)(3) of this section. 21475

(4) No more than forty individuals in the state may receive 21476
priority for services pursuant to division (E) of this section for 21477
each year that priority category is in effect as specified in 21478
rules adopted under division (K) of this section. 21479

(H) Prior to establishing any waiting list under this 21480
section, a county board shall develop and implement a policy for 21481
waiting lists that complies with this section and rules adopted 21482
under division (K) of this section. 21483

Prior to placing an individual on a waiting list, the county 21484
board shall assess the service needs of the individual in 21485
accordance with all applicable state and federal laws. The county 21486
board shall place the individual on the appropriate waiting list 21487
and may place the individual on more than one waiting list. The 21488
county board shall notify the individual of the individual's 21489
placement and position on each waiting list on which the 21490
individual is placed. 21491

At least annually, the county board shall reassess the 21492
service needs of each individual on a waiting list. If it 21493
determines that an individual no longer needs a program or 21494
service, the county board shall remove the individual from the 21495
waiting list. If it determines that an individual needs a program 21496

or service other than the one for which the individual is on the 21497
waiting list, the county board shall provide the program or 21498
service to the individual or place the individual on a waiting 21499
list for the program or service in accordance with the board's 21500
policy for waiting lists. 21501

When a program or service for which there is a waiting list 21502
becomes available, the county board shall reassess the service 21503
needs of the individual next scheduled on the waiting list to 21504
receive that program or service. If the reassessment demonstrates 21505
that the individual continues to need the program or service, the 21506
board shall offer the program or service to the individual. If it 21507
determines that an individual no longer needs a program or 21508
service, the county board shall remove the individual from the 21509
waiting list. If it determines that an individual needs a program 21510
or service other than the one for which the individual is on the 21511
waiting list, the county board shall provide the program or 21512
service to the individual or place the individual on a waiting 21513
list for the program or service in accordance with the board's 21514
policy for waiting lists. The county board shall notify the 21515
individual of the individual's placement and position on the 21516
waiting list on which the individual is placed. 21517

(I) A child subject to a determination made pursuant to 21518
section 121.38 of the Revised Code who requires the home and 21519
community-based services provided through a medicaid component 21520
that the department of mental retardation and developmental 21521
disabilities administers under section ~~5111.871~~ 5163.651 of the 21522
Revised Code shall receive services through that medicaid 21523
component. For all other services, a child subject to a 21524
determination made pursuant to section 121.38 of the Revised Code 21525
shall be treated as an emergency by the county boards and shall 21526
not be subject to a waiting list. 21527

(J) Not later than the fifteenth day of March of each 21528

even-numbered year, each county board shall prepare and submit to 21529
the director of mental retardation and developmental disabilities 21530
its recommendations for the funding of services for individuals 21531
with mental retardation and developmental disabilities and its 21532
proposals for reducing the waiting lists for services. 21533

(K)(1) The department of mental retardation and developmental 21534
disabilities shall adopt rules in accordance with Chapter 119. of 21535
the Revised Code governing waiting lists established under this 21536
section. The rules shall include procedures to be followed to 21537
ensure that the due process rights of individuals placed on 21538
waiting lists are not violated. 21539

(2) As part of the rules adopted under this division, the 21540
department shall adopt rules establishing criteria a county board 21541
may use under division (F) of this section in determining the 21542
order in which individuals with priority for home and 21543
community-based services will be offered the services. The rules 21544
shall also specify conditions under which a county board, when 21545
there is no individual with priority for home and community-based 21546
services pursuant to division (D)(1) or (2) or (E) of this section 21547
available and appropriate for the services, may offer the services 21548
to an individual on a waiting list for the services but not given 21549
such priority for the services. The rules adopted under division 21550
(K)(2) of this section shall cease to have effect December 31, 21551
2007. 21552

(3) As part of the rules adopted under this division, the 21553
department shall adopt rules specifying both of the following for 21554
the priority category established under division (E) of this 21555
section: 21556

(a) The number of years, which shall not exceed five, that 21557
the priority category will be in effect; 21558

(b) The date that the priority category is to go into effect. 21559

(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, 21591
and community employment services when required by section 21592
5126.057 of the Revised Code. The department of mental retardation 21593
and developmental disabilities shall pay the nonfederal share of 21594
such habilitation, vocational, and community employment services 21595
when required by section 5123.047 of the Revised Code. 21596

(B) Each month, the department of mental retardation and 21597
developmental disabilities shall create a list of all persons and 21598
government entities eligible to provide residential services and 21599
supported living. The department shall include on the list all 21600
residential facilities licensed under section 5123.19 of the 21601
Revised Code and all supported living providers certified under 21602
section 5126.431 of the Revised Code. The department shall 21603
distribute the monthly lists to county boards that have local 21604
administrative authority under division (A) of section 5126.055 of 21605
the Revised Code for residential services and supported living 21606
provided as part of home and community-based services. A county 21607
board that receives a list shall make it available to each 21608
individual with mental retardation or other developmental 21609
disability who resides in the county and is eligible for such 21610
residential services or supported living. The county board shall 21611
also make the list available to the families of those individuals. 21612

An individual who is eligible for residential services or 21613
supported living may choose the provider of the residential 21614
services or supported living. 21615

A county board that has medicaid local administrative 21616
authority under division (A) of section 5126.055 of the Revised 21617
Code for residential services and supported living provided as 21618
part of home and community-based services shall pay the nonfederal 21619
share of the residential services and supported living when 21620
required by section 5126.057 of the Revised Code. The department 21621
shall pay the nonfederal share of the residential services and 21622

supported living when required by section 5123.047 of the Revised Code. 21623
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(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. 21625
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(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. 21633
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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: 21642
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(1) An assessment component that includes all of the following: 21646
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(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 21648
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individuals; and the projected annualized cost for services; 21654

(b) The source of funds available to the county board to pay 21655
the nonfederal share of medicaid expenditures that the county 21656
board is required by division (A) of section 5126.057 of the 21657
Revised Code to pay; 21658

(c) Any other applicable information or conditions that the 21659
department of mental retardation and developmental disabilities 21660
requires as a condition of approving the component under section 21661
5123.046 of the Revised Code. 21662

(2) A component that provides for the recruitment, training, 21663
and retention of existing and new direct care staff necessary to 21664
implement services included in individualized service plans, 21665
including behavior management services and health management 21666
services such as delegated nursing and other habilitation 21667
services, and protect the health and welfare of individuals 21668
receiving services included in the individual's individualized 21669
service plan by complying with safeguards for unusual and major 21670
unusual incidents, day-to-day program management, and other 21671
requirements the department shall identify. A county board shall 21672
develop this component in collaboration with providers of 21673
medicaid-funded services with which the county board contracts. A 21674
county board shall include all of the following in the component: 21675

(a) The source and amount of funds available for the 21676
component; 21677

(b) A plan and timeline for implementing the component with 21678
the medicaid providers under contract with the county board; 21679

(c) The mechanisms the county board shall use to ensure the 21680
financial and program accountability of the medicaid provider's 21681
implementation of the component. 21682

(3) A preliminary implementation component that specifies the 21683
number of individuals to be provided, during the first year that 21684

the plan is in effect, home and community-based services pursuant 21685
to the priority given to them under divisions (D)(1) and (2) of 21686
section 5126.042 of the Revised Code and the types of home and 21687
community-based services the individuals are to receive; 21688

(4) A component that provides for the implementation of 21689
medicaid case management services and home and community-based 21690
services for individuals who begin to receive the services on or 21691
after the date the plan is approved under section 5123.046 of the 21692
Revised Code. A county board shall include all of the following in 21693
the component: 21694

(a) If the department of mental retardation and developmental 21695
disabilities or department of ~~job and family services~~ health care 21696
administration requires, an agreement to pay the nonfederal share 21697
of medicaid expenditures that the county board is required by 21698
division (A) of section 5126.057 of the Revised Code to pay; 21699

(b) How the services are to be phased in over the period the 21700
plan covers, including how the county board will serve individuals 21701
on a waiting list established under division (C) of section 21702
5126.042 who are given priority status under division (D)(1) of 21703
that section; 21704

(c) Any agreement or commitment regarding the county board's 21705
funding of home and community-based services that the county board 21706
has with the department at the time the county board develops the 21707
component; 21708

(d) Assurances adequate to the department that the county 21709
board will comply with all of the following requirements: 21710

(i) To provide the types of home and community-based services 21711
specified in the preliminary implementation component required by 21712
division (A)(3) of this section to at least the number of 21713
individuals specified in that component; 21714

(ii) To use any additional funds the county board receives 21715

for the services to improve the county board's resource 21716
capabilities for supporting such services available in the county 21717
at the time the component is developed and to expand the services 21718
to accommodate the unmet need for those services in the county; 21719

(iii) To employ a business manager who is either a new 21720
employee who has earned at least a bachelor's degree in business 21721
administration or a current employee who has the equivalent 21722
experience of a bachelor's degree in business administration. If 21723
the county board will employ a new employee, the county board 21724
shall include in the component a timeline for employing the 21725
employee. 21726

(iv) To employ or contract with a medicaid services manager 21727
who is either a new employee who has earned at least a bachelor's 21728
degree or a current employee who has the equivalent experience of 21729
a bachelor's degree. If the county board will employ a new 21730
employee, the county board shall include in the component a 21731
timeline for employing the employee. Two or three county boards 21732
that have a combined total enrollment in county board services not 21733
exceeding one thousand individuals as determined pursuant to 21734
certifications made under division (B) of section 5126.12 of the 21735
Revised Code may satisfy this requirement by sharing the services 21736
of a medicaid services manager or using the services of a medicaid 21737
services manager employed by or under contract with a regional 21738
council that the county boards establish under section 5126.13 of 21739
the Revised Code. 21740

(e) An agreement to comply with the method, developed by 21741
rules adopted under section 5123.0413 of the Revised Code, of 21742
paying for extraordinary costs, including extraordinary costs for 21743
services to individuals with mental retardation or other 21744
developmental disability, and ensuring the availability of 21745
adequate funds in the event a county property tax levy for 21746
services for individuals with mental retardation or other 21747

developmental disability fails; 21748

(f) Programmatic and financial accountability measures and 21749
projected outcomes expected from the implementation of the plan; 21750

(g) Any other applicable information or conditions that the 21751
department requires as a condition of approving the component 21752
under section 5123.046 of the Revised Code. 21753

(B) For the purpose of obtaining the department's approval 21754
under section 5123.046 of the Revised Code of the plan the county 21755
board develops under division (A) of this section, a county board 21756
shall do all of the following: 21757

(1) Submit the components required by divisions (A)(1) and 21758
(2) of this section to the department not later than August 1, 21759
2001; 21760

(2) Submit the component required by division (A)(3) of this 21761
section to the department not later than January 31, 2002; 21762

(3) Submit the component required by division (A)(4) of this 21763
section to the department not later than July 1, 2002. 21764

(C) A county board whose plan developed under division (A) of 21765
this section is approved by the department under section 5123.046 21766
of the Revised Code shall update and renew the plan in accordance 21767
with a schedule the department shall develop. 21768

Sec. 5126.055. (A) Except as provided in section 5126.056 of 21769
the Revised Code, a county board of mental retardation and 21770
developmental disabilities has medicaid local administrative 21771
authority to, and shall, do all of the following for an individual 21772
with mental retardation or other developmental disability who 21773
resides in the county that the county board serves and seeks or 21774
receives home and community-based services: 21775

(1) Perform assessments and evaluations of the individual. As 21776
part of the assessment and evaluation process, the county board 21777

shall do all of the following: 21778

(a) Make a recommendation to the department of mental 21779
retardation and developmental disabilities on whether the 21780
department should approve or deny the individual's application for 21781
the services, including on the basis of whether the individual 21782
needs the level of care an intermediate care facility for the 21783
mentally retarded provides; 21784

(b) If the individual's application is denied because of the 21785
county board's recommendation and the individual requests a 21786
hearing under section ~~5101.35~~ 5160.34 of the Revised Code, 21787
present, with the department of mental retardation and 21788
developmental disabilities or department of ~~job and family~~ 21789
~~services~~ health care administration, whichever denies the 21790
application, the reasons for the recommendation and denial at the 21791
hearing; 21792

(c) If the individual's application is approved, recommend to 21793
the departments of mental retardation and developmental 21794
disabilities and ~~job and family services~~ health care 21795
administration the services that should be included in the 21796
individual's individualized service plan and, if either department 21797
approves, reduces, denies, or terminates a service included in the 21798
individual's individualized service plan under section ~~5111.871~~ 21799
5163.651 of the Revised Code because of the county board's 21800
recommendation, present, with the department that made the 21801
approval, reduction, denial, or termination, the reasons for the 21802
recommendation and approval, reduction, denial, or termination at 21803
a hearing under section ~~5101.35~~ 5160.34 of the Revised Code. 21804

(2) If the individual has been identified by the department 21805
of mental retardation and developmental disabilities as an 21806
individual to receive priority for home and community-based 21807
services pursuant to division (D)(3) of section 5126.042 of the 21808
Revised Code, assist the department in expediting the transfer of 21809

the individual from an intermediate care facility for the mentally 21810
retarded or nursing facility to the home and community-based 21811
services; 21812

(3) In accordance with the rules adopted under section 21813
5126.046 of the Revised Code, perform the county board's duties 21814
under that section regarding assisting the individual's right to 21815
choose a qualified and willing provider of the services and, at a 21816
hearing under section 5101.35 of the Revised Code, present 21817
evidence of the process for appropriate assistance in choosing 21818
providers; 21819

(4) Unless the county board provides the services under 21820
division (A)(5) of this section, contract with the person or 21821
government entity the individual chooses in accordance with 21822
section 5126.046 of the Revised Code to provide the services if 21823
the person or government entity is qualified and agrees to provide 21824
the services. The contract shall contain all the provisions 21825
required by section 5126.035 of the Revised Code and require the 21826
provider to agree to furnish, in accordance with the provider's 21827
medicaid provider agreement and for the authorized reimbursement 21828
rate, the services the individual requires. 21829

(5) If the county board is certified under section 5123.16 of 21830
the Revised Code to provide the services and agrees to provide the 21831
services to the individual and the individual chooses the county 21832
board to provide the services, furnish, in accordance with the 21833
county board's medicaid provider agreement and for the authorized 21834
reimbursement rate, the services the individual requires; 21835

(6) Monitor the services provided to the individual and 21836
ensure the individual's health, safety, and welfare. The 21837
monitoring shall include quality assurance activities. If the 21838
county board provides the services, the department of mental 21839
retardation and developmental disabilities shall also monitor the 21840
services. 21841

(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 21872
administration shall communicate with and provide training to 21873
county boards regarding medicaid local administrative authority 21874
granted by this section. The communication and training shall 21875
include issues regarding audit protocols and other standards 21876
established by the United States department of health and human 21877
services that the departments determine appropriate for 21878
communication and training. County boards shall participate in the 21879
training. The departments shall assess the county board's 21880
compliance against uniform standards that the departments shall 21881
establish. 21882

(D) A county board may not delegate its medicaid local 21883
administrative authority granted under this section but may 21884
contract with a person or government entity, including a council 21885
of governments, for assistance with its medicaid local 21886
administrative authority. A county board that enters into such a 21887
contract shall notify the director of mental retardation and 21888
developmental disabilities. The notice shall include the tasks and 21889
responsibilities that the contract gives to the person or 21890
government entity. The person or government entity shall comply in 21891
full with all requirements to which the county board is subject 21892
regarding the person or government entity's tasks and 21893
responsibilities under the contract. The county board remains 21894
ultimately responsible for the tasks and responsibilities. 21895

(E) A county board that has medicaid local administrative 21896
authority under this section shall, through the departments of 21897
mental retardation and developmental disabilities and ~~job and~~ 21898
~~family services~~ health care administration, reply to, and 21899
cooperate in arranging compliance with, a program or fiscal audit 21900
or program violation exception that a state or federal audit or 21901
review discovers. The department of ~~job and family services~~ health 21902
care administration shall timely notify the department of mental 21903

retardation and developmental disabilities and the county board of 21904
any adverse findings. After receiving the notice, the county 21905
board, in conjunction with the department of mental retardation 21906
and developmental disabilities, shall cooperate fully with the 21907
department of ~~job and family services~~ health care administration 21908
and timely prepare and send to the department a written plan of 21909
correction or response to the adverse findings. The county board 21910
is liable for any adverse findings that result from an action it 21911
takes or fails to take in its implementation of medicaid local 21912
administrative authority. 21913

(F) If the department of mental retardation and developmental 21914
disabilities or department of ~~job and family services~~ health care 21915
administration determines that a county board's implementation of 21916
its medicaid local administrative authority under this section is 21917
deficient, the department that makes the determination shall 21918
require that county board do the following: 21919

(1) If the deficiency affects the health, safety, or welfare 21920
of an individual with mental retardation or other developmental 21921
disability, correct the deficiency within twenty-four hours; 21922

(2) If the deficiency does not affect the health, safety, or 21923
welfare of an individual with mental retardation or other 21924
developmental disability, receive technical assistance from the 21925
department or submit a plan of correction to the department that 21926
is acceptable to the department within sixty days and correct the 21927
deficiency within the time required by the plan of correction. 21928

Sec. 5126.082. (A) In addition to the rules adopted under 21929
division (A)(2) of section 5126.08 of the Revised Code 21930
establishing standards to be followed by county boards of mental 21931
retardation and developmental disabilities in administering, 21932
providing, arranging, and operating programs and services and in 21933
addition to the board accreditation system established under 21934

section 5126.081 of the Revised Code, the director of mental 21935
retardation and developmental disabilities shall adopt rules in 21936
accordance with Chapter 119. of the Revised Code establishing 21937
standards for promoting and advancing the quality of life of 21938
individuals with mental retardation and developmental disabilities 21939
receiving any of the following: 21940

(1) Early childhood services pursuant to section 5126.05 of 21941
the Revised Code for children under age three; 21942

(2) Adult services pursuant to section 5126.05 and division 21943
(B) of section 5126.051 of the Revised Code for individuals age 21944
sixteen or older; 21945

(3) Family support services pursuant to section 5126.11 of 21946
the Revised Code. 21947

(B) The rules adopted under this section shall specify the 21948
actions county boards of mental retardation and developmental 21949
disabilities and the agencies with which they contract should take 21950
to do the following: 21951

(1) Offer individuals with mental retardation and 21952
developmental disabilities, and their families when appropriate, 21953
choices in programs and services that are centered on the needs 21954
and desires of those individuals; 21955

(2) Maintain infants with their families whenever possible by 21956
collaborating with other agencies that provide services to infants 21957
and their families and taking other appropriate actions; 21958

(3) Provide families that have children with mental 21959
retardation and developmental disabilities under age eighteen 21960
residing in their homes the resources necessary to allow the 21961
children to remain in their homes; 21962

(4) Create and implement community employment services based 21963
on the needs and desires of adults with mental retardation and 21964

developmental disabilities;	21965
(5) Create, in collaboration with other agencies,	21966
transportation systems that provide safe and accessible	21967
transportation within the county to individuals with disabilities;	21968
(6) Provide services that allow individuals with disabilities	21969
to be integrated into the community by engaging in educational,	21970
vocational, and recreational activities with individuals who do	21971
not have disabilities;	21972
(7) Provide age-appropriate retirement services for	21973
individuals age sixty-five and older with mental retardation and	21974
developmental disabilities;	21975
(8) Establish residential services and supported living for	21976
individuals with mental retardation and developmental disabilities	21977
in accordance with their needs.	21978
(C) To assist in funding programs and services that meet the	21979
standards established under this section, each county board of	21980
mental retardation and developmental disabilities shall make a	21981
good faith effort to acquire available federal funds, including	21982
reimbursements under Title XIX of the "Social Security Act," 79	21983
Stat. 286 (1965), 42 U.S.C.A. 1396, as amended <u>medicaid program</u> .	21984
(D) Each county board of mental retardation and developmental	21985
disabilities shall work toward full compliance with the standards	21986
established under this section, based on its available resources.	21987
Funds received under this chapter shall be used to comply with the	21988
standards. Annually, each board shall conduct a self audit to	21989
evaluate the board's progress in complying fully with the	21990
standards.	21991
(E) The department shall complete a program quality review of	21992
each county board of mental retardation and developmental	21993
disabilities to determine the extent to which the board has	21994
complied with the standards. The review shall be conducted in	21995

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 22026
behaviors necessary for an individual with mental retardation or 22027
other developmental disability to function with as much 22028
self-determination and independence as possible and toward the 22029
prevention of deceleration, regression, or loss of current optimal 22030
functional status. 22031

(4) "Eligible for active treatment" means that an individual 22032
with mental retardation or other developmental disability resides 22033
in an intermediate care facility for the mentally retarded 22034
certified under ~~Title XIX of the "Social Security Act," 79 Stat.~~ 22035
~~286 (1965), 42 U.S.C. 1396, as amended~~ medicaid program; resides 22036
in a state institution operated by the department of mental 22037
retardation and developmental disabilities; or is enrolled in home 22038
and community-based services. 22039

(5) "Traditional adult services" means vocational and 22040
nonvocational activities conducted within a sheltered workshop or 22041
adult activity center or supportive home services. 22042

(B) Each county board of mental retardation and developmental 22043
disabilities shall certify to the director of mental retardation 22044
and developmental disabilities all of the following: 22045

(1) On or before the fifteenth day of October, the average 22046
daily membership for the first full week of programs and services 22047
during October receiving: 22048

(a) Early childhood services provided pursuant to section 22049
5126.05 of the Revised Code for children who are less than three 22050
years of age on the thirtieth day of September of the academic 22051
year; 22052

(b) Special education for handicapped children in approved 22053
school age classes; 22054

(c) Adult services for persons sixteen years of age and older 22055
operated pursuant to section 5126.05 and division (B) of section 22056

5126.051 of the Revised Code. Separate counts shall be made for 22057
the following: 22058

(i) Persons enrolled in traditional adult services who are 22059
eligible for but not enrolled in active treatment; 22060

(ii) Persons enrolled in traditional adult services who are 22061
eligible for and enrolled in active treatment; 22062

(iii) Persons enrolled in traditional adult services but who 22063
are not eligible for active treatment; 22064

(iv) Persons participating in community employment services. 22065
To be counted as participating in community employment services, a 22066
person must have spent an average of no less than ten hours per 22067
week in that employment during the preceding six months. 22068

(d) Other programs in the county for individuals with mental 22069
retardation and developmental disabilities that have been approved 22070
for payment of subsidy by the department of mental retardation and 22071
developmental disabilities. 22072

The membership in each such program and service in the county 22073
shall be reported on forms prescribed by the department of mental 22074
retardation and developmental disabilities. 22075

The department of mental retardation and developmental 22076
disabilities shall adopt rules defining full-time equivalent 22077
enrollees and for determining the average daily membership 22078
therefrom, except that certification of average daily membership 22079
in approved school age classes shall be in accordance with rules 22080
adopted by the state board of education. The average daily 22081
membership figure shall be determined by dividing the amount 22082
representing the sum of the number of enrollees in each program or 22083
service in the week for which the certification is made by the 22084
number of days the program or service was offered in that week. No 22085
enrollee may be counted in average daily membership for more than 22086
one program or service. 22087

(2) By the fifteenth day of December, the number of children 22088
enrolled in approved preschool units on the first day of December; 22089

(3) On or before the thirtieth day of March, an itemized 22090
report of all income and operating expenditures for the 22091
immediately preceding calendar year, in the format specified by 22092
the department of mental retardation and developmental 22093
disabilities; 22094

(4) By the fifteenth day of February, a report of the total 22095
annual cost per enrollee for operation of programs and services in 22096
the preceding calendar year. The report shall include a grand 22097
total of all programs operated, the cost of the individual 22098
programs, and the sources of funds applied to each program. 22099

(5) That each required certification and report is in 22100
accordance with rules established by the department of mental 22101
retardation and developmental disabilities and the state board of 22102
education for the operation and subsidization of the programs and 22103
services. 22104

(C) To compute payments under this section to the board for 22105
the fiscal year, the department of mental retardation and 22106
developmental disabilities shall use the certification of average 22107
daily membership required by division (B)(1) of this section 22108
exclusive of the average daily membership in any approved school 22109
age class and the number in any approved preschool unit. 22110

(D) The department shall pay each county board for each 22111
fiscal year an amount equal to nine hundred fifty dollars times 22112
the certified number of persons who on the first day of December 22113
of the academic year are under three years of age and are not in 22114
an approved preschool unit. For persons who are at least age 22115
sixteen and are not in an approved school age class, the 22116
department shall pay each county board for each fiscal year the 22117
following amounts: 22118

(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; 22119
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(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; 22122
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(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; 22125
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(4) No less than one thousand five hundred dollars times the certified average daily membership of persons participating in community employment services. 22129
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(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. 22132
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(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. 22137
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(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 22146
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are eligible, the department shall include the average daily 22150
membership in approved school age or preschool units. The 22151
department, in accordance with this section and upon receipt and 22152
approval of the certification required by this section and any 22153
other information it requires to enable it to determine a board's 22154
payments, shall pay the agency providing the specialized training 22155
the amounts payable under this section. 22156

Sec. 5160.01. As used in the Revised Code: 22157

"Children's health insurance program" means the program 22158
authorized by Title XXI of the Social Security Act of 1935 and 22159
Chapter 5167. of the Revised Code. 22160

"Disability medical assistance program" and "disability 22161
medical assistance" mean the program authorized by Chapter 5168. 22162
of the Revised Code. 22163

"Medicaid program" and "medicaid" mean the medical assistance 22164
program created by Title XIX of the Social Security Act of 1935 22165
and Chapters 5161., 5162., 5163., 5164., 5165., and 5166. of the 22166
Revised Code. 22167

"Medicare program" and "medicare" mean the health insurance 22168
program created by Title XVIII of the Social Security Act of 1935. 22169

"Ohio's best Rx program" means the program established under 22170
Chapter 5169. of the Revised Code. 22171

"Supplemental security income program," "SSI program," 22172
"supplemental security income," and "SSI" mean the program 22173
providing benefits to qualified aged, blind, and disabled 22174
individuals created by Title XVI of the Social Security Act of 22175
1935. 22176

"Residential state supplement program" means the program 22177
administered pursuant to section 5160.80 of the Revised Code. 22178

<u>Sec. 5160.02. As used in this chapter:</u>	22179
<u>(A) "ODHCA family services duty" means a family services duty associated with an ODHCA program.</u>	22180 22181
<u>(B) "ODHCA program" means all of the following:</u>	22182
<u>(1) The children's health insurance program;</u>	22183
<u>(2) The disability medical assistance program;</u>	22184
<u>(3) The medicaid program;</u>	22185
<u>(4) The Ohio's best Rx program;</u>	22186
<u>(5) The residential state supplement program;</u>	22187
<u>(6) Any other program that state law permits or requires the department of health care administration to administer.</u>	22188 22189
<u>Sec. 5160.03. The director of health care administration shall do all of the following as necessary for the department's efficient administration:</u>	22190 22191 22192
<u>(A) Organize the department of health care administration, including creating administrative subunits;</u>	22193 22194
<u>(B) Appoint employees and prescribe their titles and duties, including chiefs of administrative subunits;</u>	22195 22196
<u>(C) Establish procedures for conducting the business of the department, including procedures for the custody, use, and preservation of records, papers, documents, and property.</u>	22197 22198 22199
<u>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</u>	22200 22201 22202 22203 22204 22205

Chapter 4729. of the Revised Code; two doctors of medicine and two 22206
doctors of osteopathy licensed under Chapter 4731. of the Revised 22207
Code; a registered nurse licensed under Chapter 4723. of the 22208
Revised Code; and a pharmacologist who has a doctoral degree. The 22209
committee shall elect one of its members as chairperson. 22210

Sec. 5160.05. If the director of health care administration 22211
determines that a position with the department of health care 22212
administration can best be filled in accordance with division 22213
(A)(2) of section 124.30 of the Revised Code or without regard to 22214
a residency requirement established by a rule adopted by the 22215
director of administrative services, the director of health care 22216
administration shall provide the director of administrative 22217
services certification of the determination. 22218

Sec. 5160.06. The director of health care administration may 22219
require any of the employees of the department of health care 22220
administration who may be charged with custody or control of any 22221
public money or property or who is required to give bond, to give 22222
a bond, properly conditioned, in a sum to be fixed by the director 22223
which when approved by the director, shall be filed in the office 22224
of the secretary of state. The cost of such bonds, when approved 22225
by the director, shall be paid from funds available for the 22226
department. The bonds required or authorized by this section may, 22227
in the discretion of the director, be individual, schedule, or 22228
blanket bonds. 22229

Sec. 5160.08. The director of health care administration may 22230
acquire by purchase, lease, or otherwise such real and personal 22231
property rights in the name of the state as are necessary for the 22232
purposes of the department of health care administration. The 22233
director, with the approval of the governor and the attorney 22234
general, may sell, lease, or exchange portions of real and 22235

personal property of the department when the sale, lease, or 22236
exchange is advantageous to the state. Money received from such 22237
sales, leases, or exchanges shall be credited to the general 22238
revenue fund. 22239

Sec. 5160.10. There is hereby created in the state treasury 22240
the ODHCA support services federal operating fund. The fund shall 22241
consist of federal funds the department of health care 22242
administration receives and that the director of health care 22243
administration determines are appropriate for deposit into the 22244
fund. Money in the fund shall be used to pay the federal share of 22245
both of the following: 22246

(A) The department's costs for computer projects; 22247

(B) The operating costs of the parts of the department that 22248
provide general support services for the department's 22249
administrative subunits. 22250

Sec. 5160.101. There is hereby created in the state treasury 22251
the ODHCA support services state operating fund. The fund shall 22252
consist of payments made to the fund from other appropriation 22253
items by intrastate transfer voucher. Money in the fund shall be 22254
used to pay for both of the following: 22255

(A) The department of health care administration's costs for 22256
computer projects; 22257

(B) The operating costs of the parts of the department that 22258
provide general support services for the department's 22259
administrative subunits. 22260

Sec. 5160.12. The director of health care administration may 22261
expend funds appropriated or available to the department of health 22262
care administration from any person or government entity. For 22263
purposes of this section, the director may enter into contracts 22264

with persons and government entities and make grants to persons 22265
and government entities. To the extent permitted by federal law, 22266
the director may advance funds to a grantee when necessary for the 22267
grantee to perform duties under the grant as specified by the 22268
director. 22269

Sec. 5160.13. (A) As used in this section: 22270

(1) "Entity" includes an agency, board, commission, or 22271
department of the state or a political subdivision of the state; a 22272
private, nonprofit entity; a school district; a private school; or 22273
a public or private institution of higher education. 22274

(2) "Federal financial participation" means the federal 22275
government's share of expenditures made by an entity in 22276
implementing an ODHCA program. 22277

(B) This section does not apply to contracts entered into 22278
under section 5161.05 or 5161.10 of the Revised Code. 22279

(C) At the request of any public entity having authority to 22280
implement an ODHCA program or any private entity under contract 22281
with a public entity to implement an ODHCA program, the department 22282
may seek to obtain federal financial participation for costs 22283
incurred by the entity. Federal financial participation may be 22284
sought only for expenditures made with funds for which federal 22285
financial participation is available under federal law. 22286

(D) All funds collected by the department pursuant to this 22287
section shall be distributed to the entities that incurred the 22288
costs, except for any amounts retained by the department pursuant 22289
to division (E)(3) of this section. 22290

(E) In distributing federal financial participation pursuant 22291
to this section, the department may either enter into an agreement 22292
with the entity that is to receive the funds or distribute the 22293
funds in accordance with rules adopted under division (F) of this 22294

section. If the department decides to enter into an agreement to 22295
distribute the funds, the agreement may include terms that do any 22296
of the following: 22297

(1) Provide for the whole or partial reimbursement of any 22298
cost incurred by the entity in implementing the program; 22299

(2) In the event that federal financial participation is 22300
disallowed or otherwise unavailable for any expenditure, require 22301
the department or the entity, whichever party caused the 22302
disallowance or unavailability of federal financial participation, 22303
to assume responsibility for the expenditures; 22304

(3) Permit the department to retain not more than five per 22305
cent of the amount of the federal financial participation to be 22306
distributed to the entity; 22307

(4) Require the public entity to certify the availability of 22308
sufficient unencumbered funds to match the federal financial 22309
participation it receives under this section; 22310

(5) Establish the length of the agreement, which may be for a 22311
fixed or a continuing period of time; 22312

(6) Establish any other requirements determined by the 22313
department to be necessary for the efficient administration of the 22314
agreement. 22315

(F) The director of health care administration shall adopt 22316
rules as necessary to implement this section, including rules for 22317
the distribution of federal financial participation pursuant to 22318
this section. The rules shall be adopted in accordance with 22319
Chapter 119. of the Revised Code. The director may amend the state 22320
medicaid plan or state child health plan as necessary to implement 22321
this section. 22322

(G) Federal financial participation received pursuant to this 22323
section shall not be included in any calculation made under 22324

sections 5160.26 and 5160.261 of the Revised Code. 22325

Sec. 5160.15. (A) The director of job and family services may 22326
enter into one or more written fiscal agreements with boards of 22327
county commissioners under which financial assistance is awarded 22328
for ODHCA family services duties. Boards of county commissioners 22329
shall select which ODHCA family services duties to include in a 22330
fiscal agreement. A fiscal agreement shall do all of the 22331
following: 22332

(1) Specify the ODHCA family services duties included in the 22333
agreement and the private or government entity designated under 22334
section 307.981 of the Revised Code to serve as the county 22335
department of job and family services; 22336

(2) Provide for the department of health care administration 22337
to award financial assistance for the ODHCA family services duties 22338
included in the agreement in accordance with a methodology for 22339
determining the amount of the award established by rules adopted 22340
under division (B) of this section; 22341

(3) Specify the form of the award of financial assistance 22342
which may be an allocation, cash draw, reimbursement, property, 22343
or, to the extent authorized by an appropriation made by the 22344
general assembly and to the extent practicable and not in conflict 22345
with a federal or state law, a consolidated funding allocation for 22346
two or more of the ODHCA family services duties included in the 22347
agreement; 22348

(4) Provide that the award of financial assistance is subject 22349
to the availability of federal funds and appropriations made by 22350
the general assembly; 22351

(5) Specify annual financial, administrative, or other 22352
incentive awards, if any, to be provided in accordance with 22353
section 5160.20 of the Revised Code; 22354

<u>(6) Include the assurance of the board of county commissioners that the board will do all of the following:</u>	22355
	22356
<u>(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;</u>	22357
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<u>(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;</u>	22366
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<u>(c) Require the county department to do both of the following:</u>	22370
	22371
<u>(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;</u>	22372
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	22376
<u>(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.</u>	22377
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	22379
<u>(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</u>	22380
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<u>of federal financial participation, or other sanction or penalty;</u>	22386
<u>(e) Require the county department to take prompt corrective</u>	22387
<u>action, including paying amounts resulting from an adverse</u>	22388
<u>finding, sanction, or penalty, if the department, auditor of</u>	22389
<u>state, federal agency, or other entity authorized by federal or</u>	22390
<u>state law to determine compliance with requirements for an ODHCA</u>	22391
<u>family services duties included in the agreement determines</u>	22392
<u>compliance has not been achieved.</u>	22393
<u>(7) Provide for the department taking action pursuant to</u>	22394
<u>division (C) of section 5160.21 of the Revised Code if authorized</u>	22395
<u>by division (B)(1), (2), (3), or (4) of that section;</u>	22396
<u>(8) Provide for timely audits required by federal and state</u>	22397
<u>law and require prompt release of audit findings and prompt action</u>	22398
<u>to correct problems identified in an audit;</u>	22399
<u>(9) Comply with all of the requirements for the ODHCA family</u>	22400
<u>services duties included in the agreement that have been</u>	22401
<u>established by the department, federal or state law, or any of the</u>	22402
<u>following that concern the duties and are published under section</u>	22403
<u>5160.152 of the Revised Code: the state medicaid plan, the state</u>	22404
<u>child health plan, grant agreements between the department and a</u>	22405
<u>federal agency, and executive orders issued by the governor;</u>	22406
<u>(10) Provide for dispute resolution procedures in accordance</u>	22407
<u>with section 5160.21 of the Revised Code;</u>	22408
<u>(11) Establish the method of amending or terminating the</u>	22409
<u>agreement and an expedited process for correcting terms or</u>	22410
<u>conditions of the agreement that the director and the board agree</u>	22411
<u>are erroneous;</u>	22412
<u>(12) Except as provided in rules adopted under division (C)</u>	22413
<u>of this section, begin on the first day of July of an odd-numbered</u>	22414
<u>year and end on the last day of June of the next odd-numbered</u>	22415
<u>year.</u>	22416

(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. 22417
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(C)(1) The director shall adopt rules in accordance with section 111.15 of the Revised Code governing fiscal agreements. 22422
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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: 22424
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(a) Govern the establishment of allocations; 22433

(b) Specify allowable uses of financial assistance awarded under the agreements; 22434
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(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. 22436
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(2) A requirement of a fiscal agreement established by a rule adopted under this division is applicable to a fiscal agreement 22446
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without having to be restated in the fiscal agreement. 22448

Sec. 5160.151. The director of health care administration may 22449
provide for a fiscal agreement entered into under section 5160.15 22450
of the Revised Code to have a retroactive effective date of the 22451
first day of July of an odd-numbered year if both of the following 22452
are the case: 22453

(A) The agreement is entered into after that date and before 22454
the last day of that July. 22455

(B) The board of county commissioners requests the 22456
retroactive effective date and provides the director good cause 22457
satisfactory to the director for the reason the agreement was not 22458
entered into on or before the first day of that July. 22459

Sec. 5160.152. The department of health care administration 22460
shall publish in a manner accessible to the public all of the 22461
following that concern ODHCA family services duties that are 22462
included in fiscal agreements entered into under section 5160.15 22463
of the Revised Code: the state medicaid plan, the state child 22464
health plan, grant agreements between the department and a federal 22465
agency, and executive orders issued by the governor. The 22466
department may publish the materials electronically or otherwise. 22467

Sec. 5160.16. (A) Except as provided in section 5160.151 of 22468
the Revised Code, if a fiscal agreement under section 5160.15 of 22469
the Revised Code between the director of health care 22470
administration and a board of county commissioners is not in 22471
effect, all of the following apply: 22472

(1) The department of health care administration shall award 22473
to the county the board serves financial assistance for ODHCA 22474
family services duties in accordance with a methodology for 22475
determining the amount of the award established by rules adopted 22476

<u>under division (B) of this section.</u>	22477
<u>(2) The financial assistance may be provided in the form of</u>	22478
<u>allocations, cash draws, reimbursements, and property but may not</u>	22479
<u>be made in the form of a consolidated funding allocation.</u>	22480
<u>(3) The award of the financial assistance is subject to the</u>	22481
<u>availability of federal funds and appropriations made by the</u>	22482
<u>general assembly.</u>	22483
<u>(4) The county department shall do all of the following:</u>	22484
<u>(a) Use the financial assistance, and perform the ODHCA</u>	22485
<u>family services duties, in accordance with requirements for the</u>	22486
<u>duties established by the department, a federal or state law, or</u>	22487
<u>any of the following that concern the duties: the state medicaid</u>	22488
<u>plan, the child health plan, grant agreements between the</u>	22489
<u>department and a federal agency, and executive orders issued by</u>	22490
<u>the governor;</u>	22491
<u>(b) Utilize a financial management system and other</u>	22492
<u>accountability mechanisms for the financial assistance that meet</u>	22493
<u>requirements the department establishes;</u>	22494
<u>(c) Monitor all private and government entities that receive</u>	22495
<u>a payment from the financial assistance to ensure that each entity</u>	22496
<u>uses the payment in accordance with requirements for the ODHCA</u>	22497
<u>family services duties and take action to recover payments that</u>	22498
<u>are not used in accordance with the requirements for the ODHCA</u>	22499
<u>family services duties;</u>	22500
<u>(d) Promptly reimburse the department the amount that</u>	22501
<u>represents the amount the county department is responsible for,</u>	22502
<u>pursuant to action the department takes under division (C) of</u>	22503
<u>section 5160.21 of the Revised Code, of funds the department pays</u>	22504
<u>to any entity because of an adverse audit finding, adverse quality</u>	22505
<u>control finding, final disallowance of federal financial</u>	22506
<u>participation, or other sanction or penalty;</u>	22507

(e) Take prompt corrective action, including paying amounts 22508
resulting from an adverse finding, sanction, or penalty, if the 22509
department, auditor of state, federal agency, or other entity 22510
authorized by federal or state law to determine compliance with 22511
requirements for an ODHCA family services duty determines 22512
compliance has not been achieved. 22513

(B) The director shall adopt rules in accordance with section 22514
111.15 of the Revised Code as necessary to implement this section. 22515
The director shall adopt the rules as if they were internal 22516
management rules. Before adopting the rules, the director shall 22517
give the public an opportunity to review and comment on the 22518
proposed rules. The rules shall establish methodologies to be used 22519
to determine the amount of financial assistance to be awarded and 22520
may do any or all of the following: 22521

(1) Govern the establishment of funding allocations; 22522

(2) Specify allowable uses of financial assistance the 22523
department awards under this section; 22524

(3) Establish reporting, cash management, audit, and other 22525
requirements the director determines are necessary to provide 22526
accountability for the use of the financial assistance and 22527
determine compliance with requirements established by the 22528
department, a federal or state law, or any of the following that 22529
concern the ODHCA family services duties for which the financial 22530
assistance is awarded: the state medicaid plan, the state child 22531
health plan, grant agreements between the department and a federal 22532
entity, and executive orders issued by the governor. 22533

Sec. 5160.17. The director of health care administration may 22534
enter into a written agreement with one or more state agencies, as 22535
defined in section 117.01 of the Revised Code, and state 22536
universities and colleges to assist in the coordination, 22537
provision, or enhancement of ODHCA family services duties. The 22538

director also may enter into written agreements or contracts with, 22539
or issue grants to, private and government entities under which 22540
funds are provided for the enhancement or innovation of ODHCA 22541
family services duties on the state or local level. 22542

The director may adopt internal management rules in 22543
accordance with section 111.15 of the Revised Code to implement 22544
this section. 22545

Sec. 5160.18. The director of health care administration may 22546
enter into one or more written operational agreements with boards 22547
of county commissioners to do one or more of the following 22548
regarding ODHCA family services duties: 22549

(A) Provide for the director to amend or rescind a rule the 22550
director previously adopted; 22551

(B) Provide for the director to modify procedures or 22552
establish alternative procedures to accommodate special 22553
circumstances in a county; 22554

(C) Provide for the director and board to jointly identify 22555
operational problems of mutual concern and develop a joint plan to 22556
address the problems; 22557

(D) Establish a framework for the director and board to 22558
modify the use of existing resources in a manner that is 22559
beneficial to the department of health care administration and the 22560
county that the board serves and improves ODHCA family services 22561
duties for the recipients of the services. 22562

Sec. 5160.19. The department of health care administration 22563
may establish performance and other administrative standards for 22564
the administration and outcomes of ODHCA family services duties 22565
and determine at intervals the department decides the degree to 22566
which a county department of job and family services complies with 22567
a performance or other administrative standard. The department may 22568

use statistical sampling, performance audits, case reviews, or 22569
other methods it determines necessary and appropriate to determine 22570
compliance with performance and administrative standards. 22571

Sec. 5160.191. (A) Except as provided by division (C) of this 22572
section, if the department of health care administration 22573
determines that a county department of job and family services has 22574
failed to comply with a performance or other administrative 22575
standard established under section 5160.19 of the Revised Code or 22576
by federal law for the administration or outcome of an ODHCA 22577
family services duty, the department shall require the county 22578
department to develop, submit to the department for approval, and 22579
comply with a corrective action plan. 22580

(B) If a county department fails to develop, submit to the 22581
department, or comply with a corrective action plan under division 22582
(A) of this section, or the department disapproves the county 22583
department's corrective action plan, the department may require 22584
the county department to develop, submit to the department for 22585
approval, and comply with a corrective action plan that requires 22586
the county department to commit existing resources to the plan. 22587

(C) The department may not require a county department to 22588
take action under this section for failure to comply with a 22589
performance or other administrative standard established for an 22590
incentive awarded by the department. Instead, the department may 22591
require a county department that fails to comply with that kind of 22592
performance or other administrative standard to take action in 22593
accordance with rules adopted by the department governing the 22594
standard. 22595

(D) At the request of a county department, the department 22596
shall assist the county department with the development of a 22597
corrective action plan under this section and provide the county 22598
department technical assistance in the implementation of the plan. 22599

Sec. 5160.192. The director of health care administration may 22600
adopt rules in accordance with section 111.15 of the Revised Code 22601
to implement sections 5160.19 to 5160.192 of the Revised Code. If 22602
the director adopts the rules, the director shall adopt the rules 22603
as if they were internal management rules. 22604

Sec. 5160.20. Subject to the availability of funds, the 22605
department of health care administration may provide annual 22606
financial, administrative, or other incentive awards to county 22607
departments of job and family services. A county department may 22608
spend funds provided as a financial incentive award only for the 22609
purpose for which the funds are appropriated. The department may 22610
adopt internal management rules in accordance with section 111.15 22611
of the Revised Code to establish the amounts of awards, 22612
methodology for distributing the awards, types of awards, and 22613
standards for administration by the department. 22614

There is hereby created in the state treasury the medicaid 22615
local incentive fund. The director of health care administration 22616
may request that the director of budget and management transfer 22617
funds appropriated for ODHCA family services duties into the fund. 22618
If the director of budget and management determines that the funds 22619
identified by the director of health care administration are 22620
available and appropriate for transfer, the director of budget and 22621
management shall make the transfer. Money in the fund shall be 22622
used to provide incentive awards under this section. 22623

Sec. 5160.21. (A) As used in this section, "responsible 22624
entity" means a board of county commissioners or a county 22625
department of job and family services, whichever the director of 22626
health care administration determines is appropriate to take 22627
action against under division (C) of this section. 22628

(B) Regardless of whether an ODHCA family services duty is 22629

performed by a county department of job and family services, 22630
private or government entity pursuant to a contract entered into 22631
under section 307.982 of the Revised Code, or private or 22632
government provider of an ODHCA family service duty, the 22633
department of health care administration may take action under 22634
division (C) of this section against the responsible entity if the 22635
department determines any of the following are the case: 22636

(1) A requirement of a fiscal agreement entered into under 22637
section 5160.15 of the Revised Code that includes the ODHCA family 22638
services duty, including a requirement for fiscal agreements 22639
established by rules adopted under that section, is not complied 22640
with; 22641

(2) A county department fails to develop, submit to the 22642
department, or comply with a corrective action plan under division 22643
(B) of section 5160.191 of the Revised Code, or the department 22644
disapproves the county department's corrective action plan 22645
developed under division (B) of section 5160.191 of the Revised 22646
Code; 22647

(3) A requirement for the ODHCA family services duty 22648
established by the department or any of the following is not 22649
complied with: a federal or state law, the state medicaid plan, 22650
the state child health plan, grant agreement between the 22651
department and a federal agency, or executive order issued by the 22652
governor; 22653

(4) The responsible entity is solely or partially 22654
responsible, as determined by the director of health care 22655
administration, for an adverse audit finding, adverse quality 22656
control finding, final disallowance of federal financial 22657
participation, or other sanction or penalty regarding the medicaid 22658
family services duty. 22659

(C) The department may take one or more of the following 22660

actions against the responsible entity when authorized by division 22661
(B)(1), (2), (3), or (4) of this section: 22662

(1) Require the responsible entity to comply with a 22663
corrective action plan pursuant to a time schedule specified by 22664
the department. The corrective action plan shall be established or 22665
approved by the department and shall not require a county 22666
department to commit resources to the plan. 22667

(2) Require the responsible entity to comply with a 22668
corrective action plan pursuant to a time schedule specified by 22669
the department. The corrective action plan shall be established or 22670
approved by the department and require a county department to 22671
commit to the plan existing resources identified by the county 22672
department. 22673

(3) Require the responsible entity to do one of the 22674
following: 22675

(a) Share with the department a final disallowance of federal 22676
financial participation or other sanction or penalty; 22677

(b) Reimburse the department the final amount the department 22678
pays to the federal government or another entity that represents 22679
the amount the responsible entity is responsible for of an adverse 22680
audit finding, adverse quality control finding, final disallowance 22681
of federal financial participation, or other sanction or penalty 22682
issued by the federal government, auditor of state, or other 22683
entity; 22684

(c) Pay the federal government or another entity the final 22685
amount that represents the amount the responsible entity is 22686
responsible for of an adverse audit finding, adverse quality 22687
control finding, final disallowance of federal financial 22688
participation, or other sanction or penalty issued by the federal 22689
government, auditor of state, or other entity; 22690

(d) Pay the department the final amount that represents the 22691

amount the responsible entity is responsible for of an adverse 22692
audit finding or adverse quality control finding. 22693

(4) Impose an administrative sanction issued by the 22694
department against the responsible entity. A sanction may be 22695
increased if the department has previously taken action against 22696
the responsible entity under this division. 22697

(5) Perform, or contract with a government or private entity 22698
for the entity to perform, the ODHCA family services duty until 22699
the department is satisfied that the responsible entity ensures 22700
that the duty will be performed satisfactorily. If the department 22701
performs or contracts with an entity to perform an ODHCA family 22702
services duty under division (C)(5) of this section, the 22703
department may do either or both of the following: 22704

(a) Spend funds in the county treasury appropriated by the 22705
board of county commissioners for the duty; 22706

(b) Withhold funds allocated or reimbursements due to the 22707
responsible entity for the duty and spend the funds for the duty. 22708

(6) Request that the attorney general bring mandamus 22709
proceedings to compel the responsible entity to take or cease the 22710
action that causes division (B)(1), (2), (3), or (4) of this 22711
section to apply. The attorney general shall bring mandamus 22712
proceedings in the Franklin county court of appeals at the 22713
department's request. 22714

(7) If the department takes action under this division 22715
because of division (B)(3) of this section, temporarily withhold 22716
funds allocated or reimbursement due to the responsible entity 22717
until the department determines that the responsible entity is in 22718
compliance with the requirement. The department shall release the 22719
funds when the department determines that compliance has been 22720
achieved. 22721

(D) If the department proposes to take action against the 22722

responsible entity under division (C) of this section, the 22723
department shall notify the responsible entity and county auditor. 22724
The notice shall be in writing and specify the action the 22725
department proposes to take. The department shall send the notice 22726
by regular United States mail. 22727

Except as provided by division (E) of this section, the 22728
responsible entity may request an administrative review of a 22729
proposed action in accordance with administrative review 22730
procedures the department shall establish. The administrative 22731
review procedures shall comply with all of the following: 22732

(1) A request for an administrative review shall state 22733
specifically all of the following: 22734

(a) The proposed action specified in the notice from the 22735
department for which the review is requested; 22736

(b) The reason why the responsible entity believes the 22737
proposed action is inappropriate; 22738

(c) All facts and legal arguments that the responsible entity 22739
wants the department to consider; 22740

(d) The name of the person who will serve as the responsible 22741
entity's representative in the review. 22742

(2) If the department's notice specifies more than one 22743
proposed action and the responsible entity does not specify all of 22744
the proposed actions in its request pursuant to division (D)(1)(a) 22745
of this section, the proposed actions not specified in the request 22746
shall not be subject to administrative review and the parts of the 22747
notice regarding those proposed actions shall be final and binding 22748
on the responsible entity. 22749

(3) In the case of a proposed action under division (C)(1) of 22750
this section, the responsible entity shall have fifteen calendar 22751
days after the department mails the notice to the responsible 22752

entity to send a written request to the department for an 22753
administrative review. If it receives such a request within the 22754
required time, the department shall postpone taking action under 22755
division (C)(1) of this section for fifteen calendar days 22756
following the day it receives the request or extended period of 22757
time provided for in division (D)(5) of this section to allow a 22758
representative of the department and a representative of the 22759
responsible entity an informal opportunity to resolve any dispute 22760
during that fifteen-day or extended period. 22761

(4) In the case of a proposed action under division (C)(2), 22762
(3), (4), (5), or (7) of this section, the responsible entity 22763
shall have thirty calendar days after the department mails the 22764
notice to the responsible entity to send a written request to the 22765
department for an administrative review. If it receives such a 22766
request within the required time, the department shall postpone 22767
taking action under division (C)(2), (3), (4), (5), or (7) of this 22768
section for thirty calendar days following the day it receives the 22769
request or extended period of time provided for in division (D)(5) 22770
of this section to allow a representative of the department and a 22771
representative of the responsible entity an informal opportunity 22772
to resolve any dispute during that thirty-day or extended period. 22773

(5) If the informal opportunity provided in division (D)(3) 22774
or (4) of this section does not result in a written resolution to 22775
the dispute within the fifteen- or thirty-day period, the director 22776
of health care administration and representative of the 22777
responsible entity may enter into a written agreement extending 22778
the time period for attempting an informal resolution of the 22779
dispute under division (D)(3) or (4) of this section. 22780

(6) In the case of a proposed action under division (C)(3) of 22781
this section, the responsible entity may not include in its 22782
request disputes over a finding, final disallowance of federal 22783
financial participation, or other sanction or penalty issued by 22784

the federal government, auditor of state, or entity other than the 22785
department. 22786

(7) If the responsible entity fails to request an 22787
administrative review within the required time, the responsible 22788
entity loses the right to request an administrative review of the 22789
proposed actions specified in the notice and the notice becomes 22790
final and binding on the responsible entity. 22791

(8) If the informal opportunity provided in division (D)(3) 22792
or (4) of this section does not result in a written resolution to 22793
the dispute within the time provided by division (D)(3), (4), or 22794
(5) of this section, the director shall appoint an administrative 22795
review panel to conduct the administrative review. The review 22796
panel shall consist of department employees and one director or 22797
other representative of a county department that serves a 22798
different county than the county served by the responsible entity. 22799
No individual involved in the department's proposal to take action 22800
against the responsible entity may serve on the review panel. The 22801
review panel shall review the responsible entity's request. The 22802
review panel may require that the department or responsible entity 22803
submit additional information and schedule and conduct an informal 22804
hearing to obtain testimony or additional evidence. A review of a 22805
proposal to take action under division (C)(3) of this section 22806
shall be limited solely to the issue of the amount the responsible 22807
entity shall share with the department, reimburse the department, 22808
or pay to the federal government, department, or other entity 22809
under division (C)(3) of this section. The review panel is not 22810
required to make a stenographic record of its hearing or other 22811
proceedings. 22812

(9) After finishing an administrative review, an 22813
administrative review panel appointed under division (D)(8) of 22814
this section shall submit a written report to the director setting 22815
forth its findings of fact, conclusions of law, and 22816

recommendations for action. The director may approve, modify, or 22817
disapprove the recommendations. If the director modifies or 22818
disapproves the recommendations, the director shall state the 22819
reasons for the modification or disapproval and the actions to be 22820
taken against the responsible entity. 22821

(10) The director's approval, modification, or disapproval 22822
under division (D)(9) of this section shall be final and binding 22823
on the responsible entity and shall not be subject to further 22824
departmental review. 22825

(E) The responsible entity is not entitled to an 22826
administrative review under division (D) of this section for any 22827
of the following: 22828

(1) An action taken under division (C)(6) of this section; 22829

(2) An action taken under section 5160.211 of the Revised 22830
Code; 22831

(3) An action taken under division (C)(3) of this section if 22832
the federal government, auditor of state, or entity other than the 22833
department has identified the county department as being solely or 22834
partially responsible for an adverse audit finding, adverse 22835
quality control finding, final disallowance of federal financial 22836
participation, or other sanction or penalty; 22837

(4) An adjustment to an allocation, cash draw, advance, or 22838
reimbursement to a county department that the department 22839
determines necessary for budgetary reasons; 22840

(5) Withholding of a cash draw or reimbursement due to 22841
noncompliance with a reporting requirement established in rules 22842
adopted under section 5160.22 of the Revised Code. 22843

(F) This section does not apply to other actions the 22844
department takes against the responsible entity pursuant to 22845
authority granted by another state law unless the other state law 22846

requires the department to take the action in accordance with this 22847
section. 22848

(G) The director of job and family services may adopt rules 22849
in accordance with Chapter 119. of the Revised Code as necessary 22850
to implement this section. 22851

Sec. 5160.211. The department of health care administration 22852
may certify a claim to the attorney general under section 131.02 22853
of the Revised Code for the attorney general to take action under 22854
that section against a responsible entity to recover any funds 22855
that the department determines the responsible entity owes the 22856
department for actions taken under division (C)(2), (3), (4), or 22857
(5) of section 5160.21 of the Revised Code. 22858

Sec. 5160.22. The director of health care administration may 22859
adopt rules in accordance with section 111.15 of the Revised Code 22860
establishing reporting requirements for ODHCA family services 22861
duties. If the director adopts the rules, the director shall adopt 22862
the rules as if they were internal management rules and, before 22863
adopting the rules, give the public an opportunity to review and 22864
comment on the proposed rules. 22865

Sec. 5160.23. If a county department of job and family 22866
services submits an expenditure report to the department of health 22867
care administration and the department subsequently determines 22868
that an allocation, advance, or reimbursement the department makes 22869
to the county department, or a cash draw the county department 22870
makes, for an expenditure exceeds the allowable amount for the 22871
expenditure, the department may adjust, offset, withhold, or 22872
reduce an allocation, cash draw, advance, reimbursement, or other 22873
financial assistance to the county department as necessary to 22874
recover the amount of the excess allocation, advance, 22875
reimbursement, or cash draw. The department is not required to 22876

make the adjustment, offset, withholding, or reduction in 22877
accordance with section 5160.21 of the Revised Code. 22878

The director of health care administration may adopt rules 22879
under section 111.15 of the Revised Code as necessary to implement 22880
this section. The director shall adopt the rules as if they were 22881
internal management rules. 22882

Sec. 5160.24. The department of health care administration, 22883
in consultation with county representatives, shall develop annual 22884
training goals and model training curriculum regarding ODHCA 22885
family services duties for employees of county departments of job 22886
and family services and identify a variety of state funded 22887
training opportunities to meet the proposed goals. 22888

Sec. 5160.26. (A) As used in sections 5160.26 to 5160.262 of 22889
the Revised Code: 22890

"Disability medical assistance expenditures" means 22891
expenditures for the disability medical assistance program and 22892
county administration of the disability medical assistance 22893
program. 22894

"Medicaid expenditures" means expenditures for county 22895
administration of the medicaid program. "Medicaid expenditures" 22896
does not include expenditures for transportation services provided 22897
under the medicaid program. 22898

"Public assistance expenditures" has the same meaning as in 22899
section 5101.16 of the Revised Code. 22900

"Public medical assistance expenditures" means disability 22901
medical assistance expenditures and medicaid expenditures. 22902

(B) Except as provided in division (C) of this section, a 22903
county's share of public medical assistance expenditures is the 22904
sum of the following for each state fiscal year: 22905

(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. 22906
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(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. 22910
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(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. 22918
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(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. 22933
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(D)(1) If the per capita tax duplicate of a county is less 22937

than the per capita tax duplicate of the state as a whole and 22938
division (D)(2) of this section does not apply to the county, the 22939
percentage to be used for the purpose of division (B)(2) of this 22940
section is the product of ten multiplied by a fraction of which 22941
the numerator is the per capita tax duplicate of the county and 22942
the denominator is the per capita tax duplicate of the state as a 22943
whole. The department of health care administration shall compute 22944
the per capita tax duplicate for the state and for each county by 22945
dividing the tax duplicate for the most recent available year by 22946
the current estimate of population prepared by the department of 22947
development. 22948

(2) If the percentage of families in a county with an annual 22949
income of less than three thousand dollars is greater than the 22950
percentage of such families in the state and division (D)(1) of 22951
this section does not apply to the county, the percentage to be 22952
used for the purpose of division (B)(2) of this section is the 22953
product of ten multiplied by a fraction of which the numerator is 22954
the percentage of families in the state with an annual income of 22955
less than three thousand dollars a year and the denominator is the 22956
percentage of such families in the county. The department of 22957
health care administration shall compute the percentage of 22958
families with an annual income of less than three thousand dollars 22959
for the state and for each county by multiplying the most recent 22960
estimate of such families published by the department of 22961
development, by a fraction, the numerator of which is the estimate 22962
of average annual personal income published by the bureau of 22963
economic analysis of the United States department of commerce for 22964
the year on which the census estimate is based and the denominator 22965
of which is the most recent such estimate published by the bureau. 22966

(3) If the per capita tax duplicate of a county is less than 22967
the per capita tax duplicate of the state as a whole and the 22968
percentage of families in the county with an annual income of less 22969

than three thousand dollars is greater than the percentage of such 22970
families in the state, the percentage to be used for the purpose 22971
of division (B)(2) of this section shall be determined as follows: 22972

(a) Multiply ten by the fraction determined under division 22973
(D)(1) of this section; 22974

(b) Multiply the product determined under division (D)(3)(a) 22975
of this section by the fraction determined under division (D)(2) 22976
of this section. 22977

(4) The department of health care administration shall 22978
determine, for each county, the percentage to be used for the 22979
purpose of division (B)(2) of this section not later than the 22980
first day of July of the year preceding the state fiscal year for 22981
which the percentage is used. 22982

(E) The department of health care administration shall credit 22983
to a county the amount of federal reimbursement the department 22984
receives from the United States department of health and human 22985
services for the county's medicaid expenditures that the 22986
department determines are allowable administrative expenditures. 22987

(F) The director of health care administration shall adopt 22988
rules in accordance with section 111.15 of the Revised Code to 22989
establish all of the following: 22990

(1) The method the department of health care administration 22991
is to use to change a county's share of public medical assistance 22992
expenditures determined under division (B) of this section as 22993
provided in division (C) of this section; 22994

(2) The allocation methodology and formula the department 22995
will use to determine the amount of funds to credit to a county 22996
under this section; 22997

(3) The method the department will use to change the payment 22998
of the county share of public medical assistance expenditures from 22999

a calendar-year basis to a state fiscal year basis; 23000

(4) Other procedures and requirements necessary to implement 23001
this section. 23002

Sec. 5160.261. Prior to the sixteenth day of May annually, 23003
the department of health care administration shall certify to the 23004
board of county commissioners of each county the amount estimated 23005
by the department to be needed in the following state fiscal year 23006
to meet the county share, as determined under section 5160.26 of 23007
the Revised Code, of public medical assistance expenditures. Each 23008
January, the board shall appropriate the amount certified by the 23009
department and an additional five per cent of that amount. Each 23010
June, the board may reappropriate, for any purpose the board 23011
determines to be appropriate, the amount appropriated in January 23012
that exceeds the total of the amount certified by the department 23013
for the last six months of the current state fiscal year and the 23014
first six months of the following state fiscal year. 23015

Before the fifteenth day of each payment period the director 23016
of health care administration establishes by rule, the department 23017
of health care administration shall pay a county the estimated 23018
state and federal share of the county's public medical assistance 23019
expenditures for that payment period increased or decreased by the 23020
amount the department underpaid or overpaid the county for the 23021
most recent payment period that the department knows an 23022
underpayment or overpayment was made. 23023

If the department establishes a maximum amount that it will 23024
reimburse a county for public medical assistance expenditures and 23025
a county spends more for public medical assistance expenditures 23026
than is reimbursable, the department shall not pay the county a 23027
state or, except as provided in section 5160.262 of the Revised 23028
Code, a federal share for the amount of the expenditure that 23029
exceeds the maximum allowable reimbursement amount. County 23030

expenditures that exceed the maximum allowable reimbursement 23031
amount shall not be credited to a county's share of public medical 23032
assistance expenditures under section 5160.26 of the Revised Code. 23033
The department also shall not pay a county a state or, except as 23034
provided in section 5160.262 of the Revised Code, a federal share 23035
for an administrative expenditure that is not allowed by the 23036
department. 23037

A county shall deposit all funds appropriated by a board of 23038
county commissioners and received from the department under this 23039
section in a special fund in the county treasury known as the 23040
public assistance fund. A county shall make payments for public 23041
medical assistance expenditures from the public assistance fund. 23042

The attorney general shall bring mandamus proceedings in the 23043
Franklin county court of appeals against any board of county 23044
commissioners that fails to make appropriations or deposits into 23045
the public assistance fund required by this section. 23046

The director shall adopt internal management rules in 23047
accordance with section 111.15 of the Revised Code to do all of 23048
the following: 23049

(A) Establish the method by which the department is to make 23050
payments to counties under this section; 23051

(B) Establish procedures for payment by counties of the 23052
county share of public medical assistance expenditures; 23053

(C) Establish payment periods for paying a county its 23054
estimated state and federal share of public medical assistance 23055
expenditures; 23056

(D) Allow county departments of job and family services to 23057
use the public assistance fund for other purposes and programs 23058
similar to the disability medical assistance program and medicaid 23059
program. 23060

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. 23061
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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. 23065
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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. 23077
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The department shall keep a record of its investigations stating the time, place, charges or subject, witnesses summoned and examined, and their conclusions. 23083
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The fees of witnesses for attendance and travel shall be the same as in the court of common pleas. 23086
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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 23088
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production of books or papers, and the giving of testimony before 23091
the department, by a judgment for contempt or otherwise, in the 23092
same manner as in cases before those courts. 23093

Sec. 5160.30. The department of health care administration 23094
may appoint and commission any competent officer, employee, 23095
agency, or person to serve as a special agent, investigator, or 23096
representative to perform a designated duty for and in behalf of 23097
the department. Specific credentials shall be given by the 23098
department to each person so designated, and each credential shall 23099
state: 23100

(A) The person's name; 23101

(B) Agency with which such person is connected; 23102

(C) Purpose of appointment; 23103

(D) Date of expiration of appointment, if appropriate; 23104

(E) Such information as the department considers proper. 23105

Sec. 5160.32. (A) Subject to division (B) of this section, 23106
the director of health care administration may accept 23107
applications, determine eligibility, redetermine eligibility, and 23108
perform related administrative activities for one or more of the 23109
following: 23110

(1) The medicaid program; 23111

(2) The children's health insurance program; 23112

(3) Other programs regarding which the director determines 23113
administrative cost savings and efficiency may be achieved through 23114
the department accepting applications, determining eligibility, 23115
redetermining eligibility, or performing related administrative 23116
activities. 23117

(B) If federal law requires a face-to-face interview to 23118

complete an eligibility determination for a program, the 23119
face-to-face interview shall not be conducted by the department of 23120
health care administration. 23121

(C) Subject to division (B) of this section, if the director 23122
elects to accept applications, determine eligibility, redetermine 23123
eligibility, and perform related administrative activities for a 23124
program under this section, both of the following apply: 23125

(1) An individual seeking services under the program may 23126
apply for the program to the director or to the entity that state 23127
law governing the program authorizes to accept applications for 23128
the program. 23129

(2) The director is subject to federal statutes and 23130
regulations and state statutes and rules that require, permit, or 23131
prohibit an action regarding accepting applications, determining 23132
or redetermining eligibility, and performing related 23133
administrative activities for the program. 23134

(D) The director may adopt rules as necessary to implement 23135
this section. 23136

Sec. 5160.34. (A) As used in this section: 23137

(1) "Agency" means the following entities that administer an 23138
ODHCA program: 23139

(a) The department of health care administration; 23140

(b) A county department of job and family services; 23141

(c) A private or government entity administering, in whole or 23142
in part, an ODHCA program for or on behalf of the department of 23143
health care administration or a county department of job and 23144
family services. 23145

(2) "Appellant" means an applicant, participant, former 23146
participant, recipient, or former recipient of an ODHCA program 23147

who is entitled by federal or state law to a hearing regarding a 23148
decision or order of the agency that administers the program. 23149

(3) "ODHCA program" means the disability medical assistance 23150
program, the medicaid program, and residential state supplement 23151
program. 23152

(B) Except as provided by division (F) of this section, an 23153
appellant who appeals under federal or state law a decision or 23154
order of an agency administering an ODHCA program shall, at the 23155
appellant's request, be granted a state hearing by the department 23156
of health care administration. This state hearing shall be 23157
conducted in accordance with rules adopted under this section. The 23158
state hearing shall be recorded, but neither the recording nor a 23159
transcript of the recording shall be part of the official record 23160
of the proceeding. A state hearing decision is binding upon the 23161
agency and department, unless it is reversed or modified on appeal 23162
to the director of health care administration or a court of common 23163
pleas. 23164

(C) An appellant who disagrees with a state hearing decision 23165
may make an administrative appeal to the director of health care 23166
administration in accordance with rules adopted under this 23167
section. This administrative appeal does not require a hearing, 23168
but the director or the director's designee shall review the state 23169
hearing decision and previous administrative action and may 23170
affirm, modify, remand, or reverse the state hearing decision. Any 23171
person designated to make an administrative appeal decision on 23172
behalf of the director shall have been admitted to the practice of 23173
law in this state. An administrative appeal decision is the final 23174
decision of the department and is binding upon the department and 23175
agency, unless it is reversed or modified on appeal to the court 23176
of common pleas. 23177

(D) An agency shall comply with a decision issued pursuant to 23178
division (B) or (C) of this section within the time limits 23179

established by rules adopted under this section. If a county 23180
department of job and family services fails to comply within these 23181
time limits, the department may take action pursuant to section 23182
5160.21 of the Revised Code. If another agency fails to comply 23183
within the time limits, the department may force compliance by 23184
withholding funds due the agency or imposing another sanction 23185
established by rules adopted under this section. 23186

(E) An appellant who disagrees with an administrative appeal 23187
decision of the director of health care administration or the 23188
director's designee issued under division (C) of this section may 23189
appeal from the decision to the court of common pleas pursuant to 23190
section 119.12 of the Revised Code. The appeal shall be governed 23191
by section 119.12 of the Revised Code except that: 23192

(1) The person may appeal to the court of common pleas of the 23193
county in which the person resides, or to the court of common 23194
pleas of Franklin county if the person does not reside in this 23195
state. 23196

(2) The person may apply to the court for designation as an 23197
indigent and, if the court grants this application, the appellant 23198
shall not be required to furnish the costs of the appeal. 23199

(3) The appellant shall mail the notice of appeal to the 23200
department of health care administration and file notice of appeal 23201
with the court within thirty days after the department mails the 23202
administrative appeal decision to the appellant. For good cause 23203
shown, the court may extend the time for mailing and filing notice 23204
of appeal, but such time shall not exceed six months from the date 23205
the department mails the administrative appeal decision. Filing 23206
notice of appeal with the court shall be the only act necessary to 23207
vest jurisdiction in the court. 23208

(4) The department shall be required to file a transcript of 23209
the testimony of the state hearing with the court only if the 23210

court orders the department to file the transcript. The court 23211
shall make such an order only if it finds that the department and 23212
the appellant are unable to stipulate to the facts of the case and 23213
that the transcript is essential to a determination of the appeal. 23214
The department shall file the transcript not later than thirty 23215
days after the day such an order is issued. 23216

(F) If an appellant receiving medicaid through a health 23217
insuring corporation that holds a certificate of authority under 23218
Chapter 1751. of the Revised Code is appealing a denial of 23219
medicaid services based on lack of medical necessity or other 23220
clinical issues regarding coverage by the health insuring 23221
corporation, the person hearing the appeal may order an 23222
independent medical review if that person determines that a review 23223
is necessary. The review shall be performed by a health care 23224
professional with appropriate clinical expertise in treating the 23225
recipient's condition or disease. The department shall pay the 23226
costs associated with the review. 23227

A review ordered under this division shall be part of the 23228
record of the hearing and shall be given appropriate evidentiary 23229
consideration by the person hearing the appeal. 23230

(G) The director of health care administration shall adopt 23231
rules in accordance with Chapter 119. of the Revised Code to 23232
implement this section, including rules governing the following: 23233

(1) State hearings under division (B) of this section. The 23234
rules shall include provisions regarding notice of eligibility 23235
termination and the opportunity of an appellant appealing a 23236
decision or order of a county department of job and family 23237
services to request a county conference with the county department 23238
before the state hearing is held. 23239

(2) Administrative appeals under division (C) of this 23240
section; 23241

<u>(3) Time limits for complying with a decision issued under</u>	23242
<u>division (B) or (C) of this section;</u>	23243
<u>(4) Sanctions that may be applied against an agency under</u>	23244
<u>division (D) of this section.</u>	23245
<u>(H) The requirements of Chapter 119. of the Revised Code</u>	23246
<u>apply to a state hearing or administrative appeal under this</u>	23247
<u>section only to the extent, if any, specifically provided by rules</u>	23248
<u>adopted under this section.</u>	23249
<u>Sec. 5160.341. The department of health care administration</u>	23250
<u>may employ or contract with hearing officers to draft and</u>	23251
<u>recommend state hearing decisions under division (B) of section</u>	23252
<u>5160.34 of the Revised Code. The department may employ or contract</u>	23253
<u>with hearing authorities to issue state hearing decisions under</u>	23254
<u>division (B) of section 5160.34 of the Revised Code. Except in the</u>	23255
<u>case of an individual who was employed by or under contract with</u>	23256
<u>the department of job and family services to perform the duties of</u>	23257
<u>a hearing authority under division (B) of section 5101.35 of the</u>	23258
<u>Revised Code before July 1, 2000, an individual performing the</u>	23259
<u>duties of a hearing authority shall have been admitted to the</u>	23260
<u>practice of law in this state.</u>	23261
<u>Sec. 5101.571 5160.36. As used in sections 5101.571 5160.36</u>	23262
<u>to 5101.59 5160.40 of the Revised Code:</u>	23263
<u>(A) "Medical support" means support specified as support for</u>	23264
<u>the purpose of medical care by order of a court or administrative</u>	23265
<u>agency.</u>	23266
<u>(B) "Third party" means any health insurer as defined in</u>	23267
<u>section 3924.41 of the Revised Code, individual, entity, or public</u>	23268
<u>or private program, that is or may be liable to pay all or part of</u>	23269
<u>the medical cost of injury, disease, or disability of an applicant</u>	23270
<u>or recipient. "Third party" includes any such insurer, individual,</u>	23271

entity, or program that would have been obligated to pay for the 23272
service, even when such third party limits or excludes payments in 23273
the case of an individual who is eligible for medicaid. "Third 23274
party" does not include the program for medically handicapped 23275
children established under section 3701.023 of the Revised Code. 23276

Sec. ~~5101.59~~ 5160.37. (A) The application for or acceptance 23277
of ~~public medicaid or disability medical~~ assistance constitutes an 23278
automatic assignment of certain rights to the department of ~~job~~ 23279
~~and family services~~ health care administration. This assignment 23280
includes the rights of the applicant, or recipient, ~~or participant~~ 23281
and also the rights of any other member of the assistance group 23282
for whom the applicant, or recipient, ~~or participant~~ can legally 23283
make an assignment. 23284

Pursuant to this section, the applicant, or recipient, ~~or~~ 23285
~~participant~~ assigns to the department any rights to medical 23286
support available to the applicant, or recipient, ~~or participant~~ 23287
or for other members of the assistance group under an order of a 23288
court or administrative agency, and any rights to payments from 23289
any third party liable to pay for the cost of medical care and 23290
services arising out of injury, disease, or disability of the 23291
applicant, recipient, ~~participant~~, or other members of the 23292
assistance group. 23293

Medicare benefits shall not be assigned pursuant to this 23294
section. Benefits assigned to the department by operation of this 23295
section are directly reimbursable to the department by liable 23296
third parties. 23297

(B) Refusal by the applicant, or recipient, ~~or participant~~ to 23298
cooperate in obtaining medical support and payments for self or 23299
any other member of the assistance group renders the applicant, or 23300
recipient, ~~or participant~~ ineligible for public medicaid or 23301
disability medical assistance, unless cooperation is waived by the 23302

department. Eligibility shall continue for any individual who 23303
cannot legally assign the individual's own rights and who would 23304
have been eligible for ~~public~~ medicaid or disability medical 23305
assistance but for the refusal to assign the individual's rights 23306
or to cooperate as required by this section by another person 23307
legally able to assign the individual's rights. 23308

If the applicant, ~~or recipient, or participant~~ or any member 23309
of the assistance group becomes ineligible for ~~public~~ medicaid or 23310
disability medical assistance, the department shall restore to the 23311
applicant, recipient, ~~participant~~, or member of the assistance 23312
group any future rights to benefits assigned under this section. 23313

The rights of assignment given to the department under this 23314
section do not include rights to support assigned to the 23315
department of job and family services under section 5107.20 or 23316
5115.07 of the Revised Code. 23317

(C) The director of ~~job and family services~~ health care 23318
administration may adopt rules in accordance with Chapter 119. of 23319
the Revised Code to implement this section, including rules that 23320
specify what constitutes cooperating with efforts to obtain 23321
medical support and payments and when the cooperation requirement 23322
may be waived. 23323

~~Sec. 5101.58 5160.38. As used in this section and section~~ 23324
~~5101.59 of the Revised Code, "public assistance" means aid~~ 23325
~~provided under Chapter 5111. or 5115. of the Revised Code and~~ 23326
~~participation in the Ohio works first program established under~~ 23327
~~Chapter 5107. of the Revised Code.~~ 23328

The acceptance of ~~public~~ medicaid or disability medical 23329
assistance gives a right of recovery to the department of ~~job and~~ 23330
~~family services~~ health care administration and a county department 23331
of job and family services against the liability of a third party 23332
for the cost of medical services and care arising out of injury, 23333

disease, or disability of the ~~public~~ medicaid recipient or 23334
disability medical assistance recipient ~~or participant~~. When an 23335
action or claim is brought against a third party by a ~~public~~ 23336
~~assistance~~ recipient ~~or participant~~, the entire amount of any 23337
settlement or compromise of the action or claim, or any court 23338
award or judgment, is subject to the recovery right of the 23339
department of ~~job and family services~~ health care administration 23340
or county department of job and family services. Except in the 23341
case of a recipient ~~or participant~~ who receives medical services 23342
or care through a managed care organization, the department's or 23343
county department's claim shall not exceed the amount of medical 23344
expenses paid by the departments on behalf of the recipient ~~or~~ 23345
~~participant~~. In the case of a recipient ~~or participant~~ who 23346
receives medical services or care through a managed care 23347
organization, the amount of the department's or county 23348
department's claim shall be the amount the managed care 23349
organization pays for medical services or care rendered to the 23350
recipient ~~or participant~~, even if that amount is more than the 23351
amount the departments pay to the managed care organization for 23352
the recipient's ~~or participant's~~ medical services or care. Any 23353
settlement, compromise, judgment, or award that excludes the cost 23354
of medical services or care shall not preclude the departments 23355
from enforcing their rights under this section. 23356

Prior to initiating any recovery action, the recipient ~~or~~ 23357
~~participant~~, or the recipient's ~~or participant's~~ representative, 23358
shall disclose the identity of any third party against whom the 23359
recipient ~~or participant~~ has or may have a right of recovery. 23360
Disclosure shall be made to the department ~~of job and family~~ 23361
~~services~~ when medical expenses have been paid pursuant to ~~Chapter~~ 23362
~~5111. or 5115. of the Revised Code~~ the medicaid program. 23363
Disclosure shall be made to both the department ~~of job and family~~ 23364
~~services~~ and the appropriate county department ~~of job and family~~ 23365
~~services~~ when medical expenses have been paid pursuant to ~~Chapter~~ 23366

~~5115. of the Revised Code~~ the disability medical assistance 23367
program. No settlement, compromise, judgment, or award or any 23368
recovery in any action or claim by a recipient ~~or participant~~ 23369
where the departments have a right of recovery shall be made final 23370
without first giving the appropriate departments notice and a 23371
reasonable opportunity to perfect their rights of recovery. If the 23372
departments are not given appropriate notice, the recipient ~~or~~ 23373
~~participant~~ is liable to reimburse the departments for the 23374
recovery received to the extent of medical payments made by the 23375
departments. The departments shall be permitted to enforce their 23376
recovery rights against the third party even though they accepted 23377
prior payments in discharge of their rights under this section if, 23378
at the time the departments received such payments, they were not 23379
aware that additional medical expenses had been incurred but had 23380
not yet been paid by the departments. The third party becomes 23381
liable to the department ~~of job and family services~~ or county 23382
department ~~of job and family services~~ as soon as the third party 23383
is notified in writing of the valid claims for recovery under this 23384
section. 23385

The right of recovery does not apply to that portion of any 23386
judgment, award, settlement, or compromise of a claim, to the 23387
extent of attorneys' fees, costs, or other expenses incurred by a 23388
recipient ~~or participant~~ in securing the judgment, award, 23389
settlement, or compromise, or to the extent of medical, surgical, 23390
and hospital expenses paid by such recipient ~~or participant~~ from 23391
the recipient's ~~or participant's~~ own resources. Attorney fees and 23392
costs or other expenses in securing any recovery shall not be 23393
assessed against any claims of the departments. 23394

To enforce their recovery rights, the departments may do any 23395
of the following: 23396

(A) Intervene or join in any action or proceeding brought by 23397
the recipient ~~or participant~~ or on the recipient's ~~or~~ 23398

~~participant's~~ behalf against any third party who may be liable for 23399
the cost of medical services and care arising out of the 23400
recipient's ~~or participant's~~ injury, disease, or disability; 23401

(B) Institute and pursue legal proceedings against any third 23402
party who may be liable for the cost of medical services and care 23403
arising out of the recipient's ~~or participant's~~ injury, disease, 23404
or disability; 23405

(C) Initiate legal proceedings in conjunction with the 23406
injured, diseased, or disabled recipient ~~or participant~~ or the 23407
recipient's ~~or participant's~~ legal representative. 23408

Recovery rights created by this section may be enforced 23409
separately or jointly by the department ~~of job and family services~~ 23410
and the county department ~~of job and family services~~. 23411

The right of recovery given to the department of health care 23412
administration under this section does not include rights to 23413
support from any other person assigned to the ~~state~~ department of 23414
job and family services under sections 5107.20 and 5115.07 of the 23415
Revised Code, but includes payments made by a third party under 23416
contract with a person having a duty to support. 23417

The director of ~~job and family services~~ health care 23418
administration may adopt rules in accordance with Chapter 119. of 23419
the Revised Code the ~~department~~ director considers necessary to 23420
implement this section. 23421

Sec. ~~5111.121~~ 5160.39. (A) ~~As used in this section, "third~~ 23422
~~party" has the same meaning as in section 5101.571 of the Revised~~ 23423
~~Code.~~ 23424

~~(B)~~ In addition to the authority granted under section 23425
~~5101.59~~ 5160.37 of the Revised Code, the department of ~~job and~~ 23426
~~family services~~ health care administration may, to the extent 23427
necessary to reimburse its costs, garnish the wages, salary, or 23428

other employment income of, and withhold amounts from state tax 23429
refunds to, any person to whom both of the following apply: 23430

(1) The person is required by a court or administrative order 23431
to provide coverage of the cost of health care services to a child 23432
eligible for ~~medical assistance under this chapter~~ the medicaid 23433
program. 23434

(2) The person has received payment from a third party for 23435
the costs of such services but has not used the payment to 23436
reimburse either the other parent or guardian of the child or the 23437
provider of the services. 23438

~~(C)~~(B) Claims for current and past due child support shall 23439
take priority over claims under division ~~(B)~~(A) of this section. 23440

Sec. ~~5101.572~~ 5160.40. Upon the request of the department of 23441
~~job and family services~~ health care administration, any third 23442
party ~~as defined in section 5101.571 of the Revised Code~~ shall 23443
cooperate with the department in identifying individuals for the 23444
purpose of establishing third party liability ~~pursuant to Title~~ 23445
~~XIX of the Social Security Act, as amended~~ for the medicaid 23446
program. The department ~~of job and family services~~ shall limit its 23447
use of information gained from third parties to purposes directly 23448
connected with the administration of the medicaid program. ~~No~~ 23449
~~third party shall disclose to other parties or make use of any~~ 23450
~~information regarding recipients of aid under Chapter 5107. or~~ 23451
~~5111. of the Revised Code that it obtains from the department of~~ 23452
~~job and family services, except in the manner provided for by the~~ 23453
~~director of job and family services in administrative rules.~~ Any 23454
information provided by a third party to the department ~~of job and~~ 23455
~~family services~~ shall not be considered a violation of any right 23456
of confidentiality or contract that the third party may have with 23457
covered persons including, but not limited to, contractees, 23458
beneficiaries, heirs, assignees, and subscribers. The third party 23459

is immune from any liability that it may otherwise incur through 23460
its release of information to the department ~~of job and family~~ 23461
~~services.~~ 23462

Sec. 5160.41. Any application for the medicaid program or 23463
disability medical assistance program gives a right of subrogation 23464
to the department of health care administration for any workers' 23465
compensation benefits payable to a person who is subject to a 23466
support order, as defined in section 3119.01 of the Revised Code, 23467
on behalf of the applicant, to the extent of any payments made on 23468
the applicant's behalf under the medicaid program or disability 23469
medical assistance program. If the director of health care 23470
administration, in consultation with a child support enforcement 23471
agency and the administrator of the bureau of workers' 23472
compensation, determines that a person responsible for support 23473
payments to a medicaid recipient or disability medical assistance 23474
recipient is receiving workers' compensation, the director shall 23475
notify the administrator of the amount of the benefit to be paid 23476
to the department of health care administration. 23477

Sec. 5160.43. As used in sections 5160.43 to 5160.46 of the 23478
Revised Code, "public medical assistance program" means the 23479
disability medical assistance program and medicaid program. 23480

As part of the procedure for the determination of whether 23481
benefits were incorrectly paid on behalf of public medical 23482
assistance program recipients, the director of health care 23483
administration shall furnish quarterly the name and social 23484
security number of each public medical assistance program 23485
recipient to the director of administrative services, the 23486
administrator of the bureau of workers' compensation, and each of 23487
the state's retirement boards. Within fourteen days after 23488
receiving the name and social security number of a public medical 23489
assistance program recipient, the director of administrative 23490

services, administrator, or board shall inform the auditor of 23491
state as to whether the recipient is receiving wages or benefits, 23492
the amount of any wages or benefits being received, the social 23493
security number, and the address of the recipient. The director of 23494
administrative services, administrator, boards, and any agent or 23495
employee of those officials and boards shall comply with the rules 23496
adopted under section 5160.64 of the Revised Code restricting the 23497
disclosure of information regarding public medical assistance 23498
program recipients. Any person who violates this provision shall 23499
thereafter be disqualified from acting as an agent or employee or 23500
in any other capacity under appointment or employment of any state 23501
board, commission, or agency. 23502

Sec. 5160.44. As part of the procedure for the determination 23503
of whether benefits were incorrectly paid on behalf of a public 23504
medical assistance program recipient, the director of health care 23505
administration shall semiannually, at times determined jointly by 23506
the auditor of state and the tax commissioner, furnish to the tax 23507
commissioner in computer format the name and social security 23508
number of each public medical assistance program recipient. Within 23509
sixty days after receiving the name and social security number of 23510
a public medical assistance program recipient, the commissioner 23511
shall inform the auditor of state whether the recipient filed an 23512
Ohio individual income tax return, separate or joint, as provided 23513
by section 5747.08 of the Revised Code, for either or both of the 23514
two taxable years preceding the year in which the director 23515
furnished the names and social security numbers to the 23516
commissioner. If the recipient did so file, at the same time the 23517
commissioner shall also inform the auditor of state of the amount 23518
of the federal adjusted gross income as reported on such returns 23519
and of the addresses on such returns. The commissioner shall also 23520
advise the auditor of state whether such returns were filed on a 23521
joint basis, as provided in section 5747.08 of the Revised Code, 23522

in which case the federal adjusted gross income as reported may be 23523
that of the recipient or the recipient's spouse. 23524

If the auditor of state determines that further investigation 23525
is needed, the auditor of state may ask the commissioner to 23526
determine whether the public medical assistance program recipient 23527
filed income tax returns for any previous taxable years in which 23528
the recipient received medical assistance under a public medical 23529
assistance program and for which the tax department retains income 23530
tax returns. Within fourteen days of receipt of the request, the 23531
commissioner shall inform the auditor of state whether the 23532
recipient filed an individual income tax return for the taxable 23533
years in question, of the amount of the federal adjusted gross 23534
income as reported on such returns, of the addresses on such 23535
returns, and whether the returns were filed on a joint or separate 23536
basis. 23537

If the auditor of state determines that further investigation 23538
is needed of a public medical assistance program recipient who 23539
filed an Ohio individual income tax return, the auditor of state 23540
may request a certified copy of the Ohio individual income tax 23541
return or returns of that person for the taxable years described 23542
above, together with any other documents the commissioner has 23543
concerning the return or returns. Within fourteen days of receipt 23544
of such a request in writing, the commissioner shall forward the 23545
returns and documents to the auditor of state. 23546

The director of health care administration, county director 23547
of job and family services, county prosecutor, attorney general, 23548
auditor of state, or any agent or employee of those officials 23549
having access to any information or documents furnished by the 23550
commissioner pursuant to this section shall not divulge or use any 23551
such information except for the purpose of determining whether 23552
benefits were incorrectly paid on behalf of a public medical 23553
assistance program recipient, or for an audit, investigation, or 23554

prosecution, or in accordance with a proper judicial order. Any 23555
person who violates this provision shall thereafter be 23556
disqualified from acting as an agent or employee or in any other 23557
capacity under appointment or employment of any state or county 23558
board, commission, or agency. 23559

Sec. 5160.45. The director of health care administration 23560
shall work with the tax commissioner to recover benefits 23561
incorrectly paid on behalf of public medical assistance program 23562
recipients from refunds of state income taxes that are payable to 23563
the recipients. Any benefit incorrectly paid, because of fraud or 23564
misrepresentation, as the result of an error by the recipient or 23565
by the agency making the payment, or for any other reason, may be 23566
collected under this section. Any reduction under section 5747.12 23567
or 5747.121 of the Revised Code to an income tax refund shall be 23568
made before a reduction under this section. No reduction shall be 23569
made under this section if the amount of the refund is less than 23570
twenty-five dollars after any reduction under section 5747.12 of 23571
the Revised Code. A reduction under this section shall be made 23572
before any part of the refund is contributed under section 23573
5747.113 of the Revised Code or is credited under section 5747.12 23574
of the Revised Code against tax due in any subsequent year. 23575

The director and the tax commissioner, by rules adopted in 23576
accordance with Chapter 119. of the Revised Code, shall establish 23577
procedures to implement this section. The procedures shall provide 23578
for notice to a public medical assistance program recipient and an 23579
opportunity for the recipient to be heard before the recipient's 23580
income tax refund is reduced. 23581

Sec. 5160.46. The director of health care administration may 23582
enter into agreements with the federal government to recover 23583
benefits incorrectly paid on behalf of public medical assistance 23584
program recipients from refunds of federal income taxes that are 23585

payable to the recipients. 23586

Sec. 5160.50. As used in sections 5160.50 to 5160.64 of the 23587
Revised Code: 23588

"Community control sanction" has the same meaning as in 23589
section 2929.01 of the Revised Code. 23590

"Fugitive felon" means an individual who is fleeing to avoid 23591
prosecution, or custody or confinement after conviction, under the 23592
laws of the place from which the individual is fleeing, for a 23593
crime or an attempt to commit a crime that is a felony under the 23594
laws of the place from which the individual is fleeing or, in the 23595
case of New Jersey, a high misdemeanor, regardless of whether the 23596
individual has departed from the individual's usual place of 23597
residence. 23598

"Information" means records as defined in section 149.011 of 23599
the Revised Code, any other documents in any format, and data 23600
derived from records and documents that are generated, acquired, 23601
or maintained by the department of health care administration, a 23602
county department of job and family services, or an entity 23603
performing duties on behalf of the department or a county 23604
department. 23605

"Law enforcement agency" means the state highway patrol, an 23606
agency that employs peace officers as defined in section 109.71 of 23607
the Revised Code, the adult parole authority, a county department 23608
of probation, a prosecuting attorney, the attorney general, 23609
similar agencies of other states, federal law enforcement 23610
agencies, and postal inspectors. "Law enforcement agency" includes 23611
the peace officers and other law enforcement officers employed by 23612
the agency. 23613

"Medical assistance provided under a government-funded 23614
program" means medical assistance provided under the medicaid 23615

program, children's health insurance program, disability medical assistance program, or any other program established under the Revised Code. 23616
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"Post-release control sanction" has the same meaning as in section 2967.01 of the Revised Code. 23619
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"Public medical assistance program" means the children's health insurance program, disability medical assistance program, and medicaid program. 23621
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"Public medical assistance program recipient" means an applicant for, or recipient or former recipient of, a public medical assistance program. 23624
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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. 23627
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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. 23635
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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 23642
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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. 23645
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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: 23649
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(1) The recipient; 23654

(2) The authorized representative; 23655

(3) The legal guardian of the recipient; 23656

(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. 23657
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(B) The director of health care administration may adopt rules defining "authorized representative" for the purpose of this section. 23660
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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: 23663
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(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; 23668
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(2) For the purpose of protecting children, to a government entity responsible for administering a children's protective 23672
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services program; 23674

(3) Subject to division (B) of this section, to any person or 23675
government entity to whom the recipient authorizes to receive the 23676
information by providing the department or county department 23677
voluntary, written authorization that complies with section 23678
5160.57 of the Revised Code. 23679

(B) The department and a county department shall release 23680
information pursuant to division (A)(3) of this section only in 23681
accordance with the public medical assistance program recipient's 23682
authorization. The department or county department shall provide, 23683
at no cost, a copy of each written authorization to the individual 23684
who signed it. 23685

(C) Neither the department nor a county department may 23686
release information under this section concerning a public medical 23687
assistance program recipient's receipt of medical assistance 23688
provided under a government-funded program unless all of the 23689
following conditions are met: 23690

(1) The release of information is for purposes directly 23691
connected to the administration of or provision of medical 23692
assistance provided under a government-funded program; 23693

(2) The information is released to persons or government 23694
entities that are subject to standards of confidentiality and 23695
safeguarding information substantially comparable to those 23696
established for medical assistance provided under a 23697
government-funded program; 23698

(3) The department or county department has obtained an 23699
authorization consistent with section 5160.57 of the Revised Code. 23700

Sec. 5160.56. Information concerning the receipt of medical 23701
assistance provided under a government-funded program may be 23702
released only if the release complies with the more restrictive of 23703

the following: 23704

(A) Sections 5160.52 to 5160.55 of the Revised Code and rules 23705
adopted under section 5160.64 of the Revised Code; 23706

(B) The Health Insurance Portability and Accountability Act 23707
of 1996, 110 Stat. 1955, 42 U.S.C. 1320d, et seq., as amended, and 23708
regulations adopted by the United States department of health and 23709
human services to implement the act. 23710

Sec. 5160.57. (A) For the purposes of sections 5160.54 and 23711
5160.55 of the Revised Code, an authorization shall be made on a 23712
form that uses language understandable to the average person and 23713
contains all of the following: 23714

(1) A description of the information to be used or disclosed 23715
that identifies the information in a specific and meaningful 23716
fashion; 23717

(2) The name or other specific identification of the person 23718
or class of persons authorized to make the requested use or 23719
disclosure; 23720

(3) The name or other specific identification of the person 23721
or governmental entity to which the information may be released; 23722

(4) A description of each purpose of the requested use or 23723
disclosure of the information; 23724

(5) The date on which the authorization expires or an event 23725
related either to the individual who is the subject of the request 23726
or to the purposes of the requested use or disclosure, the 23727
occurrence of which will cause the authorization to expire; 23728

(6) A statement that the information used or disclosed 23729
pursuant to the authorization may be disclosed by the recipient of 23730
the information and may no longer be protected from disclosure; 23731

(7) The signature of the individual or the individual's 23732

authorized representative and the date on which the authorization
was signed; 23733
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(8) If signed by an authorized representative, a description
of the representative's authority to act for the individual; 23735
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(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: 23737
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(a) A description of how the individual or authorized
representative may revoke the authorization; 23740
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(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. 23742
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(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. 23746
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(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. 23750
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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 23756
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probation, a community control sanction, parole, or a post-release 23763
control sanction imposed under state or federal law. 23764

A county department may enter into a written agreement with a 23765
local law enforcement agency establishing procedures concerning 23766
access to information and providing for compliance with this 23767
section. 23768

The auditor of state shall prepare an annual report on the 23769
outcome of the agreements required by this section. The report 23770
shall include the number of fugitive felons, probation and parole 23771
violators, and violators of community control sanctions and 23772
post-release control sanctions apprehended during the immediately 23773
preceding year as a result of the exchange of information pursuant 23774
to this section. The auditor of state shall file the report with 23775
the governor, the president and minority leader of the senate, and 23776
the speaker and minority leader of the house of representatives. 23777
The department, county departments, and law enforcement agencies 23778
shall cooperate with the auditor of state's office in gathering 23779
the information needed for the report. 23780

Sec. 5160.59. To the extent permitted by federal law, the 23781
department of health care administration and county departments of 23782
job and family services shall provide information, except 23783
information directly related to the receipt of medical assistance 23784
or medical services, regarding disability medical assistance 23785
program recipients to law enforcement agencies on request for the 23786
purposes of investigations, prosecutions, and criminal and civil 23787
proceedings that are within the scope of the law enforcement 23788
agencies' official duties. 23789

Sec. 5160.60. Information about a public medical assistance 23790
program recipient shall be exchanged, obtained, or shared under 23791
sections 5160.58 and 5160.59 of the Revised Code only if the 23792

department of health care administration, county department of job 23793
and family services, or law enforcement agency requesting the 23794
information gives sufficient information to specifically identify 23795
the recipient. In addition to the recipient's name, identifying 23796
information may include the recipient's current or last known 23797
address, social security number, other identifying number, age, 23798
gender, physical characteristics, any information specified in an 23799
agreement entered into under section 5160.58 of the Revised Code, 23800
or any information considered appropriate by the department or 23801
county department. 23802

Sec. 5160.61. The department of health care administration 23803
and its officers and employees are not liable in damages in a 23804
civil action for any injury, death, or loss to person or property 23805
that allegedly arises from the release of information in 23806
accordance with sections 5160.58 and 5160.59 of the Revised Code. 23807
This section does not affect any immunity or defense that the 23808
department and its officers and employees may be entitled to under 23809
another section of the Revised Code or the common law of this 23810
state, including section 9.86 of the Revised Code. 23811

Sec. 5160.62. As used in this section, "employee" has the 23812
same meaning as in division (B) of section 2744.01 of the Revised 23813
Code. 23814

County departments of job and family services and their 23815
employees are not liable in damages in a civil action for any 23816
injury, death, or loss to person or property that allegedly arises 23817
from the release of information in accordance with sections 23818
5160.58 and 5160.59 of the Revised Code. This section does not 23819
affect any immunity or defense that the county departments and 23820
their employees may be entitled to under another section of the 23821
Revised Code or the common law of this state, including section 23822
2744.02 and division (A)(6) of section 2744.03 of the Revised 23823

Code. 23824

Sec. 5160.63. To the extent permitted by federal law, the 23825
department of health care administration and county departments of 23826
job and family services shall provide access to information to the 23827
auditor of state acting pursuant to Chapter 117. or sections 23828
117.54, 117.55, 117.56, 5160.43, and 5160.44 of the Revised Code 23829
and to any other government entity authorized by federal law to 23830
conduct an audit of or similar activity involving a public medical 23831
assistance program. 23832

Sec. 5160.64. The director of health care administration 23833
shall adopt rules in accordance with Chapter 119. of the Revised 23834
Code implementing sections 5160.50 to 5160.63 of the Revised Code 23835
and governing the custody, use, and preservation of the 23836
information generated or received by the department of health care 23837
administration, county departments of job and family services, 23838
other state and county entities, contractors, grantees, private 23839
entities, or officials participating in the administration of a 23840
public medical assistance program. The rules shall specify 23841
conditions and procedures for the release of information. The 23842
rules shall comply with applicable federal statutes and 23843
regulations. To the extent permitted by federal law: 23844

(A) The rules may permit providers of services or assistance 23845
under a public medical assistance program limited access to 23846
information that is essential for the providers to render services 23847
or assistance or to bill for services or assistance rendered. The 23848
department of aging, when investigating a complaint under section 23849
173.20 of the Revised Code, shall be granted any limited access 23850
permitted in the rules pursuant to division (A) of this section. 23851

(B) The rules may permit a contractor, grantee, or other 23852
state or county entity limited access to information that is 23853

essential for the contractor, grantee, or entity to perform 23854
administrative or other duties on behalf of the department or 23855
county department. A contractor, grantee, or entity given access 23856
to information pursuant to division (B) of this section is bound 23857
by the director's rules, and disclosure of the information by the 23858
contractor, grantee, or entity in a manner not authorized by the 23859
rules is a violation of section 5160.51 of the Revised Code. 23860

Sec. 5160.65. Whenever names, addresses, or other information 23861
relating to public medical assistance program recipients is held 23862
by any agency other than the department of health care 23863
administration or a county department of job and family services, 23864
that other agency shall adopt rules consistent with sections 23865
5160.50 to 5160.64 of the Revised Code to prevent the publication 23866
or disclosure of names, lists, or other information concerning 23867
those recipients. 23868

Sec. ~~5101.31~~ 5160.66. Any record, data, pricing information, 23869
or other information regarding a drug rebate agreement or a 23870
supplemental drug rebate agreement for the medicaid program 23871
established under ~~Chapter 5111.~~ of the Revised Code or the 23872
disability medical assistance program established under section 23873
~~5115.10~~ of the Revised Code that the department of ~~job and family~~ 23874
~~services~~ health care administration receives from a pharmaceutical 23875
manufacturer or creates pursuant to negotiation of the agreement 23876
is not a public record under section 149.43 of the Revised Code 23877
and shall be treated by the department as confidential 23878
information. 23879

Sec. 5160.70. Not later than the last day of each July and 23880
January, the department of health care administration shall 23881
complete a report on the characteristics of the individuals who 23882
receive services through the programs operated by the department 23883

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. 23884
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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. 23888
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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. 23894
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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. 23900
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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 23910
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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; 23945
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(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; 23947
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(c) A community alternative home licensed under section 3724.03 of the Revised Code; 23950
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(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; 23952
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(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. 23955
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(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. 23960
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(3) The individual satisfies all eligibility requirements 23976
established by rules adopted under division (D) of this section. 23977

(D) The ~~directors~~ director of ~~aging and job and family~~ 23978
~~services~~ health care administration shall adopt rules in 23979
accordance with section 111.15 of the Revised Code as necessary to 23980
implement the residential state supplement program. 23981

To the extent permitted by Title XVI of the "Social Security 23982
Act of 1935," and any other provision of federal law, the director 23983
of ~~job and family services~~ health care administration shall adopt 23984
rules establishing standards for adjusting the eligibility 23985
requirements concerning the level of impairment a person must have 23986
so that the amount appropriated for the program by the general 23987
assembly is adequate for the number of eligible individuals. The 23988
rules shall not limit the eligibility of disabled persons solely 23989
on a basis classifying disabilities as physical or mental. The 23990
director of ~~job and family services~~ health care administration 23991
also shall adopt rules that establish eligibility standards for 23992
aged, blind, or disabled individuals who reside in one of the 23993
homes or facilities specified in division (C)(1) of this section 23994
but who, because of their income, do not receive supplemental 23995
security income payments. The rules may provide that these 23996
individuals may include individuals who receive other types of 23997
benefits, including, social security disability insurance benefits 23998
provided under Title II of the "Social Security Act, of 1935" 49 23999
~~Stat. 620 (1935), 42 U.S.C.A. 401, as amended~~. Notwithstanding 24000
division (B) of this section, such payments may be made if funds 24001
are available for them. 24002

The director of ~~aging~~ health care administration shall adopt 24003
rules establishing the method to be used to determine the amount 24004
an eligible individual will receive under the program. The amount 24005
the general assembly appropriates for the program shall be a 24006
factor included in the method that department establishes. 24007

(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. 24039
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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. 24041
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~~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: 24051
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(1) Adopt rules; 24058

(2) Assign duties to county departments of job and family services; 24059
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(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. 24061
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(B) Rules adopted under division (A)(1) of this section shall be adopted as follows: 24065
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(1) If the rules concern the department's duties regarding 24067

service providers, in accordance with Chapter 119. of the Revised Code; 24068
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(2) If the rules concern the department's duties concerning individuals' eligibility for services, in accordance with section 111.15 of the Revised Code; 24070
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(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. 24073
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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: 24078
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(A) A state medicaid plan. 24083

(B) Amendments to the state medicaid plan. 24084

~~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 24085
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of an interagency agreement. The interagency agreement shall 24098
include a requirement for the state agency to submit an annual 24099
financing plan to the department. 24100

A state agency or political subdivision that enters into a 24101
contract with the department under this section shall reimburse 24102
the department for the nonfederal share of the cost to the 24103
department of performing, or contracting for the performance of, a 24104
fiscal audit of the component of the medicaid program, or aspect 24105
of the component, that the state agency or political subdivision 24106
administers if rules governing the component, or aspect of the 24107
component, require that a fiscal audit be conducted. 24108

There is hereby created in the state treasury the medicaid 24109
administrative reimbursement fund. The department shall use money 24110
in the fund to pay for the nonfederal share of the cost of a 24111
fiscal audit for which a state agency or political subdivision is 24112
required by this section to reimburse the department. The 24113
department shall deposit the reimbursements into the fund. 24114

Sec. ~~5111.911~~ 5161.06. Any contract the department of ~~job and~~ 24115
~~family services~~ health care administration enters into with the 24116
department of mental health or department of alcohol and drug 24117
addiction services under section ~~5111.91~~ 5161.05 of the Revised 24118
Code is subject to the approval of the director of budget and 24119
management and shall require or specify all of the following: 24120

(A) In the case of a contract with the department of mental 24121
health, that section ~~5111.912~~ 5161.07 of the Revised Code be 24122
complied with; 24123

(B) In the case of a contract with the department of alcohol 24124
and drug addiction services, that section ~~5111.913~~ 5161.08 of the 24125
Revised Code be complied with; 24126

(C) How providers will be paid for providing the services; 24127

(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. 24128
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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. 24132
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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. 24140
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Sec. ~~5111.90~~ 5161.10. (A) As used in sections ~~5111.90~~ 5161.10 to ~~5111.93~~ 5161.13 of the Revised Code: 24149
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(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. 24151
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(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 24155
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for the exercise of any function of state government. 24158

(B) To the extent permitted by Title XIX of the "Social 24159
Security Act, of 1935" ~~79 Stat. 286 (1965), 42 U.S.C.A. 1396, as~~ 24160
~~amended,~~ and regulations adopted under that title, the department 24161
of ~~job and family services~~ health care administration may enter 24162
into contracts with political subdivisions to use funds of the 24163
political subdivision to pay the nonfederal share of expenditures 24164
under the medicaid program. The determination and provision of 24165
federal financial reimbursement to a subdivision entering into a 24166
contract under this section shall be determined by the department, 24167
subject to section ~~5111.92~~ 5161.12 of the Revised Code, approval 24168
by the United States secretary of health and human services, and 24169
the availability of federal financial participation. 24170

Sec. ~~5111.92~~ 5161.12. (A)(1) Except as provided in division 24171
(B) of this section, if a state agency or political subdivision 24172
administers one or more components of the medicaid program that 24173
the United States department of health and human services 24174
approved, and for which federal financial participation was 24175
initially obtained, prior to January 1, 2002, or administers one 24176
or more aspects of such a component, the department of ~~job and~~ 24177
~~family services~~ health care administration may retain or collect 24178
not more than ten per cent of the federal financial participation 24179
the state agency or political subdivision obtains through an 24180
approved, administrative claim regarding the component or aspect 24181
of the component. If the department retains or collects a 24182
percentage of such federal financial participation, the percentage 24183
the department retains or collects shall be specified in a 24184
contract the department enters into with the state agency or 24185
political subdivision under section ~~5111.91~~ 5161.05 of the Revised 24186
Code. 24187

(2) Except as provided in division (B) of this section, if a 24188

state agency or political subdivision administers one or more 24189
components of the medicaid program that the United States 24190
department of health and human services approved on or after 24191
January 1, 2002, or administers one or more aspects of such a 24192
component, the department of ~~job and family services~~ health care
administration shall retain or collect not less than three and not 24193
more than ten per cent of the federal financial participation the 24194
state agency or political subdivision obtains through an approved, 24195
administrative claim regarding the component or aspect of the 24196
component. The percentage the department retains or collects shall 24197
be specified in a contract the department enters into with the 24198
state agency or political subdivision under section ~~5111.91~~ 24199
5161.05 of the Revised Code. 24200
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(B) The department of ~~job and family services~~ health care
administration may retain or collect a percentage of federal 24202
financial participation under divisions (A)(1) and (2) of this 24203
section only to the extent permitted by federal statutes and 24204
regulations. 24205
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(C) All amounts the department retains or collects under this 24207
section shall be deposited into the health care services 24208
administration fund created under section ~~5111.94~~ 5161.15 of the 24209
Revised Code. 24210

Sec. ~~5111.93~~ 5161.13. The department of ~~job and family~~
~~services~~ health care administration may retain or collect a 24211
percentage of the federal financial participation included in a 24212
supplemental medicaid payment to one or more medicaid providers 24213
owned or operated by a state agency or political subdivision that 24214
brings the payment to such provider or providers to the upper 24215
payment limit established by 42 C.F.R. 447.272. If the department 24216
retains or collects a percentage of that federal financial 24217
participation, the department shall adopt a rule under Chapter 24218
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119. of the Revised Code specifying the percentage the department 24220
is to retain or collect. All amounts the department retains or 24221
collects under this section shall be deposited into the health 24222
care services administration fund created under section ~~5111.94~~ 24223
5161.15 of the Revised Code. 24224

Sec. ~~5111.94~~ 5161.15. (A) As used in this section, "vendor 24225
offset" means a reduction of a medicaid payment to a medicaid 24226
provider to correct a previous, incorrect medicaid payment to that 24227
provider. 24228

(B) There is hereby created in the state treasury the health 24229
care services administration fund. Except as provided in division 24230
(C) of this section, all the following shall be deposited into the 24231
fund: 24232

(1) Amounts deposited into the fund pursuant to sections 24233
~~5111.92~~ 5161.12 and ~~5111.93~~ 5161.13 of the Revised Code; 24234

(2) The amount of the state share of all money the department 24235
of ~~job and family services~~ health care administration, in fiscal 24236
year 2003 and each fiscal year thereafter, recovers pursuant to a 24237
tort action under the department's right of recovery under section 24238
~~5101.58~~ 5160.38 of the Revised Code that exceeds the state share 24239
of all money the department, in fiscal year 2002, recovers 24240
pursuant to a tort action under that right of recovery; 24241

(3) Subject to division (D) of this section, the amount of 24242
the state share of all money the department of ~~job and family~~ 24243
~~services~~ health care administration, in fiscal year 2003 and each 24244
fiscal year thereafter, recovers through audits of medicaid 24245
providers that exceeds the state share of all money the 24246
department, in fiscal year 2002, recovers through such audits; 24247

(4) Amounts from assessments on hospitals under section 24248
~~5112.06~~ 5166.05 of the Revised Code and intergovernmental 24249

transfers by governmental hospitals under section ~~5112.07~~ 5166.06 24250
of the Revised Code that are deposited into the fund in accordance 24251
with the law. 24252

(C) No funds shall be deposited into the health care services 24253
administration fund in violation of federal statutes or 24254
regulations. 24255

(D) In determining under division (B)(3) of this section the 24256
amount of money the department, in a fiscal year, recovers through 24257
audits of medicaid providers, the amount recovered in the form of 24258
vendor offset shall be excluded. 24259

(E) The director of ~~job and family services~~ health care 24260
administration shall use funds available in the health care 24261
services administration fund to pay for costs associated with the 24262
administration of the medicaid program. 24263

Sec. ~~5111.941~~ 5161.16. The medicaid revenue and collections 24264
fund is hereby created in the state treasury. Except as otherwise 24265
provided by statute or as authorized by the controlling board, the 24266
~~non-federal~~ nonfederal share of all medicaid-related revenues, 24267
collections, and recoveries shall be credited to the fund. The 24268
department of ~~job and family services~~ health care administration 24269
shall use money credited to the fund to pay for medicaid services 24270
and contracts. 24271

Sec. ~~5111.942~~ 5161.17. (A) The prescription drug rebates fund 24272
is hereby created in the state treasury. Both of the following 24273
shall be credited to the fund: 24274

(1) The ~~non-federal~~ nonfederal share of all rebates paid by 24275
drug manufacturers to the department of ~~job and family services~~ 24276
health care administration in accordance with a rebate agreement 24277
required by 42 U.S.C.A. 1396r-8; 24278

(2) The ~~non-federal~~ nonfederal share of all supplemental 24279

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. 24310

Sec. ~~5111.915~~ 5161.25. (A) The department of ~~job and family~~ 24311
~~services~~ health care administration shall enter into an agreement 24312
with the department of administrative services for the department 24313
of administrative services to contract through competitive 24314
selection pursuant to section 125.07 of the Revised Code with a 24315
vendor to perform an assessment of the data collection and data 24316
warehouse functions of the medicaid data warehouse system, 24317
including the ability to link the data sets of all agencies 24318
serving medicaid recipients. 24319

The assessment of the data system shall include functions 24320
related to fraud and abuse detection, program management and 24321
budgeting, and performance measurement capabilities of all 24322
agencies serving medicaid recipients, including the departments of 24323
aging, alcohol and drug addiction services, health, ~~job and family~~ 24324
~~services~~ health care administration, mental health, and mental 24325
retardation and developmental disabilities. 24326

The department of administrative services shall enter into 24327
this contract within thirty days after ~~the effective date of this~~ 24328
~~section~~ September 29, 2005. The contract shall require the vendor 24329
to complete the assessment within ninety days after ~~the effective~~ 24330
~~date of this section~~ September 29, 2005. 24331

A qualified vendor with whom the department of administrative 24332
services contracts to assess the data system shall also assist the 24333
medicaid agencies in the definition of the requirements for an 24334
enhanced data system or a new data system and assist the 24335
department of administrative services in the preparation of a 24336
request for proposal to enhance or develop a data system. 24337

(B) Based on the assessment performed pursuant to division 24338
(A) of this section, the department of administrative services 24339
shall seek a qualified vendor through competitive selection 24340

pursuant to section 125.07 of the Revised Code to develop or 24341
enhance a data collection and data warehouse system for the 24342
department of ~~job and family services~~ health care administration 24343
and all agencies serving medicaid recipients. 24344

Within ninety days after ~~the effective date of this section~~ 24345
September 29, 2005, the department of ~~job and family services~~ 24346
health care administration shall seek enhanced federal funding for 24347
ninety per cent of the funds required to establish or enhance the 24348
data system. The department of administrative services shall not 24349
award a contract for establishing or enhancing the data system 24350
until the department of ~~job and family services~~ health care 24351
administration receives approval from the secretary of the United 24352
States department of health and human services for the ninety per 24353
cent federal match. 24354

Sec. ~~5111.10~~ 5161.30. The director of ~~job and family services~~ 24355
health care administration may conduct reviews of the medicaid 24356
program. The reviews may include physical inspections of records 24357
and sites where medicaid-funded services are provided and 24358
interviews of providers and recipients of the services. If the 24359
director determines pursuant to a review that a person or 24360
government entity has violated a rule governing the medicaid 24361
program, the director may establish a corrective action plan for 24362
the violator and impose fiscal, administrative, or both types of 24363
sanctions on the violator in accordance with rules governing the 24364
medicaid program. Such action to be taken against a responsible 24365
entity, as defined in section ~~5101.24~~ 5160.21 of the Revised Code, 24366
shall be taken in accordance with that section. 24367

Sec. ~~5111.09~~ 5161.32. On or before the first day of January 24368
of each year, the department of ~~job and family services~~ health 24369
care administration shall submit to the speaker and minority 24370
leader of the house of representatives and the president and 24371

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 24403
medicaid program. As the single state agency, the department shall 24404
comply with 42 C.F.R. 431.10(c). The department's rules governing 24405
medicaid are binding on other agencies that administer components 24406
of the medicaid program. No agency may establish, by rule or 24407
otherwise, a policy governing medicaid that is inconsistent with a 24408
medicaid policy established, in rule or otherwise, by the director 24409
of job and family services. 24410~~

~~(A) The department of job and family services health care 24411
administration may provide medical assistance under the medicaid 24412
program as long as federal funds are provided for such assistance, 24413
to the following: 24414~~

~~(1)(A) Families with children that meet either of the 24415
following conditions: 24416~~

~~(a) The family meets the income, resource, and family 24417
composition requirements in effect on July 16, 1996, for the 24418
former aid to dependent children program as those requirements 24419
were established by Chapter 5107. of the Revised Code, federal 24420
waivers granted pursuant to requests made under former section 24421
5101.09 of the Revised Code, and rules adopted by the department 24422
for that former program or any changes the department makes to 24423
those requirements in accordance with ~~paragraph (a)(2) of section 24424
114 of the "Personal Responsibility and Work Opportunity 24425
Reconciliation Act of 1996," 110 Stat. 2177, 42 U.S.C.A. 1396u-1, 24426
for the purpose of implementing section ~~5111.019~~ 5162.05 of the 24427
Revised Code. An adult loses eligibility for ~~medical assistance 24428
medicaid~~ under division (A)(1)(a) of this section pursuant to 24429
division (E) of section 5107.16 of the Revised Code. 24430~~~~

~~(b) The family does not meet the requirements specified in 24431
division (A)(1)(a) of this section but is eligible for medical 24432
assistance pursuant to section 5101.18 of the Revised Code. 24433~~

~~(2)(B)~~ Aged, blind, and disabled persons who meet either of 24434
the following conditions: 24435

~~(a)(1)~~ Receive federal aid benefits under ~~Title XVI of the~~ 24436
~~"Social Security Act,"~~ the supplemental security income program or 24437
are eligible for but are not receiving ~~such aid~~ SSI benefits, 24438
provided that the income from all other sources for individuals 24439
with independent living arrangements shall not exceed one hundred 24440
seventy-five dollars per month. The income standards hereby 24441
established shall be adjusted annually at the rate that is used by 24442
the United States department of health and human services to 24443
adjust the ~~amounts~~ benefits payable under ~~Title XVI~~ the SSI 24444
program. 24445

~~(b)(2)~~ Do not receive ~~aid under Title XVI~~ supplemental 24446
security income benefits, but meet any of the following criteria: 24447

~~(i)(a)~~ Would be eligible ~~to receive such aid~~ for SSI 24448
benefits, except that their income, other than that excluded from 24449
consideration as income ~~under Title XVI~~ for the SSI program, 24450
exceeds the maximum under division ~~(A)(2)(a)(B)(1)~~ of this 24451
section, and incurred expenses for medical care, as determined 24452
under federal regulations applicable to section 209(b) of the 24453
"Social Security Amendments of 1972," 86 Stat. 1381, 42 U.S.C.A. 24454
1396a(f), as amended, equal or exceed the amount by which their 24455
income exceeds the maximum under division ~~(A)(2)(a)(B)(1)~~ of this 24456
section; 24457

~~(ii)(b)~~ Received aid for the aged, aid to the blind, or aid 24458
for the permanently and totally disabled prior to January 1, 1974, 24459
and continue to meet all the same eligibility requirements; 24460

~~(iii)~~ ~~Are eligible for medical assistance pursuant to section~~ 24461
~~5101.18 of the Revised Code~~ (c) Lost eligibility for SSI benefits 24462
due to a general increase in old-age, survivors, and disability 24463
insurance benefits under Title II of the Social Security Act of 24464

1935. 24465

~~(3)(C)~~ Persons to whom federal law requires, as a condition 24466
of state participation in the medicaid program, that medical 24467
assistance be provided; 24468

~~(4)(D)~~ Persons under age twenty-one who meet the income 24469
requirements for the Ohio works first program established under 24470
Chapter 5107. of the Revised Code but do not meet other 24471
eligibility requirements for the program. The director shall adopt 24472
rules in accordance with Chapter 119. of the Revised Code 24473
specifying which Ohio works first requirements shall be waived for 24474
the purpose of providing medicaid eligibility under division 24475
~~(A)(4)(D)~~ of this section. 24476

~~(B)~~ If funds are appropriated for such purpose by the general 24477
assembly, the department may provide medical assistance to persons 24478
in groups designated by federal law as groups to which a state, at 24479
its option, may provide medical assistance under the medicaid 24480
program. 24481

~~(C)~~ The department may expand eligibility for medical 24482
assistance to include individuals under age nineteen with family 24483
incomes at or below one hundred fifty per cent of the federal 24484
poverty guidelines, except that the eligibility expansion shall 24485
not occur unless the department receives the approval of the 24486
federal government. The department may implement the eligibility 24487
expansion authorized under this division on any date selected by 24488
the department, but not sooner than January 1, 1998. 24489

~~(D)~~ In addition to any other authority or requirement to 24490
adopt rules under this chapter, the director may adopt rules in 24491
accordance with section 111.15 of the Revised Code as the director 24492
considers necessary to establish standards, procedures, and other 24493
requirements regarding the provision of medical assistance. The 24494
rules may establish requirements to be followed in applying for 24495

~~medical assistance, making determinations of eligibility for 24496
medical assistance, and verifying eligibility for medical 24497
assistance. The rules may include special conditions as the 24498
department determines appropriate for making applications, 24499
determining eligibility, and verifying eligibility for any medical 24500
assistance that the department may provide pursuant to division 24501
(C) of this section and section 5111.014 or 5111.019 of the 24502
Revised Code. 24503~~

Sec. 5162.02. If funds are appropriated for such purpose by 24504
the general assembly, the department of health care administration 24505
may expand eligibility for the medicaid program to persons in 24506
groups designated by federal law as groups to which a state, at 24507
its option, may provide medical assistance under the medicaid 24508
program. 24509

Sec. 5162.03. The department of health care administration 24510
may expand eligibility for the medicaid program to individuals 24511
under nineteen years of age with family incomes at or below one 24512
hundred fifty per cent of the federal poverty guidelines, except 24513
that the eligibility expansion shall not occur unless the 24514
department receives the approval of the United States department 24515
of health and human services. The department may implement the 24516
eligibility expansion authorized by this section on any date 24517
selected by the department. 24518

~~Sec. 5111.014~~ 5162.04. (A) The director of ~~job and family 24519
services~~ health care administration shall submit to the United 24520
States secretary of health and human services an amendment to the 24521
state medicaid plan to make an individual who meets all of the 24522
following requirements eligible for medicaid: 24523

(1) The individual is pregnant; 24524

(2) The individual's family income does not exceed one 24525

hundred fifty per cent of the federal poverty guidelines; 24526

(3) The individual satisfies all relevant requirements 24527
established by rules adopted under ~~division (D) of section 5111.01~~ 24528
5162.20 of the Revised Code. 24529

(B) If approved by the United States secretary of health and 24530
human services, the director of ~~job and family services~~ health 24531
care administration shall implement the medicaid plan amendment 24532
submitted under division (A) of this section as soon as possible 24533
after receipt of notice of the approval, but not sooner than 24534
January 1, 2000. 24535

Sec. ~~5111.019~~ 5162.05. (A) The director of ~~job and family~~ 24536
~~services~~ health care administration shall submit to the United 24537
States secretary of health and human services an amendment to the 24538
state medicaid plan to make an individual who meets all of the 24539
following requirements eligible for medicaid for the amount of 24540
time provided by division (B) of this section: 24541

(1) The individual is the parent of a child under nineteen 24542
years of age and resides with the child; 24543

(2) The individual's family income does not exceed ninety per 24544
cent of the federal poverty guidelines; 24545

(3) The individual is not otherwise eligible for medicaid; 24546

(4) The individual satisfies all relevant requirements 24547
established by rules adopted under ~~division (D) of section 5111.01~~ 24548
5162.20 of the Revised Code. 24549

(B) An individual is eligible to receive medicaid under this 24550
section for a period that does not exceed two years beginning on 24551
the date on which eligibility is established. 24552

Sec. ~~5111.0111~~ 5162.06. The director of ~~job and family~~ 24553
~~services~~ health care administration may submit to the United 24554

States secretary of health and human services an amendment to the 24555
state medicaid plan to make an individual receiving independent 24556
living services pursuant to sections 2151.81 to 2151.84 of the 24557
Revised Code eligible for medicaid. If approved by the United 24558
States secretary of health and human services, the director of ~~job~~ 24559
~~and family services~~ health care administration shall implement the 24560
medicaid plan amendment submitted under this section. 24561

Sec. ~~5111.0113~~ 5162.07. Children who are in the temporary or 24562
permanent custody of a certified public or private nonprofit 24563
agency or institution or in adoptions subsidized under division 24564
(B) of section 5153.163 of the Revised Code are eligible for 24565
~~medical assistance through~~ the medicaid program ~~established under~~ 24566
~~section 5111.01 of the Revised Code.~~ 24567

Sec. ~~5111.0110~~ 5162.08. (A) The director of ~~job and family~~ 24568
~~services~~ health care administration shall submit to the United 24569
States secretary of health and human services an amendment to the 24570
state medicaid plan to implement the "Breast and Cervical Cancer 24571
Prevention and Treatment Act of 2000," 114 Stat. 1381, 42 U.S.C.A. 24572
1396a, as amended, to provide medical assistance to women who meet 24573
all of the following requirements: 24574

(1) Are under age sixty-five; 24575

(2) Are not otherwise eligible for medicaid; 24576

(3) Have been screened for breast and cervical cancer under 24577
the centers for disease control and prevention breast and cervical 24578
cancer early detection program established under 42 U.S.C.A. 300k 24579
in accordance with 42 U.S.C.A. 300n; 24580

(4) Need treatment for breast or cervical cancer; 24581

(5) Are not otherwise covered under creditable coverage, as 24582
defined in 42 U.S.C.A. 300gg(c). 24583

(B) If the United States secretary of health and human 24584
services approves the state medicaid plan amendment submitted 24585
under division (A) of this section, the director of ~~job and family~~ 24586
~~services~~ health care administration shall implement the amendment. 24587
The medical assistance provided under the amendment shall be 24588
limited to medical assistance provided during the period in which 24589
a woman who meets the requirements of division (A) of this section 24590
requires treatment for breast or cervical cancer. 24591

Sec. ~~5111.0115~~ 5162.09. (A) The department of ~~job and family~~ 24592
~~services~~ health care administration may provide medical assistance 24593
under the medicaid program, as long as federal funds are provided 24594
for such assistance, to each former participant of the Ohio works 24595
first program established under Chapter 5107. of the Revised Code 24596
who meets all of the following requirements: 24597

(1) Is ineligible to participate in Ohio works first solely 24598
as a result of increased income due to employment; 24599

(2) Is not covered by, and does not have access to, medical 24600
insurance coverage through the employer with benefits comparable 24601
to those provided under this section, as determined in accordance 24602
with rules adopted by the director of ~~job and family services~~ 24603
health care administration under division (B) of this section; 24604

(3) Meets any other requirement established by rule adopted 24605
under division (B) of this section. 24606

(B) The director of ~~job and family services~~ health care 24607
administration shall adopt such rules under Chapter 119. of the 24608
Revised Code as are necessary to implement and administer the 24609
~~medical assistance~~ medicaid program under this section. 24610

(C) A person seeking to participate in ~~a program of medical~~ 24611
~~assistance under~~ the medicaid program pursuant to this section 24612
shall apply to the county department of job and family services in 24613

the county in which the applicant resides. The application shall 24614
be made on a form prescribed by the department of ~~job and family~~ 24615
~~services~~ health care administration and furnished by the county 24616
department. 24617

(D) If the county department of job and family services 24618
determines that a person is eligible to receive ~~medical assistance~~ 24619
medicaid under this section, the department shall provide 24620
assistance, to the same extent and in the same manner as ~~medical~~ 24621
~~assistance~~ medicaid is provided to a person eligible for ~~medical~~ 24622
~~assistance~~ medicaid pursuant to division (A)~~(1)~~~~(a)~~ of section 24623
~~5111.01~~ 5162.01 of the Revised Code, for no longer than twelve 24624
months, beginning the month after the date the participant's 24625
eligibility for Ohio works first is terminated. 24626

Sec. ~~5111.013~~ 5162.15. (A) The provision of ~~medical~~ 24627
~~assistance~~ medicaid to pregnant women and young children who are 24628
eligible for ~~medical assistance~~ medicaid under division ~~(A)(3)(C)~~ 24629
of section ~~5111.01~~ 5162.01 of the Revised Code, but who are not 24630
otherwise eligible for ~~medical assistance~~ medicaid under that 24631
section, shall be known as the healthy start program. 24632

(B) The department of ~~job and family services~~ health care 24633
administration shall do all of the following with regard to the 24634
application procedures for the healthy start program: 24635

(1) Establish a short application form for the program that 24636
requires the applicant to provide no more information than is 24637
necessary for making determinations of eligibility for the healthy 24638
start program, except that the form may require applicants to 24639
provide their social security numbers. The form shall include a 24640
statement, which must be signed by the applicant, indicating that 24641
she does not choose at the time of making application for the 24642
program to apply for assistance provided under any other program 24643
administered by the department and that she understands that she 24644

is permitted at any other time to apply at the county department 24645
of job and family services of the county in which she resides for 24646
any other assistance administered by the department or department 24647
of job and family services. 24648

(2) To the extent permitted by federal law, do one or both of 24649
the following: 24650

(a) Distribute the application form for the program to each 24651
public or private entity that serves as a women, infants, and 24652
children clinic or as a child and family health clinic and to each 24653
administrative body for such clinics and train employees of each 24654
such agency or entity to provide applicants assistance in 24655
completing the form; 24656

(b) In cooperation with the department of health, develop 24657
arrangements under which employees of county departments of job 24658
and family services are stationed at public or private agencies or 24659
entities selected by the department of ~~job and family services~~ 24660
health care administration that serve as women, infants, and 24661
children clinics; child and family health clinics; or 24662
administrative bodies for such clinics for the purpose both of 24663
assisting applicants for the program in completing the application 24664
form and of making determinations at that location of eligibility 24665
for the program. 24666

(3) Establish performance standards by which a county 24667
department of job and family services' level of enrollment of 24668
persons potentially eligible for the program can be measured, and 24669
establish acceptable levels of enrollment for each county 24670
department. 24671

(4) Direct any county department of job and family services 24672
whose rate of enrollment of potentially eligible enrollees in the 24673
program is below acceptable levels established under division 24674
(B)(3) of this section to implement corrective action. Corrective 24675

action may include but is not limited to any one or more of the 24676
following to the extent permitted by federal law: 24677

(a) Establishing formal referral and outreach methods with 24678
local health departments and local entities receiving funding 24679
through the bureau of maternal and child health; 24680

(b) Designating a specialized intake unit within the county 24681
department for healthy start applicants; 24682

(c) Establishing abbreviated timeliness requirements to 24683
shorten the time between receipt of an application and the 24684
scheduling of an initial application interview; 24685

(d) Establishing a system for telephone scheduling of intake 24686
interviews for applicants; 24687

(e) Establishing procedures to minimize the time an applicant 24688
must spend in completing the application and eligibility 24689
determination process, including permitting applicants to complete 24690
the process at times other than the regular business hours of the 24691
county department and at locations other than the offices of the 24692
county department. 24693

(C) To the extent permitted by federal law, local funds, 24694
whether from public or private sources, expended by a county 24695
department for administration of the healthy start program shall 24696
be considered to have been expended by the state for the purpose 24697
of determining the extent to which the state has complied with any 24698
federal requirement that the state provide funds to match federal 24699
funds for ~~medical assistance~~ medicaid, except that this division 24700
shall not affect the amount of funds the county is entitled to 24701
receive under section 5101.16, or 5101.161, ~~or 5111.012~~ of the 24702
Revised Code. 24703

(D) The director of ~~job and family services~~ health care 24704
administration shall do one or both of the following: 24705

(1) To the extent that federal funds are provided for such 24706
assistance, adopt a plan for granting presumptive eligibility for 24707
pregnant women applying for healthy start; 24708

(2) To the extent permitted by federal medicaid regulations, 24709
adopt a plan for making same-day determinations of eligibility for 24710
pregnant women applying for healthy start. 24711

(E) A county department of job and family services that 24712
maintains offices at more than one location shall accept 24713
applications for the healthy start program at all of those 24714
locations. 24715

(F) The director of ~~job and family services~~ health care 24716
administration shall adopt rules in accordance with section 111.15 24717
of the Revised Code as necessary to implement this section. 24718

Sec. ~~5111.016~~ 5162.16. (A) As used in this section, 24719
"healthcheck" has the same meaning as in section 3313.714 of the 24720
Revised Code. 24721

(B) In accordance with federal law and regulations, the 24722
department of ~~job and family services~~ health care administration 24723
shall establish a combination of written and oral methods designed 24724
to provide information about healthcheck to all persons eligible 24725
for the program or their parents or guardians. The department 24726
shall ensure that its methods of providing information are 24727
effective. 24728

Each county department of job and family services or other 24729
entity that distributes or accepts applications for ~~medical~~ 24730
~~assistance~~ medicaid shall prominently display in a conspicuous 24731
place the following notice: 24732

"Under state and federal law, if you are a Medicaid 24733
recipient, your child is entitled to a thorough medical 24734
examination provided through Healthcheck. Once this examination is 24735

completed, your child is entitled to receive, at no cost to you, 24736
any service determined to be medically necessary." 24737

Sec. 5162.17. The department of health care administration 24738
shall establish a disability determination unit and develop 24739
guidelines for expediting reviews of applications for the medicaid 24740
program for persons who have been referred to the unit under 24741
division (D) of section 329.043 of the Revised Code. The 24742
department shall make determinations of eligibility for medicaid 24743
for any such person within the time prescribed by federal 24744
regulations. 24745

~~Sec. 5111.011~~ 5162.20. (A) The director of ~~job and family~~ 24746
~~services~~ health care administration shall adopt rules establishing 24747
eligibility requirements for the medicaid program. The rules shall 24748
be adopted pursuant to section 111.15 of the Revised Code and 24749
shall be consistent with federal and state law. The rules shall 24750
include rules that do all of the following: 24751

(1) Establish requirements to be followed in applying for 24752
medicaid, making determinations of eligibility for medicaid, and 24753
verifying eligibility for medicaid; 24754

(2) Establish standards consistent with federal law for 24755
allocating income and resources as income and resources of the 24756
spouse, children, parents, or stepparents of a recipient of or 24757
applicant for medicaid; 24758

~~(3)~~(3) Define the term "resources" as used in division 24759
(A)~~(1)~~(2) of this section; 24760

~~(3)~~(4) Specify the number of months that is to be used for 24761
the purpose of the term "look-back date" used in section ~~5111.0116~~ 24762
5162.21 of the Revised Code; 24763

~~(4)~~(5) Establish processes to be used to determine both of 24764
the following: 24765

(a) The date an institutionalized individual's ineligibility 24766
for services under section ~~5111.0116~~ 5162.21 of the Revised Code 24767
is to begin; 24768

(b) The number of months an institutionalized individual's 24769
ineligibility for such services is to continue. 24770

~~(5)~~(6) Establish exceptions to the period of ineligibility 24771
that an institutionalized individual would otherwise be subject to 24772
under section ~~5111.0116~~ 5162.21 of the Revised Code; 24773

~~(6)~~(7) Define the term "other medicaid-funded long-term care 24774
services" as used in sections ~~5111.0117~~ 5162.22 and ~~5111.0118~~
5162.23 of the Revised Code; 24775
24776

~~(7)~~(8) For the purpose of division (C)(2)(c) of section 24777
~~5111.0117~~ 5162.22 of the Revised Code, establish the process to 24778
determine whether the child of an aged, blind, or disabled 24779
individual is financially dependent on the individual for housing. 24780

(B) Notwithstanding any provision of state law, including 24781
statutes, administrative rules, common law, and court rules, 24782
regarding real or personal property or domestic relations, the 24783
standards established under rules adopted under division (A)~~(1)~~(2) 24784
of this section shall be used to determine eligibility for 24785
medicaid. 24786

Sec. ~~5111.0116~~ 5162.21. (A) As used in this section: 24787

(1) "Assets" include all of an individual's income and 24788
resources and those of the individual's spouse, including any 24789
income or resources the individual or spouse is entitled to but 24790
does not receive because of action by any of the following: 24791

(a) The individual or spouse; 24792

(b) A person or government entity, including a court or 24793
administrative agency, with legal authority to act in place of or 24794
on behalf of the individual or spouse; 24795

(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.	24796 24797 24798
(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).	24799 24800 24801 24802
(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).	24803 24804 24805 24806 24807
(4) "Look-back date" means the date that is a number of months specified in rules adopted under section 5111.011 <u>5162.20</u> of the Revised Code immediately before either of the following:	24808 24809 24810
(a) The date an individual becomes an institutionalized individual if the individual is eligible for medicaid on that date;	24811 24812 24813
(b) The date an individual applies for medicaid while an institutionalized individual.	24814 24815
(5) "Nursing facility" has the same meaning as in section 5111.20 <u>5164.01</u> of the Revised Code.	24816 24817
(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.	24818 24819 24820 24821 24822 24823
(7) "Nursing facility services" means nursing facility services covered by the medicaid program that a nursing facility	24824 24825

provides to a resident of the nursing facility who is a medicaid recipient eligible for medicaid-covered nursing facility services. 24826
24827

(B) Except as provided in rules adopted under section 24828
~~5111.011~~ 5162.20 of the Revised Code, an institutionalized 24829
individual is ineligible for nursing facility services, nursing 24830
facility equivalent services, and home and community-based 24831
services if the individual or individual's spouse disposes of 24832
assets for less than fair market value on or after the look-back 24833
date. The institutionalized individual's ineligibility shall begin 24834
on a date determined in accordance with rules adopted under 24835
section ~~5111.011~~ 5162.20 of the Revised Code and shall continue 24836
for a number of months determined in accordance with such rules. 24837

(C) To secure compliance with this section, the director of 24838
~~job and family services~~ health care administration may require an 24839
individual, as a condition of initial or continued eligibility for 24840
medicaid, to provide documentation of the individual's assets up 24841
to five years before the date the individual becomes an 24842
institutionalized individual if the individual is eligible for 24843
medicaid on that date or the date the individual applies for 24844
medicaid while an institutionalized individual. Documentation may 24845
include tax returns, records from financial institutions, and real 24846
property records. 24847

Sec. ~~5111.0117~~ 5162.22. (A) As used in this section and 24848
section ~~5111.0118~~ 5162.23 of the Revised Code: 24849

(1) "ICF/MR services" means intermediate care facility for 24850
the mentally retarded services covered by the medicaid program 24851
that an intermediate care facility for the mentally retarded 24852
provides to a resident of the facility who is a medicaid recipient 24853
eligible for medicaid-covered intermediate care facility for the 24854
mentally retarded services. 24855

(2) "Intermediate care facility for the mentally retarded" 24856

has the same meaning as in section ~~5111.20~~ 5164.01 of the Revised Code. 24857
24858

(3) "Nursing facility" has the same meaning as in section 24859
~~5111.20~~ 5164.01 of the Revised Code. 24860

(4) "Nursing facility services" means nursing facility 24861
services covered by the medicaid program that a nursing facility 24862
provides to a resident of the nursing facility who is a medicaid 24863
recipient eligible for medicaid-covered nursing facility services. 24864

(5) "Other medicaid-funded long-term care services" has the 24865
meaning specified in rules adopted under section ~~5111.011~~ 5162.20 24866
of the Revised Code. 24867

(B) Except as provided by division (C) of this section and 24868
for the purpose of determining whether an aged, blind, or disabled 24869
individual is eligible for nursing facility services, ICF/MR 24870
services, or other medicaid-funded long-term care services, the 24871
director of ~~job and family services~~ health care administration may 24872
consider an aged, blind, or disabled individual's real property to 24873
not be the individual's homestead or principal place of residence 24874
once the individual has resided in a nursing facility, 24875
intermediate care facility for the mentally retarded, or other 24876
medical institution for at least thirteen months. 24877

(C) Division (B) of this section does not apply to an 24878
individual if any of the following reside in the individual's real 24879
property that, because of this division, continues to be 24880
considered the individual's homestead or principal place of 24881
residence: 24882

(1) The individual's spouse; 24883

(2) The individual's child if any of the following apply: 24884

(a) The child is under twenty-one years of age. 24885

(b) The child is considered blind or disabled under 42 U.S.C. 24886

1382c.	24887
(c) The child is financially dependent on the individual for housing as determined in accordance with rules adopted under section 5111.011 <u>5162.20</u> of the Revised Code.	24888 24889 24890
(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.	24891 24892 24893 24894 24895
Sec. 5111.0118 <u>5162.23</u>. (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 <u>health care administration</u> 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.	24896 24897 24898 24899 24900 24901 24902 24903 24904 24905
(B) This section does not apply to an individual if either of the following applies:	24906 24907
(1) Either of the following lawfully reside in the individual's home:	24908 24909
(a) The individual's spouse;	24910
(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.	24911 24912 24913
(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.	24914 24915 24916

(C) The director shall establish a process by which 24917
individuals may obtain a waiver of this section due to a 24918
demonstrated hardship. The process shall be consistent with the 24919
process for such waivers established by the United States 24920
secretary of health and human services under 42 U.S.C. 24921
1396p(f)(4). 24922

(D) Nothing in this section shall be construed as preventing 24923
an individual from using a reverse mortgage or home equity loan to 24924
reduce the individual's total equity interest in the home. 24925

Sec. ~~5111.015~~ 5162.24. (A) If the United States secretary of 24926
health and human services grants a waiver of any contrary federal 24927
requirements governing the ~~medical assistance~~ medicaid program or 24928
the director of ~~job and family services~~ health care administration 24929
determines that there are no contrary federal requirements, 24930
divisions (A)(1) and (2) of this section apply to determinations 24931
of eligibility under this chapter: 24932

(1) In determining the eligibility of an assistance group for 24933
assistance under this chapter, the department of ~~job and family~~ 24934
~~services~~ health care administration shall exclude from the income 24935
and resources applicable to the assistance group the value of any 24936
tuition payment contract entered into under section 3334.09 of the 24937
Revised Code or any scholarship awarded under section 3334.18 of 24938
the Revised Code and the amount of payments made by the Ohio 24939
tuition trust authority under section 3334.09 of the Revised Code 24940
pursuant to the contract or scholarship. 24941

(2) The department shall not require any person to terminate 24942
a tuition payment contract entered into under Chapter 3334. of the 24943
Revised Code as a condition of an assistance group's eligibility 24944
for ~~assistance under this chapter~~ medicaid. 24945

(B) To the extent required by federal law, the department 24946
shall include as income any refund paid under section 3334.10 of 24947

the Revised Code to a member of the assistance group. 24948

(C) Not later than sixty days after July 1, 1994, the 24949
department shall apply to the United States department of health 24950
and human services for a waiver of any federal requirements that 24951
otherwise would be violated by implementation of division (A) of 24952
this section. 24953

Sec. ~~5111.15~~ 5162.25. If a medicaid recipient ~~of medical~~ 24954
~~assistance~~ is the beneficiary of a trust created pursuant to 24955
section 5815.28 of the Revised Code, then, notwithstanding any 24956
contrary provision of this chapter or of a rule adopted pursuant 24957
to this chapter, divisions (C) and (D) of that section shall apply 24958
in determining the assets or resources of the recipient, the 24959
recipient's estate, the settlor, or the settlor's estate and to 24960
claims arising under this chapter against the recipient, the 24961
recipient's estate, the settlor, or the settlor's estate. 24962

Sec. ~~5111.151~~ 5162.26. (A) This section applies to 24963
eligibility determinations for all cases involving ~~medicaid~~ 24964
medical assistance provided pursuant to this chapter under the 24965
medicaid program, qualified medicare beneficiaries, specified 24966
low-income medicare beneficiaries, qualifying individuals-1, 24967
qualifying individuals-2, and ~~medical assistance~~ medicaid for 24968
covered families and children. 24969

(B) As used in this section: 24970

(1) "Trust" means any arrangement in which a grantor 24971
transfers real or personal property to a trust with the intention 24972
that it be held, managed, or administered by at least one trustee 24973
for the benefit of the grantor or beneficiaries. "Trust" includes 24974
any legal instrument or device similar to a trust. 24975

(2) "Legal instrument or device similar to a trust" includes, 24976
but is not limited to, escrow accounts, investment accounts, 24977

partnerships, contracts, and other similar arrangements that are	24978
not called trusts under state law but are similar to a trust and	24979
to which all of the following apply:	24980
(a) The property in the trust is held, managed, retained, or	24981
administered by a trustee.	24982
(b) The trustee has an equitable, legal, or fiduciary duty to	24983
hold, manage, retain, or administer the property for the benefit	24984
of the beneficiary.	24985
(c) The trustee holds identifiable property for the	24986
beneficiary.	24987
(3) "Grantor" is a person who creates a trust, including all	24988
of the following:	24989
(a) An individual;	24990
(b) An individual's spouse;	24991
(c) A person, including a court or administrative body, with	24992
legal authority to act in place of or on behalf of an individual	24993
or an individual's spouse;	24994
(d) A person, including a court or administrative body, that	24995
acts at the direction or on request of an individual or the	24996
individual's spouse.	24997
(4) "Beneficiary" is a person or persons, including a	24998
grantor, who benefits in some way from a trust.	24999
(5) "Trustee" is a person who manages a trust's principal and	25000
income for the benefit of the beneficiaries.	25001
(6) "Person" has the same meaning as in section 1.59 of the	25002
Revised Code and includes an individual, corporation, business	25003
trust, estate, trust, partnership, and association.	25004
(7) "Applicant" is an individual who applies for medicaid or	25005
the individual's spouse.	25006

(8) "Recipient" is an individual who receives medicaid or the individual's spouse. 25007
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(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: 25009
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(a) A trust that provides that the trust can be terminated only by a court; 25012
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(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. 25014
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(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. 25017
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(11) "Payment" is any disbursement from the principal or income of the trust, including actual cash, noncash or property disbursements, or the right to use and occupy real property. 25021
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(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. 25024
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(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. 25027
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(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 25030
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trust is one of the following:	25037
(1) A countable resource;	25038
(2) Countable income;	25039
(3) A countable resource and countable income;	25040
(4) Not a countable resource or countable income.	25041
(D)(1) A trust or legal instrument or device similar to a	25042
trust shall be considered a medicaid qualifying trust if all of	25043
the following apply:	25044
(a) The trust was established on or prior to August 10, 1993.	25045
(b) The trust was not established by a will.	25046
(c) The trust was established by an applicant or recipient.	25047
(d) The applicant or recipient is or may become the	25048
beneficiary of all or part of the trust.	25049
(e) Payment from the trust is determined by one or more	25050
trustees who are permitted to exercise any discretion with respect	25051
to the distribution to the applicant or recipient.	25052
(2) If a trust meets the requirement of division (D)(1) of	25053
this section, the amount of the trust that is considered by the	25054
county department of job and family services as an available	25055
resource to the applicant or recipient shall be the maximum amount	25056
of payments permitted under the terms of the trust to be	25057
distributed to the applicant or recipient, assuming the full	25058
exercise of discretion by the trustee or trustees. The maximum	25059
amount shall include only amounts that are permitted to be	25060
distributed but are not distributed from either the income or	25061
principal of the trust.	25062
(3) Amounts that are actually distributed from a medicaid	25063
qualifying trust to a beneficiary for any purpose shall be treated	25064
in accordance with rules adopted by the department of job and	25065

family services <u>health care administration</u> governing income.	25066
(4) Availability of a medicaid qualifying trust shall be considered without regard to any of the following:	25067 25068
(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 <u>medicaid</u> for covered families and children, or as a qualified medicare beneficiary, specified low-income medicare beneficiary, qualifying individual-1, or qualifying individual-2;	25069 25070 25071 25072 25073 25074
(b) Whether or not the trustee actually exercises discretion.	25075
(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 <u>5162.21</u> of the Revised Code and rules to implement that section adopted under section 5111.011 <u>5162.20</u> of the Revised Code.	25076 25077 25078 25079 25080 25081 25082
(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.	25083 25084 25085 25086
(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:	25087 25088 25089
(a) The trust was established on or after August 11, 1993.	25090
(b) The trust was not established by a will.	25091
(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	25092 25093 25094 25095

at the direction or on request of an applicant, recipient, or spouse. 25096
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(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: 25098
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(a) The corpus of the trust shall be considered a resource available to the applicant or recipient. 25101
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(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. 25103
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(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. 25106
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(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: 25111
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(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. 25114
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(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. 25121
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(c) If a payment is made to someone other than to the applicant or recipient and the payment is not for the benefit of 25124
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the applicant or recipient, the payment shall be considered an 25126
improper disposition of assets and shall be subject to section 25127
~~5111.0116~~ 5162.21 of the Revised Code and rules to implement that 25128
section adopted under section ~~5111.011~~ 5162.20 of the Revised 25129
Code. 25130

(d) The date of the disposition shall be the later of the 25131
date of establishment of the trust or the date of the occurrence 25132
of the event. 25133

(e) When determining the value of the disposed asset under 25134
this provision, the value of the trust shall be its value on the 25135
date payment to the applicant or recipient was foreclosed. 25136

(f) Any income earned or other resources added subsequent to 25137
the foreclosure date shall be added to the total value of the 25138
trust. 25139

(g) Any payments to or for the benefit of the applicant or 25140
recipient after the foreclosure date but prior to the application 25141
date shall be subtracted from the total value. Any other payments 25142
shall not be subtracted from the value. 25143

(h) Any addition of assets after the foreclosure date shall 25144
be considered a separate disposition. 25145

(4) If a trust is funded with assets of another person or 25146
persons in addition to assets of the applicant or recipient, the 25147
applicable provisions of this section and rules adopted by the 25148
department of ~~job and family services~~ health care administration 25149
governing trusts shall apply only to the portion of the trust 25150
attributable to the applicant or recipient. 25151

(5) The availability of a self-settled trust shall be 25152
considered without regard to any of the following: 25153

(a) The purpose for which the trust is established; 25154

(b) Whether the trustees have exercised or may exercise 25155

discretion under the trust;	25156
(c) Any restrictions on when or whether distributions may be made from the trust;	25157 25158
(d) Any restrictions on the use of distributions from the trust.	25159 25160
(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.	25161 25162 25163 25164
(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:	25165 25166 25167
(1)(a) A special needs trust that meets all of the following requirements:	25168 25169
(i) The trust contains assets of an applicant or recipient under sixty-five years of age and may contain the assets of other individuals.	25170 25171 25172
(ii) The applicant or recipient is disabled as defined in rules adopted by the department of job and family services <u>health care administration</u> .	25173 25174 25175
(iii) The trust is established for the benefit of the applicant or recipient by a parent, grandparent, legal guardian, or a court.	25176 25177 25178
(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.	25179 25180 25181 25182
(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	25183 25184 25185

exemption for the trust granted pursuant to division (F) of this 25186
section shall continue after the disabled applicant or recipient 25187
becomes sixty-five years of age if the applicant or recipient 25188
continues to be disabled as defined in rules adopted by the 25189
department of ~~job and family services~~ health care administration. 25190
Except for income earned by the trust, the grantor shall not add 25191
to or otherwise augment the trust after the applicant or recipient 25192
attains sixty-five years of age. An addition or augmentation of 25193
the trust by the applicant or recipient with the applicant's own 25194
assets after the applicant or recipient attains sixty-five years 25195
of age shall be treated as an improper disposition of assets. 25196

(c) Cash distributions to the applicant or recipient shall be 25197
counted as unearned income. All other distributions from the trust 25198
shall be treated as provided in rules adopted by the department of 25199
~~job and family services~~ health care administration governing 25200
in-kind income. 25201

(d) Transfers of assets to a special needs trust shall not be 25202
treated as an improper transfer of resources. Assets held prior to 25203
the transfer to the trust shall be considered as countable assets 25204
or countable income or countable assets and income. 25205

(2)(a) A qualifying income trust that meets all of the 25206
following requirements: 25207

(i) The trust is composed only of pension, social security, 25208
and other income to the applicant or recipient, including 25209
accumulated interest in the trust. 25210

(ii) The income is received by the individual and the right 25211
to receive the income is not assigned or transferred to the trust. 25212

(iii) The trust requires that on the death of the applicant 25213
or recipient the state will receive all amounts remaining in the 25214
trust up to an amount equal to the total amount of medicaid paid 25215
on behalf of the applicant or recipient. 25216

(b) No resources shall be used to establish or augment the trust. 25217
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(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. 25219
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(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. 25223
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(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. 25230
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(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. 25234
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(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. 25241
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(3)(a) A pooled trust that meets all of the following 25247

requirements:	25248
(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 <u>health care administration</u> .	25249 25250 25251 25252
(ii) The trust is established and managed by a nonprofit association.	25253 25254
(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.	25255 25256 25257
(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.	25258 25259 25260 25261
(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.	25262 25263 25264 25265 25266
(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 <u>health care administration</u> governing in-kind income.	25267 25268 25269 25270 25271
(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.	25272 25273 25274 25275
(4) A supplemental services trust that meets the requirements of section 5815.28 of the Revised Code and to which all of the	25276 25277

following apply:	25278
(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:	25279 25280 25281 25282
(i) The department of mental retardation and developmental disabilities;	25283 25284
(ii) A county board of mental retardation and developmental disabilities;	25285 25286
(iii) The department of mental health;	25287
(iv) A board of alcohol, drug addiction, and mental health services.	25288 25289
(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:	25290 25291 25292
(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;	25293 25294 25295 25296
(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.	25297 25298 25299 25300
(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.	25301 25302 25303 25304 25305
(d) A county department of job and family services shall review the trust to determine whether it complies with the	25306 25307

provisions of section 5815.28 of the Revised Code. 25308

(e) Payments from supplemental services trusts shall be 25309
exempt as long as the payments are for supplemental services as 25310
defined in rules adopted by the department of ~~job and family~~ 25311
~~services~~ health care administration. All supplemental services 25312
shall be purchased by the trustee and shall not be purchased 25313
through direct cash payments to the beneficiary. 25314

(f) If a trust is represented as a supplemental services 25315
trust and a county department of job and family services 25316
determines that the trust does not meet the requirements provided 25317
in division (F)(4) of this section and section 5815.28 of the 25318
Revised Code, the county department of job and family services 25319
shall not consider it an exempt trust. 25320

(G)(1) A trust or legal instrument or device similar to a 25321
trust shall be considered a trust established by an individual for 25322
the benefit of the applicant or recipient if all of the following 25323
apply: 25324

(a) The trust is created by a person other than the applicant 25325
or recipient. 25326

(b) The trust names the applicant or recipient as a 25327
beneficiary. 25328

(c) The trust is funded with assets or property in which the 25329
applicant or recipient has never held an ownership interest prior 25330
to the establishment of the trust. 25331

(2) Any portion of a trust that meets the requirements of 25332
division (G)(1) of this section shall be an available resource 25333
only if the trust permits the trustee to expend principal, corpus, 25334
or assets of the trust for the applicant's or recipient's medical 25335
care, care, comfort, maintenance, health, welfare, general well 25336
being, or any combination of these purposes. 25337

(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 25369
counted as an available resource and payments shall be treated in 25370
accordance with rules adopted by the department of ~~job and family~~ 25371
~~services~~ health care administration governing income. Terms of a 25372
trust that grant discretion to limit payments shall not qualify as 25373
a clear statement requiring the trustee to make fixed periodic 25374
payments. 25375

(d) If a trust contains a clear statement that requires the 25376
trustee to terminate the trust if it is counted as an available 25377
resource, the trust shall not be counted as an available resource. 25378
Terms of a trust that grant discretion to terminate the trust do 25379
not qualify as a clear statement requiring the trustee to 25380
terminate the trust. 25381

(e) If a person obtains a judgment from a court of competent 25382
jurisdiction that expressly prevents the trustee from using part 25383
or all of the trust for the medical care, care, comfort, 25384
maintenance, welfare, or general well being of the applicant or 25385
recipient, the trust or that portion of the trust subject to the 25386
court order shall not be counted as a resource. 25387

(f) If a trust is specifically exempt from being counted as 25388
an available resource by a provision of the Revised Code, rules, 25389
or federal law, the trust shall not be counted as a resource. 25390

(g) If an applicant or recipient presents a final judgment 25391
from a court demonstrating that the applicant or recipient was 25392
unsuccessful in a civil action against the trustee to compel 25393
payments from the trust, the trust shall not be counted as an 25394
available resource. 25395

(h) If an applicant or recipient presents a final judgment 25396
from a court demonstrating that in a civil action against the 25397
trustee the applicant or recipient was only able to compel limited 25398
or periodic payments, the trust shall not be counted as an 25399

available resource and payments shall be treated in accordance 25400
with rules adopted by the department of ~~job and family services~~ 25401
health care administration governing income. 25402

(i) If an applicant or recipient provides written 25403
documentation showing that the cost of a civil action brought to 25404
compel payments from the trust would be cost prohibitive, the 25405
trust shall not be counted as an available resource. 25406

(5) Any actual payments to the applicant or recipient from a 25407
trust that meet the requirements of division (G)(1) of this 25408
section, including trusts that are not counted as an available 25409
resource, shall be treated as provided in rules adopted by the 25410
department of ~~job and family services~~ health care administration 25411
governing income. Payments to any person other than the applicant 25412
or recipient shall not be considered income to the applicant or 25413
recipient. Payments from the trust to a person other than the 25414
applicant or recipient shall not be considered an improper 25415
disposition of assets. 25416

Sec. ~~5111.181~~ 5162.30. (A) The general assembly hereby finds 25417
that the state has an insurable interest in ~~medical assistance~~ 25418
medicaid recipients because of the state's statutory right to 25419
recover from the estate of a recipient state funds used to provide 25420
the recipient with medical care and services. 25421

(B) As used in this section: 25422

(1) "Beneficiary" means the person or entity designated in a 25423
life insurance policy to receive the proceeds of the policy on the 25424
death of the insured or maturity of the policy. 25425

(2) "Owner" means the person who has the right to designate 25426
the beneficiary of a life insurance policy and to change the 25427
designation. 25428

(C) Notwithstanding section ~~5111.011~~ 5162.20 of the Revised 25429

Code, the value of a life insurance policy that would otherwise be 25430
considered a resource in determining eligibility for the ~~medical~~ 25431
~~assistance~~ medicaid program shall be excluded from any 25432
determination of a person's eligibility for the ~~medical assistance~~ 25433
medicaid program if the owner designates the department of ~~job and~~ 25434
~~family services~~ health care administration as beneficiary of the 25435
policy. The department may pay premiums to keep the policy in 25436
force. Premiums paid by the department are ~~medical assistance~~ 25437
medicaid payments correctly paid on behalf of a ~~medical assistance~~ 25438
medicaid recipient and subject to recovery under section ~~5111.11~~ 25439
5162.40 of the Revised Code. 25440

(D) The director of ~~job and family services~~ health care 25441
administration shall deposit the proceeds of a life insurance 25442
policy that do not exceed the amount the department may recover 25443
against the property and estate of the owner under section ~~5111.11~~ 25444
5162.40 of the Revised Code into the general revenue fund. The 25445
director shall pay any remaining proceeds to the person designated 25446
by the owner. If the owner failed to designate a person, the 25447
director shall pay the remaining proceeds to the surviving spouse, 25448
or, if there is no surviving spouse, to the estate of the owner. 25449

(E) If the owner designates the department of ~~job and family~~ 25450
~~services~~ health care administration as the policy's beneficiary, 25451
the department shall notify the owner that the owner may designate 25452
a person to receive proceeds of the policy that exceed the amount 25453
the department may recover against the owner's property and estate 25454
under section ~~5111.11~~ 5162.40 of the Revised Code. The designation 25455
shall be made on a form provided by the department. 25456

(F) The department of ~~job and family services~~ health care 25457
administration shall not implement this section if implementation 25458
would violate any federal requirement unless the department 25459
receives a waiver of the requirement from the United States 25460
department of health and human services. 25461

Sec. ~~5111.0112~~ 5162.35. (A) Not later than July 1, 2006, the 25462
director of ~~job and family services~~ health care administration 25463
shall institute a copayment program under the medicaid program. To 25464
the extent permitted by federal law, the copayment program shall 25465
establish a copayment requirement for only dental services, vision 25466
services, nonemergency emergency department services, and 25467
prescription drugs, other than generic drugs. The director shall 25468
adopt rules under section ~~5111.02~~ 5163.15 of the Revised Code 25469
governing the copayment program. 25470

(B) The copayment program shall, to the extent permitted by 25471
federal law, provide for all of the following with regard to any 25472
providers participating in the medicaid program: 25473

(1) No provider shall refuse to provide a service to a 25474
medicaid recipient who is unable to pay a required copayment for 25475
the service. 25476

(2) Division (B)(1) of this section shall not be considered 25477
to do either of the following with regard to a medicaid recipient 25478
who is unable to pay a required copayment: 25479

(a) Relieve the medicaid recipient from the obligation to pay 25480
a copayment; 25481

(b) Prohibit the provider from attempting to collect an 25482
unpaid copayment. 25483

(3) Except as provided in division (C) of this section, no 25484
provider shall waive a medicaid recipient's obligation to pay the 25485
provider a copayment. 25486

(4) No provider or drug manufacturer, including the 25487
manufacturer's representative, employee, independent contractor, 25488
or agent, shall pay any copayment on behalf of a medicaid 25489
recipient. 25490

(5) If it is the routine business practice of the provider to 25491

refuse service to any individual who owes an outstanding debt to 25492
the provider, the provider may consider an unpaid copayment 25493
imposed by the copayment program as an outstanding debt and may 25494
refuse service to a medicaid recipient who owes the provider an 25495
outstanding debt. If the provider intends to refuse service to a 25496
medicaid recipient who owes the provider an outstanding debt, the 25497
provider shall notify the individual of the provider's intent to 25498
refuse services. 25499

(C) In the case of a provider that is a hospital, the 25500
copayment program shall permit the hospital to take action to 25501
collect a copayment by providing, at the time services are 25502
rendered to a medicaid recipient, notice that a copayment may be 25503
owed. If the hospital provides the notice and chooses not to take 25504
any further action to pursue collection of the copayment, the 25505
prohibition against waiving copayments specified in division 25506
(B)(3) of this section does not apply. 25507

Sec. ~~5111.114~~ 5162.36. As used in this section, "nursing 25508
facility" and "intermediate care facility for the mentally 25509
retarded" have the same meanings as in section ~~5111.20~~ 5164.01 of 25510
the Revised Code. 25511

In determining the amount of income that a medicaid recipient 25512
~~of medical assistance~~ must apply monthly toward payment of the 25513
cost of care in a nursing facility or intermediate care facility 25514
for the mentally retarded, the county department of job and family 25515
services shall deduct from the recipient's monthly income a 25516
monthly personal needs allowance in accordance with ~~section 1902~~ 25517
~~of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A.~~ 25518
~~1396a, as amended~~ 1396a(g). 25519

For a resident of a nursing facility, the monthly personal 25520
needs allowance shall be not less than forty dollars for an 25521
individual resident and not less than eighty dollars for a married 25522

couple if both spouses are residents of a nursing facility. 25523

For a resident of an intermediate care facility for the 25524
mentally retarded, the monthly personal needs allowance shall be 25525
forty dollars unless the resident has earned income, in which case 25526
the monthly personal needs allowance shall be determined by the 25527
state department of ~~job and family services~~ health care 25528
administration but shall not exceed one hundred five dollars. 25529

Sec. ~~5111.113~~ 5162.37. (A) As used in this section: 25530

(1) "Adult care facility" has the same meaning as in section 25531
3722.01 of the Revised Code. 25532

(2) "Commissioner" means a person appointed by a probate 25533
court under division (B) of section 2113.03 of the Revised Code to 25534
act as a commissioner. 25535

(3) "Home" has the same meaning as in section 3721.10 of the 25536
Revised Code. 25537

(4) "Personal needs allowance account" means an account or 25538
petty cash fund that holds the money of a resident of an adult 25539
care facility or home and that the facility or home manages for 25540
the resident. 25541

(B) Except as provided in divisions (C) and (D) of this 25542
section, the owner or operator of an adult care facility or home 25543
shall transfer to the department of ~~job and family services~~ health 25544
care administration the money in the personal needs allowance 25545
account of a resident of the facility or home who was a medicaid 25546
recipient ~~of the medical assistance program~~ no earlier than sixty 25547
days but not later than ninety days after the resident dies. The 25548
adult care facility or home shall transfer the money even though 25549
the owner or operator of the facility or home has not been issued 25550
letters testamentary or letters of administration concerning the 25551
resident's estate. 25552

(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 25585
~~5111.11~~ 5162.40 of the Revised Code. 25586

Sec. ~~5111.11~~ 5162.40. (A) As used in this section and section 25587
~~5111.111~~ 5162.41 of the Revised Code: 25588

(1) "Estate" includes both of the following: 25589

(a) All real and personal property and other assets to be 25590
administered under Title XXI of the Revised Code and property that 25591
would be administered under that title if not for section 2113.03 25592
or 2113.031 of the Revised Code; 25593

(b) Any other real and personal property and other assets in 25594
which an individual had any legal title or interest at the time of 25595
death (to the extent of the interest), including assets conveyed 25596
to a survivor, heir, or assign of the individual through joint 25597
tenancy, tenancy in common, survivorship, life estate, living 25598
trust, or other arrangement. 25599

(2) "Institution" means a nursing facility, intermediate care 25600
facility for the mentally retarded, or a medical institution. 25601

(3) "Intermediate care facility for the mentally retarded" 25602
and "nursing facility" have the same meanings as in section 25603
~~5111.20~~ 5164.01 of the Revised Code. 25604

(4) "Permanently institutionalized individual" means an 25605
individual to whom all of the following apply: 25606

(a) Is an inpatient in an institution; 25607

(b) Is required, as a condition of the medicaid program 25608
paying for the individual's services in the institution, to spend 25609
for costs of medical or nursing care all of the individual's 25610
income except for an amount for personal needs specified by the 25611
department of ~~job and family services~~ health care administration; 25612

(c) Cannot reasonably be expected to be discharged from the 25613

institution and return home as determined by the department of ~~job~~ 25614
~~and family services~~ health care administration. 25615

(5) "Qualified state long-term care insurance partnership 25616
program" means the program established under section ~~5111.18~~ 25617
5162.43 of the Revised Code. 25618

(6) "Time of death" shall not be construed to mean a time 25619
after which a legal title or interest in real or personal property 25620
or other asset may pass by survivorship or other operation of law 25621
due to the death of the decedent or terminate by reason of the 25622
decedent's death. 25623

(B) To the extent permitted by federal law, the department of 25624
~~job and family services~~ health care administration shall institute 25625
an estate recovery program under which the department shall, 25626
except as provided in divisions (C), (D), and (E) of this section, 25627
do both of the following: 25628

(1) For the costs of medicaid services the medicaid program 25629
correctly paid or will pay on behalf of a permanently 25630
institutionalized individual of any age, seek adjustment or 25631
recovery from the individual's estate or on the sale of property 25632
of the individual or spouse that is subject to a lien imposed 25633
under section ~~5111.111~~ 5162.41 of the Revised Code; 25634

(2) For the costs of medicaid services the medicaid program 25635
correctly paid or will pay on behalf of an individual fifty-five 25636
years of age or older who is not a permanently institutionalized 25637
individual, seek adjustment or recovery from the individual's 25638
estate. 25639

(C)(1) No adjustment or recovery may be made under division 25640
(B)(1) of this section from a permanently institutionalized 25641
individual's estate or on the sale of property of a permanently 25642
institutionalized individual that is subject to a lien imposed 25643
under section ~~5111.111~~ 5162.41 of the Revised Code or under 25644

division (B)(2) of this section from an individual's estate while 25645
either of the following are alive: 25646

(a) The spouse of the permanently institutionalized 25647
individual or individual; 25648

(b) The son or daughter of a permanently institutionalized 25649
individual or individual if the son or daughter is under age 25650
twenty-one or, under 42 U.S.C. 1382c, is considered blind or 25651
disabled. 25652

(2) No adjustment or recovery may be made under division 25653
(B)(1) of this section from a permanently institutionalized 25654
individual's home that is subject to a lien imposed under section 25655
~~5111.111~~ 5162.41 of the Revised Code while either of the following 25656
lawfully reside in the home: 25657

(a) The permanently institutionalized individual's sibling 25658
who resided in the home for at least one year immediately before 25659
the date of the permanently institutionalized individual's 25660
admission to the institution and on a continuous basis since that 25661
time; 25662

(b) The permanently institutionalized individual's son or 25663
daughter who provided care to the permanently institutionalized 25664
individual that delayed the permanently institutionalized 25665
individual's institutionalization and resided in the home for at 25666
least two years immediately before the date of the permanently 25667
institutionalized individual's admission to the institution and on 25668
a continuous basis since that time. 25669

(D) In the case of a participant of the qualified state 25670
long-term care insurance partnership program, adjustment or 25671
recovery required by this section may be reduced in accordance 25672
with rules adopted under division (G) of this section. 25673

(E) The department shall, in accordance with procedures and 25674
criteria established in rules adopted under division (G) of this 25675

section, waive seeking an adjustment or recovery otherwise 25676
required by this section if the director of ~~job and family~~ 25677
~~services~~ health care administration determines that adjustment or 25678
recovery would work an undue hardship. The department may limit 25679
the duration of the waiver to the period during which the undue 25680
hardship exists. 25681

(F) For the purpose of determining whether an individual 25682
meets the definition of "permanently institutionalized individual" 25683
established for this section, a rebuttable presumption exists that 25684
the individual cannot reasonably be expected to be discharged from 25685
an institution and return home if either of the following is the 25686
case: 25687

(1) The individual declares that he or she does not intend to 25688
return home. 25689

(2) The individual has been an inpatient in an institution 25690
for at least six months. 25691

(G) The director of ~~job and family services~~ health care 25692
administration shall adopt rules in accordance with Chapter 119. 25693
of the Revised Code regarding the estate recovery program, 25694
including rules that do both of the following: 25695

(1) For the purpose of division (D) of this section and 25696
consistent with 42 U.S.C. 1396p(b)(1)(C), provide for reducing an 25697
adjustment or recovery in the case of a participant of the 25698
qualified state long-term care insurance partnership program; 25699

(2) For the purpose of division (E) of this section and 25700
consistent with the standards specified by the United States 25701
secretary of health and human services under 42 U.S.C. 25702
1396p(b)(3), establish procedures and criteria for waiving 25703
adjustment or recovery due to an undue hardship. 25704

Sec. ~~5111.111~~ 5162.41. (A) Except as provided in division (B) 25705

of this section and section ~~5111.12~~ 5162.45 of the Revised Code, 25706
no lien may be imposed against the property of an individual 25707
before the individual's death on account of medicaid services 25708
correctly paid or to be paid on the individual's behalf. 25709

(B) Except as provided in division (C) of this section, the 25710
department of ~~job and family services~~ health care administration 25711
may impose a lien against the real property of a medicaid 25712
recipient who is a permanently institutionalized individual and 25713
against the real property of the recipient's spouse, including any 25714
real property that is jointly held by the recipient and spouse. 25715
The lien may be imposed on account of medicaid paid or to be paid 25716
on the recipient's behalf. 25717

(C) No lien may be imposed under division (B) of this section 25718
against the home of a medicaid recipient if any of the following 25719
lawfully resides in the home: 25720

(1) The recipient's spouse; 25721

(2) The recipient's son or daughter who is under twenty-one 25722
years of age or, under 42 U.S.C. 1382c, considered to be blind or 25723
disabled; 25724

(3) The recipient's sibling who has an equity interest in the 25725
home and resided in the home for at least one year immediately 25726
before the date of the recipient's admission to the institution. 25727

(D) The director of ~~job and family services~~ health care 25728
administration or a person designated by the director shall sign a 25729
certificate to effectuate a lien required to be imposed under this 25730
section. The county department of job and family services shall 25731
file for recording and indexing the certificate, or a certified 25732
copy, in the real estate mortgage records in the office of the 25733
county recorder in every county in which real property of the 25734
recipient or spouse is situated. From the time of filing the 25735
certificate in the office of the county recorder, the lien 25736

attaches to all real property of the recipient or spouse described 25737
in the certificate for all amounts for which adjustment or 25738
recovery may be made under section ~~5111.11~~ 5162.40 of the Revised 25739
Code and, except as provided in division (E) of this section, 25740
shall remain a lien until satisfied. 25741

Upon filing the certificate in the office of the recorder, 25742
all persons are charged with notice of the lien and the rights of 25743
the department of ~~job and family services~~ health care 25744
administration thereunder. 25745

The county recorder shall keep a record of every certificate 25746
filed showing its date, the time of filing, the name and residence 25747
of the recipient or spouse, and any release, waivers, or 25748
satisfaction of the lien. 25749

The priority of the lien shall be established in accordance 25750
with state and federal law. 25751

The department may waive the priority of its lien to provide 25752
for the costs of the last illness as determined by the department, 25753
administration, attorney fees, administrator fees, a sum for the 25754
payment of the costs of burial, which shall be computed by 25755
deducting from five hundred dollars whatever amount is available 25756
for the same purpose from all other sources, and a similar sum for 25757
the spouse of the decedent. 25758

(E) A lien imposed with respect to a medicaid recipient under 25759
this section shall dissolve on the recipient's discharge from the 25760
institution and return home. 25761

Sec. ~~5111.112~~ 5162.42. The department of ~~job and family~~ 25762
~~services~~ health care administration shall certify amounts due 25763
under the estate recovery program instituted under section ~~5111.11~~ 25764
5162.40 of the Revised Code to the attorney general pursuant to 25765
section 131.02 of the Revised Code. The attorney general may enter 25766

into a contract with any person or government entity to collect 25767
the amounts due on behalf of the attorney general. 25768

The attorney general, in entering into a contract under this 25769
section, shall comply with all of the requirements that must be 25770
met for the state to receive federal financial participation for 25771
the costs incurred in entering into the contract and carrying out 25772
actions under the contract. The contract may provide for the 25773
person or government entity with which the attorney general 25774
contracts to be compensated from the property recovered under the 25775
estate recovery program or may provide for another manner of 25776
compensation agreed to by the parties to the contract. 25777

Regardless of whether the attorney general collects the 25778
amounts due under the estate recovery program or contracts with a 25779
person or government entity to collect the amounts due on behalf 25780
of the attorney general, the amounts due shall be collected in 25781
accordance with applicable requirements of federal statutes and 25782
regulations and state statutes and rules. 25783

Sec. ~~5111.18~~ 5162.43. Not later than September 1, 2007, the 25784
director of ~~job and family services~~ health care administration 25785
shall establish a qualified state long-term care insurance 25786
partnership program consistent with the definition of that term in 25787
42 U.S.C. 1396p(b)(1)(C)(iii). An individual participating in the 25788
program who is subject to the medicaid estate recovery program 25789
instituted under section ~~5111.11~~ 5162.40 of the Revised Code shall 25790
be eligible for the reduced adjustment or recovery under division 25791
(D) of that section. 25792

The director of ~~job and family services~~ health care 25793
administration may adopt rules in accordance with Chapter 119. of 25794
the Revised Code as necessary to implement this section. 25795

Sec. ~~5111.12~~ 5162.45. (A) The director of ~~job and family~~ 25796

~~services~~ health care administration shall establish rules under 25797
which county departments of job and family services may take 25798
action to recover benefits incorrectly paid on behalf of medicaid 25799
recipients ~~of medical assistance~~. The rules shall provide for 25800
recovery by the following methods: 25801

(1) Soliciting voluntary payments from recipients or from 25802
persons holding property in which a recipient has a legal or 25803
equitable interest; 25804

(2) Obtaining a lien on property pursuant to division (B) of 25805
this section. 25806

(B) A county department of job and family services may bring 25807
a civil action in a court of common pleas against a medicaid 25808
recipient ~~of medical assistance~~ for the recovery of any ~~medical~~ 25809
~~assistance~~ medicaid benefits determined by the court to have been 25810
paid incorrectly on behalf of the recipient. All persons holding 25811
property in which the recipient has a legal or equitable interest 25812
may be joined as parties. The court may issue pre-judgment orders, 25813
including injunctive relief or attachment under Chapter 2715. of 25814
the Revised Code, for the preservation of real or personal 25815
property in which the recipient may have a legal or equitable 25816
interest. If the court determines that benefits were paid 25817
incorrectly and issues a judgment to that effect, the county 25818
department may obtain a lien upon property of the recipient in 25819
accordance with Chapter 2329. of the Revised Code. 25820

(C) The county department of job and family services shall 25821
retain fifty per cent of the balance remaining after deduction 25822
from the recovery of the amount required to be returned to the 25823
federal government and shall pay the other fifty per cent of the 25824
balance to the department of ~~job and family services~~ health care 25825
administration. 25826

(D) Recovery of ~~medical assistance~~ medicaid benefits 25827

incorrectly paid to a recipient may not be accomplished by 25828
reducing the amount of benefits the recipient is entitled to 25829
receive under another government assistance program. 25830

(E) The remedies provided pursuant to this section do not 25831
affect any other remedies county departments of job and family 25832
services may have to recover benefits incorrectly paid on behalf 25833
of medicaid recipients ~~of medical assistance~~. 25834

Sec. ~~5111.06~~ 5163.01. (A)(1) As used in this section and in 25835
sections ~~5111.061~~ 5163.07 and ~~5111.062~~ 5163.09 of the Revised 25836
Code: 25837

(a) "Provider" means any person, institution, or entity that 25838
furnishes medicaid services under a medicaid provider agreement 25839
with the department of ~~job and family services pursuant to Title~~ 25840
~~XIX of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A.~~ 25841
~~301, as amended~~ health care administration. 25842

(b) "Party" has the same meaning as in division (G) of 25843
section 119.01 of the Revised Code. 25844

(c) "Adjudication" has the same meaning as in division (D) of 25845
section 119.01 of the Revised Code. 25846

(2) This section does not apply to any action taken by the 25847
department of ~~job and family services~~ health care administration 25848
under sections ~~5111.35~~ 5164.50 to ~~5111.62~~ 5164.78 of the Revised 25849
Code. 25850

(B) Except as provided in division (D) of this section and 25851
section ~~5111.914~~ 5163.06 of the Revised Code, the department shall 25852
do ~~either of~~ the following by issuing an order pursuant to an 25853
adjudication conducted in accordance with Chapter 119. of the 25854
Revised Code: 25855

(1) Enter into or refuse to enter into a provider agreement 25856
with a provider, ~~or suspend;~~ 25857

(2) Suspend, terminate, renew, or refuse to renew an existing provider agreement with a provider+ 25858
25859

~~(2) Take any action based upon a final fiscal audit of a provider.~~ 25860
25861

(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. 25862
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(D) The department is not required to comply with division (B)~~(1)~~ of this section whenever any of the following occur: 25866
25867

(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. 25868
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(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; 25874
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(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; 25877
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(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; 25883
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(5) The provider agreement is denied, terminated, or 25887

suspended as a result of action by the United States department of 25888
health and human services and that action is binding on the 25889
provider's participation in the medicaid program; 25890

(6) The provider agreement is terminated or not renewed 25891
because the provider has not billed or otherwise submitted a 25892
medicaid claim to the department for two years or longer, and the 25893
department has determined that the provider has moved from the 25894
address on record with the department without leaving an active 25895
forwarding address with the department. 25896

In the case of a provider described in division (D)(6) of 25897
this section, the department may terminate or not renew the 25898
provider agreement by sending a notice explaining the department's 25899
proposed action to the address on record with the department. The 25900
notice may be sent by regular mail. 25901

(E) The department may withhold payments for services 25902
rendered by a medicaid provider under the ~~medical assistance~~ 25903
medicaid program during the pendency of proceedings initiated 25904
under division (B)(1) of this section. ~~If the proceedings are~~ 25905
~~initiated under division (B)(2) of this section, the department~~ 25906
~~may withhold payments only to the extent that they equal amounts~~ 25907
~~determined in a final fiscal audit as being due the state.~~ This 25908
division does not apply if the department fails to comply with 25909
section 119.07 of the Revised Code, requests a continuance of the 25910
hearing, or does not issue a decision within thirty days after the 25911
hearing is completed. This division does not apply to nursing 25912
facilities and intermediate care facilities for the mentally 25913
retarded as defined in section ~~5111.20~~ 5164.01 of the Revised 25914
Code. 25915

Sec. ~~5111.05~~ 5163.02. (A) The department of ~~job and family~~ 25916
~~services~~ health care administration may contract with any person 25917
or persons as a fiscal agent for the examination, processing, and 25918

determination of ~~medical assistance~~ medicaid claims ~~under this~~ 25919
~~chapter~~. The contracting party may provide any of the following 25920
services, as required by the contract: 25921

(1) Design and operate medicaid management information 25922
systems, including the provision of data processing services; 25923

(2) Determine the amounts of payments to be made upon claims 25924
for ~~medical assistance~~ medicaid; 25925

(3) Prepare and furnish to the department lists and computer 25926
tapes of such claims for payment; 25927

(4) In addition to audits which may be conducted by the 25928
department and by the auditor of state, make audits of providers 25929
and the claims of medicaid providers ~~of medical assistance~~ 25930
according to the standards set forth in the contract; 25931

(5) Assist medicaid providers ~~of medical assistance~~ in the 25932
development of procedures relating to utilization practices, make 25933
studies of the effectiveness of such procedures and methods for 25934
their improvement, implement and enforce standards of medical 25935
policy, and assist in the application of safeguards against 25936
unnecessary utilization; 25937

(6) Assist any institution, facility, or agency to qualify as 25938
a medicaid provider ~~of medical assistance~~; 25939

(7) Establish and maintain fiscal records for the ~~medical~~ 25940
~~assistance~~ medicaid program; 25941

(8) Perform statistical and research studies; 25942

(9) Develop and implement programs for ~~medical assistance~~ 25943
medicaid cost containment; 25944

(10) Perform such other duties as are necessary to carry out 25945
the ~~medical assistance~~ medicaid program. 25946

(B) The department of ~~job and family services~~ health care 25947
administration may contract with any person or persons as an 25948

insuring agent for the examination, processing, and determination 25949
of ~~medical assistance~~ medicaid claims, as provided in division (A) 25950
of this section, and for the payment of ~~medical assistance~~ 25951
medicaid claims through an underwritten program in which the state 25952
pays the insuring agent a monthly premium and the insuring agent 25953
pays for medical services authorized under the state's ~~medical~~ 25954
~~assistance~~ medicaid program. The person with whom the department 25955
contracts, with respect to the awarding, provisions, and 25956
performance of such contract, shall not be subject to the 25957
provisions of Title XXXIX of the Revised Code or to regulation by 25958
the department of insurance, nor to taxation as an insurance 25959
company pursuant to section 5725.18 or 5729.03 of the Revised 25960
Code. A contract with an insuring agent shall specify the 25961
qualifications, including capital and surplus requirements, and 25962
other conditions with which the insuring agent must comply. 25963

(C) In entering into a contract under this section, the 25964
department, in cooperation with the director of budget and 25965
management, shall determine that the contracting party is 25966
qualified to perform the required services and shall follow 25967
applicable procedures required of the department of administrative 25968
services in sections 125.07 to 125.11 of the Revised Code. A 25969
contract shall be awarded to the bidder who, with due 25970
consideration to the bidder's experience and financial capability, 25971
offers the lowest and best bid to the state for control of the 25972
costs of the ~~medical assistance~~ medicaid program consistent with 25973
meeting the obligations under that program for fair and equitable 25974
treatment of recipients and providers of medical services. Any 25975
arrangement whereby funds are paid to an insuring or fiscal agent 25976
for administrative functions under this section shall, for the 25977
purposes of section 125.081 of the Revised Code, be deemed to be a 25978
contract or purchase by the department of administrative services; 25979
however, money to be used by an insuring agent to pay for medical 25980
services authorized under the state's ~~medical assistance~~ medicaid 25981

program shall not be deemed a contract or purchase within the 25982
meaning of such section. 25983

Sec. ~~5111.03~~ 5163.03. (A) No provider of services or goods 25984
contracting with the department of ~~job and family services~~ health 25985
care administration pursuant to the medicaid program shall, by 25986
deception, obtain or attempt to obtain payments under ~~this chapter~~ 25987
the medicaid program to which the provider is not entitled 25988
pursuant to the provider agreement, or the rules of the federal 25989
government or the department of ~~job and family services~~ health 25990
care administration relating to the program. No provider shall 25991
willfully receive payments to which the provider is not entitled, 25992
or willfully receive payments in a greater amount than that to 25993
which the provider is entitled; nor shall any provider falsify any 25994
report or document required by state or federal law, rule, or 25995
provider agreement relating to medicaid payments. As used in this 25996
section, a provider engages in "deception" when the provider, 25997
acting with actual knowledge of the representation or information 25998
involved, acting in deliberate ignorance of the truth or falsity 25999
of the representation or information involved, or acting in 26000
reckless disregard of the truth or falsity of the representation 26001
or information involved, deceives another or causes another to be 26002
deceived by any false or misleading representation, by withholding 26003
information, by preventing another from acquiring information, or 26004
by any other conduct, act, or omission that creates, confirms, or 26005
perpetuates a false impression in another, including a false 26006
impression as to law, value, state of mind, or other objective or 26007
subjective fact. No proof of specific intent to defraud is 26008
required to show, for purposes of this section, that a provider 26009
has engaged in deception. 26010

(B) Any provider who violates division (A) of this section 26011
shall be liable, in addition to any other penalties provided by 26012
law, for all of the following civil penalties: 26013

(1) Payment of interest on the amount of the excess payments 26014
at the maximum interest rate allowable for real estate mortgages 26015
under section 1343.01 of the Revised Code on the date the payment 26016
was made to the provider for the period from the date upon which 26017
payment was made, to the date upon which repayment is made to the 26018
state; 26019

(2) Payment of an amount equal to three times the amount of 26020
any excess payments; 26021

(3) Payment of a sum of not less than five thousand dollars 26022
and not more than ten thousand dollars for each deceptive claim or 26023
falsification; 26024

(4) All reasonable expenses which the court determines have 26025
been necessarily incurred by the state in the enforcement of this 26026
section. 26027

(C) As used in this division, "intermediate care facility for 26028
the mentally retarded" and "nursing facility" have the same 26029
meanings given in section ~~5111.20~~ 5164.01 of the Revised Code. 26030

In addition to the civil penalties provided in division (B) 26031
of this section, the director of ~~job and family services~~ health 26032
care administration, upon the conviction of, or the entry of a 26033
judgment in either a criminal or civil action against, a medicaid 26034
provider or its owner, officer, authorized agent, associate, 26035
manager, or employee in an action brought pursuant to section 26036
109.85 of the Revised Code, shall terminate the provider agreement 26037
between the department and the provider and stop reimbursement to 26038
the provider for services rendered for a period of up to five 26039
years from the date of conviction or entry of judgment. As used in 26040
this chapter, "owner" means any person having at least five per 26041
cent ownership in the medicaid provider. No such provider, owner, 26042
officer, authorized agent, associate, manager, or employee shall 26043
own or provide services to any other medicaid provider or risk 26044

contractor or arrange for, render, or order services for medicaid 26045
recipients during the period of termination as provided in 26046
division (C) of this section, nor, during the period of 26047
termination as provided in division (C) of this section, shall 26048
such provider, owner, officer, authorized agent, associate, 26049
manager, or employee receive reimbursement in the form of direct 26050
payments from the department or indirect payments of medicaid 26051
funds in the form of salary, shared fees, contracts, kickbacks, or 26052
rebates from or through any participating provider or risk 26053
contractor. The provider agreement shall not be terminated or 26054
reimbursement terminated if the provider or owner can demonstrate 26055
that the provider or owner did not directly or indirectly sanction 26056
the action of its authorized agent, associate, manager, or 26057
employee that resulted in the conviction or entry of a judgment in 26058
a criminal or civil action brought pursuant to section 109.85 of 26059
the Revised Code. Nothing in this division prohibits any owner, 26060
officer, authorized agent, associate, manager, or employee of a 26061
medicaid provider from entering into a medicaid provider agreement 26062
if the person can demonstrate that the person had no knowledge of 26063
an action of the medicaid provider the person was formerly 26064
associated with that resulted in the conviction or entry of a 26065
judgment in a criminal or civil action brought pursuant to section 26066
109.85 of the Revised Code. 26067

Nursing facility or intermediate care facility for the 26068
mentally retarded providers whose agreements are terminated 26069
pursuant to this section may continue to receive reimbursement for 26070
up to thirty days after the effective date of the termination if 26071
the provider makes reasonable efforts to transfer recipients to 26072
another facility or to alternate care and if federal funds are 26073
provided for such reimbursement. 26074

(D) Any provider of services or goods contracting with the 26075
department of ~~job and family services pursuant to Title XIX of~~ 26076

health care administration under the "Social Security Act," 26077
medicaid program who, without intent, obtains payments under ~~this~~ 26078
~~chapter~~ the medicaid program in excess of the amount to which the 26079
provider is entitled, thereby becomes liable for payment of 26080
interest on the amount of the excess payments at the maximum real 26081
estate mortgage rate on the date the payment was made to the 26082
provider for the period from the date upon which payment was made 26083
to the date upon which repayment is made to the state. 26084

(E) The attorney general on behalf of the state may commence 26085
proceedings to enforce this section in any court of competent 26086
jurisdiction; and the attorney general may settle or compromise 26087
any case brought under this section with the approval of the 26088
department of ~~job and family services~~ health care administration. 26089
Notwithstanding any other provision of law providing a shorter 26090
period of limitations, the attorney general may commence a 26091
proceeding to enforce this section at any time within six years 26092
after the conduct in violation of this section terminates. 26093

(F) The authority, under state and federal law, of the 26094
department of ~~job and family services~~ health care administration 26095
or a county department of job and family services to recover 26096
excess payments made to a provider is not limited by the 26097
availability of remedies under sections ~~5111.11~~ 5162.40 and 26098
~~5111.12~~ 5162.45 of the Revised Code for recovering benefits paid 26099
on behalf of medicaid recipients ~~of medical assistance~~. 26100

The penalties under this chapter apply to any overpayment, 26101
billing, or falsification occurring on and after April 24, 1978. 26102
All moneys collected by the state pursuant to this section shall 26103
be deposited in the state treasury to the credit of the general 26104
revenue fund. 26105

Sec. 5163.04. The department of health care administration 26106
may conduct final fiscal audits under the medicaid program in 26107

accordance with the applicable requirements set forth in federal 26108
laws and regulations and determine any amounts the provider may 26109
owe the state. When conducting final fiscal audits, the department 26110
shall consider generally accepted auditing standards, which 26111
include the use of statistical sampling. 26112

Sec. 5163.05. This section does not apply to any action taken 26113
by the department of health care administration under sections 26114
5164.78 of the Revised Code. 26115

Except as provided in section 5163.06 of the Revised Code, 26116
the department of health care administration shall take actions 26117
based upon a final fiscal audit of a provider by issuing an order 26118
pursuant to an adjudication conducted in accordance with Chapter 26119
119. of the Revised Code. Any party who is adversely affected by 26120
the issuance of an adjudication order under this section may 26121
appeal to the court of common pleas of Franklin county in 26122
accordance with section 119.12 of the Revised Code. If the action 26123
the department takes against a provider based on a final fiscal 26124
audit is to withhold payments from the provider, the department 26125
may withhold payments only to the extent that they equal amounts 26126
determined in the final fiscal audit as being due the state. 26127

Sec. ~~5111.914~~ 5163.06. (A) As used in this section, 26128
"provider" has the same meaning as in section ~~5111.06~~ 5163.01 of 26129
the Revised Code. 26130

(B) If a state agency that enters into a contract with the 26131
department of ~~job and family services~~ health care administration 26132
under section ~~5111.91~~ 5161.05 of the Revised Code identifies that 26133
a medicaid overpayment has been made to a provider, the state 26134
agency may commence actions to recover the overpayment on behalf 26135
of the department. 26136

(C) In recovering an overpayment pursuant to this section, a 26137

state agency shall comply with the following procedures: 26138

(1) The state agency shall attempt to recover the overpayment 26139
by notifying the provider of the overpayment and requesting 26140
voluntary repayment. Not later than five business days after 26141
notifying the provider, the state agency shall notify the 26142
department in writing of the overpayment. The state agency may 26143
negotiate a settlement of the overpayment and notify the 26144
department of the settlement. A settlement negotiated by the state 26145
agency is not valid and shall not be implemented until the 26146
department has given its written approval of the settlement. 26147

(2) If the state agency is unable to obtain voluntary 26148
repayment of an overpayment, the agency shall give the provider 26149
notice of an opportunity for a hearing in accordance with Chapter 26150
119. of the Revised Code. If the provider timely requests a 26151
hearing in accordance with section 119.07 of the Revised Code, the 26152
state agency shall conduct the hearing to determine the legal and 26153
factual validity of the overpayment. On completion of the hearing, 26154
the state agency shall submit its hearing officer's report and 26155
recommendation and the complete record of proceedings, including 26156
all transcripts, to the director of ~~job and family services~~ health 26157
care administration for final adjudication. The director may issue 26158
a final adjudication order in accordance with Chapter 119. of the 26159
Revised Code. The state agency shall pay any attorney's fees 26160
imposed under section 119.092 of the Revised Code. The department 26161
of job and family services shall pay any attorney's fees imposed 26162
under section 2335.39 of the Revised Code. 26163

(D) In any action taken by a state agency under this section 26164
that requires the agency to give notice of an opportunity for a 26165
hearing in accordance with Chapter 119. of the Revised Code, if 26166
the agency gives notice of the opportunity for a hearing but the 26167
provider subject to the notice does not request a hearing or 26168
timely request a hearing in accordance with section 119.07 of the 26169

Revised Code, the agency is not required to hold a hearing. The 26170
agency may request that the director of ~~job and family services~~ 26171
health care administration issue a final adjudication order in 26172
accordance with Chapter 119. of the Revised Code. 26173

(E) This section does not preclude the department of ~~job and~~ 26174
~~family services~~ health care administration from adjudicating a 26175
final fiscal audit under section ~~5111.06~~ 5163.01 of the Revised 26176
Code, recovering overpayments under section ~~5111.061~~ 5163.07 of 26177
the Revised Code, or making findings or taking other actions 26178
authorized by this chapter. 26179

Sec. ~~5111.061~~ 5163.07. (A) The department of ~~job and family~~ 26180
~~services~~ health care administration may recover a medicaid payment 26181
or portion of a payment made to a provider to which the provider 26182
is not entitled if the department notifies the provider of the 26183
overpayment during the five-year period immediately following the 26184
end of the state fiscal year in which the overpayment was made. 26185

(B) Among the overpayments that may be recovered under this 26186
section are the following: 26187

(1) Payment for a service, or a day of service, not rendered; 26188

(2) Payment for a day of service at a full per diem rate that 26189
should have been paid at a percentage of the full per diem rate; 26190

(3) Payment for a service, or day of service, that was paid 26191
by, or partially paid by, a third-party, as defined in section 26192
~~5101.571~~ 5160.36 of the Revised Code, and the third-party's 26193
payment or partial payment was not offset against the amount paid 26194
by the medicaid program to reduce or eliminate the amount that was 26195
paid by the medicaid program; 26196

(4) Payment when a medicaid recipient's responsibility for 26197
payment was understated and resulted in an overpayment to the 26198
provider. 26199

(C) The department may recover an overpayment under this section prior to or after any of the following:	26200 26201
(1) Adjudication of a final fiscal audit that section 5111.06 <u>5163.01</u> of the Revised Code requires to be conducted in accordance with Chapter 119. of the Revised Code;	26202 26203 26204
(2) Adjudication of a finding under any other provision of this chapter or the rules adopted under it;	26205 26206
(3) Expiration of the time to issue a final fiscal audit that section 5111.06 <u>5163.01</u> of the Revised Code requires to be conducted in accordance with Chapter 119. of the Revised Code;	26207 26208 26209
(4) Expiration of the time to issue a finding under any other provision of this chapter or the rules adopted under it.	26210 26211
(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:	26212 26213 26214
(a) Issuing a final fiscal audit in accordance with Chapter 119. of the Revised Code, as required under section 5111.06 <u>5163.01</u> of the Revised Code;	26215 26216 26217
(b) Issuing a finding under any other provision of this chapter or the rules adopted under it.	26218 26219
(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.	26220 26221 26222
(E) Nothing in this section limits the department's authority to recover overpayments pursuant to any other provision of the Revised Code.	26223 26224 26225
Sec. 5111.022 <u>5163.08</u>. 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 <u>5163.04</u> of the	26226 26227 26228

Revised Code, upon the issuance of an adjudication order pursuant 26229
to Chapter 119. of the Revised Code that contains a finding that 26230
there is a preponderance of the evidence that the provider will 26231
liquidate assets or file bankruptcy in order to prevent payment of 26232
the amount determined to be owed the state, becomes a lien upon 26233
the real and personal property of the provider. Upon failure of 26234
the provider to pay the amount to the state, the director of ~~job~~ 26235
~~and family services~~ health care administration shall file notice 26236
of the lien, for which there shall be no charge, in the office of 26237
the county recorder of the county in which it is ascertained that 26238
the provider owns real or personal property. The director shall 26239
notify the provider by mail of the lien, but absence of proof that 26240
the notice was sent does not affect the validity of the lien. The 26241
lien is not valid as against the claim of any mortgagee, pledgee, 26242
purchaser, judgment creditor, or other lienholder of record at the 26243
time the notice is filed. 26244

26245
If the provider acquires real or personal property after 26246
notice of the lien is filed, the lien shall not be valid as 26247
against the claim of any mortgagee, pledgee, subsequent bona fide 26248
purchaser for value, judgment creditor, or other lienholder of 26249
record to such after-acquired property unless the notice of lien 26250
is refiled after the property is acquired by the provider and 26251
before the competing lien attaches to the after-acquired property 26252
or before the conveyance to the subsequent bona fide purchaser for 26253
value. 26254

When the amount has been paid, the provider may record with 26255
the recorder notice of the payment. For recording such notice of 26256
payment, the recorder shall charge and receive from the provider a 26257
base fee of one dollar for services and a housing trust fund fee 26258
of one dollar pursuant to section 317.36 of the Revised Code. 26259

In the event of a distribution of a provider's assets 26260

pursuant to an order of any court under the law of this state 26261
including any receivership, assignment for benefit of creditors, 26262
adjudicated insolvency, or similar proceedings, amounts then or 26263
thereafter due the state under this chapter have the same priority 26264
as provided by law for the payment of taxes due the state and 26265
shall be paid out of the receivership trust fund or other such 26266
trust fund in the same manner as provided for claims for unpaid 26267
taxes due the state. 26268

If the attorney general finds after investigation that any 26269
amount due the state under this chapter is uncollectable, in whole 26270
or in part, the attorney general shall recommend to the director 26271
the cancellation of all or part of the claim. The director may 26272
thereupon effect the cancellation. 26273

Sec. ~~5111.062~~ 5163.09. In an action taken by the department 26274
of ~~job and family services~~ health care administration under 26275
section ~~5111.06~~ 5163.01, 5163.05, or ~~5111.061~~ 5163.07 of the 26276
Revised Code or any other provision of ~~this chapter~~ law governing 26277
the medicaid program that requires the department to give notice 26278
of an opportunity for a hearing in accordance with Chapter 119. of 26279
the Revised Code, if the department gives notice of the 26280
opportunity for a hearing but the provider or other entity subject 26281
to the notice does not request a hearing or timely request a 26282
hearing in accordance with section 119.07 of the Revised Code, the 26283
department is not required to hold a hearing. The director of ~~job~~ 26284
~~and family service~~ health care administration may proceed by 26285
issuing a final adjudication order in accordance with Chapter 119. 26286
of the Revised Code. 26287

Sec. ~~5111.101~~ 5163.12. (A) As used in this section, "federal 26288
health care programs" has the same meaning as in 42 U.S.C. 26289
1320a-7b(f). 26290

(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 26321
different for different medicaid services. The rules shall 26322
establish all of the following: 26323

(A) The conditions under which the medicaid program shall 26324
cover and reimburse medicaid services; 26325

(B) The method of reimbursement applicable to each medicaid 26326
service; 26327

(C) The amount of reimbursement or, in lieu of amounts, 26328
methods by which amounts are to be determined for each medicaid 26329
service; 26330

(D) Procedures for enforcing the rules adopted under this 26331
section that provide due process protections, including procedures 26332
for corrective action plans for, and imposing financial and 26333
administrative sanctions on, persons and government entities that 26334
violate the rules. 26335

Sec. ~~5111.021~~ 5163.16. Under the medicaid program: 26336

(A) Except as otherwise permitted by federal statute or 26337
regulation and at the department's discretion, reimbursement by 26338
the department of ~~job and family services~~ health care 26339
administration to a medical provider for any medical service 26340
rendered under the program shall not exceed the authorized 26341
reimbursement level for the same service under the medicare 26342
program ~~established under Title XVIII of the "Social Security~~ 26343
~~Act," 79 Stat. 286 (1965), 42 U.S.C. 1395, as amended.~~ 26344

(B) Reimbursement for freestanding medical laboratory charges 26345
shall not exceed the customary and usual fee for laboratory 26346
profiles. 26347

(C) The department may deduct from payments for services 26348
rendered by a medicaid provider under the medicaid program any 26349
amounts the provider owes the state as the result of incorrect 26350

medicaid payments the department has made to the provider. 26351

~~(D) The department may conduct final fiscal audits in 26352
accordance with the applicable requirements set forth in federal 26353
laws and regulations and determine any amounts the provider may 26354
owe the state. When conducting final fiscal audits, the department 26355
shall consider generally accepted auditing standards, which 26356
include the use of statistical sampling. 26357~~

~~(E)~~ The number of days of inpatient hospital care for which 26358
reimbursement is made on behalf of a medicaid recipient to a 26359
hospital that is not paid under a diagnostic-related-group 26360
prospective payment system shall not exceed thirty days during a 26361
period beginning on the day of the recipient's admission to the 26362
hospital and ending sixty days after the termination of that 26363
hospital stay, except that the department may make exceptions to 26364
this limitation. The limitation does not apply to children 26365
participating in the program for medically handicapped children 26366
established under section 3701.023 of the Revised Code. 26367

~~(F)~~(E) The division of any reimbursement between a 26368
collaborating physician or podiatrist and a clinical nurse 26369
specialist, certified nurse-midwife, or certified nurse 26370
practitioner for services performed by the nurse shall be 26371
determined and agreed on by the nurse and collaborating physician 26372
or podiatrist. In no case shall reimbursement exceed the payment 26373
that the physician or podiatrist would have received had the 26374
physician or podiatrist provided the entire service. 26375

Sec. ~~5111.025~~ 5163.17. (A) In rules adopted under section 26376
~~5111.02~~ 5163.15 of the Revised Code, the director of ~~job and~~ 26377
~~family services~~ health care administration shall modify the manner 26378
or establish a new manner in which the following are paid under 26379
medicaid: 26380

(1) Community mental health facilities for providing mental 26381

health services included in the state medicaid plan pursuant to 26382
section ~~5111.023~~ 5163.20 of the Revised Code; 26383

(2) Providers of alcohol and drug addiction services for 26384
providing alcohol and drug addiction services included in the 26385
medicaid program pursuant to rules adopted under section ~~5111.02~~ 26386
5163.15 of the Revised Code. 26387

(B) The director's authority to modify the manner, or to 26388
establish a new manner, for medicaid to pay for the services 26389
specified in division (A) of this section is not limited by any 26390
rules adopted under section ~~5111.02~~ 5163.15 or 5119.61 of the 26391
Revised Code that are in effect on June 26, 2003, and govern the 26392
way medicaid pays for those services. This is the case regardless 26393
of what state agency adopted the rules. 26394

Sec. ~~5111.018~~ 5163.18. (A) The ~~provision of medical~~ 26395
~~assistance under this chapter~~ medicaid program shall ~~include~~ 26396
~~coverage of~~ cover inpatient care and follow-up care for a mother 26397
and her newborn as follows: 26398

(1) The ~~medical assistance~~ medicaid program shall cover a 26399
minimum of forty-eight hours of inpatient care following a normal 26400
vaginal delivery and a minimum of ninety-six hours of inpatient 26401
care following a cesarean delivery. Services covered as inpatient 26402
care shall include medical, educational, and any other services 26403
that are consistent with the inpatient care recommended in the 26404
protocols and guidelines developed by national organizations that 26405
represent pediatric, obstetric, and nursing professionals. 26406

(2) The ~~medical assistance~~ medicaid program shall cover a 26407
physician-directed source of follow-up care. Services covered as 26408
follow-up care shall include physical assessment of the mother and 26409
newborn, parent education, assistance and training in breast or 26410
bottle feeding, assessment of the home support system, performance 26411
of any medically necessary and appropriate clinical tests, and any 26412

other services that are consistent with the follow-up care 26413
recommended in the protocols and guidelines developed by national 26414
organizations that represent pediatric, obstetric, and nursing 26415
professionals. The coverage shall apply to services provided in a 26416
medical setting or through home health care visits. The coverage 26417
shall apply to a home health care visit only if the health care 26418
professional who conducts the visit is knowledgeable and 26419
experienced in maternity and newborn care. 26420

When a decision is made in accordance with division (B) of 26421
this section to discharge a mother or newborn prior to the 26422
expiration of the applicable number of hours of inpatient care 26423
required to be covered, the coverage of follow-up care shall apply 26424
to all follow-up care that is provided within forty-eight hours 26425
after discharge. When a mother or newborn receives at least the 26426
number of hours of inpatient care required to be covered, the 26427
coverage of follow-up care shall apply to follow-up care that is 26428
determined to be medically necessary by the health care 26429
professionals responsible for discharging the mother or newborn. 26430

(B) Any decision to shorten the length of inpatient stay to 26431
less than that specified under division (A)(1) of this section 26432
shall be made by the physician attending the mother or newborn, 26433
except that if a nurse-midwife is attending the mother in 26434
collaboration with a physician, the decision may be made by the 26435
nurse-midwife. Decisions regarding early discharge shall be made 26436
only after conferring with the mother or a person responsible for 26437
the mother or newborn. For purposes of this division, a person 26438
responsible for the mother or newborn may include a parent, 26439
guardian, or any other person with authority to make medical 26440
decisions for the mother or newborn. 26441

(C) The department of ~~job and family services~~ health care 26442
administration, in administering the ~~medical assistance~~ medicaid 26443
program, may not do either of the following: 26444

(1) Terminate the participation of a health care professional 26445
or health care facility as a provider under the program solely for 26446
making recommendations for inpatient or follow-up care for a 26447
particular mother or newborn that are consistent with the care 26448
required to be covered by this section; 26449

(2) Establish or offer monetary or other financial incentives 26450
for the purpose of encouraging a person to decline the inpatient 26451
or follow-up care required to be covered by this section. 26452

(D) This section does not do any of the following: 26453

(1) Require the ~~medical assistance~~ medicaid program to cover 26454
inpatient or follow-up care that is not received in accordance 26455
with the program's terms pertaining to the health care 26456
professionals and facilities from which an individual is 26457
authorized to receive health care services. 26458

(2) Require a mother or newborn to stay in a hospital or 26459
other inpatient setting for a fixed period of time following 26460
delivery; 26461

(3) Require a child to be delivered in a hospital or other 26462
inpatient setting; 26463

(4) Authorize a nurse-midwife to practice beyond the 26464
authority to practice nurse-midwifery in accordance with Chapter 26465
4723. of the Revised Code; 26466

(5) Establish minimum standards of medical diagnosis, care, 26467
or treatment for inpatient or follow-up care for a mother or 26468
newborn. A deviation from the care required to be covered under 26469
this section shall not, on the basis of this section, give rise to 26470
a medical claim or derivative medical claim, as those terms are 26471
defined in section 2305.113 of the Revised Code. 26472

Sec. ~~5111.024~~ 5163.19. (A) As used in this section, 26473
"screening mammography" means a radiologic examination utilized to 26474

detect unsuspected breast cancer at an early stage in asymptomatic 26475
women and includes the x-ray examination of the breast using 26476
equipment that is dedicated specifically for mammography, 26477
including the x-ray tube, filter, compression device, screens, 26478
film, and cassettes, and that has an average radiation exposure 26479
delivery of less than one rad mid-breast. "Screening mammography" 26480
includes two views for each breast. The term also includes the 26481
professional interpretation of the film. 26482

"Screening mammography" does not include diagnostic 26483
mammography. 26484

~~(B) In addition to any other services required to be included 26485
in the program or for which federal approval is received, the 26486
medical assistance The medicaid program shall include cover both 26487
of the following if ~~approval for use of federal funds is granted 26488
to the department by the federal agency responsible for 26489
distributing funds under Title XIX of the "Social Security Act," 26490
49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended~~ federal financial 26491
participation is available for them: 26492~~

~~(1) Effective July 1, 1993, screening Screening mammography 26493
to detect the presence of breast cancer in adult women; 26494~~

~~(2) Effective January 1, 1993, cytologic Cytologic screening 26495
for the presence of cervical cancer. 26496~~

(C) The service provided under division (B)(1) of this 26497
section shall be provided in accordance with all of the following: 26498

(1) If a woman is at least thirty-five years of age but under 26499
forty years of age, one screening mammography; 26500

(2) If a woman is at least forty years of age but under fifty 26501
years of age, either of the following: 26502

(a) One screening mammography every two years; 26503

(b) If a licensed physician has determined that the woman has 26504

risk factors to breast cancer, one screening mammography every year. 26505
26506

(3) If a woman is at least fifty years of age but under sixty-five years of age, one screening mammography every year. 26507
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(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. 26509
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(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. 26515
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Sec. ~~5111.023~~ 5163.20. (A) As used in this section: 26520

(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. 26521
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(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. 26527
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(B) The state medicaid plan shall include provision of the following mental health services when provided by community mental health facilities: 26531
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(1) Outpatient mental health services, including, but not 26534

limited to, preventive, diagnostic, therapeutic, rehabilitative, 26535
and palliative interventions rendered to individuals in an 26536
individual or group setting by a mental health professional in 26537
accordance with a plan of treatment appropriately established, 26538
monitored, and reviewed; 26539

(2) Partial-hospitalization mental health services of three 26540
to fourteen hours per service day, rendered by persons directly 26541
supervised by a mental health professional; 26542

(3) Unscheduled, emergency mental health services of a kind 26543
ordinarily provided to persons in crisis when rendered by persons 26544
supervised by a mental health professional; 26545

(4) Subject to receipt of federal approval, assertive 26546
community treatment and intensive home-based mental health 26547
services. 26548

(C) The comprehensive annual plan shall certify the 26549
availability of sufficient unencumbered community mental health 26550
state subsidy and local funds to match federal medicaid 26551
reimbursement funds earned by community mental health facilities. 26552

(D) The department of ~~job and family services~~ health care 26553
administration shall enter into a separate contract with the 26554
department of mental health under section ~~5111.91~~ 5161.05 of the 26555
Revised Code with regard to the component of the medicaid program 26556
provided for by this section. 26557

(E) Not later than July 21, 2006, the department of ~~job and~~ 26558
~~family services~~ health care administration shall request federal 26559
approval to provide assertive community treatment and intensive 26560
home-based mental health services under medicaid pursuant to this 26561
section. 26562

(F) On receipt of federal approval sought under division (E) 26563
of this section, the director of ~~job and family services~~ health 26564
care administration shall adopt rules in accordance with Chapter 26565

119. of the Revised Code for assertive community treatment and 26566
intensive home-based mental health services provided under 26567
medicaid pursuant to this section. The director shall consult with 26568
the department of mental health in adopting the rules. 26569

Sec. ~~5111.04~~ 5163.21. (A) As used in this section: 26570

(1) "Outpatient health facility" means a facility that 26571
provides comprehensive primary health services by or under the 26572
direction of a physician at least five days per week on a 26573
forty-hour per week basis to outpatients, is operated by the board 26574
of health of a city or general health district or another public 26575
agency or by a nonprofit private agency or organization under the 26576
direction and control of a governing board that has no 26577
health-related responsibilities other than the direction and 26578
control of one or more such outpatient health facilities, and 26579
receives at least seventy-five per cent of its operating funds 26580
from public sources, except that it does not include an outpatient 26581
hospital facility or a federally qualified health center as 26582
defined in Sec. 1905(1) (2)(B) of the "Social Security Act," 103 26583
Stat. 2264 (1989), 42 U.S.C.A. 1396d(1)(2)(B). 26584

(2) "Comprehensive primary health services" means preventive, 26585
diagnostic, therapeutic, rehabilitative, or palliative items or 26586
services that include all of the following: 26587

(a) Services of physicians, physician assistants, and 26588
certified nurse practitioners; 26589

(b) Diagnostic laboratory and radiological services; 26590

(c) Preventive health services, such as children's eye and 26591
ear examinations, perinatal services, well child services, and 26592
family planning services; 26593

(d) Arrangements for emergency medical services; 26594

(e) Transportation services. 26595

(3) "Certified nurse practitioner" has the same meaning as in section 4723.01 of the Revised Code. 26596
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(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. 26598
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(C) A facility does not qualify for classification as an outpatient health facility under this section unless it: 26620
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(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; 26622
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(2) Has a medical director, a dental director, if dental care 26627

is provided, and a nursing director responsible for the execution 26628
of such policies, and has physicians, dentists, nursing, and 26629
ancillary staff appropriate to the scope of services provided; 26630

(3) Requires that the care of every patient be under the 26631
supervision of a physician, provides for medical care in case of 26632
emergency, has in effect a written agreement with one or more 26633
hospitals and one or more other outpatient facilities, and has an 26634
established system for the referral of patients to other resources 26635
and a utilization review plan and program; 26636

(4) Maintains clinical records on all patients; 26637

(5) Provides nursing services and other therapeutic services 26638
in compliance with applicable laws and rules and under the 26639
supervision of a registered nurse, and has a registered nurse on 26640
duty at all times when the facility is in operation; 26641

(6) Follows approved methods and procedures for the 26642
dispensing and administration of drugs and biologicals; 26643

(7) Maintains the accounting and record-keeping system 26644
required under federal laws and regulations for the determination 26645
of reasonable and allowable costs. 26646

Sec. ~~5111.14~~ 5163.22. The department of ~~job and family~~ 26647
~~services~~ health care administration may require county departments 26648
of job and family services to provide case management of 26649
nonemergency transportation services provided under the ~~medical~~ 26650
~~assistance~~ medicaid program. County departments shall provide the 26651
case management if required by the department in accordance with 26652
rules adopted by the director of ~~job and family services~~ health 26653
care administration. 26654

The department shall determine, for the purposes of claiming 26655
federal reimbursement under the ~~medical assistance~~ medicaid 26656
program, whether it will claim expenditures for nonemergency 26657

transportation services as administrative or program expenditures. 26658

Sec. ~~5111.19~~ 5163.23. The director of ~~job and family services~~ 26659
health care administration shall adopt rules governing the 26660
calculation and payment of graduate medical education costs 26661
associated with services rendered to medicaid recipients after 26662
June 30, 1994. Subject to section ~~5111.191~~ 5163.231 of the Revised 26663
Code, the rules shall provide for reimbursement of graduate 26664
medical education costs associated with services rendered to 26665
medicaid recipients, including recipients enrolled in a managed 26666
care organization under contract with the department under section 26667
~~5111.17~~ 5165.05 of the Revised Code, that the department 26668
determines are allowable and reasonable. 26669

If the department requires a managed care organization to pay 26670
a provider for graduate medical education costs associated with 26671
the delivery of services to medicaid recipients enrolled in the 26672
organization, the department shall include in its payment to the 26673
organization an amount sufficient for the organization to pay such 26674
costs. If the department does not include in its payments to the 26675
managed care organization amounts for graduate medical education 26676
costs of providers, all of the following apply: 26677

(A) Except as provided in section ~~5111.191~~ 5163.231 of the 26678
Revised Code, the department shall pay the provider for graduate 26679
medical education costs associated with the delivery of services 26680
to medicaid recipients enrolled in the organization; 26681

(B) No provider shall seek reimbursement from the 26682
organization for such costs; 26683

(C) The organization is not required to pay providers for 26684
such costs. 26685

Sec. ~~5111.191~~ 5163.231. (A) Except as provided in division 26686
(B) of this section, the department of ~~job and family services~~ 26687

health care administration may deny payment to a hospital for 26688
direct graduate medical education costs associated with the 26689
delivery of services to any medicaid recipient if the hospital 26690
refuses without good cause to contract with a managed care 26691
organization that serves participants in the care management 26692
system established under section ~~5111.16~~ 5165.03 of the Revised 26693
Code who are required to be enrolled in a managed care 26694
organization and the managed care organization serves the area in 26695
which the hospital is located. 26696

(B) A hospital is not subject to division (A) of this section 26697
if all of the following are the case: 26698

(1) The hospital is located in a county in which participants 26699
in the care management system are required before January 1, 2006, 26700
to be enrolled in a medicaid managed care organization that is a 26701
health insuring corporation. 26702

(2) The hospital has entered into a contract before January 26703
1, 2006, with at least one health insuring corporation serving the 26704
participants specified in division (B)(1) of this section. 26705

(3) The hospital remains under contract with at least one 26706
health insuring corporation serving participants in the care 26707
management system who are required to be enrolled in a health 26708
insuring corporation. 26709

(C) The director of ~~job and family services~~ health care 26710
administration shall specify in the rules adopted under section 26711
~~5111.19~~ 5163.231 of the Revised Code what constitutes good cause 26712
for a hospital to refuse to contract with a managed care 26713
organization. 26714

Sec. ~~5111.082~~ 5163.24. (A) As used in this section: 26715

(1) "State maximum allowable cost" means the per unit amount 26716
the department of ~~job and family services~~ health care 26717

administration reimburses a terminal distributor of dangerous 26718
drugs for a prescription drug included in the state maximum 26719
allowable cost program established under division (B) of this 26720
section. "State maximum allowable cost" excludes dispensing fees 26721
and copayments, coinsurance, or other cost-sharing charges, if 26722
any. 26723

(2) "Terminal distributor of dangerous drugs" has the same 26724
meaning as in section 4729.01 of the Revised Code. 26725

(B) The director of ~~job and family services~~ health care 26726
administration shall establish a state maximum allowable cost 26727
program for purposes of managing reimbursement to terminal 26728
distributors of dangerous drugs for prescription drugs identified 26729
by the director pursuant to this division. The director shall do 26730
all of the following with respect to the program: 26731

(1) Identify and create a list of prescription drugs to be 26732
included in the program. 26733

(2) Update the list of prescription drugs described in 26734
division (B)(1) of this section on a weekly basis. 26735

(3) Review the state maximum allowable cost for each drug 26736
included on the list described in division (B)(1) of this section 26737
on a weekly basis. 26738

(C) The director may adopt rules in accordance with Chapter 26739
119. of the Revised Code to implement this section. 26740

Sec. ~~5111.08~~ 5163.241. In accordance with ~~subsection (g) of~~ 26741
~~section 1927 of the "Social Security Act," 49 Stat. 320 (1935), 42~~ 26742
U.S.C.A. 1396r-8(g), ~~as amended,~~ the department of ~~job and family~~ 26743
~~services~~ health care administration shall establish an outpatient 26744
drug use review program to assure that prescriptions obtained by 26745
recipients of medical assistance under this chapter are 26746
appropriate, medically necessary, and unlikely to cause adverse 26747

medical results. 26748

Sec. ~~5111.027~~ 5163.242. If the medicaid program provides 26749
prescription drug services to medicaid recipients, the program 26750
shall not provide reimbursement for prescription drugs for 26751
treatment of erectile dysfunction. 26752

Sec. ~~5111.083~~ 5163.243. (A) As used in this section, 26753
"licensed health professional authorized to prescribe drugs" has 26754
the same meaning as in section 4729.01 of the Revised Code. 26755

(B) The director of ~~job and family services~~ health care 26756
administration may establish an e-prescribing system for the 26757
medicaid program under which a medicaid provider who is a licensed 26758
health professional authorized to prescribe drugs shall use an 26759
electronic system to prescribe a drug for a medicaid recipient 26760
when required to do so by division (C) of this section. The 26761
e-prescribing system shall eliminate the need for such medicaid 26762
providers to make prescriptions for medicaid recipients by 26763
handwriting or telephone. The e-prescribing system also shall 26764
provide such medicaid providers with an up-to-date, clinically 26765
relevant drug information database and a system of electronically 26766
monitoring medicaid recipients' medical history, drug regimen 26767
compliance, and fraud and abuse. 26768

(C) If the director establishes an e-prescribing system under 26769
division (B) of this section, the director shall do all of the 26770
following: 26771

(1) Require that a medicaid provider who is a licensed health 26772
professional authorized to prescribe drugs use the e-prescribing 26773
system during a fiscal year if the medicaid provider was one of 26774
the ten medicaid providers who, during the calendar year that 26775
precedes that fiscal year, issued the most prescriptions for 26776
medicaid recipients receiving hospital services; 26777

(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 26809
are medicaid providers ~~under this chapter~~. The dispensing fee 26810
shall take into consideration the results of the survey conducted 26811
under section ~~5111.07~~ 5163.25 of the Revised Code. 26812

Sec. ~~5111.081~~ 5163.26. The director of ~~job and family~~ 26813
~~services~~ health care administration, in rules adopted under 26814
section ~~5111.02~~ 5163.15 of the Revised Code, may establish and 26815
implement a supplemental drug rebate program under which drug 26816
manufacturers may be required to provide the department of ~~job and~~ 26817
~~family services~~ health care administration a supplemental rebate 26818
as a condition of having the drug manufacturers' drug products 26819
covered by the medicaid program without prior approval. The 26820
department may receive a supplemental rebate negotiated under the 26821
program for a drug dispensed to a medicaid recipient pursuant to a 26822
prescription or a drug purchased by a medicaid provider for 26823
administration to a medicaid recipient in the provider's primary 26824
place of business. If necessary, the director may apply to the 26825
United States secretary of health and human services for a waiver 26826
of federal statutes and regulations to establish the supplemental 26827
drug rebate program. 26828

If the director establishes a supplemental drug rebate 26829
program, the director shall consult with drug manufacturers 26830
regarding the establishment and implementation of the program. 26831

Sec. ~~5111.0114~~ 5163.261. (A) As used in this section, 26832
"dangerous drug" and "manufacturer of dangerous drugs" have the 26833
same meaning as in section 4729.01 of the Revised Code. 26834

(B) The director of ~~job and family services~~ health care 26835
administration may enter into or administer an agreement or 26836
cooperative arrangement with other states to create or join a 26837
multiple-state prescription drug purchasing program for the 26838

purpose of negotiating with manufacturers of dangerous drugs to 26839
receive discounts or rebates for dangerous drugs dispensed under 26840
the medicaid program. 26841

Sec. ~~5111.042~~ 5163.28. The departments of mental retardation 26842
and developmental disabilities and ~~job and family services~~ health 26843
care administration may approve, reduce, deny, or terminate a 26844
service included in the individualized service plan developed for 26845
a medicaid recipient with mental retardation or other 26846
developmental disability who is eligible for medicaid case 26847
management services. If either department approves, reduces, 26848
denies, or terminates a service, that department shall timely 26849
notify the medicaid recipient that the recipient may request a 26850
hearing under section ~~5101.35~~ 5160.34 of the Revised Code. 26851

Sec. ~~5111.85~~ 5163.50. (A) As used in this section and 26852
sections ~~5111.851~~ 5163.51 to ~~5111.856~~ 5163.56 of the Revised Code, 26853
"medicaid waiver component" means a component of the medicaid 26854
program authorized by a waiver granted by the United States 26855
department of health and human services under ~~section 1115 or 1915~~ 26856
~~of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A.~~ 26857
1315 or 1396n. "Medicaid waiver component" does not include a care 26858
management system established under section ~~5111.16~~ 5165.03 of the 26859
Revised Code. 26860

(B) The director of ~~job and family services~~ health care 26861
administration may adopt rules under Chapter 119. of the Revised 26862
Code governing medicaid waiver components that establish all of 26863
the following: 26864

(1) Eligibility requirements for the medicaid waiver 26865
components; 26866

(2) The type, amount, duration, and scope of services the 26867
medicaid waiver components provide; 26868

(3) The conditions under which the medicaid waiver components cover services;	26869 26870
(4) The amount the medicaid waiver components pay for services or the method by which the amount is determined;	26871 26872
(5) The manner in which the medicaid waiver components pay for services;	26873 26874
(6) Safeguards for the health and welfare of medicaid recipients receiving services under a medicaid waiver component;	26875 26876
(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.	26877 26878 26879 26880 26881 26882
(8) Other policies necessary for the efficient administration of the medicaid waiver components.	26883 26884
(C) The director of job and family services <u>health care administration</u> 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.	26885 26886 26887 26888
Sec. 5111.851 <u>5163.51</u>. (A) As used in sections 5111.851 <u>5163.51</u> to 5111.855 <u>5163.55</u> of the Revised Code:	26889 26890
"Administrative agency" means, with respect to a home and community-based services medicaid waiver component, the department of job and family services <u>health care administration</u> or, if a state agency or political subdivision contracts with the department under section 5111.91 <u>5161.05</u> of the Revised Code to administer the component, that state agency or political subdivision.	26891 26892 26893 26894 26895 26896 26897
"Home and community-based services medicaid waiver component"	26898

means a medicaid waiver component under which home and 26899
community-based services are provided as an alternative to 26900
hospital, nursing facility, or intermediate care facility for the 26901
mentally retarded services. 26902

"Hospital" has the same meaning as in section 3727.01 of the 26903
Revised Code. 26904

"Intermediate care facility for the mentally retarded" has 26905
the same meaning as in section ~~5111.20~~ 5164.01 of the Revised 26906
Code. 26907

"Level of care determination" means a determination of 26908
whether an individual needs the level of care provided by a 26909
hospital, nursing facility, or intermediate care facility for the 26910
mentally retarded and whether the individual, if determined to 26911
need that level of care, would receive hospital, nursing facility, 26912
or intermediate care facility for the mentally retarded services 26913
if not for a home and community-based services medicaid waiver 26914
component. 26915

"Nursing facility" has the same meaning as in section ~~5111.20~~ 26916
5164.01 of the Revised Code. 26917

"Skilled nursing facility" means a facility certified as a 26918
skilled nursing facility ~~under Title XVIII of the "Social Security~~ 26919
~~Act," 79 Stat. 286 (1965), 42 U.S.C. 1395, as amended~~ for the 26920
medicare program. 26921

(B) The following requirements apply to each home and 26922
community-based services medicaid waiver component: 26923

(1) Only an individual who qualifies for a component shall 26924
receive that component's services. 26925

(2) A level of care determination shall be made as part of 26926
the process of determining whether an individual qualifies for a 26927
component and shall be made each year after the initial 26928

determination if, during such a subsequent year, the 26929
administrative agency determines there is a reasonable indication 26930
that the individual's needs have changed. 26931

(3) A written plan of care or individual service plan based 26932
on an individual assessment of the services that an individual 26933
needs to avoid needing admission to a hospital, nursing facility, 26934
or intermediate care facility for the mentally retarded shall be 26935
created for each individual determined eligible for a component. 26936

(4) Each individual determined eligible for a component shall 26937
receive that component's services in accordance with the 26938
individual's level of care determination and written plan of care 26939
or individual service plan. 26940

(5) No individual may receive services under a component 26941
while the individual is a hospital inpatient or resident of a 26942
skilled nursing facility, nursing facility, or intermediate care 26943
facility for the mentally retarded. 26944

(6) No individual may receive prevocational, educational, or 26945
supported employment services under a component if the individual 26946
is eligible for such services that are funded with federal funds 26947
provided under 29 U.S.C. 730 or the "Individuals with Disabilities 26948
Education Act," 111 Stat. 37 (1997), 20 U.S.C. 1400, as amended. 26949

(7) Safeguards shall be taken to protect the health and 26950
welfare of individuals receiving services under a component, 26951
including safeguards established in rules adopted under section 26952
~~5111.85~~ 5163.50 of the Revised Code and safeguards established by 26953
licensing and certification requirements that are applicable to 26954
the providers of that component's services. 26955

(8) No services may be provided under a component by a 26956
provider that is subject to standards that 42 U.S.C. 1382e(e)(1) 26957
requires be established if the provider fails to comply with the 26958
standards applicable to the provider. 26959

(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 26991
agency administers, including records of independent audits. The 26992
administrative agency shall make the financial records available 26993
on request to the United States secretary of health and human 26994
services, United States comptroller general, and their designees. 26995

Sec. ~~5111.854~~ 5163.54. Each administrative agency is 26996
financially accountable for funds expended for services provided 26997
under the home and community-based services medicaid waiver 26998
components that the agency administers. 26999

Sec. ~~5111.855~~ 5163.55. Each state agency and political 27000
subdivision that enters into a contract with the department of ~~job~~ 27001
~~and family services~~ health care administration under section 27002
~~5111.91~~ 5161.05 of the Revised Code to administer a home and 27003
community-based services medicaid waiver component, or one or more 27004
aspects of such a component, shall provide the department a 27005
written assurance that the agency or subdivision will not violate 27006
any of the requirements of sections ~~5111.85~~ 5163.50 to ~~5111.854~~ 27007
5163.54 of the Revised Code. 27008

Sec. ~~5111.856~~ 5163.56. To the extent necessary for the 27009
efficient and economical administration of medicaid waiver 27010
components, the department of ~~job and family services~~ health care 27011
administration may transfer an individual enrolled in a medicaid 27012
waiver component administered by the department to another 27013
medicaid waiver component the department administers if the 27014
individual is eligible for the medicaid waiver component and the 27015
transfer does not jeopardize the individual's health or safety. 27016

Sec. ~~5111.86~~ 5163.60. (A) As used in this section: 27017

(1) "Hospital" has the same meaning as in section 3727.01 of 27018
the Revised Code. 27019

(2) "Medicaid waiver component" has the same meaning as in section ~~5111.85~~ 5163.50 of the Revised Code. 27020
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(3) "Nursing facility" has the same meaning as in section ~~5111.20~~ 5164.01 of the Revised Code. 27022
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(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. 27024
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(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: 27030
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(1) The maximum number of individuals who may be enrolled in each of the medicaid waiver components included in the requests; 27040
27041

(2) The maximum amount the medicaid program may expend each year for each individual enrolled in the medicaid waiver components; 27042
27043
27044

(3) The maximum amount the medicaid program may expend each year for all individuals enrolled in the medicaid waiver components; 27045
27046
27047

(4) Any other requirements the director selects for the medicaid waiver components. 27048
27049

(C) If the secretary approves the medicaid waivers requested 27050
under this section, the director may create and implement the 27051
medicaid waiver components in accordance with the provisions of 27052
the approved waivers. The department of ~~job and family services~~ 27053
health care administration shall administer the medicaid waiver 27054
components. 27055

After the first of any medicaid waiver components created 27056
under this section begins to enroll eligible individuals, the 27057
director may submit to the United States secretary of health and 27058
human services an amendment to a medicaid waiver component of the 27059
Ohio home care program authorizing the department to cease 27060
enrolling additional individuals in that medicaid waiver component 27061
of the Ohio home care program. If the secretary approves the 27062
amendment, the director may cease to enroll additional individuals 27063
in that medicaid waiver component of the Ohio home care program. 27064

Sec. ~~5111.87~~ 5163.65. (A) As used in this section and section 27065
~~5111.871~~ 5163.651 of the Revised Code: 27066

(1) "Intermediate care facility for the mentally retarded" 27067
has the same meaning as in section ~~5111.20~~ 5164.01 of the Revised 27068
Code. 27069

(2) "Medicaid waiver component" has the same meaning as in 27070
section ~~5111.85~~ 5163.50 of the Revised Code. 27071

(B) The director of ~~job and family services~~ health care 27072
administration may apply to the United States secretary of health 27073
and human services for both of the following: 27074

(1) One or more medicaid waiver components under which home 27075
and community-based services are provided to individuals with 27076
mental retardation or other developmental disability as an 27077
alternative to placement in an intermediate care facility for the 27078
mentally retarded; 27079

(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. 27110
The contract shall provide for the department of mental 27111
retardation and developmental disabilities to administer the 27112
components in accordance with the terms of the waivers. The 27113
directors of ~~job and family services~~ health care administration 27114
and mental retardation and developmental disabilities shall adopt 27115
rules in accordance with Chapter 119. of the Revised Code 27116
governing the components. 27117

If the department of mental retardation and developmental 27118
disabilities or the department of ~~job and family services~~ health 27119
care administration denies an individual's application for home 27120
and community-based services provided under any of these medicaid 27121
components, the department that denied the services shall give 27122
timely notice to the individual that the individual may request a 27123
hearing under section ~~5101.35~~ 5160.34 of the Revised Code. 27124

The departments of mental retardation and developmental 27125
disabilities and ~~job and family services~~ health care 27126
administration may approve, reduce, deny, or terminate a service 27127
included in the individualized service plan developed for a 27128
medicaid recipient eligible for home and community-based services 27129
provided under any of these medicaid components. The departments 27130
shall consider the recommendations a county board of mental 27131
retardation and developmental disabilities makes under division 27132
(A)(1)(c) of section 5126.055 of the Revised Code. If either 27133
department approves, reduces, denies, or terminates a service, 27134
that department shall give timely notice to the medicaid recipient 27135
that the recipient may request a hearing under section ~~5101.35~~ 27136
5160.34 of the Revised Code. 27137

If supported living or residential services, as defined in 27138
section 5126.01 of the Revised Code, are to be provided under any 27139
of these components, any person or government entity with a 27140
current, valid medicaid provider agreement and a current, valid 27141

license under section 5123.19 or certificate under section 5123.16 27142
or 5126.431 of the Revised Code may provide the services. 27143

Sec. ~~5111.872~~ 5163.652. When the department of mental 27144
retardation and developmental disabilities allocates enrollment 27145
numbers to a county board of mental retardation and developmental 27146
disabilities for home and community-based services specified in 27147
division (B)(1) of section ~~5111.87~~ 5163.65 of the Revised Code and 27148
provided under any of the components of the medicaid program that 27149
the department administers under section ~~5111.871~~ 5163.651 of the 27150
Revised Code, the department shall consider all of the following: 27151

(A) The number of individuals with mental retardation or 27152
other developmental disability who are on a waiting list the 27153
county board establishes under division (C) of section 5126.042 of 27154
the Revised Code for those services and are given priority on the 27155
waiting list pursuant to division (D) or (E) of that section; 27156

(B) The implementation component required by division (A)(4) 27157
of section 5126.054 of the Revised Code of the county board's plan 27158
approved under section 5123.046 of the Revised Code; 27159

(C) Anything else the department considers necessary to 27160
enable county boards to provide those services to individuals in 27161
accordance with the priority requirements of divisions (D) and (E) 27162
of section 5126.042 of the Revised Code. 27163

Sec. ~~5111.873~~ 5163.653. (A) Not later than the effective date 27164
of the first of any medicaid waivers the United States secretary 27165
of health and human services grants pursuant to a request made 27166
under section ~~5111.87~~ 5163.65 of the Revised Code, the director of 27167
~~job and family services~~ health care administration shall adopt 27168
rules in accordance with Chapter 119. of the Revised Code 27169
establishing statewide fee schedules for home and community-based 27170
services specified in division (B)(1) of section ~~5111.87~~ 5163.65 27171

of the Revised Code and provided under the components of the 27172
medicaid program that the department of mental retardation and 27173
developmental disabilities administers under section ~~5111.871~~ 27174
5163.651 of the Revised Code. The rules shall provide for all of 27175
the following: 27176

(1) The department of mental retardation and developmental 27177
disabilities arranging for the initial and ongoing collection of 27178
cost information from a comprehensive, statistically valid sample 27179
of persons and government entities providing the services at the 27180
time the information is obtained; 27181

(2) The collection of consumer-specific information through 27182
an assessment instrument the department of mental retardation and 27183
developmental disabilities shall provide to the department of ~~job~~ 27184
~~and family services~~ health care administration; 27185

(3) With the information collected pursuant to divisions 27186
(A)(1) and (2) of this section, an analysis of that information, 27187
and other information the director determines relevant, methods 27188
and standards for calculating the fee schedules that do all of the 27189
following: 27190

(a) Assure that the fees are consistent with efficiency, 27191
economy, and quality of care; 27192

(b) Consider the intensity of consumer resource need; 27193

(c) Recognize variations in different geographic areas 27194
regarding the resources necessary to assure the health and welfare 27195
of consumers; 27196

(d) Recognize variations in environmental supports available 27197
to consumers. 27198

(B) As part of the process of adopting rules under this 27199
section, the director shall consult with the director of mental 27200
retardation and developmental disabilities, representatives of 27201

county boards of mental retardation and developmental 27202
disabilities, persons who provide the home and community-based 27203
services, and other persons and government entities the director 27204
identifies. 27205

(C) The directors of ~~job and family services~~ health care 27206
administration and mental retardation and developmental 27207
disabilities shall review the rules adopted under this section at 27208
times they determine to ensure that the methods and standards 27209
established by the rules for calculating the fee schedules 27210
continue to do everything that division (A)(3) of this section 27211
requires. 27212

Sec. ~~5111.88~~ 5163.66. (A) As used in sections ~~5111.88~~ 5163.66 27213
to ~~5111.8817~~ 5163.6617 of the Revised Code: 27214

"Administrative agency" means the department of ~~job and~~ 27215
~~family services~~ health care administration or, if the department 27216
assigns the day-to-day administration of the ICF/MR conversion 27217
pilot program to the department of mental retardation and 27218
developmental disabilities pursuant to section ~~5111.887~~ 5163.667 27219
of the Revised Code, the department of mental retardation and 27220
developmental disabilities. 27221

"ICF/MR conversion pilot program" means the medicaid waiver 27222
component authorized by a waiver sought under division (B)(1) of 27223
this section. 27224

"ICF/MR services" means intermediate care facility for the 27225
mentally retarded services covered by the medicaid program that an 27226
intermediate care facility for the mentally retarded provides to a 27227
resident of the facility who is a medicaid recipient eligible for 27228
medicaid-covered intermediate care facility for the mentally 27229
retarded services. 27230

"Intermediate care facility for the mentally retarded" has 27231

the same meaning as in section ~~5111.20~~ 5164.01 of the Revised Code. 27232
27233

"Medicaid waiver component" has the same meaning as in 27234
section ~~5111.85~~ 5163.50 of the Revised Code. 27235

(B) Not later than June 30, 2007, the director of ~~job and~~ 27236
~~family services~~ health care administration shall, after consulting 27237
with and receiving input from the ICF/MR conversion advisory 27238
council, submit both of the following to the United States 27239
secretary of health and human services: 27240

(1) An application for a waiver authorizing the ICF/MR 27241
conversion pilot program under which intermediate care facilities 27242
for the mentally retarded, other than such facilities operated by 27243
the department of mental retardation and developmental 27244
disabilities, may volunteer to convert in whole or in part from 27245
providing intermediate care facility for the mentally retarded 27246
services to providing home and community-based services and 27247
individuals with mental retardation or a developmental disability 27248
who are eligible for ICF/MR services may volunteer to receive 27249
instead home and community-based services; 27250

(2) An amendment to the state medicaid plan to authorize the 27251
director, beginning on the first day that the ICF/MR conversion 27252
pilot program begins implementation under section ~~5111.882~~ 27253
5163.662 of the Revised Code and except as provided by section 27254
~~5111.8811~~ 5163.6611 of the Revised Code, to refuse to enter into 27255
or amend a medicaid provider agreement with the operator of an 27256
intermediate care facility for the mentally retarded if the 27257
provider agreement or amendment would authorize the operator to 27258
receive medicaid payments for more intermediate care facility for 27259
the mentally retarded beds than the operator receives on the day 27260
before that day. 27261

(C) The director shall notify the governor, speaker and 27262

minority leader of the house of representatives, and president and 27263
minority leader of the senate when the director submits the 27264
application for the ICF/MR conversion pilot program under division 27265
(B)(1) of this section and the amendment to the state medicaid 27266
plan under division (B)(2) of this section. The director is not 27267
required to submit the application and the amendment at the same 27268
time. 27269

Sec. ~~5111.881~~ 5163.661. (A) There is hereby created the 27270
ICF/MR conversion advisory council. The council shall consist of 27271
all of the following members: 27272

(1) Two members of the house of representatives appointed by 27273
the speaker of the house of representatives, each from a different 27274
political party; 27275

(2) Two members of the senate appointed by the president of 27276
the senate, each from a different political party; 27277

(3) The director of ~~job and family services~~ health care 27278
administration or the director's designee; 27279

(4) The director of mental retardation and developmental 27280
disabilities or the director's designee; 27281

(5) One representative of each of the following 27282
organizations, appointed by the organization: 27283

(a) Advocacy and protective services, incorporated; 27284

(b) The arc of Ohio; 27285

(c) The Ohio league for the mentally retarded; 27286

(d) People first of Ohio; 27287

(e) The Ohio association of county boards of mental 27288
retardation and developmental disabilities; 27289

(f) The Ohio provider resource association; 27290

(g) The Ohio health care association;	27291
(h) The Ohio legal rights service;	27292
(i) The Ohio developmental disabilities council;	27293
(j) The cerebral palsy association of Ohio.	27294
(B) At least four members appointed to the ICF/MR conversion	27295
advisory council, other than the members appointed under division	27296
(A)(1) or (2) of this section, shall be either of the following:	27297
(1) A family member of an individual who, at the time of the	27298
family member's appointment, is a resident of an intermediate care	27299
facility for the mentally retarded;	27300
(2) An individual with mental retardation or a developmental	27301
disability.	27302
(C) The speaker of the house of representatives and the	27303
president of the senate jointly shall appoint one of the members	27304
appointed under division (A)(1) or (2) of this section to serve as	27305
chair of the ICF/MR conversion advisory council.	27306
(D) Members of the ICF/MR conversion advisory council shall	27307
receive no compensation for serving on the council.	27308
(E) The ICF/MR conversion advisory council shall do all of	27309
the following:	27310
(1) Consult with the director of job and family services	27311
<u>health care administration</u> before the director submits the	27312
application for the ICF/MR conversion pilot program and the	27313
amendment to the state medicaid plan under division (B) of section	27314
5111.88 <u>5163.66</u> of the Revised Code;	27315
(2) Consult with the administrative agency before the	27316
administrative agency makes adjustments to the program under	27317
division (F) of section 5111.882 <u>5163.662</u> of the Revised Code;	27318
(3) Consult with the director of job and family services	27319

health care administration when the director adopts the rules for 27320
the program; 27321

(4) Consult with the administrative agency when the 27322
administrative agency conducts the evaluation of the program and 27323
prepares the initial and final reports of the evaluation under 27324
section ~~5111.889~~ 5163.669 of the Revised Code. 27325

(F) The ICF/MR conversion advisory council shall cease to 27326
exist on the issuance of the final report of the evaluation 27327
conducted under section ~~5111.889~~ 5163.669 of the Revised Code. 27328

Sec. ~~5111.882~~ 5163.662. If the United States secretary of 27329
health and human services approves the waiver requested under 27330
division (B)(1) of section ~~5111.88~~ 5163.66 of the Revised Code, 27331
the administrative agency shall implement the ICF/MR conversion 27332
pilot program for not less than three years as follows: 27333

(A) Permit no more than two hundred individuals to 27334
participate in the program at one time; 27335

(B) Select, from among volunteers only, enough intermediate 27336
care facilities for the mentally retarded to convert in whole or 27337
in part from providing ICF/MR services to providing home and 27338
community-based services as necessary to accommodate each 27339
individual participating in the program; 27340

(C) Subject to division (A) of this section, permit 27341
individuals who reside in an intermediate care facility for the 27342
mentally retarded that converts in whole or in part to providing 27343
home and community-based services to choose whether to participate 27344
in the program or, if the facility ceases to have enough 27345
ICF/MR-certified beds for the individual, to transfer to another 27346
intermediate care facility for the mentally retarded that has an 27347
available ICF/MR-certified bed for the individual; 27348

(D) Ensure that no individual receiving ICF/MR services 27349

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 27380
and developmental disabilities may not convert any of the 27381
intermediate care facilities for the mentally retarded that the 27382
department operates to a provider of home and community-based 27383
services under the ICF/MR conversion pilot program. 27384

Sec. ~~5111.887~~ 5163.667. (A) If the United States secretary of 27385
health and human services approves the waiver requested under 27386
division (B)(1) of section ~~5111.88~~ 5163.66 of the Revised Code, 27387
the department of ~~job and family services~~ health care 27388
administration may do both of the following: 27389

(1) Contract with the department of mental retardation and 27390
developmental disabilities under section ~~5111.91~~ 5161.05 of the 27391
Revised Code to assign the day-to-day administration of the ICF/MR 27392
conversion pilot program to the department of mental retardation 27393
and developmental disabilities; 27394

(2) Transfer funds to pay for the nonfederal share of the 27395
costs of the ICF/MR conversion pilot program to the department of 27396
mental retardation and developmental disabilities. 27397

(B) If the department of ~~job and family services~~ health care 27398
administration takes both actions authorized by division (A) of 27399
this section, the department of mental retardation and 27400
developmental disabilities shall be responsible for paying the 27401
nonfederal share of the costs of the ICF/MR conversion pilot 27402
program. 27403

Sec. ~~5111.888~~ 5163.668. The director of ~~job and family~~ 27404
~~services~~ health care administration, in consultation with the 27405
ICF/MR conversion advisory council, shall adopt rules under 27406
section ~~5111.85~~ 5163.50 of the Revised Code as necessary to 27407
implement the ICF/MR conversion pilot program, including rules 27408
establishing both of the following: 27409

(A) The type, amount, duration, and scope of home and community-based services provided under the program;	27410 27411
(B) The amount the program pays for the home and community-based services or the method by which the amount is determined.	27412 27413 27414
Sec. 5111.889 <u>5163.669</u>. (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:	27415 27416 27417 27418
(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;	27419 27420 27421 27422
(2) The satisfaction of the individuals participating in the program with the home and community-based services;	27423 27424
(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;	27425 27426 27427 27428
(4) The program's cost effectiveness, including administrative cost effectiveness;	27429 27430
(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;	27431 27432 27433 27434 27435
(6) Other matters the administrative agency considers appropriate for evaluation.	27436 27437
(B) The administrative agency, in consultation with the ICF/MR conversion advisory council, shall prepare two reports of	27438 27439

the evaluation conducted under this section. The initial report 27440
shall be finished not sooner than the last day of the ICF/MR 27441
conversion pilot program's first year of operation. The final 27442
report shall be finished not sooner than the last day of the 27443
program's second year of operation. The administrative agency 27444
shall provide a copy of each report to the governor, president and 27445
minority leader of the senate, and speaker and minority leader of 27446
the house of representatives. 27447

Sec. ~~5111.8810~~ 5163.6610. The ICF/MR conversion pilot program 27448
shall not be implemented statewide unless the general assembly 27449
enacts law authorizing the statewide implementation. 27450

Sec. ~~5111.8811~~ 5163.6611. An intermediate care facility for 27451
the mentally retarded that converts in whole or in part from 27452
providing ICF/MR services to providing home and community-based 27453
services under the ICF/MR conversion pilot program may reconvert 27454
the converted beds to providing ICF/MR services after the program 27455
terminates unless any of the following is the case: 27456

(A) The program, following the general assembly's enactment 27457
of law authorizing the program's statewide implementation, is 27458
implemented statewide; 27459

(B) The facility no longer meets the requirements for 27460
certification as an intermediate care facility for the mentally 27461
retarded; 27462

(C) The facility no longer meets the requirements for 27463
licensure as a residential facility under section 5123.19 of the 27464
Revised Code or, if the facility is eligible under section 27465
5123.192 of the Revised Code to be licensed as a nursing home, the 27466
requirements for licensure as a nursing home under section 3721.02 27467
or 3721.09 of the Revised Code. 27468

Sec. ~~5111.8812~~ 5163.6612. (A) Subject to division (B) of this 27469
section and beginning not later than two and one-half years after 27470
the date the ICF/MR conversion pilot program terminates, the 27471
department of mental retardation and developmental disabilities 27472
shall be responsible for a portion of the nonfederal share of 27473
medicaid expenditures for ICF/MR services incurred for any beds of 27474
an intermediate care facility for the mentally retarded that are 27475
reconverted to providing ICF/MR services under section ~~5111.8811~~ 27476
5163.6611 of the Revised Code. The portion for which the 27477
department shall be responsible shall be the portion that the 27478
department and department of ~~job and family services~~ health care 27479
administration specify in an agreement. 27480

(B) The department of mental retardation and developmental 27481
disabilities shall not be responsible for any portion of the 27482
nonfederal share of medicaid expenditures for ICF/MR services 27483
incurred for any beds of an intermediate care facility for the 27484
mentally retarded that are in excess of the number of beds the 27485
facility had while participating in the ICF/MR conversion pilot 27486
program. 27487

Sec. ~~5111.8813~~ 5163.6613. The operator of an intermediate 27488
care facility for the mentally retarded that converts only in part 27489
from providing ICF/MR services to providing home and 27490
community-based services under the ICF/MR conversion pilot program 27491
shall place the beds that convert in a distinct part of the 27492
facility that houses the intermediate care facility for the 27493
mentally retarded. 27494

Sec. ~~5111.8814~~ 5163.6614. An intermediate care facility for 27495
the mentally retarded that converts in whole to providing home and 27496
community-based services under the ICF/MR conversion pilot program 27497
shall either be licensed as a residential facility under section 27498

5123.19 of the Revised Code or certified to provide supported 27499
living under section 5126.431 of the Revised Code. If an 27500
intermediate care facility for the mentally retarded converts in 27501
part to providing such home and community-based services, the 27502
distinct part of the facility that provides the home and 27503
community-based services shall either be licensed as a residential 27504
facility under section 5123.19 of the Revised Code or certified to 27505
provide supported living under section 5126.431 of the Revised 27506
Code. The facility or distinct part of the facility shall be 27507
licensed as a residential facility rather than certified to 27508
provide supported living if it meets the definition of 27509
"residential facility" in section 5123.19 of the Revised Code. 27510

Sec. ~~5111.8815~~ 5163.6615. (A) Not later than thirty days 27511
after the date a resident of an intermediate care facility for the 27512
mentally retarded is enrolled in the ICF/MR conversion pilot 27513
program, the operator of the intermediate care facility for the 27514
mentally retarded shall do the following regardless of whether the 27515
resident resides in a distinct part of a facility that also houses 27516
the intermediate care facility for the mentally retarded: 27517

(1) If the intermediate care facility for the mentally 27518
retarded is licensed as a residential facility under section 27519
5123.19 of the Revised Code, notify the director of mental 27520
retardation and developmental disabilities of the resident's 27521
enrollment; 27522

(2) If the intermediate care facility for the mentally 27523
retarded is licensed as a nursing home under section 3721.02 of 27524
the Revised Code, notify the director of health of the resident's 27525
enrollment; 27526

(3) If the intermediate care facility for the mentally 27527
retarded is licensed as a nursing home by a political subdivision 27528
under section 3721.09 of the Revised Code, notify the officials of 27529

the political subdivision of the resident's enrollment. 27530

(B) The director of mental retardation and developmental 27531
disabilities, director of health, and officials of a political 27532
subdivision shall reduce the licensed capacity of a residential 27533
facility or nursing home by the number of the residential 27534
facility's or nursing home's residents who enroll in the ICF/MR 27535
conversion pilot program. The director of ~~job and family services~~ 27536
health care administration shall be notified of each reduction in 27537
licensed capacity made under this section. 27538

Sec. ~~5111.8816~~ 5163.6616. Not later than thirty days after 27539
the date an intermediate care facility for the mentally retarded 27540
converts in whole or in part to providing home and community-based 27541
services under the ICF/MR conversion pilot program, the operator 27542
of the facility shall notify the director of ~~job and family~~ 27543
~~services~~ health care administration of the number of beds that 27544
converted. The director of ~~job and family services~~ health care 27545
administration shall notify the director of health of the 27546
operator's notice. The director of health shall reduce the 27547
facility's certified capacity by the number of beds that convert. 27548
The director of health shall notify the director of ~~job and family~~ 27549
~~services~~ health care administration whenever the director of 27550
health takes action under this section. 27551

Sec. ~~5111.8817~~ 5163.6617. On receipt of notice from the 27552
director of health under section ~~5111.8816~~ 5163.6616 of the 27553
Revised Code that the director has reduced the certified capacity 27554
of an intermediate care facility for the mentally retarded, the 27555
director of ~~job and family services~~ health care administration 27556
shall amend the facility's medicaid provider agreement to reflect 27557
the facility's reduced certified capacity or, if the facility's 27558
certified capacity is reduced to zero, terminate the facility's 27559
medicaid provider agreement. 27560

Sec. ~~5111.89~~ 5163.68. (A) As used in sections ~~5111.89~~ 5163.68 27561
to ~~5111.893~~ 5163.683 of the Revised Code: 27562

"Assisted living program" means the medicaid waiver component 27563
for which the director of ~~job and family services~~ health care 27564
administration is authorized by this section to request a medicaid 27565
waiver. 27566

"Assisted living services" means the following home and 27567
community-based services: personal care, homemaker, chore, 27568
attendant care, companion, medication oversight, and therapeutic 27569
social and recreational programming. 27570

"County or district home" means a county or district home 27571
operated under Chapter 5155. of the Revised Code. 27572

"Medicaid waiver component" has the same meaning as in 27573
section ~~5111.85~~ 5163.50 of the Revised Code. 27574

"Nursing facility" has the same meaning as in section ~~5111.20~~ 27575
5164.01 of the Revised Code. 27576

"Residential care facility" has the same meaning as in 27577
section 3721.01 of the Revised Code. 27578

(B) The director of ~~job and family services~~ health care 27579
administration may submit a request to the United States secretary 27580
of health and human services under 42 U.S.C. 1396n to obtain a 27581
waiver of federal medicaid requirements that would otherwise be 27582
violated in the creation and implementation of a program under 27583
which assisted living services are provided to not more than one 27584
thousand eight hundred individuals who meet the program's 27585
eligibility requirements established under section ~~5111.891~~ 27586
5163.681 of the Revised Code. 27587

If the secretary approves the medicaid waiver requested under 27588
this section and the director of budget and management approves 27589
the contract, the department of ~~job and family services~~ health 27590

care administration shall enter into a contract with the 27591
department of aging under section ~~5111.91~~ 5161.05 of the Revised 27592
Code that provides for the department of aging to administer the 27593
assisted living program. The contract shall include an estimate of 27594
the program's costs. 27595

The director of ~~job and family services~~ health care 27596
administration may adopt rules under section ~~5111.85~~ 5163.50 of 27597
the Revised Code regarding the assisted living program. The 27598
director of aging may adopt rules under Chapter 119. of the 27599
Revised Code regarding the program that the rules adopted by the 27600
director of ~~job and family services~~ health care administration 27601
authorize the director of aging to adopt. 27602

Sec. ~~5111.891~~ 5163.681. To be eligible for the assisted 27603
living program, an individual must meet all of the following 27604
requirements: 27605

(A) Need an intermediate level of care as determined under 27606
rule 5101:3-3-06 of the Administrative Code; 27607

(B) At the time the individual applies for the assisted 27608
living program, be one of the following: 27609

(1) A nursing facility resident who is seeking to move to a 27610
residential care facility and would remain in a nursing facility 27611
for long term care if not for the assisted living program; 27612

(2) A participant of any of the following medicaid waiver 27613
components who would move to a nursing facility if not for the 27614
assisted living program: 27615

(a) The PASSPORT program created under section 173.40 of the 27616
Revised Code; 27617

(b) The medicaid waiver component called the choices program 27618
that the department of aging administers; 27619

(c) A medicaid waiver component that the department of ~~job~~ 27620

and ~~family services~~ health care administration administrators. 27621

(C) At the time the individual receives assisted living 27622
services under the assisted living program, reside in a 27623
residential care facility, including both of the following: 27624

(1) A residential care facility that is owned or operated by 27625
a metropolitan housing authority that has a contract with the 27626
United States department of housing and urban development to 27627
receive an operating subsidy or rental assistance for the 27628
residents of the facility; 27629

(2) A county or district home licensed as a residential care 27630
facility. 27631

(D) Meet all other eligibility requirements for the assisted 27632
living program established in rules adopted under section ~~5111.85~~ 27633
5163.50 of the Revised Code. 27634

Sec. ~~5111.892~~ 5163.682. A residential care facility providing 27635
services covered by the assisted living program to an individual 27636
enrolled in the program shall have staff on-site twenty-four hours 27637
each day who are able to do all of the following: 27638
27639

(A) Meet the scheduled and unpredicted needs of the 27640
individuals enrolled in the assisted living program in a manner 27641
that promotes the individuals' dignity and independence; 27642

(B) Provide supervision services for those individuals; 27643

(C) Help keep the individuals safe and secure. 27644

Sec. ~~5111.893~~ 5163.683. If the United States secretary of 27645
health and human services approves a medicaid waiver authorizing 27646
the assisted living program, the director of aging shall contract 27647
with a person or government entity to evaluate the program's cost 27648
effectiveness. The director shall provide the results of the 27649

evaluation to the governor, president and minority leader of the 27650
senate, and speaker and minority leader of the house of 27651
representatives not later than June 30, 2007. 27652

Sec. ~~5111.971~~ 5163.69. (A) As used in this section, 27653
"long-term care medicaid waiver component" means any of the 27654
following: 27655

(1) The PASSPORT program created under section 173.40 of the 27656
Revised Code; 27657

(2) The medicaid waiver component called the choices program 27658
that the department of aging administers; 27659

(3) A medicaid waiver component that the department of ~~job~~ 27660
~~and family services~~ health care administration administers. 27661

(B) The director of ~~job and family services~~ health care 27662
administration shall submit a request to the United States 27663
secretary of health and human services for a waiver of federal 27664
medicaid requirements that would be otherwise violated in the 27665
creation of a pilot program under which not more than two hundred 27666
individuals who meet the pilot program's eligibility requirements 27667
specified in division (D) of this section receive a spending 27668
authorization to pay for the cost of medically necessary home and 27669
community-based services that the pilot program covers. The 27670
spending authorization shall be in an amount not exceeding seventy 27671
per cent of the average cost under the medicaid program for 27672
providing nursing facility services to an individual. An 27673
individual participating in the pilot program shall also receive 27674
necessary support services, including fiscal intermediary and 27675
other case management services, that the pilot program covers. 27676

(C) If the United States secretary of health and human 27677
services approves the waiver submitted under division (B) of this 27678
section, the department of ~~job and family services~~ health care 27679

administration shall enter into a contract with the department of 27680
aging under section ~~5111.91~~ 5161.05 of the Revised Code that 27681
provides for the department of aging to administer the pilot 27682
program that the waiver authorizes. 27683

(D) To be eligible to participate in the pilot program 27684
created under division (B) of this section, an individual must 27685
meet all of the following requirements: 27686

(1) Need an intermediate level of care as determined under 27687
rule 5101:3-3-06 of the Administrative Code or a skilled level of 27688
care as determined under rule 5101:3-3-05 of the Administrative 27689
Code; 27690

(2) At the time the individual applies to participate in the 27691
pilot program, be one of the following: 27692

(a) A nursing facility resident who would remain in a nursing 27693
facility if not for the pilot program; 27694

(b) A participant of any long-term care medicaid waiver 27695
component who would move to a nursing facility if not for the 27696
pilot program. 27697

(3) Meet all other eligibility requirements for the pilot 27698
program established in rules adopted under section ~~5111.85~~ 5163.50 27699
of the Revised Code. 27700

(E) The director of ~~job and family services~~ health care 27701
administration may adopt rules under section ~~5111.85~~ 5163.50 of 27702
the Revised Code as the director considers necessary to implement 27703
the pilot program created under division (B) of this section. The 27704
director of aging may adopt rules under Chapter 119. of the 27705
Revised Code as the director considers necessary for the pilot 27706
program's implementation. The rules may establish a list of 27707
medicaid-covered services not covered by the pilot program that an 27708
individual participating in the pilot program may not receive if 27709
the individual also receives medicaid-covered services outside of 27710

the pilot program. 27711

Sec. ~~5111.97~~ 5163.73. (A) As used in this section and in 27712
section ~~5111.971~~ 5163.69 of the Revised Code, "nursing facility" 27713
has the same meaning as in section ~~5111.20~~ 5164.01 of the Revised 27714
Code. 27715

(B) To the extent funds are available, the director of ~~job~~ 27716
~~and family services~~ health care administration may establish the 27717
Ohio access success project to help medicaid recipients make the 27718
transition from residing in a nursing facility to residing in a 27719
community setting. The program may be established as a separate 27720
~~non-medicaid~~ nonmedicaid program or integrated into a new or 27721
existing program of medicaid-funded home and community-based 27722
services authorized by a waiver approved by the United States 27723
department of health and human services. The director shall permit 27724
any recipient of medicaid-funded nursing facility services to 27725
apply for participation in the program, but may limit the number 27726
of program participants. If an application is received before the 27727
applicant has been a recipient of medicaid-funded nursing facility 27728
services for six months, the director shall ensure that an 27729
assessment is conducted as soon as practicable to determine 27730
whether the applicant is eligible for participation in the 27731
program. To the maximum extent possible, the assessment and 27732
eligibility determination shall be completed not later than the 27733
date that occurs six months after the applicant became a recipient 27734
of medicaid-funded nursing facility services. 27735

(C) To be eligible for benefits under the project, a medicaid 27736
recipient must satisfy all of the following requirements: 27737

(1) Be a recipient of medicaid-funded nursing facility 27738
services, at the time of applying for the benefits; 27739

(2) Need the level of care provided by nursing facilities; 27740

(3) For participation in a ~~non-medicaid~~ nonmedicaid program, 27741
receive services to remain in the community with a projected cost 27742
not exceeding eighty per cent of the average monthly medicaid cost 27743
of a medicaid recipient in a nursing facility; 27744

(4) For participation in a program established as part of a 27745
medicaid-funded home and community-based services waiver program, 27746
meet waiver enrollment criteria. 27747

(D) If the director establishes the Ohio access success 27748
project, the benefits provided under the project may include 27749
payment of all of the following: 27750

(1) The first month's rent in a community setting; 27751

(2) Rental deposits; 27752

(3) Utility deposits; 27753

(4) Moving expenses; 27754

(5) Other expenses not covered by the medicaid program that 27755
facilitate a medicaid recipient's move from a nursing facility to 27756
a community setting. 27757

(E) If the project is established as a ~~non-medicaid~~ 27758
nonmedicaid program, no participant may receive more than two 27759
thousand dollars worth of benefits under the project. 27760

(F) The director may submit a request to the United States 27761
secretary of health and human services pursuant to ~~section 1915 of~~ 27762
~~the "Social Security Act," 79 Stat. 286 (1965),~~ 42 U.S.C. 1396n, 27763
~~as amended,~~ to create a medicaid home and community-based services 27764
waiver program to serve individuals who meet the criteria for 27765
participation in the Ohio access success project. The director may 27766
adopt rules under Chapter 119. of the Revised Code for the 27767
administration and operation of the program. 27768

Sec. ~~5111.95~~ 5163.75. (A) As used in this section: 27769

(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 27802
the five-year period immediately prior to the date the criminal 27803
records check is requested or provide evidence that within that 27804
five-year period the superintendent has requested information 27805
about the applicant from the federal bureau of investigation in a 27806
criminal records check, the chief administrator shall request that 27807
the superintendent obtain information from the federal bureau of 27808
investigation as part of the criminal records check of the 27809
applicant. Even if an applicant for whom a criminal records check 27810
request is required under this division presents proof of having 27811
been a resident of this state for the five-year period, the chief 27812
administrator may request that the superintendent include 27813
information from the federal bureau of investigation in the 27814
criminal records check. 27815

(2) A person required by division (B)(1) of this section to 27816
request a criminal records check shall do both of the following: 27817

(a) Provide to each applicant for whom a criminal records 27818
check request is required under division (B)(1) of this section a 27819
copy of the form prescribed pursuant to division (C)(1) of section 27820
109.572 of the Revised Code and a standard fingerprint impression 27821
sheet prescribed pursuant to division (C)(2) of that section, and 27822
obtain the completed form and impression sheet from the applicant; 27823

(b) Forward the completed form and impression sheet to the 27824
superintendent of the bureau of criminal identification and 27825
investigation. 27826

(3) An applicant provided the form and fingerprint impression 27827
sheet under division (B)(2)(a) of this section who fails to 27828
complete the form or provide fingerprint impressions shall not be 27829
employed in any position in a waiver agency for which a criminal 27830
records check is required by this section. 27831

(C)(1) Except as provided in rules adopted by the department 27832

of ~~job and family services~~ health care administration in 27833
accordance with division (F) of this section and subject to 27834
division (C)(2) of this section, no waiver agency shall employ a 27835
person in a position that involves providing home and 27836
community-based waiver services to persons with disabilities if 27837
the person has been convicted of or pleaded guilty to any of the 27838
following: 27839

(a) A violation of section 2903.01, 2903.02, 2903.03, 27840
2903.04, 2903.041, 2903.11, 2903.12, 2903.13, 2903.16, 2903.21, 27841
2903.34, 2905.01, 2905.02, 2905.05, 2905.11, 2905.12, 2907.02, 27842
2907.03, 2907.04, 2907.05, 2907.06, 2907.07, 2907.08, 2907.09, 27843
2907.21, 2907.22, 2907.23, 2907.25, 2907.31, 2907.32, 2907.321, 27844
2907.322, 2907.323, 2911.01, 2911.02, 2911.11, 2911.12, 2911.13, 27845
2913.02, 2913.03, 2913.04, 2913.11, 2913.21, 2913.31, 2913.40, 27846
2913.43, 2913.47, 2913.51, 2919.12, 2919.24, 2919.25, 2921.36, 27847
2923.12, 2923.13, 2923.161, 2925.02, 2925.03, 2925.04, 2925.05, 27848
2925.06, 2925.11, 2925.13, 2925.22, 2925.23, or 3716.11 of the 27849
Revised Code, felonious sexual penetration in violation of former 27850
section 2907.12 of the Revised Code, a violation of section 27851
2905.04 of the Revised Code as it existed prior to July 1, 1996, a 27852
violation of section 2919.23 of the Revised Code that would have 27853
been a violation of section 2905.04 of the Revised Code as it 27854
existed prior to July 1, 1996, had the violation been committed 27855
prior to that date; 27856

(b) An existing or former law of this state, any other state, 27857
or the United States that is substantially equivalent to any of 27858
the offenses listed in division (C)(1)(a) of this section. 27859

(2)(a) A waiver agency may employ conditionally an applicant 27860
for whom a criminal records check request is required under 27861
division (B) of this section prior to obtaining the results of a 27862
criminal records check regarding the individual, provided that the 27863
agency shall request a criminal records check regarding the 27864

individual in accordance with division (B)(1) of this section not 27865
later than five business days after the individual begins 27866
conditional employment. 27867

(b) A waiver agency that employs an individual conditionally 27868
under authority of division (C)(2)(a) of this section shall 27869
terminate the individual's employment if the results of the 27870
criminal records check request under division (B) of this section, 27871
other than the results of any request for information from the 27872
federal bureau of investigation, are not obtained within the 27873
period ending sixty days after the date the request is made. 27874
Regardless of when the results of the criminal records check are 27875
obtained, if the results indicate that the individual has been 27876
convicted of or pleaded guilty to any of the offenses listed or 27877
described in division (C)(1) of this section, the agency shall 27878
terminate the individual's employment unless the agency chooses to 27879
employ the individual pursuant to division (F) of this section. 27880

(D)(1) Each waiver agency shall pay to the bureau of criminal 27881
identification and investigation the fee prescribed pursuant to 27882
division (C)(3) of section 109.572 of the Revised Code for each 27883
criminal records check conducted pursuant to a request made under 27884
division (B) of this section. 27885

(2) A waiver agency may charge an applicant a fee not 27886
exceeding the amount the agency pays under division (D)(1) of this 27887
section. An agency may collect a fee only if the agency notifies 27888
the person at the time of initial application for employment of 27889
the amount of the fee and that, unless the fee is paid, the person 27890
will not be considered for employment. 27891

(E) The report of any criminal records check conducted 27892
pursuant to a request made under this section is not a public 27893
record for the purposes of section 149.43 of the Revised Code and 27894
shall not be made available to any person other than the 27895
following: 27896

(1) The individual who is the subject of the criminal records check or the individual's representative; 27897
27898

(2) The chief administrator of the agency requesting the criminal records check or the administrator's representative; 27899
27900

(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. 27901
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(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. 27905
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(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. 27911
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(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. 27918
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(2) This section shall not apply to a person to whom all of the following apply: 27925
27926

(a) On ~~the effective date of this section~~ September 26, 2003, 27927

the person is an employee of a waiver agency in a full-time, 27928
part-time, or temporary position that involves providing home and 27929
community-based waiver services to a person with disabilities. 27930

(b) The person previously had been the subject of a criminal 27931
background check relating to that position; 27932

(c) The person has been continuously employed in that 27933
position since that criminal background check had been conducted. 27934

Sec. ~~5111.96~~ 5163.76. (A) As used in this section: 27935

(1) "Anniversary date" means the later of the effective date 27936
of the provider agreement relating to the independent provider or 27937
sixty days after ~~the effective date of this section~~ September 26, 27938
2003. 27939

(2) "Criminal records check" has the same meaning as in 27940
section 109.572 of the Revised Code. 27941

(3) "The department" means the department of ~~job and family~~ 27942
~~services~~ health care administration or its designee. 27943

(4) "Independent provider" means a person who is submitting 27944
an application for a provider agreement or who has a provider 27945
agreement as an independent provider in a department of ~~job and~~ 27946
~~family services~~ health care administration administered home and 27947
community-based services program providing home and 27948
community-based waiver services to consumers with disabilities. 27949

(5) "Home and community-based waiver services" has the same 27950
meaning as in section ~~5111.95~~ 5163.75 of the Revised Code. 27951

(B)(1) The department shall inform each independent provider, 27952
at the time of initial application for a provider agreement that 27953
involves providing home and community-based waiver services to 27954
consumers with disabilities, that the independent provider is 27955
required to provide a set of fingerprint impressions and that a 27956
criminal records check is required to be conducted if the person 27957

is to become an independent provider in a department administered 27958
home and community-based waiver program. 27959

(2) Beginning on ~~the effective date of this section~~ September 27960
26, 2003, the department shall inform each enrolled medicaid 27961
independent provider on or before time of the anniversary date of 27962
the provider agreement that involves providing home and 27963
community-based waiver services to consumers with disabilities 27964
that the independent provider is required to provide a set of 27965
fingerprint impressions and that a criminal records check is 27966
required to be conducted. 27967

(C)(1) The department shall require the independent provider 27968
to complete a criminal records check prior to entering into a 27969
provider agreement with the independent provider and at least 27970
annually thereafter. If an independent provider for whom a 27971
criminal records check is required under this division does not 27972
present proof of having been a resident of this state for the 27973
five-year period immediately prior to the date the criminal 27974
records check is requested or provide evidence that within that 27975
five-year period the superintendent has requested information 27976
about the applicant from the federal bureau of investigation in a 27977
criminal records check, the department shall request the 27978
independent provider obtain through the superintendent a criminal 27979
records request from the federal bureau of investigation as part 27980
of the criminal records check of the independent provider. Even if 27981
an independent provider for whom a criminal records check request 27982
is required under this division presents proof of having been a 27983
resident of this state for the five-year period, the department 27984
may request that the independent provider obtain information 27985
through the superintendent from the federal bureau of 27986
investigation in the criminal records check. 27987

(2) The department shall do both of the following: 27988

(a) Provide information to each independent provider for whom 27989

a criminal records check request is required under division (C)(1) 27990
of this section about requesting a copy of the form prescribed 27991
pursuant to division (C)(1) of section 109.572 of the Revised Code 27992
and a standard fingerprint impression sheet prescribed pursuant to 27993
division (C)(2) of that section, and obtain the completed form and 27994
impression sheet and fee from the independent provider; 27995

(b) Forward the completed form, impression sheet, and fee to 27996
the superintendent of the bureau of criminal identification and 27997
investigation. 27998

(3) An independent provider given information about obtaining 27999
the form and fingerprint impression sheet under division (C)(2)(a) 28000
of this section who fails to complete the form or provide 28001
fingerprint impressions shall not be approved as an independent 28002
provider. 28003

(D) Except as provided in rules adopted by the department in 28004
accordance with division (G) of this section, the department shall 28005
not issue a new provider agreement to, and shall terminate an 28006
existing provider agreement of, an independent provider if the 28007
person has been convicted of or pleaded guilty to any of the 28008
following: 28009

(1) A violation of section 2903.01, 2903.02, 2903.03, 28010
2903.04, 2903.041, 2903.11, 2903.12, 2903.13, 2903.16, 2903.21, 28011
2903.34, 2905.01, 2905.02, 2905.05, 2905.11, 2905.12, 2907.02, 28012
2907.03, 2907.04, 2907.05, 2907.06, 2907.07, 2907.08, 2907.09, 28013
2907.21, 2907.22, 2907.23, 2907.25, 2907.31, 2907.32, 2907.321, 28014
2907.322, 2907.323, 2911.01, 2911.02, 2911.11, 2911.12, 2911.13, 28015
2913.02, 2913.03, 2913.04, 2913.11, 2913.21, 2913.31, 2913.40, 28016
2913.43, 2913.47, 2913.51, 2919.12, 2919.24, 2919.25, 2921.36, 28017
2923.12, 2923.13, 2923.161, 2925.02, 2925.03, 2925.04, 2925.05, 28018
2925.06, 2925.11, 2925.13, 2925.22, 2925.23, or 3716.11 of the 28019
Revised Code, felonious sexual penetration in violation of former 28020
section 2907.12 of the Revised Code, a violation of section 28021

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 28053
standards set by the department. 28054

Sec. ~~5111.20~~ 5164.01. As used in sections ~~5111.20~~ 5164.01 to 28055
~~5111.34~~ 5164.47 of the Revised Code: 28056

(A) "Allowable costs" are those costs determined by the 28057
department of ~~job and family services~~ health care administration 28058
to be reasonable and do not include fines paid under sections 28059
~~5111.35~~ 5164.50 to ~~5111.61~~ 5164.78 and section ~~5111.99~~ 5164.99 of 28060
the Revised Code. 28061

(B) "Ancillary and support costs" means all reasonable costs 28062
incurred by a nursing facility other than direct care costs or 28063
capital costs. "Ancillary and support costs" includes, but is not 28064
limited to, costs of activities, social services, pharmacy 28065
consultants, habilitation supervisors, qualified mental 28066
retardation professionals, program directors, medical and 28067
habilitation records, program supplies, incontinence supplies, 28068
food, enterals, dietary supplies and personnel, laundry, 28069
housekeeping, security, administration, medical equipment, 28070
utilities, liability insurance, bookkeeping, purchasing 28071
department, human resources, communications, travel, dues, license 28072
fees, subscriptions, home office costs not otherwise allocated, 28073
legal services, accounting services, minor equipment, maintenance 28074
and repairs, help-wanted advertising, informational advertising, 28075
start-up costs, organizational expenses, other interest, property 28076
insurance, employee training and staff development, employee 28077
benefits, payroll taxes, and workers' compensation premiums or 28078
costs for self-insurance claims and related costs as specified in 28079
rules adopted ~~by the director of job and family services~~ under 28080
section ~~5111.02~~ 5163.15 of the Revised Code, for personnel listed 28081
in this division. "Ancillary and support costs" also means the 28082
cost of equipment, including vehicles, acquired by operating lease 28083

executed before December 1, 1992, if the costs are reported as 28084
administrative and general costs on the facility's cost report for 28085
the cost reporting period ending December 31, 1992. 28086

(C) "Capital costs" means costs of ownership and, in the case 28087
of an intermediate care facility for the mentally retarded, costs 28088
of nonextensive renovation. 28089

(1) "Cost of ownership" means the actual expense incurred for 28090
all of the following: 28091

(a) Depreciation and interest on any capital assets that cost 28092
five hundred dollars or more per item, including the following: 28093

(i) Buildings; 28094

(ii) Building improvements that are not approved as 28095
nonextensive renovations under section ~~5111.251~~ 5164.08 of the 28096
Revised Code; 28097

(iii) Except as provided in division (B) of this section, 28098
equipment; 28099

(iv) In the case of an intermediate care facility for the 28100
mentally retarded, extensive renovations; 28101

(v) Transportation equipment. 28102

(b) Amortization and interest on land improvements and 28103
leasehold improvements; 28104

(c) Amortization of financing costs; 28105

(d) Except as provided in division (K) of this section, lease 28106
and rent of land, building, and equipment. 28107

The costs of capital assets of less than five hundred dollars 28108
per item may be considered capital costs in accordance with a 28109
provider's practice. 28110

(2) "Costs of nonextensive renovation" means the actual 28111
expense incurred by an intermediate care facility for the mentally 28112

retarded for depreciation or amortization and interest on 28113
renovations that are not extensive renovations. 28114

(D) "Capital lease" and "operating lease" shall be construed 28115
in accordance with generally accepted accounting principles. 28116

(E) "Case-mix score" means the measure determined under 28117
section 5164.051 of the Revised Code of the relative direct-care 28118
resources needed to provide care and habilitation to a resident of 28119
an intermediate care facility for the mentally retarded and the 28120
measure determined under section ~~5111.232~~ 5164.191 of the Revised 28121
Code of the relative direct-care resources needed to provide care 28122
and habilitation to a resident of a nursing facility ~~or~~ 28123
~~intermediate care facility for the mentally retarded.~~ 28124

(F) "Date of licensure," for a facility originally licensed 28125
as a nursing home under Chapter 3721. of the Revised Code, means 28126
the date specific beds were originally licensed as nursing home 28127
beds under that chapter, regardless of whether they were 28128
subsequently licensed as residential facility beds under section 28129
5123.19 of the Revised Code. For a facility originally licensed as 28130
a residential facility under section 5123.19 of the Revised Code, 28131
"date of licensure" means the date specific beds were originally 28132
licensed as residential facility beds under that section. 28133

(1) If nursing home beds licensed under Chapter 3721. of the 28134
Revised Code or residential facility beds licensed under section 28135
5123.19 of the Revised Code were not required by law to be 28136
licensed when they were originally used to provide nursing home or 28137
residential facility services, "date of licensure" means the date 28138
the beds first were used to provide nursing home or residential 28139
facility services, regardless of the date the present provider 28140
obtained licensure. 28141

(2) If a facility adds nursing home beds or residential 28142
facility beds or extensively renovates all or part of the facility 28143

after its original date of licensure, it will have a different 28144
date of licensure for the additional beds or extensively renovated 28145
portion of the facility, unless the beds are added in a space that 28146
was constructed at the same time as the previously licensed beds 28147
but was not licensed under Chapter 3721. or section 5123.19 of the 28148
Revised Code at that time. 28149

(G) "Desk-reviewed" means that costs as reported on a cost 28150
report submitted under section ~~5111.26~~ 5164.37 of the Revised Code 28151
have been subjected to a desk review under division (A) of section 28152
~~5111.27~~ 5164.38 of the Revised Code and preliminarily determined 28153
to be allowable costs. 28154

(H) "Direct care costs" means all of the following: 28155

(1)(a) Costs for registered nurses, licensed practical 28156
nurses, and nurse aides employed by the facility; 28157

(b) Costs for direct care staff, administrative nursing 28158
staff, medical directors, respiratory therapists, and except as 28159
provided in division (H)(2) of this section, other persons holding 28160
degrees qualifying them to provide therapy; 28161

(c) Costs of purchased nursing services; 28162

(d) Costs of quality assurance; 28163

(e) Costs of training and staff development, employee 28164
benefits, payroll taxes, and workers' compensation premiums or 28165
costs for self-insurance claims and related costs as specified in 28166
rules adopted ~~by the director of job and family services in~~ 28167
~~accordance with Chapter 119. under section 5163.15~~ of the Revised 28168
Code, for personnel listed in divisions (H)(1)(a), (b), and (d) of 28169
this section; 28170

(f) Costs of consulting and management fees related to direct 28171
care; 28172

(g) Allocated direct care home office costs. 28173

(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 28205
habilitation records, program supplies, incontinence supplies, 28206
food, enterals, dietary supplies and personnel, laundry, 28207
housekeeping, security, administration, liability insurance, 28208
bookkeeping, purchasing department, human resources, 28209
communications, travel, dues, license fees, subscriptions, home 28210
office costs not otherwise allocated, legal services, accounting 28211
services, minor equipment, maintenance and repairs, help-wanted 28212
advertising, informational advertising, start-up costs, 28213
organizational expenses, other interest, property insurance, 28214
employee training and staff development, employee benefits, 28215
payroll taxes, and workers' compensation premiums or costs for 28216
self-insurance claims and related costs as specified in rules 28217
adopted under section ~~5111.02~~ 5163.15 of the Revised Code, for 28218
personnel listed in this division. Notwithstanding division (C)(1) 28219
of this section, "indirect care costs" also means the cost of 28220
equipment, including vehicles, acquired by operating lease 28221
executed before December 1, 1992, if the costs are reported as 28222
administrative and general costs on the facility's cost report for 28223
the cost reporting period ending December 31, 1992. 28224

(L) "Inpatient days" means all days during which a resident, 28225
regardless of payment source, occupies a bed in a nursing facility 28226
or intermediate care facility for the mentally retarded that is 28227
included in the facility's certified capacity under Title XIX. 28228
Therapeutic or hospital leave days for which payment is made under 28229
section ~~5111.33~~ 5164.35 of the Revised Code are considered 28230
inpatient days proportionate to the percentage of the facility's 28231
per resident per day rate paid for those days. 28232

(M) "Intermediate care facility for the mentally retarded" 28233
means an intermediate care facility for the mentally retarded 28234
certified as in compliance with applicable standards for the 28235
medicaid program by the director of health in accordance with 28236

Title XIX.	28237
(N) "Maintenance and repair expenses" means, except as	28238
provided in division (BB)(2) of this section, expenditures that	28239
are necessary and proper to maintain an asset in a normally	28240
efficient working condition and that do not extend the useful life	28241
of the asset two years or more. "Maintenance and repair expenses"	28242
includes but is not limited to the cost of ordinary repairs such	28243
as painting and wallpapering.	28244
(O) "Medicaid days" means all days during which a resident	28245
who is a Medicaid recipient eligible for nursing facility services	28246
occupies a bed in a nursing facility that is included in the	28247
nursing facility's certified capacity under Title XIX. Therapeutic	28248
or hospital leave days for which payment is made under section	28249
5111.33 <u>5164.35</u> of the Revised Code are considered Medicaid days	28250
proportionate to the percentage of the nursing facility's per	28251
resident per day rate paid for those days.	28252
(P) "Nursing facility" means a facility, or a distinct part	28253
of a facility, that is certified as a nursing facility by the	28254
director of health in accordance with Title XIX for the medicaid	28255
<u>program</u> and is not an intermediate care facility for the mentally	28256
retarded. "Nursing facility" includes a facility, or a distinct	28257
part of a facility, that is certified as a nursing facility by the	28258
director of health in accordance with Title XIX for the medicaid	28259
<u>program</u> and is certified as a skilled nursing facility by the	28260
director in accordance with Title XVIII for the medicare program.	28261
(Q) "Operator" means the person or government entity	28262
responsible for the daily operating and management decisions for a	28263
nursing facility or intermediate care facility for the mentally	28264
retarded.	28265
(R) "Other protected costs" means costs incurred by an	28266
intermediate care facility for the mentally retarded for medical	28267

supplies; real estate, franchise, and property taxes; natural gas, 28268
fuel oil, water, electricity, sewage, and refuse and hazardous 28269
medical waste collection; allocated other protected home office 28270
costs; and any additional costs defined as other protected costs 28271
in rules adopted under section ~~5111.02~~ 5163.15 of the Revised 28272
Code. 28273

(S)(1) "Owner" means any person or government entity that has 28274
at least five per cent ownership or interest, either directly, 28275
indirectly, or in any combination, in any of the following 28276
regarding a nursing facility or intermediate care facility for the 28277
mentally retarded: 28278

(a) The land on which the facility is located; 28279

(b) The structure in which the facility is located; 28280

(c) Any mortgage, contract for deed, or other obligation 28281
secured in whole or in part by the land or structure on or in 28282
which the facility is located; 28283

(d) Any lease or sublease of the land or structure on or in 28284
which the facility is located. 28285

(2) "Owner" does not mean a holder of a debenture or bond 28286
related to the nursing facility or intermediate care facility for 28287
the mentally retarded and purchased at public issue or a regulated 28288
lender that has made a loan related to the facility unless the 28289
holder or lender operates the facility directly or through a 28290
subsidiary. 28291

(T) "Patient" includes "resident." 28292

(U) Except as provided in divisions (U)(1) and (2) of this 28293
section, "per diem" means a nursing facility's or intermediate 28294
care facility for the mentally retarded's actual, allowable costs 28295
in a given cost center in a cost reporting period, divided by the 28296
facility's inpatient days for that cost reporting period. 28297

(1) When calculating indirect care costs for the purpose of 28298
establishing rates under section ~~5111.241~~ 5164.07 of the Revised 28299
Code, "per diem" means an intermediate care facility for the 28300
mentally retarded's actual, allowable indirect care costs in a 28301
cost reporting period divided by the greater of the facility's 28302
inpatient days for that period or the number of inpatient days the 28303
facility would have had during that period if its occupancy rate 28304
had been eighty-five per cent. 28305

(2) When calculating capital costs for the purpose of 28306
establishing rates under section ~~5111.251~~ 5164.08 of the Revised 28307
Code, "per diem" means a facility's actual, allowable capital 28308
costs in a cost reporting period divided by the greater of the 28309
facility's inpatient days for that period or the number of 28310
inpatient days the facility would have had during that period if 28311
its occupancy rate had been ninety-five per cent. 28312

(V) "Provider" means an operator with a provider agreement. 28313

(W) "Provider agreement" means a contract between the 28314
department of ~~job and family services~~ health care administration 28315
and the operator of a nursing facility or intermediate care 28316
facility for the mentally retarded for the provision of nursing 28317
facility services or intermediate care facility services for the 28318
mentally retarded under the medicaid program. 28319

(X) "Purchased nursing services" means services that are 28320
provided in a nursing facility by registered nurses, licensed 28321
practical nurses, or nurse aides who are not employees of the 28322
facility. 28323

(Y) "Reasonable" means that a cost is an actual cost that is 28324
appropriate and helpful to develop and maintain the operation of 28325
patient care facilities and activities, including normal standby 28326
costs, and that does not exceed what a prudent buyer pays for a 28327
given item or services. Reasonable costs may vary from provider to 28328

provider and from time to time for the same provider. 28329

(Z) "Related party" means an individual or organization that, 28330
to a significant extent, has common ownership with, is associated 28331
or affiliated with, has control of, or is controlled by, the 28332
provider. 28333

(1) An individual who is a relative of an owner is a related 28334
party. 28335

(2) Common ownership exists when an individual or individuals 28336
possess significant ownership or equity in both the provider and 28337
the other organization. Significant ownership or equity exists 28338
when an individual or individuals possess five per cent ownership 28339
or equity in both the provider and a supplier. Significant 28340
ownership or equity is presumed to exist when an individual or 28341
individuals possess ten per cent ownership or equity in both the 28342
provider and another organization from which the provider 28343
purchases or leases real property. 28344

(3) Control exists when an individual or organization has the 28345
power, directly or indirectly, to significantly influence or 28346
direct the actions or policies of an organization. 28347

(4) An individual or organization that supplies goods or 28348
services to a provider shall not be considered a related party if 28349
all of the following conditions are met: 28350

(a) The supplier is a separate bona fide organization. 28351

(b) A substantial part of the supplier's business activity of 28352
the type carried on with the provider is transacted with others 28353
than the provider and there is an open, competitive market for the 28354
types of goods or services the supplier furnishes. 28355

(c) The types of goods or services are commonly obtained by 28356
other nursing facilities or intermediate care facilities for the 28357
mentally retarded from outside organizations and are not a basic 28358

element of patient care ordinarily furnished directly to patients 28359
by the facilities. 28360

(d) The charge to the provider is in line with the charge for 28361
the goods or services in the open market and no more than the 28362
charge made under comparable circumstances to others by the 28363
supplier. 28364

(AA) "Relative of owner" means an individual who is related 28365
to an owner of a nursing facility or intermediate care facility 28366
for the mentally retarded by one of the following relationships: 28367

(1) Spouse; 28368

(2) Natural parent, child, or sibling; 28369

(3) Adopted parent, child, or sibling; 28370

(4) Stepparent, stepchild, stepbrother, or stepsister; 28371

(5) Father-in-law, mother-in-law, son-in-law, 28372
daughter-in-law, brother-in-law, or sister-in-law; 28373

(6) Grandparent or grandchild; 28374

(7) Foster caregiver, foster child, foster brother, or foster 28375
sister. 28376

(BB) "Renovation" and "extensive renovation" mean: 28377

(1) Any betterment, improvement, or restoration of an 28378
intermediate care facility for the mentally retarded started 28379
before July 1, 1993, that meets the definition of a renovation or 28380
extensive renovation established in rules ~~adopted by the director~~ 28381
~~of job and family services~~ in effect on December 22, 1992. 28382

(2) In the case of betterments, improvements, and 28383
restorations of intermediate care facilities for the mentally 28384
retarded started on or after July 1, 1993: 28385

(a) "Renovation" means the betterment, improvement, or 28386
restoration of an intermediate care facility for the mentally 28387

retarded beyond its current functional capacity through a 28388
structural change that costs at least five hundred dollars per 28389
bed. A renovation may include betterment, improvement, 28390
restoration, or replacement of assets that are affixed to the 28391
building and have a useful life of at least five years. A 28392
renovation may include costs that otherwise would be considered 28393
maintenance and repair expenses if they are an integral part of 28394
the structural change that makes up the renovation project. 28395
"Renovation" does not mean construction of additional space for 28396
beds that will be added to a facility's licensed or certified 28397
capacity. 28398

(b) "Extensive renovation" means a renovation that costs more 28399
than sixty-five per cent and no more than eighty-five per cent of 28400
the cost of constructing a new bed and that extends the useful 28401
life of the assets for at least ten years. 28402

For the purposes of division (BB)(2) of this section, the 28403
cost of constructing a new bed shall be considered to be forty 28404
thousand dollars, adjusted for the estimated rate of inflation 28405
from January 1, 1993, to the end of the calendar year during which 28406
the renovation is completed, using the consumer price index for 28407
shelter costs for all urban consumers for the north central 28408
region, as published by the United States bureau of labor 28409
statistics. 28410

The department of ~~job and family services~~ health care 28411
administration may treat a renovation that costs more than 28412
eighty-five per cent of the cost of constructing new beds as an 28413
extensive renovation if the department determines that the 28414
renovation is more prudent than construction of new beds. 28415

(CC) "Title XIX" means Title XIX of the "Social Security 28416
Act," 79 Stat. 286 (1965), 42 U.S.C. 1396, as amended. 28417

(DD) "Title XVIII" means Title XVIII of the "Social Security 28418

Act," 79 Stat. 286 (1965), 42 U.S.C. 1395, as amended. 28419

Sec. ~~5111.201~~ 5164.011. Whenever "skilled nursing facility," 28420
"intermediate care facility," or "dual skilled nursing and 28421
intermediate care facility" is referred to or designated in any 28422
statute, rule, contract, provider agreement, or other document 28423
pertaining to the ~~medical assistance~~ medicaid program, the 28424
reference or designation is deemed to refer to a nursing facility, 28425
except that a reference to or designation of an "intermediate care 28426
facility for the mentally retarded" is not deemed to refer to a 28427
nursing facility. 28428

Sec. ~~5111.21~~ 5164.02. (A) In order to be eligible for 28429
medicaid payments, the operator of a nursing facility or 28430
intermediate care facility for the mentally retarded shall do all 28431
of the following: 28432

(1) Enter into a provider agreement with the department of 28433
health care administration as provided in section ~~5111.22~~ 5164.03, 28434
~~5111.671~~ 5164.841, or ~~5111.672~~ 5164.842 of the Revised Code; 28435

(2) Apply for and maintain a valid license to operate if so 28436
required by law; 28437

(3) Comply with all applicable state and federal laws and 28438
rules. 28439

(B)(1) Except as provided in division (B)(2) of this section, 28440
the operator of a nursing facility that elects to obtain and 28441
maintain eligibility for payments under the medicaid program shall 28442
qualify all of the facility's medicaid-certified beds in the 28443
medicare program ~~established by Title XVIII~~. The director of ~~job~~ 28444
~~and family services~~ health care administration may adopt rules 28445
under section ~~5111.02~~ 5163.15 of the Revised Code to establish the 28446
time frame in which a nursing facility must comply with this 28447
requirement. 28448

(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 28479
eligible to be medicaid recipients; 28480

(7) Comply with section ~~5111.31~~ 5164.033 of the Revised Code. 28481

The provider agreement may contain other provisions that are 28482
consistent with law and considered necessary by the department. 28483

A provider agreement shall be effective for no longer than 28484
twelve months, except that if federal statute or regulations 28485
authorize a longer term, it may be effective for a longer term so 28486
authorized. A provider agreement may be renewed only if the 28487
facility is certified by the department of health for 28488
participation in the medicaid program. 28489

The department of ~~job and family services~~ health care 28490
administration, in accordance with rules adopted under section 28491
~~5111.02~~ 5163.15 of the Revised Code, may elect not to enter into, 28492
not to renew, or to terminate a provider agreement when the 28493
department determines that such an agreement would not be in the 28494
best interests of medicaid recipients or of the state. 28495

Sec. ~~5111.223~~ 5164.031. The operator of a nursing facility or 28496
intermediate care facility for the mentally retarded may enter 28497
into provider agreements for more than one nursing facility or 28498
intermediate care facility for the mentally retarded. 28499

Sec. ~~5111.30~~ 5164.032. The department of ~~job and family~~ 28500
~~services~~ health care administration shall terminate the provider 28501
agreement with a provider that does not comply with the 28502
requirements of section 3721.071 of the Revised Code for the 28503
installation of fire extinguishing and fire alarm systems. 28504

Sec. ~~5111.31~~ 5164.033. (A) Every provider agreement with the 28505
provider of a nursing facility or intermediate care facility for 28506
the mentally retarded shall: 28507

(1) Prohibit the provider from failing or refusing to retain 28508
as a patient any person because the person is, becomes, or may, as 28509
a patient in the facility, become a medicaid recipient. For the 28510
purposes of this division, a medicaid recipient who is a patient 28511
in a facility shall be considered a patient in the facility during 28512
any hospital stays totaling less than twenty-five days during any 28513
twelve-month period. Recipients who have been identified by the 28514
department of ~~job and family services~~ health care administration 28515
or its designee as requiring the level of care of an intermediate 28516
care facility for the mentally retarded shall not be subject to a 28517
maximum period of absences during which they are considered 28518
patients if prior authorization of the department for visits with 28519
relatives and friends and participation in therapeutic programs is 28520
obtained under rules adopted under section ~~5111.02~~ 5163.15 of the 28521
Revised Code. 28522

(2) Except as provided by division (B)(1) of this section, 28523
include any part of the facility that meets standards for 28524
certification of compliance with federal and state laws and rules 28525
for participation in the medicaid program. 28526

(3) Prohibit the provider from discriminating against any 28527
patient on the basis of race, color, sex, creed, or national 28528
origin. 28529

(4) Except as otherwise prohibited under section ~~5111.55~~ 28530
5164.71 of the Revised Code, prohibit the provider from failing or 28531
refusing to accept a patient because the patient is, becomes, or 28532
may, as a patient in the facility, become a medicaid recipient if 28533
less than eighty per cent of the patients in the facility are 28534
medicaid recipients. 28535

(B)(1) Except as provided by division (B)(2) of this section, 28536
the following are not required to be included in a provider 28537
agreement unless otherwise required by federal law: 28538

(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; 28539
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(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; 28542
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(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. 28546
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(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. 28550
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(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. 28555
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(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. 28562
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(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. 28566
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(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 28601
that brings an action on behalf of a patient actual damages, 28602
costs, and reasonable attorney's fees. 28603

Sec. ~~5111.23~~ 5164.05. (A) The department of ~~job and family~~ 28604
~~services~~ health care administration shall pay a provider for each 28605
of the provider's eligible intermediate care facilities for the 28606
mentally retarded a per resident per day rate for direct care 28607
costs established prospectively for each facility. The department 28608
shall establish each facility's rate for direct care costs 28609
quarterly. 28610

(B) Each facility's rate for direct care costs shall be based 28611
on the facility's cost per case-mix unit, subject to the maximum 28612
costs per case-mix unit established under division (B)(2) of this 28613
section, from the calendar year preceding the fiscal year in which 28614
the rate is paid. To determine the rate, the department shall do 28615
all of the following: 28616

(1) Determine each facility's cost per case-mix unit for the 28617
calendar year preceding the fiscal year in which the rate will be 28618
paid by dividing the facility's desk-reviewed, actual, allowable, 28619
per diem direct care costs for that year by its average case-mix 28620
score determined under section ~~5111.232~~ 5164.051 of the Revised 28621
Code for the same calendar year. 28622

(2)(a) Set the maximum cost per case-mix unit for each peer 28623
group of intermediate care facilities for the mentally retarded 28624
with more than eight beds specified in rules adopted under 28625
division (E) of this section at a percentage above the cost per 28626
case-mix unit of the facility in the group that has the group's 28627
median medicaid inpatient day for the calendar year preceding the 28628
fiscal year in which the rate will be paid, as calculated under 28629
division (B)(1) of this section, that is no less than the 28630
percentage calculated under division (D)(2) of this section. 28631

(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 28664
maximum cost per case-mix units or percentage only if it made an 28665
error in computing the maximum cost per case-mix unit or 28666
percentage based on information available at the time of the 28667
original calculation. 28668

(C) Each facility's rate for direct care costs shall be 28669
determined as follows for each calendar quarter within a fiscal 28670
year: 28671

(1) Multiply the lesser of the following by the facility's 28672
average case-mix score determined under section ~~5111.232~~ 5164.051 28673
of the Revised Code for the calendar quarter that preceded the 28674
immediately preceding calendar quarter: 28675

(a) The facility's cost per case-mix unit for the calendar 28676
year preceding the fiscal year in which the rate will be paid, as 28677
determined under division (B)(1) of this section; 28678

(b) The maximum cost per case-mix unit established for the 28679
fiscal year in which the rate will be paid for the facility's peer 28680
group under division (B)(2) of this section; 28681

(2) Adjust the product determined under division (C)(1) of 28682
this section by the inflation rate estimated under division (B)(3) 28683
of this section. 28684

(D)(1) The department shall calculate the percentage above 28685
the median cost per case-mix unit determined under division (B)(1) 28686
of this section for the facility that has the median medicaid 28687
inpatient day for calendar year 1992 for all intermediate care 28688
facilities for the mentally retarded with more than eight beds 28689
that would result in payment of all desk-reviewed, actual, 28690
allowable direct care costs for eighty and one-half per cent of 28691
the medicaid inpatient days for such facilities for calendar year 28692
1992. 28693

(2) The department shall calculate the percentage above the 28694

median cost per case-mix unit determined under division (B)(1) of 28695
this section for the facility that has the median medicaid 28696
inpatient day for calendar year 1992 for all intermediate care 28697
facilities for the mentally retarded with eight or fewer beds that 28698
would result in payment of all desk-reviewed, actual, allowable 28699
direct care costs for eighty and one-half per cent of the medicaid 28700
inpatient days for such facilities for calendar year 1992. 28701

(E) The director of ~~job and family services~~ health care 28702
administration shall adopt rules under section ~~5111.02~~ 5163.15 of 28703
the Revised Code that specify peer groups of intermediate care 28704
facilities for the mentally retarded with more than eight beds and 28705
intermediate care facilities for the mentally retarded with eight 28706
or fewer beds, based on findings of significant per diem direct 28707
care cost differences due to geography and facility bed-size. The 28708
rules also may specify peer groups based on findings of 28709
significant per diem direct care cost differences due to other 28710
factors which may include case-mix. 28711

(F) The department, in accordance with division ~~(D)~~(C) of 28712
section ~~5111.232~~ 5164.051 of the Revised Code and rules adopted 28713
under division ~~(E)~~(D) of that section, may assign case-mix scores 28714
or costs per case-mix unit if a provider fails to submit 28715
assessment data necessary to calculate an intermediate care 28716
facility for the mentally retarded's case-mix score in accordance 28717
with that section. 28718

Sec. 5164.051. (A) The department of health care 28719
administration shall determine case-mix scores for intermediate 28720
care facilities for the mentally retarded using data for each 28721
resident, regardless of payment source, from a resident assessment 28722
instrument and grouper methodology prescribed in rules adopted 28723
under section 5163.15 of the Revised Code and expressed in 28724
case-mix values established by the department in those rules. 28725

(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 28758
preceding quarter. 28759

The department may use a quarterly average case-mix score 28760
assigned under division (C)(1) of this section, instead of a 28761
quarterly average case-mix score calculated based on the 28762
provider's submitted information, to calculate the facility's rate 28763
for direct care costs being established under section 5164.05 of 28764
the Revised Code for one or more months, as specified in rules 28765
authorized by division (D) of this section, of the quarter for 28766
which the rate established under section 5164.05 of the Revised 28767
Code will be paid. 28768

Before taking action under division (C)(1) of this section, 28769
the department shall permit the provider a reasonable period of 28770
time, specified in rules authorized by division (D) of this 28771
section, to correct the information. The department shall not 28772
assign a quarterly average case-mix score due to late submission 28773
of corrections to assessment information unless the provider fails 28774
to submit corrected information prior to the eighty-first day 28775
after the end of the calendar quarter to which the information 28776
pertains. 28777

(2) If a provider is paid a rate for an intermediate care 28778
facility for the mentally retarded calculated using a quarterly 28779
average case-mix score assigned under division (C)(1) of this 28780
section for more than six months in a calendar year, the 28781
department may assign the facility a cost per case-mix unit that 28782
is five per cent less than the facility's actual or assigned cost 28783
per case-mix unit for the preceding calendar year. The department 28784
may use the assigned cost per case-mix unit, instead of 28785
calculating the facility's actual cost per case-mix unit in 28786
accordance with section 5164.05 of the Revised Code, to establish 28787
the facility's rate for direct care costs for the following fiscal 28788
year. 28789

(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. 28790
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(D) The director shall adopt rules under section 5163.15 of the Revised Code that do all of the following: 28795
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(1) Specify the medium or media through which the completed assessment data shall be submitted; 28797
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(2) Establish procedures under which the assessment data shall be reviewed for accuracy and providers shall be notified of any data that requires correction; 28799
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(3) Establish procedures for providers to correct assessment data and specify a reasonable period of time by which providers shall submit the corrections. 28802
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(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. 28805
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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 28816
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costs established prospectively each fiscal year for each 28820
facility. The rate for each facility shall be the facility's 28821
desk-reviewed, actual, allowable, per diem other protected costs 28822
from the calendar year preceding the fiscal year in which the rate 28823
will be paid, all adjusted for the estimated inflation rate for 28824
the eighteen-month period beginning on the first day of July of 28825
the calendar year preceding the fiscal year in which the rate will 28826
be paid and ending on the thirty-first day of December of that 28827
fiscal year. The department shall estimate inflation using the 28828
consumer price index for all urban consumers for nonprescription 28829
drugs and medical supplies, as published by the United States 28830
bureau of labor statistics. If the estimated inflation rate for 28831
the eighteen-month period is different from the actual inflation 28832
rate for that period, the difference shall be added to or 28833
subtracted from the inflation rate estimated for the following 28834
year. 28835

Sec. ~~5111.241~~ 5164.07. (A) The department of ~~job and family~~ 28836
~~services~~ health care administration shall pay a provider for each 28837
of the provider's eligible intermediate care facilities for the 28838
mentally retarded a per resident per day rate for indirect care 28839
costs established prospectively each fiscal year for each 28840
facility. The rate for each intermediate care facility for the 28841
mentally retarded shall be the sum of the following, but shall not 28842
exceed the maximum rate established for the facility's peer group 28843
under division (B) of this section: 28844

(1) The facility's desk-reviewed, actual, allowable, per diem 28845
indirect care costs from the calendar year preceding the fiscal 28846
year in which the rate will be paid, adjusted for the inflation 28847
rate estimated under division (C)(1) of this section; 28848

(2) An efficiency incentive in the following amount: 28849

(a) For fiscal years ending in even-numbered calendar years: 28850

(i) In the case of intermediate care facilities for the 28851
mentally retarded with more than eight beds, seven and one-tenth 28852
per cent of the maximum rate established for the facility's peer 28853
group under division (B) of this section; 28854

(ii) In the case of intermediate care facilities for the 28855
mentally retarded with eight or fewer beds, seven per cent of the 28856
maximum rate established for the facility's peer group under 28857
division (B) of this section; 28858

(b) For fiscal years ending in odd-numbered calendar years, 28859
the amount calculated for the preceding fiscal year under division 28860
(A)(2)(a) of this section. 28861

(B)(1) The maximum rate for indirect care costs for each peer 28862
group of intermediate care facilities for the mentally retarded 28863
with more than eight beds specified in rules adopted under 28864
division (D) of this section shall be determined as follows: 28865

(a) For fiscal years ending in even-numbered calendar years, 28866
the maximum rate for each peer group shall be the rate that is no 28867
less than twelve and four-tenths per cent above the median 28868
desk-reviewed, actual, allowable, per diem indirect care cost for 28869
all intermediate care facilities for the mentally retarded with 28870
more than eight beds in the group, excluding facilities in the 28871
group whose indirect care costs for that period are more than 28872
three standard deviations from the mean desk-reviewed, actual, 28873
allowable, per diem indirect care cost for all intermediate care 28874
facilities for the mentally retarded with more than eight beds, 28875
for the calendar year preceding the fiscal year in which the rate 28876
will be paid, adjusted by the inflation rate estimated under 28877
division (C)(1) of this section. 28878

(b) For fiscal years ending in odd-numbered calendar years, 28879
the maximum rate for each peer group is the group's maximum rate 28880
for the previous fiscal year, adjusted for the inflation rate 28881

estimated under division (C)(2) of this section. 28882

(2) The maximum rate for indirect care costs for each peer 28883
group of intermediate care facilities for the mentally retarded 28884
with eight or fewer beds specified in rules adopted under division 28885
(D) of this section shall be determined as follows: 28886

(a) For fiscal years ending in even-numbered calendar years, 28887
the maximum rate for each peer group shall be the rate that is no 28888
less than ten and three-tenths per cent above the median 28889
desk-reviewed, actual, allowable, per diem indirect care cost for 28890
all intermediate care facilities for the mentally retarded with 28891
eight or fewer beds in the group, excluding facilities in the 28892
group whose indirect care costs are more than three standard 28893
deviations from the mean desk-reviewed, actual, allowable, per 28894
diem indirect care cost for all intermediate care facilities for 28895
the mentally retarded with eight or fewer beds, for the calendar 28896
year preceding the fiscal year in which the rate will be paid, 28897
adjusted by the inflation rate estimated under division (C)(1) of 28898
this section. 28899

(b) For fiscal years that end in odd-numbered calendar years, 28900
the maximum rate for each peer group is the group's maximum rate 28901
for the previous fiscal year, adjusted for the inflation rate 28902
estimated under division (C)(2) of this section. 28903

(3) The department shall not recalculate a maximum rate for 28904
indirect care costs under division (B)(1) or (2) of this section 28905
based on additional information that it receives after the maximum 28906
rate is set. The department shall recalculate the maximum rate for 28907
indirect care costs only if it made an error in computing the 28908
maximum rate based on the information available at the time of the 28909
original calculation. 28910

(C)(1) When adjusting rates for inflation under divisions 28911
(A)(1), (B)(1)(a), and (B)(2)(a) of this section, the department 28912

shall estimate the rate of inflation for the eighteen-month period 28913
beginning on the first day of July of the calendar year preceding 28914
the fiscal year in which the rate will be paid and ending on the 28915
thirty-first day of December of the fiscal year in which the rate 28916
will be paid, using the consumer price index for all items for all 28917
urban consumers for the north central region, published by the 28918
United States bureau of labor statistics. 28919

(2) When adjusting rates for inflation under divisions 28920
(B)(1)(b) and (B)(2)(b) of this section, the department shall 28921
estimate the rate of inflation for the twelve-month period 28922
beginning on the first day of January of the fiscal year preceding 28923
the fiscal year in which the rate will be paid and ending on the 28924
thirty-first day of December of the fiscal year in which the rate 28925
will be paid, using the consumer price index for all items for all 28926
urban consumers for the north central region, published by the 28927
United States bureau of labor statistics. 28928

(3) If an inflation rate estimated under division (C)(1) or 28929
(2) of this section is different from the actual inflation rate 28930
for the relevant time period, as measured using the same index, 28931
the difference shall be added to or subtracted from the inflation 28932
rate estimated pursuant to this division for the following fiscal 28933
year. 28934

(D) The director of ~~job and family services~~ health care 28935
administration shall adopt rules under section ~~5111.02~~ 5163.15 of 28936
the Revised Code that specify peer groups of intermediate care 28937
facilities for the mentally retarded with more than eight beds, 28938
and peer groups of intermediate care facilities for the mentally 28939
retarded with eight or fewer beds, based on findings of 28940
significant per diem indirect care cost differences due to 28941
geography and facility bed-size. The rules also may specify peer 28942
groups based on findings of significant per diem indirect care 28943
cost differences due to other factors, including case-mix. 28944

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 28976
reimbursed by any government agency shall not be included in costs 28977
of ownership or renovation unless that part of the payment under 28978
sections ~~5111.20~~ 5164.01 to ~~5111.33~~ 5164.41 of the Revised Code is 28979
used to reimburse the government agency. 28980

(B) The department of ~~job and family services~~ health care 28981
administration shall pay to a provider for each of the provider's 28982
eligible intermediate care facilities for the mentally retarded an 28983
efficiency incentive equal to fifty per cent of the difference 28984
between any desk-reviewed, actual, allowable cost of ownership and 28985
the applicable limit on cost of ownership payments under division 28986
(C) of this section. For purposes of computing the efficiency 28987
incentive, depreciation for costs paid or reimbursed by any 28988
government agency shall be considered as a cost of ownership, and 28989
the applicable limit under division (C) of this section shall 28990
apply both to facilities with more than eight beds and facilities 28991
with eight or fewer beds. The efficiency incentive paid to a 28992
provider for a facility with eight or fewer beds shall not exceed 28993
three dollars per patient day, adjusted annually for the inflation 28994
rate for the twelve-month period beginning on the first day of 28995
July of the calendar year preceding the calendar year that 28996
precedes the fiscal year for which the efficiency incentive is 28997
determined and ending on the thirtieth day of the following June, 28998
using the consumer price index for shelter costs for all urban 28999
consumers for the north central region, as published by the United 29000
States bureau of labor statistics. 29001

(C) Cost of ownership payments for intermediate care 29002
facilities for the mentally retarded with more than eight beds 29003
shall not exceed the following limits: 29004

(1) For facilities with dates of licensure prior to January 29005
1, 1958, not exceeding two dollars and fifty cents per patient 29006
day; 29007

(2) For facilities with dates of licensure after December 31, 1957, but prior to January 1, 1968, not exceeding:	29008
	29009
(a) Three dollars and fifty cents per patient day if the cost of construction was three thousand five hundred dollars or more per bed;	29010
	29011
	29012
(b) Two dollars and fifty cents per patient day if the cost of construction was less than three thousand five hundred dollars per bed.	29013
	29014
	29015
(3) For facilities with dates of licensure after December 31, 1967, but prior to January 1, 1976, not exceeding:	29016
	29017
(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;	29018
	29019
	29020
(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;	29021
	29022
	29023
	29024
(c) Two dollars and fifty cents per patient day if the cost of construction was three thousand five hundred dollars or less per bed.	29025
	29026
	29027
(4) For facilities with dates of licensure after December 31, 1975, but prior to January 1, 1979, not exceeding:	29028
	29029
(a) Five dollars and fifty cents per patient day if the cost of construction was six thousand eight hundred dollars or more per bed;	29030
	29031
	29032
(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;	29033
	29034
	29035
	29036
(c) Three dollars and fifty cents per patient day if the cost	29037

of construction was five thousand one hundred fifty dollars or 29038
less per bed, but exceeds three thousand five hundred dollars per 29039
bed; 29040

(d) Two dollars and fifty cents per patient day if the cost 29041
of construction was three thousand five hundred dollars or less 29042
per bed. 29043

(5) For facilities with dates of licensure after December 31, 29044
1978, but prior to January 1, 1980, not exceeding: 29045

(a) Six dollars per patient day if the cost of construction 29046
was seven thousand six hundred twenty-five dollars or more per 29047
bed; 29048

(b) Five dollars and fifty cents per patient day if the cost 29049
of construction was less than seven thousand six hundred 29050
twenty-five dollars per bed but exceeds six thousand eight hundred 29051
dollars per bed; 29052

(c) Four dollars and fifty cents per patient day if the cost 29053
of construction was six thousand eight hundred dollars or less per 29054
bed but exceeds five thousand one hundred fifty dollars per bed; 29055

(d) Three dollars and fifty cents per patient day if the cost 29056
of construction was five thousand one hundred fifty dollars or 29057
less but exceeds three thousand five hundred dollars per bed; 29058

(e) Two dollars and fifty cents per patient day if the cost 29059
of construction was three thousand five hundred dollars or less 29060
per bed. 29061

(6) For facilities with dates of licensure after December 31, 29062
1979, but prior to January 1, 1981, not exceeding: 29063

(a) Twelve dollars per patient day if the beds were 29064
originally licensed as residential facility beds by the department 29065
of mental retardation and developmental disabilities; 29066

(b) Six dollars per patient day if the beds were originally 29067

licensed as nursing home beds by the department of health.	29068
(7) For facilities with dates of licensure after December 31, 1980, but prior to January 1, 1982, not exceeding:	29069
(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;	29070
(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;	29071
(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;	29072
(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;	29073
(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.	29074
(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.	29075
(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.	29076
(8) For facilities with dates of licensure after December 31, 1981, but prior to January 1, 1983, not exceeding:	29077
(8) For facilities with dates of licensure after December 31, 1981, but prior to January 1, 1983, not exceeding:	29078
(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;	29079
(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;	29080
(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;	29081
(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.	29082
(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.	29083
(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.	29084
(9) For facilities with dates of licensure after December 31, 1982, but prior to January 1, 1984, not exceeding:	29085
(9) For facilities with dates of licensure after December 31, 1982, but prior to January 1, 1984, not exceeding:	29086
(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;	29087
(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;	29088
(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;	29089
(b) Seven dollars and nine cents per patient day if the beds were originally licensed as nursing home beds by the department of health.	29090
(b) Seven dollars and nine cents per patient day if the beds were originally licensed as nursing home beds by the department of health.	29091
(b) Seven dollars and nine cents per patient day if the beds were originally licensed as nursing home beds by the department of health.	29092
(10) For facilities with dates of licensure after December 31, 1983, but prior to January 1, 1985, not exceeding:	29093
(10) For facilities with dates of licensure after December 31, 1983, but prior to January 1, 1985, not exceeding:	29094
(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	29095
(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	29096
(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	29097

disabilities;	29098
(b) Seven dollars and twenty-three cents per patient day if	29099
the beds were originally licensed as nursing home beds by the	29100
department of health.	29101
(11) For facilities with dates of licensure after December	29102
31, 1984, but prior to January 1, 1986, not exceeding:	29103
(a) Twelve dollars and fifty-three cents per patient day if	29104
the beds were originally licensed as residential facility beds by	29105
the department of mental retardation and developmental	29106
disabilities;	29107
(b) Seven dollars and forty cents per patient day if the beds	29108
were originally licensed as nursing home beds by the department of	29109
health.	29110
(12) For facilities with dates of licensure after December	29111
31, 1985, but prior to January 1, 1987, not exceeding:	29112
(a) Twelve dollars and seventy cents per patient day if the	29113
beds were originally licensed as residential facility beds by the	29114
department of mental retardation and developmental disabilities;	29115
(b) Seven dollars and fifty cents per patient day if the beds	29116
were originally licensed as nursing home beds by the department of	29117
health.	29118
(13) For facilities with dates of licensure after December	29119
31, 1986, but prior to January 1, 1988, not exceeding:	29120
(a) Twelve dollars and ninety-nine cents per patient day if	29121
the beds were originally licensed as residential facility beds by	29122
the department of mental retardation and developmental	29123
disabilities;	29124
(b) Seven dollars and sixty-seven cents per patient day if	29125
the beds were originally licensed as nursing home beds by the	29126
department of health.	29127

(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;	29128 29129 29130
(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;	29131 29132 29133
(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;	29134 29135 29136
(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;	29137 29138 29139
(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;	29140 29141 29142
(19) For facilities with dates of licensure after December 31, 1992, not exceeding fourteen dollars and twenty-eight cents per patient day.	29143 29144 29145
(D) Beginning January 1, 1981, regardless of the original date of licensure, the department of job and family services <u>health care administration</u> shall pay a rate for the per diem capitalized costs of renovations to intermediate care facilities for the mentally retarded made after January 1, 1981, 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	29146 29147 29148 29149 29150 29151 29152 29153 29154 29155 29156 29157 29158

renovation costs shall not be included in cost of ownership, and a 29159
nonextensive renovation shall not affect the date of licensure for 29160
purposes of division (C) of this section. This division applies to 29161
nonextensive renovations regardless of whether they are made by an 29162
owner or a lessee. If the tenancy of a lessee that has made 29163
renovations ends before the depreciation expense for the 29164
renovation costs has been fully reported, the former lessee shall 29165
not report the undepreciated balance as an expense. 29166

For a nonextensive renovation to qualify for payment under 29167
this division, both of the following conditions must be met: 29168

(1) At least five years have elapsed since the date of 29169
licensure or date of an extensive renovation of the portion of the 29170
facility that is proposed to be renovated, except that this 29171
condition does not apply if the renovation is necessary to meet 29172
the requirements of federal, state, or local statutes, ordinances, 29173
rules, or policies. 29174

(2) The provider has obtained prior approval from the 29175
department of ~~job and family services~~ health care administration. 29176
The provider shall submit a plan that describes in detail the 29177
changes in capital assets to be accomplished by means of the 29178
renovation and the timetable for completing the project. The time 29179
for completion of the project shall be no more than eighteen 29180
months after the renovation begins. The director of ~~job and family~~ 29181
~~services~~ health care administration shall adopt rules under 29182
section ~~5111.02~~ 5163.15 of the Revised Code that specify criteria 29183
and procedures for prior approval of renovation projects. No 29184
provider shall separate a project with the intent to evade the 29185
characterization of the project as a renovation or as an extensive 29186
renovation. No provider shall increase the scope of a project 29187
after it is approved by the department of ~~job and family services~~ 29188
health care administration unless the increase in scope is 29189
approved by the department. 29190

(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 29223
of the facility. If the department does not give prior approval, 29224
cost of ownership payments shall not exceed the amount specified 29225
in division (C) of this section. 29226

(3) Notwithstanding divisions (D) and (F)(1) and (2) of this 29227
section, the total payment for cost of ownership, cost of 29228
ownership efficiency incentive, and capitalized costs of 29229
renovations for an intermediate care facility for the mentally 29230
retarded with eight or fewer beds shall not exceed the sum of the 29231
limitations specified in divisions (C) and (D) of this section. 29232

(G) Notwithstanding any provision of this section or section 29233
~~5111.241~~ 5164.07 of the Revised Code, the director of ~~job and~~ 29234
~~family services~~ health care administration may adopt rules under 29235
section ~~5111.02~~ 5163.15 of the Revised Code that provide for a 29236
calculation of a combined maximum payment limit for indirect care 29237
costs and cost of ownership for intermediate care facilities for 29238
the mentally retarded with eight or fewer beds. 29239

(H) After the date on which a transaction of sale is closed, 29240
the provider shall refund to the department the amount of excess 29241
depreciation paid to the provider for the facility by the 29242
department for each year the provider has operated the facility 29243
under a provider agreement and prorated according to the number of 29244
medicaid patient days for which the provider has received payment 29245
for the facility. For the purposes of this division, "depreciation 29246
paid to the provider for the facility" means the amount paid to 29247
the provider for the intermediate care facility for the mentally 29248
retarded for cost of ownership pursuant to this section less any 29249
amount paid for interest costs. For the purposes of this division, 29250
"excess depreciation" is the intermediate care facility for the 29251
mentally retarded's depreciated basis, which is the provider's 29252
cost less accumulated depreciation, subtracted from the purchase 29253
price but not exceeding the amount of depreciation paid to the 29254

provider for the facility. 29255

(I) The department of ~~job and family services~~ health care 29256
administration shall pay a provider for each of the provider's 29257
eligible proprietary intermediate care facilities for the mentally 29258
retarded a return on the facility's net equity computed at the 29259
rate of one and one-half times the average of interest rates on 29260
special issues of public debt obligations issued to the federal 29261
hospital insurance trust fund for the cost reporting period. No 29262
facility's return on net equity paid under this division shall 29263
exceed one dollar per patient day. 29264

In calculating the rate for return on net equity, the 29265
department shall use the greater of the facility's inpatient days 29266
during the applicable cost reporting period or the number of 29267
inpatient days the facility would have had during that period if 29268
its occupancy rate had been ninety-five per cent. 29269

(J)(1) Except as provided in division (J)(2) of this section, 29270
if a provider leases or transfers an interest in a facility to 29271
another provider who is a related party, the related party's 29272
allowable cost of ownership shall include the lesser of the 29273
following: 29274

(a) The annual lease expense or actual cost of ownership, 29275
whichever is applicable; 29276

(b) The reasonable cost to the lessor or provider making the 29277
transfer. 29278

(2) If a provider leases or transfers an interest in a 29279
facility to another provider who is a related party, regardless of 29280
the date of the lease or transfer, the related party's allowable 29281
cost of ownership shall include the annual lease expense or actual 29282
cost of ownership, whichever is applicable, subject to the 29283
limitations specified in divisions (B) to (I) of this section, if 29284
all of the following conditions are met: 29285

(a) The related party is a relative of owner;	29286
(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;	29287 29288 29289 29290
(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;	29291 29292 29293
(d) The department of job and family services <u>health care administration</u> determines that the lease or transfer is an arm's length transaction pursuant to rules adopted under section 5111.02 <u>5163.15</u> 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:	29294 29295 29296 29297 29298 29299
(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.	29300 29301 29302 29303 29304 29305
(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.	29306 29307 29308 29309 29310 29311
(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	29312 29313 29314 29315 29316

excluding interest as a creditor. 29317

(iv) In the case of a transfer, the provider that made the 29318
transfer does not reacquire an interest in the facility except 29319
through the exercise of a creditor's rights in the event of a 29320
default. If the provider reacquires an interest in the facility in 29321
this manner, the department shall treat the facility as if the 29322
transfer never occurred when the department calculates its 29323
reimbursement rates for capital costs. 29324

(v) The lease or transfer satisfies any other criteria 29325
specified in the rules. 29326

(e) Except in the case of hardship caused by a catastrophic 29327
event, as determined by the department, or in the case of a lessor 29328
or provider making the transfer who is at least sixty-five years 29329
of age, not less than twenty years have elapsed since, for the 29330
same facility, allowable cost of ownership was determined most 29331
recently under this division. 29332

Sec. ~~5111.261~~ 5164.10. Except as otherwise provided in 29333
section ~~5111.264~~ 5164.372 of the Revised Code, the department of 29334
~~job and family services~~ health care administration, in determining 29335
whether an intermediate care facility for the mentally retarded's 29336
direct care costs and indirect care costs are allowable, shall 29337
place no limit on specific categories of reasonable costs other 29338
than compensation of owners, compensation of relatives of owners, 29339
compensation of administrators and costs for resident meals that 29340
are prepared and consumed outside the facility. 29341

Compensation cost limits for owners and relatives of owners 29342
shall be based on compensation costs for individuals who hold 29343
comparable positions but who are not owners or relatives of 29344
owners, as reported on facility cost reports. As used in this 29345
section, "comparable position" means the position that is held by 29346
the owner or the owner's relative, if that position is listed 29347

separately on the cost report form, or if the position is not 29348
listed separately, the group of positions that is listed on the 29349
cost report form and that includes the position held by the owner 29350
or the owner's relative. In the case of an owner or owner's 29351
relative who serves the facility in a capacity such as corporate 29352
officer, proprietor, or partner for which no comparable position 29353
or group of positions is listed on the cost report form, the 29354
compensation cost limit shall be based on civil service 29355
equivalents and shall be specified in rules adopted under section 29356
~~5111.02~~ 5163.15 of the Revised Code. 29357

Compensation cost limits for administrators shall be based on 29358
compensation costs for administrators who are not owners or 29359
relatives of owners, as reported on facility cost reports. 29360
Compensation cost limits for administrators of four or more 29361
intermediate care facilities for the mentally retarded shall be 29362
the same as the limits for administrators of intermediate care 29363
facilities for the mentally retarded with one hundred fifty or 29364
more beds. 29365

Sec. ~~5111.255~~ 5164.12. (A) The department of ~~job and family~~ 29366
~~services~~ health care administration shall establish initial rates 29367
for an intermediate care facility for the mentally retarded with a 29368
first date of licensure that is on or after January 1, 1993, 29369
including a facility that replaces one or more existing 29370
facilities, or for an intermediate care facility for the mentally 29371
retarded with a first date of licensure before that date that was 29372
initially certified for the medicaid program on or after that 29373
date, in the following manner: 29374

(1) The rate for direct care costs shall be determined as 29375
follows: 29376

(a) If there are no cost or resident assessment data as 29377
necessary to calculate a rate under section ~~5111.23~~ 5164.05 of the 29378

Revised Code, the rate shall be the median cost per case-mix unit 29379
calculated under division (B)(1) of that section for the relevant 29380
peer group for the calendar year preceding the fiscal year in 29381
which the rate will be paid, multiplied by the median annual 29382
average case-mix score for the peer group for that period and by 29383
the rate of inflation estimated under division (B)(3) of that 29384
section. This rate shall be recalculated to reflect the facility's 29385
actual quarterly average case-mix score, in accordance with that 29386
section, after it submits its first quarterly assessment data that 29387
qualifies for use in calculating a case-mix score in accordance 29388
with rules authorized by division ~~(E)(D)~~ of section ~~5111.232~~ 29389
5164.051 of the Revised Code. If the facility's first two 29390
quarterly submissions do not contain assessment data that 29391
qualifies for use in calculating a case-mix score, the department 29392
shall continue to calculate the rate using the median annual 29393
case-mix score for the peer group in lieu of an assigned quarterly 29394
case-mix score. The department shall assign a case-mix score or, 29395
if necessary, a cost per case-mix unit under division ~~(D)(C)~~ of 29396
section ~~5111.232~~ 5164.051 of the Revised Code for any subsequent 29397
submissions that do not contain assessment data that qualifies for 29398
use in calculating a case-mix score. 29399

(b) If the facility is a replacement facility and the 29400
facility or facilities that are being replaced are in operation 29401
immediately before the replacement facility opens, the rate shall 29402
be the same as the rate for the replaced facility or facilities, 29403
proportionate to the number of beds in each replaced facility. If 29404
one or more of the replaced facilities is not in operation 29405
immediately before the replacement facility opens, its proportion 29406
shall be determined under division (A)(1)(a) of this section. 29407

(2) The rate for other protected costs shall be one hundred 29408
fifteen per cent of the median rate for intermediate care 29409
facilities for the mentally retarded calculated for the fiscal 29410

year under section ~~5111.235~~ 5164.06 of the Revised Code. 29411

(3) The rate for indirect care costs shall be the applicable 29412
maximum rate for the facility's peer group as specified in 29413
division (B) of section ~~5111.241~~ 5164.07 of the Revised Code. 29414

(4) The rate for capital costs shall be determined under 29415
section ~~5111.251~~ 5164.08 of the Revised Code using the greater of 29416
actual inpatient days or an imputed occupancy rate of eighty per 29417
cent. 29418

(B) The department shall adjust the rates established under 29419
division (A) of this section at both of the following times: 29420

(1) Effective the first day of July, to reflect new rate 29421
calculations for all facilities under sections ~~5111.20~~ 5164.01 to 29422
~~5111.33~~ 5164.41 of the Revised Code; 29423

(2) Following the provider's submission of the facility's 29424
cost report under division (A)(1)(b) of section ~~5111.26~~ 5164.37 of 29425
the Revised Code. 29426

The department shall pay the rate adjusted based on the cost 29427
report beginning the first day of the calendar quarter that begins 29428
more than ninety days after the department receives the cost 29429
report. 29430

Sec. ~~5111.291~~ 5164.13. Notwithstanding sections ~~5111.20~~ 29431
5164.01 to ~~5111.33~~ 5164.41 of the Revised Code, the department of 29432
~~job and family services~~ health care administration may compute the 29433
rate for intermediate care facilities for the mentally retarded 29434
operated by the department of mental retardation and developmental 29435
disabilities or the department of mental health according to the 29436
reasonable cost principles of ~~Title XVIII~~ the medicare program. 29437

Sec. ~~5111.211~~ 5164.14. (A) The department of mental 29438
retardation and developmental disabilities is responsible for the 29439

nonfederal share of claims submitted for services that are covered 29440
by the medicaid program and provided to an eligible medicaid 29441
recipient by an intermediate care facility for the mentally 29442
retarded if all of the following are the case: 29443

(1) The services are provided on or after July 1, 2003; 29444

(2) The facility receives initial certification by the 29445
director of health as an intermediate care facility for the 29446
mentally retarded on or after June 1, 2003; 29447

(3) The facility, or a portion of the facility, is licensed 29448
by the director of mental retardation and developmental 29449
disabilities as a residential facility under section 5123.19 of 29450
the Revised Code; 29451

(4) There is a valid provider agreement for the facility. 29452

(B) Each month, the department of ~~job and family services~~ 29453
health care administration shall invoice the department of mental 29454
retardation and developmental disabilities by interagency transfer 29455
voucher for the claims for which the department of mental 29456
retardation and developmental disabilities is responsible pursuant 29457
to this section. 29458

Sec. ~~5111.222~~ 5164.18. (A) Except as otherwise provided by 29459
sections ~~5111.20~~ 5164.01 to ~~5111.33~~ 5164.41 of the Revised Code 29460
and by division (B) of this section, the payments that the 29461
department of ~~job and family services~~ health care administration 29462
shall agree to make to the provider of a nursing facility pursuant 29463
to a provider agreement shall equal the sum of all of the 29464
following: 29465

(1) The rate for direct care costs determined for the nursing 29466
facility under section ~~5111.231~~ 5164.19 of the Revised Code; 29467

(2) The rate for ancillary and support costs determined for 29468
the nursing facility's ancillary and support cost peer group under 29469

section 5111.24 <u>5164.20</u> of the Revised Code;	29470
(3) The rate for tax costs determined for the nursing facility under section 5111.242 <u>5164.21</u> of the Revised Code;	29471 29472
(4) The rate for franchise permit fees determined for the nursing facility under section 5111.243 <u>5164.22</u> of the Revised Code;	29473 29474 29475
(5) The quality incentive payment paid to the nursing facility under section 5111.244 <u>5164.23</u> of the Revised Code;	29476 29477
(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 <u>5164.24</u> of the Revised Code.	29478 29479 29480
(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:	29481 29482 29483 29484 29485
(1) Establishes factors by which the rates are to be adjusted;	29486 29487
(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 <u>5164.01</u> to 5111.33 <u>5164.41</u> of the Revised Code.	29488 29489 29490 29491 29492
Sec. 5111.231 <u>5164.19</u>. (A) As used in this section, "applicable calendar year" means the following:	29493 29494
(1) For the purpose of the department of job and family services <u>health care administration</u> 's initial determination under division (D) of this section of each peer group's cost per case-mix unit, calendar year 2003;	29495 29496 29497 29498

(2) For the purpose of the department's subsequent 29499
determinations under division (D) of this section of each peer 29500
group's cost per case-mix unit, the calendar year the department 29501
selects. 29502

(B) The department of ~~job and family services~~ health care 29503
administration shall pay a provider for each of the provider's 29504
eligible nursing facilities a per resident per day rate for direct 29505
care costs determined semiannually by multiplying the cost per 29506
case-mix unit determined under division (D) of this section for 29507
the facility's peer group by the facility's semiannual case-mix 29508
score determined under section ~~5111.232~~ 5164.191 of the Revised 29509
Code. 29510

(C) For the purpose of determining nursing facilities' rate 29511
for direct care costs, the department shall establish three peer 29512
groups. 29513

Each nursing facility located in any of the following 29514
counties shall be placed in peer group one: Brown, Butler, 29515
Clermont, Clinton, Hamilton, and Warren. 29516

Each nursing facility located in any of the following 29517
counties shall be placed in peer group two: Ashtabula, Champaign, 29518
Clark, Cuyahoga, Darke, Delaware, Fairfield, Fayette, Franklin, 29519
Fulton, Geauga, Greene, Hancock, Knox, Lake, Licking, Lorain, 29520
Lucas, Madison, Marion, Medina, Miami, Montgomery, Morrow, Ottawa, 29521
Pickaway, Portage, Preble, Ross, Sandusky, Seneca, Summit, Union, 29522
and Wood. 29523

Each nursing facility located in any of the following 29524
counties shall be placed in peer group three: Adams, Allen, 29525
Ashland, Athens, Auglaize, Belmont, Carroll, Columbiana, 29526
Coshocton, Crawford, Defiance, Erie, Gallia, Guernsey, Hardin, 29527
Harrison, Henry, Highland, Hocking, Holmes, Huron, Jackson, 29528
Jefferson, Lawrence, Logan, Mahoning, Meigs, Mercer, Monroe, 29529

Morgan, Muskingum, Noble, Paulding, Perry, Pike, Putnam, Richland, 29530
Scioto, Shelby, Stark, Trumbull, Tuscarawas, Van Wert, Vinton, 29531
Washington, Wayne, Williams, and Wyandot. 29532

(D)(1) At least once every ten years, the department shall 29533
determine a cost per case-mix unit for each peer group established 29534
under division (C) of this section. A cost per case-mix unit 29535
determined under this division for a peer group shall be used for 29536
subsequent years until the department redetermines it. To 29537
determine a peer group's cost per case-mix unit, the department 29538
shall do all of the following: 29539

(a) Determine the cost per case-mix unit for each nursing 29540
facility in the peer group for the applicable calendar year by 29541
dividing each facility's desk-reviewed, actual, allowable, per 29542
diem direct care costs for the applicable calendar year by the 29543
facility's annual average case-mix score determined under section 29544
~~5111.232~~ 5164.191 of the Revised Code for the applicable calendar 29545
year. 29546

(b) Subject to division (D)(2) of this section, identify 29547
which nursing facility in the peer group is at the twenty-fifth 29548
percentile of the cost per case-mix units determined under 29549
division (D)(1)(a) of this section. 29550

(c) Calculate the amount that is seven per cent above the 29551
cost per case-mix unit determined under division (D)(1)(a) of this 29552
section for the nursing facility identified under division 29553
(D)(1)(b) of this section. 29554

(d) Multiply the amount calculated under division (D)(1)(c) 29555
of this section by the rate of inflation for the eighteen-month 29556
period beginning on the first day of July of the applicable 29557
calendar year and ending the last day of December of the calendar 29558
year immediately following the applicable calendar year using the 29559
employment cost index for total compensation, health services 29560

component, published by the United States bureau of labor 29561
statistics. 29562

(2) In making the identification under division (D)(1)(b) of 29563
this section, the department shall exclude both of the following: 29564

(a) Nursing facilities that participated in the medicaid 29565
program under the same provider for less than twelve months in the 29566
applicable calendar year; 29567

(b) Nursing facilities whose cost per case-mix unit is more 29568
than one standard deviation from the mean cost per case-mix unit 29569
for all nursing facilities in the nursing facility's peer group 29570
for the applicable calendar year. 29571

(3) The department shall not redetermine a peer group's cost 29572
per case-mix unit under this division based on additional 29573
information that it receives after the peer group's per case-mix 29574
unit is determined. The department shall redetermine a peer 29575
group's cost per case-mix unit only if it made an error in 29576
determining the peer group's cost per case-mix unit based on 29577
information available to the department at the time of the 29578
original determination. 29579

Sec. ~~5111.232~~ 5164.191. (A)(1) The department of ~~job and~~ 29580
~~family services~~ health care administration shall determine 29581
semiannual and annual average case-mix scores for nursing 29582
facilities by using all of the following: 29583

(a) Data from a resident assessment instrument specified in 29584
rules adopted under section ~~5111.02~~ 5163.15 of the Revised Code 29585
pursuant to ~~section 1919(e)(5) of the "Social Security Act," 49~~ 29586
~~Stat. 620 (1935), 42 U.S.C.A. 1396r(e)(5), as amended,~~ for the 29587
following residents: 29588

(i) When determining ~~semi-annual~~ semiannual case-mix scores, 29589
each resident who is a medicaid recipient; 29590

(ii) When determining annual average case-mix scores, each resident regardless of payment source. 29591
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(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; 29593
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(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~~. 29597
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(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: 29602
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(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; 29605
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29607

(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; 29608
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29611

(c) Modify the grouper methodology specified in division (A)(1)(c) of this section as follows: 29612
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(i) Establish a different hierarchy for assigning residents to case-mix categories under the methodology; 29614
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(ii) Prohibit the use of the index maximizer element of the methodology; 29616
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(iii) Incorporate changes to the methodology the United States department of health and human services makes after June 30, 1999; 29618
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(iv) Make other changes the department determines are necessary. 29621
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~~(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.~~ 29623
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~~(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. 29629
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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 29643
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the calculations pursuant to procedures specified in rules adopted 29653
under section ~~5111.02~~ 5163.15 of the Revised Code. 29654

~~(D)~~(C)(1) If a provider of a nursing facility does not timely 29655
submit information for a calendar quarter necessary to calculate a 29656
facility's case-mix score, or submits incomplete or inaccurate 29657
information for a calendar quarter, the department may assign the 29658
facility a quarterly average case-mix score that is five per cent 29659
less than the facility's quarterly average case-mix score for the 29660
preceding calendar quarter. If the facility was subject to an 29661
exception review under division (C) of section ~~5111.27~~ 5164.38 of 29662
the Revised Code for the preceding calendar quarter, the 29663
department may assign a quarterly average case-mix score that is 29664
five per cent less than the score determined by the exception 29665
review. If the facility was assigned a quarterly average case-mix 29666
score for the preceding quarter, the department may assign a 29667
quarterly average case-mix score that is five per cent less than 29668
that score assigned for the preceding quarter. 29669

The department may use a quarterly average case-mix score 29670
assigned under division ~~(D)~~(C)(1) of this section, instead of a 29671
quarterly average case-mix score calculated based on the 29672
provider's submitted information, to calculate the facility's rate 29673
for direct care costs being established under section ~~5111.23~~ or 29674
~~5111.231~~ 5164.19 of the Revised Code for one or more months, as 29675
specified in rules authorized by division ~~(E)~~(D) of this section, 29676
of the quarter for which the rate established under section 29677
~~5111.23~~ or ~~5111.231~~ 5164.19 of the Revised Code will be paid. 29678

Before taking action under division ~~(D)~~(C)(1) of this 29679
section, the department shall permit the provider a reasonable 29680
period of time, specified in rules authorized by division ~~(E)~~(D) 29681
of this section, to correct the information. ~~In the case of an~~ 29682
~~intermediate care facility for the mentally retarded, the~~ 29683
~~department shall not assign a quarterly average case-mix score due~~ 29684

~~to late submission of corrections to assessment information unless~~ 29685
~~the provider fails to submit corrected information prior to the~~ 29686
~~eighty first day after the end of the calendar quarter to which~~ 29687
~~the information pertains. In the case of a nursing facility, the~~ 29688
The department shall not assign a quarterly average case-mix score 29689
due to late submission of corrections to assessment information 29690
unless the provider fails to submit corrected information prior to 29691
the earlier of the eighty-first day after the end of the calendar 29692
quarter to which the information pertains or the deadline for 29693
submission of such corrections established by regulations adopted 29694
by the United States department of health and human services under 29695
Titles XVIII and XIX. 29696

(2) If a provider is paid a rate for a nursing facility 29697
calculated using a quarterly average case-mix score assigned under 29698
division ~~(D)~~(C)(1) of this section for more than six months in a 29699
calendar year, the department may assign the facility a cost per 29700
case-mix unit that is five per cent less than the facility's 29701
actual or assigned cost per case-mix unit for the preceding 29702
calendar year. The department may use the assigned cost per 29703
case-mix unit, instead of calculating the facility's actual cost 29704
per case-mix unit in accordance with section ~~5111.23~~ or ~~5111.231~~ 29705
5164.19 of the Revised Code, to establish the facility's rate for 29706
direct care costs for the following fiscal year. 29707

(3) The department shall take action under division ~~(D)~~(C)(1) 29708
or (2) of this section only in accordance with rules authorized by 29709
division ~~(E)~~(D) of this section. The department shall not take an 29710
action that affects rates for prior payment periods except in 29711
accordance with sections ~~5111.27~~ 5164.38 and ~~5111.28~~ 5164.39 of 29712
the Revised Code. 29713

~~(E)~~(D) The director shall adopt rules under section ~~5111.02~~ 29714
5163.15 of the Revised Code that do all of the following: 29715

(1) Specify whether providers of a nursing facility must 29716

submit the assessment data to the department of ~~job and family~~ 29717
~~services~~ health care administration; 29718

(2) Specify the medium or media through which the completed 29719
assessment data shall be submitted; 29720

(3) Establish procedures under which the assessment data 29721
shall be reviewed for accuracy and providers shall be notified of 29722
any data that requires correction; 29723

(4) Establish procedures for providers to correct assessment 29724
data and specify a reasonable period of time by which providers 29725
shall submit the corrections. The procedures may limit the content 29726
of corrections by providers of nursing facilities in the manner 29727
required by regulations adopted by the United States department of 29728
health and human services under Titles XVIII and XIX. 29729

(5) Specify when and how the department will assign case-mix 29730
scores or costs per case-mix unit under division ~~(D)~~(C) of this 29731
section if information necessary to calculate the facility's 29732
case-mix score is not provided or corrected in accordance with the 29733
procedures established by the rules. Notwithstanding any other 29734
provision of sections ~~5111.20~~ 5164.01 to ~~5111.33~~ 5164.41 of the 29735
Revised Code, the rules also may provide for ~~the following:~~ 29736

~~(a) Exclusion of case mix scores assigned under division (D)~~ 29737
~~of this section from calculation of an intermediate care facility~~ 29738
~~for the mentally retarded's annual average case mix score and the~~ 29739
~~maximum cost per case mix unit for the facility's peer group;~~ 29740

~~(b) Exclusion of~~ excluding case-mix scores assigned under 29741
division ~~(D)~~(C) of this section from calculation of a nursing 29742
facility's semiannual or annual average case-mix score and the 29743
cost per case-mix unit for the facility's peer group. 29744

Sec. ~~5111.24~~ 5164.20. (A) As used in this section, 29745
"applicable calendar year" means the following: 29746

(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 29778
counties that has one hundred or more beds shall be placed in peer 29779
group four. 29780

Each nursing facility located in any of the following 29781
counties shall be placed in peer group five or six: Adams, Allen, 29782
Ashland, Athens, Auglaize, Belmont, Carroll, Columbiana, 29783
Coshocton, Crawford, Defiance, Erie, Gallia, Guernsey, Hardin, 29784
Harrison, Henry, Highland, Hocking, Holmes, Huron, Jackson, 29785
Jefferson, Lawrence, Logan, Mahoning, Meigs, Mercer, Monroe, 29786
Morgan, Muskingum, Noble, Paulding, Perry, Pike, Putnam, Richland, 29787
Scioto, Shelby, Stark, Trumbull, Tuscarawas, Van Wert, Vinton, 29788
Washington, Wayne, Williams, and Wyandot. Each nursing facility 29789
located in any of those counties that has fewer than one hundred 29790
beds shall be placed in peer group five. Each nursing facility 29791
located in any of those counties that has one hundred or more beds 29792
shall be placed in peer group six. 29793

(D)(1) At least once every ten years, the department shall 29794
determine the rate for ancillary and support costs for each peer 29795
group established under division (C) of this section. The rate for 29796
ancillary and support costs determined under this division for a 29797
peer group shall be used for subsequent years until the department 29798
redetermines it. To determine a peer group's rate for ancillary 29799
and support costs, the department shall do all of the following: 29800

(a) Determine the rate for ancillary and support costs for 29801
each nursing facility in the peer group for the applicable 29802
calendar year by using the greater of the nursing facility's 29803
actual inpatient days for the applicable calendar year or the 29804
inpatient days the nursing facility would have had for the 29805
applicable calendar year if its occupancy rate had been ninety per 29806
cent. For the purpose of determining a nursing facility's 29807
occupancy rate under division (D)(1)(a) of this section, the 29808
department shall include any beds that the nursing facility 29809

removes from its medicaid-certified capacity unless the nursing 29810
facility also removes the beds from its licensed bed capacity. 29811

(b) Subject to division (D)(2) of this section, identify 29812
which nursing facility in the peer group is at the twenty-fifth 29813
percentile of the rate for ancillary and support costs for the 29814
applicable calendar year determined under division (D)(1)(a) of 29815
this section. 29816

(c) Calculate the amount that is three per cent above the 29817
rate for ancillary and support costs determined under division 29818
(D)(1)(a) of this section for the nursing facility identified 29819
under division (D)(1)(b) of this section. 29820

(d) Multiply the amount calculated under division (D)(1)(c) 29821
of this section by the rate of inflation for the eighteen-month 29822
period beginning on the first day of July of the applicable 29823
calendar year and ending the last day of December of the calendar 29824
year immediately following the applicable calendar year using the 29825
consumer price index for all items for all urban consumers for the 29826
north central region, published by the United States bureau of 29827
labor statistics. 29828

(2) In making the identification under division (D)(1)(b) of 29829
this section, the department shall exclude both of the following: 29830

(a) Nursing facilities that participated in the medicaid 29831
program under the same provider for less than twelve months in the 29832
applicable calendar year; 29833

(b) Nursing facilities whose ancillary and support costs are 29834
more than one standard deviation from the mean desk-reviewed, 29835
actual, allowable, per diem ancillary and support cost for all 29836
nursing facilities in the nursing facility's peer group for the 29837
applicable calendar year. 29838

(3) The department shall not redetermine a peer group's rate 29839
for ancillary and support costs under this division based on 29840

additional information that it receives after the rate is 29841
determined. The department shall redetermine a peer group's rate 29842
for ancillary and support costs only if it made an error in 29843
determining the rate based on information available to the 29844
department at the time of the original determination. 29845

Sec. ~~5111.242~~ 5164.21. (A) As used in this section: 29846

(1) "Applicable calendar year" means the following: 29847

(a) For the purpose of the department of ~~job and family~~ 29848
~~services~~ health care administration's initial determination under 29849
this section of nursing facilities' rate for tax costs, calendar 29850
year 2003; 29851

(b) For the purpose of the department's subsequent 29852
determinations under division (D) of this section of nursing 29853
facilities' rate for tax costs, the calendar year the department 29854
selects. 29855

(2) "Tax costs" means the costs of taxes imposed under 29856
Chapter 5751. of the Revised Code, real estate taxes, personal 29857
property taxes, and corporate franchise taxes. 29858

(B) The department of ~~job and family services~~ health care 29859
administration shall pay a provider for each of the provider's 29860
eligible nursing facilities a per resident per day rate for tax 29861
costs determined under division (C) of this section. 29862

(C) At least once every ten years, the department shall 29863
determine the rate for tax costs for each nursing facility. The 29864
rate for tax costs determined under this division for a nursing 29865
facility shall be used for subsequent years until the department 29866
redetermines it. To determine a nursing facility's rate for tax 29867
costs, the department shall divide the nursing facility's 29868
desk-reviewed, actual, allowable tax costs paid for the applicable 29869
calendar year by the number of inpatient days the nursing facility 29870

would have had if its occupancy rate had been one hundred per cent 29871
during the applicable calendar year. 29872

Sec. ~~5111.243~~ 5164.22. The department of ~~job and family~~ 29873
~~services~~ health care administration shall pay a provider for each 29874
of the provider's eligible nursing facilities a per resident per 29875
day rate for the franchise permit fees paid for the nursing 29876
facility. The rate shall be equal to the franchise permit fee for 29877
the fiscal year for which the rate is paid. 29878

Sec. ~~5111.244~~ 5164.23. (A) As used in this section, 29879
"deficiency" and "standard survey" have the same meanings as in 29880
section ~~5111.35~~ 5164.50 of the Revised Code. 29881

(B) Each fiscal year, the department of ~~job and family~~ 29882
~~services~~ health care administration shall pay the provider of each 29883
nursing facility a quality incentive payment. The amount of a 29884
quality incentive payment paid to a provider for a fiscal year 29885
shall be based on the number of points the provider's nursing 29886
facility is awarded under division (C) of this section for that 29887
fiscal year. The amount of a quality incentive payment paid to a 29888
provider of a nursing facility that is awarded no points may be 29889
zero. The mean payment for fiscal year 2007, weighted by medicaid 29890
days, shall be three dollars per medicaid day. The department 29891
shall adjust the mean payment for subsequent fiscal years by the 29892
same adjustment factors the department uses to adjust, pursuant to 29893
division (B) of section ~~5111.222~~ 5164.18 of the Revised Code, 29894
nursing facilities' rates otherwise determined under divisions 29895
(A)(1), (2), (3), and (6) of that section. 29896

(C)(1) Except as provided by division (C)(2) of this section, 29897
the department shall annually award each nursing facility 29898
participating in the medicaid program one point for each of the 29899
following accountability measures the facility meets: 29900

(a) The facility had no health deficiencies on the facility's most recent standard survey. 29901
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(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. 29903
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(c) The facility's resident satisfaction is above the statewide average. 29907
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(d) The facility's family satisfaction is above the statewide average. 29909
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(e) The number of hours the facility employs nurses is above the statewide average. 29911
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(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. 29913
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(g) The facility's occupancy rate is above the statewide average. 29916
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(h) The facility's medicaid utilization rate is above the statewide average. 29918
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(i) The facility's case-mix score is above the statewide average. 29920
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(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. 29922
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(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 29927
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under division (C) of this section. 29931

Sec. ~~5111.25~~ 5164.24. (A) As used in this section, 29932
"applicable calendar year" means the following: 29933

(1) For the purpose of the department of ~~job and family~~ 29934
~~services~~ health care administration's initial determination under 29935
division (D) of this section of each peer group's median rate for 29936
capital costs, calendar year 2003; 29937

(2) For the purpose of the department's subsequent 29938
determinations under division (D) of this section of each peer 29939
group's median rate for capital costs, the calendar year the 29940
department selects. 29941

(B) The department of ~~job and family services~~ health care 29942
administration shall pay a provider for each of the provider's 29943
eligible nursing facilities a per resident per day rate for 29944
capital costs. A nursing facility's rate for capital costs shall 29945
be the median rate for capital costs for the nursing facilities in 29946
the nursing facility's peer group as determined under division (D) 29947
of this section. 29948

(C) For the purpose of determining nursing facilities' rate 29949
for capital costs, the department shall establish six peer groups. 29950

Each nursing facility located in any of the following 29951
counties shall be placed in peer group one or two: Brown, Butler, 29952
Clermont, Clinton, Hamilton, and Warren. Each nursing facility 29953
located in any of those counties that has fewer than one hundred 29954
beds shall be placed in peer group one. Each nursing facility 29955
located in any of those counties that has one hundred or more beds 29956
shall be placed in peer group two. 29957

Each nursing facility located in any of the following 29958
counties shall be placed in peer group three or four: Ashtabula, 29959
Champaign, Clark, Cuyahoga, Darke, Delaware, Fairfield, Fayette, 29960

Franklin, Fulton, Geauga, Greene, Hancock, Knox, Lake, Licking, 29961
Lorain, Lucas, Madison, Marion, Medina, Miami, Montgomery, Morrow, 29962
Ottawa, Pickaway, Portage, Preble, Ross, Sandusky, Seneca, Summit, 29963
Union, and Wood. Each nursing facility located in any of those 29964
counties that has fewer than one hundred beds shall be placed in 29965
peer group three. Each nursing facility located in any of those 29966
counties that has one hundred or more beds shall be placed in peer 29967
group four. 29968

Each nursing facility located in any of the following 29969
counties shall be placed in peer group five or six: Adams, Allen, 29970
Ashland, Athens, Auglaize, Belmont, Carroll, Columbiana, 29971
Coshocton, Crawford, Defiance, Erie, Gallia, Guernsey, Hardin, 29972
Harrison, Henry, Highland, Hocking, Holmes, Huron, Jackson, 29973
Jefferson, Lawrence, Logan, Mahoning, Meigs, Mercer, Monroe, 29974
Morgan, Muskingum, Noble, Paulding, Perry, Pike, Putnam, Richland, 29975
Scioto, Shelby, Stark, Trumbull, Tuscarawas, Van Wert, Vinton, 29976
Washington, Wayne, Williams, and Wyandot. Each nursing facility 29977
located in any of those counties that has fewer than one hundred 29978
beds shall be placed in peer group five. Each nursing facility 29979
located in any of those counties that has one hundred or more beds 29980
shall be placed in peer group six. 29981

(D)(1) At least once every ten years, the department shall 29982
determine the median rate for capital costs for each peer group 29983
established under division (C) of this section. The median rate 29984
for capital costs determined under this division for a peer group 29985
shall be used for subsequent years until the department 29986
redetermines it. To determine a peer group's median rate for 29987
capital costs, the department shall do both of the following: 29988

(a) Subject to division (D)(2) of this section, use the 29989
greater of each nursing facility's actual inpatient days for the 29990
applicable calendar year or the inpatient days the nursing 29991
facility would have had for the applicable calendar year if its 29992

occupancy rate had been one hundred per cent. 29993

(b) Exclude both of the following: 29994

(i) Nursing facilities that participated in the medicaid 29995
program under the same provider for less than twelve months in the 29996
applicable calendar year; 29997

(ii) Nursing facilities whose capital costs are more than one 29998
standard deviation from the mean desk-reviewed, actual, allowable, 29999
per diem capital cost for all nursing facilities in the nursing 30000
facility's peer group for the applicable calendar year. 30001

(2) For the purpose of determining a nursing facility's 30002
occupancy rate under division (D)(1)(a) of this section, the 30003
department shall include any beds that the nursing facility 30004
removes from its medicaid-certified capacity after June 30, 2005, 30005
unless the nursing facility also removes the beds from its 30006
licensed bed capacity. 30007

(E) Buildings shall be depreciated using the straight line 30008
method over forty years or over a different period approved by the 30009
department. Components and equipment shall be depreciated using 30010
the straight-line method over a period designated in rules adopted 30011
under section ~~5111.02~~ 5163.15 of the Revised Code, consistent with 30012
the guidelines of the American hospital association, or over a 30013
different period approved by the department. Any rules authorized 30014
by this division that specify useful lives of buildings, 30015
components, or equipment apply only to assets acquired on or after 30016
July 1, 1993. Depreciation for costs paid or reimbursed by any 30017
government agency shall not be included in capital costs unless 30018
that part of the payment under sections ~~5111.20~~ 5164.01 to ~~5111.33~~ 30019
5164.41 of the Revised Code is used to reimburse the government 30020
agency. 30021

(F) The capital cost basis of nursing facility assets shall 30022
be determined in the following manner: 30023

(1) Except as provided in division (F)(3) of this section, 30024
for purposes of calculating the rates to be paid for facilities 30025
with dates of licensure on or before June 30, 1993, the capital 30026
cost basis of each asset shall be equal to the desk-reviewed, 30027
actual, allowable, capital cost basis that is listed on the 30028
facility's cost report for the calendar year preceding the fiscal 30029
year during which the rate will be paid. 30030

(2) For facilities with dates of licensure after June 30, 30031
1993, the capital cost basis shall be determined in accordance 30032
with the principles of the medicare program established under 30033
Title XVIII, except as otherwise provided in sections ~~5111.20~~ 30034
5164.01 to ~~5111.33~~ 5164.41 of the Revised Code. 30035

(3) Except as provided in division (F)(4) of this section, if 30036
a provider transfers an interest in a facility to another provider 30037
after June 30, 1993, there shall be no increase in the capital 30038
cost basis of the asset if the providers are related parties or 30039
the provider to which the interest is transferred authorizes the 30040
provider that transferred the interest to continue to operate the 30041
facility under a lease, management agreement, or other 30042
arrangement. If the previous sentence does not prohibit the 30043
adjustment of the capital cost basis under this division, the 30044
basis of the asset shall be adjusted by the lesser of the 30045
following: 30046

(a) One-half of the change in construction costs during the 30047
time that the transferor held the asset, as calculated by the 30048
department of ~~job and family services~~ health care administration 30049
using the "Dodge building cost indexes, northeastern and north 30050
central states," published by Marshall and Swift; 30051

(b) One-half of the change in the consumer price index for 30052
all items for all urban consumers, as published by the United 30053
States bureau of labor statistics, during the time that the 30054
transferor held the asset. 30055

(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 30117
capital asset cost basis, adjusted by the lesser of the following 30118
amounts: 30119

(a) One-half of the change in construction costs during the 30120
time the lessor held each asset until the beginning of the lease, 30121
as calculated by the department using the "Dodge building cost 30122
indexes, northeastern and north central states," published by 30123
Marshall and Swift; 30124

(b) One-half of the change in the consumer price index for 30125
all items for all urban consumers, as published by the United 30126
States bureau of labor statistics, during the time the lessor held 30127
each asset until the beginning of the lease. 30128

(3) Subject to division (B) of this section, for a lease of a 30129
facility with a date of licensure on or after May 27, 1992, that 30130
is initially operated under a lease, actual, allowable capital 30131
costs shall include the annual lease expense if there was a 30132
substantial commitment of money for construction of the facility 30133
after December 22, 1992, and before July 1, 1993. If there was not 30134
a substantial commitment of money after December 22, 1992, and 30135
before July 1, 1993, actual, allowable capital costs shall include 30136
the lesser of the annual lease expense or the sum of the 30137
following: 30138

(a) The annual depreciation expense that would be calculated 30139
at the inception of the lease using the lessor's entire historical 30140
capital asset cost basis; 30141

(b) The greater of the lessor's actual annual amortization of 30142
financing costs and interest expense at the inception of the lease 30143
or the imputed interest expense calculated at the inception of the 30144
lease using seventy per cent of the lessor's historical capital 30145
asset cost basis. 30146

(4) Subject to division (B) of this section, for a lease of a 30147

facility with a date of licensure on or after May 27, 1992, that 30148
was not initially operated under a lease and has been in existence 30149
for ten years, actual, allowable capital costs shall include the 30150
lesser of the annual lease expense or the annual depreciation 30151
expense and imputed interest expense that would be calculated at 30152
the inception of the lease using the entire historical capital 30153
asset cost basis of the lessor, adjusted by the lesser of the 30154
following: 30155

(a) One-half of the change in construction costs during the 30156
time the lessor held each asset until the beginning of the lease, 30157
as calculated by the department using the "Dodge building cost 30158
indexes, northeastern and north central states," published by 30159
Marshall and Swift; 30160

(b) One-half of the change in the consumer price index for 30161
all items for all urban consumers, as published by the United 30162
States bureau of labor statistics, during the time the lessor held 30163
each asset until the beginning of the lease. 30164

(5) Subject to division (B) of this section, for a new lease 30165
of a facility that was operated under a lease on May 27, 1992, 30166
actual, allowable capital costs shall include the lesser of the 30167
annual new lease expense or the annual old lease payment. If the 30168
old lease was in effect for ten years or longer, the old lease 30169
payment from the beginning of the old lease shall be adjusted by 30170
the lesser of the following: 30171

(a) One-half of the change in construction costs from the 30172
beginning of the old lease to the beginning of the new lease, as 30173
calculated by the department using the "Dodge building cost 30174
indexes, northeastern and north central states," published by 30175
Marshall and Swift; 30176

(b) One-half of the change in the consumer price index for 30177
all items for all urban consumers, as published by the United 30178

States bureau of labor statistics, from the beginning of the old 30179
lease to the beginning of the new lease. 30180

(6) Subject to division (B) of this section, for a new lease 30181
of a facility that was not in existence or that was in existence 30182
but not operated under a lease on May 27, 1992, actual, allowable 30183
capital costs shall include the lesser of annual new lease expense 30184
or the annual amount calculated for the old lease under division 30185
(G)(2), (3), (4), or (6) of this section, as applicable. If the 30186
old lease was in effect for ten years or longer, the lessor's 30187
historical capital asset cost basis shall be adjusted by the 30188
lesser of the following for purposes of calculating the annual 30189
amount under division (G)(2), (3), (4), or (6) of this section: 30190

(a) One-half of the change in construction costs from the 30191
beginning of the old lease to the beginning of the new lease, as 30192
calculated by the department using the "Dodge building cost 30193
indexes, northeastern and north central states," published by 30194
Marshall and Swift; 30195

(b) One-half of the change in the consumer price index for 30196
all items for all urban consumers, as published by the United 30197
States bureau of labor statistics, from the beginning of the old 30198
lease to the beginning of the new lease. 30199

In the case of a lease under division (G)(3) of this section 30200
of a facility for which a substantial commitment of money was made 30201
after December 22, 1992, and before July 1, 1993, the old lease 30202
payment shall be adjusted for the purpose of determining the 30203
annual amount. 30204

(7) For any revision of a lease described in division (G)(1), 30205
(2), (3), (4), (5), or (6) of this section, or for any subsequent 30206
lease of a facility operated under such a lease, other than 30207
execution of a new lease, the portion of actual, allowable capital 30208
costs attributable to the lease shall be the same as before the 30209

revision or subsequent lease. 30210

(8) Except as provided in division (G)(9) of this section, if 30211
a provider leases an interest in a facility to another provider 30212
who is a related party or previously operated the facility, the 30213
related party's or previous operator's actual, allowable capital 30214
costs shall include the lesser of the annual lease expense or the 30215
reasonable cost to the lessor. 30216

(9) If a provider leases an interest in a facility to another 30217
provider who is a related party, regardless of the date of the 30218
lease, the related party's actual, allowable capital costs shall 30219
include the annual lease expense, subject to the limitations 30220
specified in divisions (G)(1) to (7) of this section, if all of 30221
the following conditions are met: 30222

(a) The related party is a relative of owner; 30223

(b) If the lessor retains an ownership interest, it is, 30224
except as provided in division (G)(9)(c)(ii) of this section, in 30225
only the real property and any improvements on the real property; 30226

(c) The department of ~~job and family services~~ health care 30227
administration determines that the lease is an arm's length 30228
transaction pursuant to rules adopted under section ~~5111.02~~ 30229
5163.15 of the Revised Code. The rules shall provide that a lease 30230
is an arm's length transaction if all of the following apply: 30231

(i) Once the lease goes into effect, the lessor has no direct 30232
or indirect interest in the lessee or, except as provided in 30233
division (G)(9)(b) of this section, the facility itself, including 30234
interest as an owner, officer, director, employee, independent 30235
contractor, or consultant, but excluding interest as a lessor. 30236

(ii) The lessor does not reacquire an interest in the 30237
facility except through the exercise of a lessor's rights in the 30238
event of a default. If the lessor reacquires an interest in the 30239
facility in this manner, the department shall treat the facility 30240

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. 30273

Sec. ~~5111.263~~ 5164.26. (A) As used in this section, "covered 30274
therapy services" means physical therapy, occupational therapy, 30275
audiology, and speech therapy services that are provided by 30276
appropriately licensed therapists or therapy assistants and that 30277
are covered for nursing facility residents either by the medicare 30278
program ~~established under Title XVIII~~ or the medicaid program as 30279
specified in rules adopted by the director of ~~job and family~~ 30280
~~services~~ health care administration under section ~~5111.02~~ 5163.15 30281
of the Revised Code. 30282

(B) Except as provided in division (G) of this section, the 30283
costs of therapy are not allowable costs for nursing facilities 30284
for the purpose of determining rates under sections ~~5111.20~~ 30285
5164.01 to ~~5111.33~~ 5164.41 of the Revised Code. 30286

(C) The department of ~~job and family services~~ health care 30287
administration shall process no claims for payment under the 30288
medicaid program for covered therapy services rendered to a 30289
resident of a nursing facility other than such claims submitted, 30290
in accordance with this section, by a nursing facility that has a 30291
valid provider agreement with the department. 30292

(D) Providers of nursing facilities may bill the department 30293
of ~~job and family services~~ health care administration for covered 30294
therapy services the nursing facilities provide to residents of 30295
any nursing facility who are medicaid recipients and not eligible 30296
for the medicare program. 30297

(E) The department shall not process any claim for a covered 30298
therapy service provided to a nursing facility resident who is 30299
eligible for the medicare program unless the claim is for a 30300
copayment or deductible or the conditions in division (E)(1) or 30301
(2) of this section apply: 30302

(1) The covered therapy service provided is, under the 30303
federal statutes, regulations, or policies governing the medicare 30304
program, not covered by the medicare program and the service is, 30305
under the provisions of this chapter or the rules adopted under 30306
this chapter, covered by the medicaid program. 30307

(2) All of the following apply: 30308

(a) The individual or entity who provided the covered therapy 30309
service was eligible to bill the medicare program for the service. 30310

(b) A complete, accurate, and timely claim was submitted to 30311
the medicare program and the program denied payment for the 30312
service as not medically necessary for the resident. For the 30313
purposes of division (E)(2)(b) of this section, a claim is not 30314
considered to have been denied by the medicare program until 30315
either a denial has been issued following a medicare fair hearing 30316
or six months have elapsed since the request for a fair hearing 30317
was filed. 30318

(c) The facility is required to provide or arrange for the 30319
provision of the service by a licensed therapist or therapy 30320
assistant to be in compliance with federal or state nursing 30321
facility certification requirements for the medicaid program. 30322

(d) The claim for payment for the services under the medicaid 30323
program is accompanied by documentation that divisions (E)(2)(b) 30324
and (c) of this section apply to the service. 30325

(F) The reimbursement allowed by the department for covered 30326
therapy services provided to nursing facility residents and billed 30327
under division (D) or (E) of this section shall be fifteen per 30328
cent less than the fees it pays for the same services rendered to 30329
hospital outpatients. The director may adopt rules under section 30330
~~5111.02~~ 5163.15 of the Revised Code establishing comparable fees 30331
for covered therapy services that are not included in its schedule 30332
of fees paid for services rendered to hospital outpatients. 30333

(G) A nursing facility's reasonable costs for rehabilitative, 30334
restorative, or maintenance therapy services rendered to facility 30335
residents by nurses or nurse aides, and the facility's overhead 30336
costs to support provision of therapy services provided to nursing 30337
facility residents, are allowable costs for the purposes of 30338
establishing rates under sections ~~5111.20~~ 5164.01 to ~~5111.33~~ 30339
5164.41 of the Revised Code. 30340

Sec. ~~5111.257~~ 5164.27. If a provider of a nursing facility 30341
adds or replaces one or more medicaid certified beds to or at the 30342
nursing facility, or renovates one or more of the nursing 30343
facility's beds, the rate for the added, replaced, or renovated 30344
beds shall be the same as the rate for the nursing facility's 30345
existing beds. 30346

Sec. ~~5111.265~~ 5164.28. If one or more medicaid-certified beds 30347
are relocated from one nursing facility to another nursing 30348
facility owned by a different person or government entity and the 30349
application for the certificate of need authorizing the relocation 30350
is filed with the director of health on or after ~~the effective~~ 30351
~~date of this section~~ July 1, 2005, amortization of the cost of 30352
acquiring operating rights for the relocated beds is not an 30353
allowable cost for the purpose of determining the nursing 30354
facility's medicaid reimbursement rate. 30355

Sec. ~~5111.34~~ 5164.30. The director of ~~job and family services~~ 30356
health care administration shall prepare an annual report 30357
containing recommendations on the methodology that should be used 30358
to transition paying providers of nursing facilities the rate 30359
determined for nursing facilities for one fiscal year to the 30360
immediately succeeding fiscal year. The director shall submit a 30361
copy of the annual report to the governor, the president and 30362
minority leader of the senate, and the speaker and minority leader 30363

of the house of representatives not later than the first day of 30364
each October. 30365

Sec. ~~5111.254~~ 5164.32. (A) The department of ~~job and family~~ 30366
~~services~~ health care administration shall establish initial rates 30367
for a nursing facility with a first date of licensure that is on 30368
or after July 1, 2006, including a facility that replaces one or 30369
more existing facilities, or for a nursing facility with a first 30370
date of licensure before that date that was initially certified 30371
for the medicaid program on or after that date, in the following 30372
manner: 30373

(1) The rate for direct care costs shall be the product of 30374
the cost per case-mix unit determined under division (D) of 30375
section ~~5111.231~~ 5164.19 of the Revised Code for the facility's 30376
peer group and the nursing facility's case-mix score. For the 30377
purpose of division (A)(1) of this section, the nursing facility's 30378
case-mix score shall be the following: 30379

(a) Unless the nursing facility replaces an existing nursing 30380
facility that participated in the medicaid program immediately 30381
before the replacement nursing facility begins participating in 30382
the medicaid program, the median annual average case-mix score for 30383
the nursing facility's peer group; 30384

(b) If the nursing facility replaces an existing nursing 30385
facility that participated in the medicaid program immediately 30386
before the replacement nursing facility begins participating in 30387
the medicaid program, the semiannual case-mix score most recently 30388
determined under section ~~5111.232~~ 5164.191 of the Revised Code for 30389
the replaced nursing facility as adjusted, if necessary, to 30390
reflect any difference in the number of beds in the replaced and 30391
replacement nursing facilities. 30392

(2) The rate for ancillary and support costs shall be the 30393
rate for the facility's peer group determined under division (D) 30394

of section ~~5111.24~~ 5164.20 of the Revised Code. 30395

(3) The rate for capital costs shall be the median rate for 30396
the facility's peer group determined under division (D) of section 30397
~~5111.25~~ 5164.24 of the Revised Code. 30398

(4) The rate for tax costs as defined in section ~~5111.242~~ 30399
5164.21 of the Revised Code shall be the median rate for tax costs 30400
for the facility's peer group in which the facility is placed 30401
under division (C) of section ~~5111.24~~ 5164.20 of the Revised Code. 30402

(5) The quality incentive payment shall be the mean payment 30403
specified in division (B) of section ~~5111.244~~ 5164.23 of the 30404
Revised Code. 30405

(B) Subject to division (C) of this section, the department 30406
shall adjust the rates established under division (A) of this 30407
section effective the first day of July, to reflect new rate 30408
calculations for all nursing facilities under sections ~~5111.20~~ 30409
5164.01 to ~~5111.33~~ 5164.41 of the Revised Code. 30410

(C) If a rate for direct care costs is determined under this 30411
section for a nursing facility using the median annual average 30412
case-mix score for the nursing facility's peer group, the rate 30413
shall be redetermined to reflect the replacement nursing 30414
facility's actual semiannual case-mix score determined under 30415
section ~~5111.232~~ 5164.191 of the Revised Code after the nursing 30416
facility submits its first two quarterly assessment data that 30417
qualify for use in calculating a case-mix score in accordance with 30418
rules authorized by division (E) of section ~~5111.232~~ 5164.191 of 30419
the Revised Code. If the nursing facility's quarterly submissions 30420
do not qualify for use in calculating a case-mix score, the 30421
department shall continue to use the median annual average 30422
case-mix score for the nursing facility's peer group in lieu of 30423
the nursing facility's semiannual case-mix score until the nursing 30424
facility submits two consecutive quarterly assessment data that 30425

qualify for use in calculating a case-mix score. 30426

Sec. ~~5111.258~~ 5164.34. (A) Notwithstanding sections ~~5111.20~~ 30427
~~5164.01~~ to ~~5111.33~~ 5164.41 of the Revised Code, the director of 30428
~~job and family services~~ health care administration shall adopt 30429
rules under section ~~5111.02~~ 5163.15 of the Revised Code that 30430
establish a methodology for calculating the prospective rates that 30431
will be paid each fiscal year to a provider for each of the 30432
provider's eligible nursing facilities and intermediate care 30433
facilities for the mentally retarded, and discrete units of the 30434
provider's nursing facilities or intermediate care facilities for 30435
the mentally retarded, that serve residents who have diagnoses or 30436
special care needs that require direct care resources that are not 30437
measured adequately by the applicable assessment instrument 30438
specified in rules authorized by section ~~5111.232~~ 5164.051 or 30439
5164.191 of the Revised Code, or who have diagnoses or special 30440
care needs specified in the rules as otherwise qualifying for 30441
consideration under this section. The facilities and units of 30442
facilities whose rates are established under this division may 30443
include, but shall not be limited to, any of the following: 30444

(1) In the case of nursing facilities, facilities and units 30445
of facilities that serve medically fragile pediatric residents, 30446
residents who are dependent on ventilators, or residents who have 30447
severe traumatic brain injury, end-stage Alzheimer's disease, or 30448
end-stage acquired immunodeficiency syndrome; 30449

(2) In the case of intermediate care facilities for the 30450
mentally retarded, facilities and units of facilities that serve 30451
residents who have complex medical conditions or severe behavioral 30452
problems. 30453

The department shall use the methodology established under 30454
this division to pay for services rendered by such facilities and 30455
units after June 30, 1993. 30456

The rules authorized by this division shall specify the 30457
criteria and procedures the department will apply when designating 30458
facilities and units that qualify for calculation of rates under 30459
this division. The criteria shall include consideration of whether 30460
all of the allowable costs of the facility or unit would be paid 30461
by rates established under sections ~~5111.20~~ 5164.01 to ~~5111.33~~ 30462
5164.41 of the Revised Code, and shall establish a minimum bed 30463
size for a facility or unit to qualify to have its rates 30464
established under this division. The criteria shall not be 30465
designed to require that residents be served only in facilities 30466
located in large cities. The methodology established by the rules 30467
shall consider the historical costs of providing care to the 30468
residents of the facilities or units. 30469

The rules may require that a facility designated under this 30470
division or containing a unit designated under this division 30471
receive authorization from the department to admit or retain a 30472
resident to the facility or unit and shall specify the criteria 30473
and procedures the department will apply when granting that 30474
authorization. 30475

Notwithstanding any other provision of sections ~~5111.20~~ 30476
5164.01 to ~~5111.33~~ 5164.41 of the Revised Code, the costs incurred 30477
by facilities or units whose rates are established under this 30478
division shall not be considered in establishing payment rates for 30479
other facilities or units. 30480

(B) The director may adopt rules under section ~~5111.02~~ 30481
5163.15 of the Revised Code under which the department, 30482
notwithstanding any other provision of sections ~~5111.20~~ 5164.01 to 30483
~~5111.33~~ 5164.41 of the Revised Code, may adjust the rates 30484
determined under sections ~~5111.20~~ 5164.01 to ~~5111.33~~ 5164.41 of 30485
the Revised Code for a facility that serves a resident who has a 30486
diagnosis or special care need that, in the rules authorized by 30487
division (A) of this section, would qualify a facility or unit of 30488

a facility to have its rate determined under that division, but 30489
who is not in such a unit. The rules may require that a facility 30490
that qualifies for a rate adjustment under this division receive 30491
authorization from the department to admit or retain a resident 30492
who qualifies the facility for the rate adjustment and shall 30493
specify the criteria and procedures the department will apply when 30494
granting that authorization. 30495

Sec. ~~5111.33~~ 5164.35. Reimbursement to a provider under 30496
sections ~~5111.20~~ 5164.01 to ~~5111.32~~ 5164.41 of the Revised Code 30497
shall include payments to the provider, at a rate equal to the 30498
percentage of the per resident per day rates that the department 30499
of ~~job and family services~~ health care administration has 30500
established for the provider's nursing facility or intermediate 30501
care facility for the mentally retarded under sections ~~5111.20~~ 30502
5164.01 to ~~5111.33~~ 5164.41 of the Revised Code for the fiscal year 30503
for which the cost of services is reimbursed, to reserve a bed for 30504
a recipient during a temporary absence under conditions prescribed 30505
by the department, to include hospitalization for an acute 30506
condition, visits with relatives and friends, and participation in 30507
therapeutic programs outside the facility, when the resident's 30508
plan of care provides for such absence and federal participation 30509
in the payments is available. The maximum period during which 30510
payments may be made to reserve a bed shall not exceed the maximum 30511
period specified under federal regulations, and shall not be more 30512
than thirty days during any calendar year for hospital stays, 30513
visits with relatives and friends, and participation in 30514
therapeutic programs. Recipients who have been identified by the 30515
department as requiring the level of care of an intermediate care 30516
facility for the mentally retarded shall not be subject to a 30517
maximum period during which payments may be made to reserve a bed 30518
if prior authorization of the department is obtained for hospital 30519
stays, visits with relatives and friends, and participation in 30520

therapeutic programs. The director of ~~job and family services~~ 30521
health care administration shall adopt rules under section ~~5111.02~~ 30522
5163.15 of the Revised Code establishing conditions under which 30523
prior authorization may be obtained. 30524

Sec. ~~5111.26~~ 5164.37. (A)(1)(a) Except as provided in 30525
division (A)(1)(b) of this section, each provider shall file with 30526
the department of ~~job and family services~~ health care 30527
administration an annual cost report for each of the provider's 30528
nursing facilities and intermediate care facilities for the 30529
mentally retarded that participate in the medicaid program. A 30530
provider shall prepare the reports in accordance with guidelines 30531
established by the department. A report shall cover a calendar 30532
year or the portion of a calendar year during which the facility 30533
participated in the medicaid program. A provider shall file the 30534
reports within ninety days after the end of the calendar year. The 30535
department, for good cause, may grant a fourteen-day extension of 30536
the time for filing cost reports upon written request from a 30537
provider. The director of ~~job and family services~~ health care 30538
administration shall prescribe, in rules adopted under section 30539
~~5111.02~~ 5163.15 of the Revised Code, the cost reporting form and a 30540
uniform chart of accounts for the purpose of cost reporting, and 30541
shall distribute cost reporting forms or computer software for 30542
electronic submission of the cost report to each provider at least 30543
sixty days before the reporting date. 30544

(b) If rates for a provider's nursing facility or 30545
intermediate care facility for the mentally retarded were most 30546
recently established under section ~~5111.254~~ 5164.32 or ~~5111.255~~ 30547
5164.12 of the Revised Code, the provider shall submit a cost 30548
report for that facility no later than ninety days after the end 30549
of the facility's first three full calendar months of operation. 30550
If a nursing facility or intermediate care facility for the 30551
mentally retarded undergoes a change of provider that the 30552

department determines, in accordance with rules adopted under 30553
section ~~5111.02~~ 5163.15 of the Revised Code, is an arm's length 30554
transaction, the new provider shall submit a cost report for that 30555
facility not later than ninety days after the end of the 30556
facility's first three full calendar months of operation under the 30557
new provider. The provider of a facility that opens or undergoes a 30558
change of provider that is an arm's length transaction after the 30559
first day of October in any calendar year is not required to file 30560
a cost report for that calendar year. 30561

(c) If a nursing facility undergoes a change of provider that 30562
the department determines, in accordance with rules adopted under 30563
section ~~5111.02~~ 5163.15 of the Revised Code, is not an ~~arms~~ arm's 30564
length transaction, the new provider shall file a cost report 30565
under division (A)(1)(a) of this section for the facility. The 30566
cost report shall cover the portion of the calendar year during 30567
which the new provider operated the nursing facility and the 30568
portion of the calendar year during which the previous provider 30569
operated the nursing facility. 30570

(2) If a provider required to submit a cost report for a 30571
nursing facility or intermediate care facility for the mentally 30572
retarded does not file the report within the required time period 30573
or within fourteen days thereafter if an extension is granted 30574
under division (A)(1)(a) of this section, or files an incomplete 30575
or inadequate report for the facility, the department shall 30576
provide immediate written notice to the provider that the provider 30577
agreement for the facility will be terminated in thirty days 30578
unless the provider submits a complete and adequate cost report 30579
for the facility within thirty days. During the thirty-day 30580
termination period or any additional time allowed for an appeal of 30581
the proposed termination of a provider agreement, the provider 30582
shall be paid the facility's then current per resident per day 30583
rate, minus two dollars. On July 1, 1994, the department shall 30584

adjust the two-dollar reduction to reflect the rate of inflation 30585
during the preceding twelve months, as shown in the consumer price 30586
index for all items for all urban consumers for the north central 30587
region, published by the United States bureau of labor statistics. 30588
On July 1, 1995, and the first day of July of each year 30589
thereafter, the department shall adjust the amount of the 30590
reduction in effect during the previous twelve months to reflect 30591
the rate of inflation during the preceding twelve months, as shown 30592
in the same index. 30593

(B) No provider shall report fines paid under sections 30594
~~5111.35~~ 5164.50 to ~~5111.62~~ 5164.78 or section ~~5111.99~~ 5164.99 of 30595
the Revised Code in any cost report filed under this section. 30596

(C) The department shall develop an addendum to the cost 30597
report form that a provider may use to set forth costs that the 30598
provider believes may be disputed by the department. Any costs 30599
reported by the provider on the addendum may be considered by the 30600
department in setting the facility's rate. If the department does 30601
not consider the costs listed on the addendum in setting the 30602
facility's rate, the provider may seek reconsideration of that 30603
determination under section ~~5111.29~~ 5164.41 of the Revised Code. 30604
If the department subsequently includes the costs listed in the 30605
addendum in the facility's rate, the department shall pay the 30606
provider interest at a reasonable rate established in rules 30607
adopted under section ~~5111.02~~ 5163.15 of the Revised Code for the 30608
time that the rate paid excluded the costs. 30609

Sec. ~~5111.266~~ 5164.371. A provider of a nursing facility 30610
filing the facility's cost report with the department of ~~job and~~ 30611
~~family services~~ health care administration under section ~~5111.26~~ 30612
5164.37 of the Revised Code shall report as a nonreimbursable 30613
expense the cost of the nursing facility's franchise permit fee. 30614

Sec. ~~5111.264~~ 5164.372. Except as provided in section ~~5111.25~~ 30615
~~5164.24~~ or ~~5111.251~~ 5164.08 of the Revised Code, the costs of 30616
goods, services, and facilities, furnished to a provider by a 30617
related party are includable in the allowable costs of the 30618
provider at the reasonable cost to the related party. 30619

Sec. ~~5111.27~~ 5164.38. (A) The department of ~~job and family~~ 30620
~~services~~ health care administration shall conduct a desk review of 30621
each cost report it receives under section ~~5111.26~~ 5164.37 of the 30622
Revised Code. Based on the desk review, the department shall make 30623
a preliminary determination of whether the reported costs are 30624
allowable costs. The department shall notify each provider of 30625
whether any of the reported costs are preliminarily determined not 30626
to be allowable, the rate calculation under sections ~~5111.20~~ 30627
5164.01 to ~~5111.33~~ 5164.41 of the Revised Code that results from 30628
that determination, and the reasons for the determination and 30629
resulting rate. The department shall allow the provider to verify 30630
the calculation and submit additional information. 30631

(B) The department may conduct an audit, as defined by rule 30632
adopted under section ~~5111.02~~ 5163.15 of the Revised Code, of any 30633
cost report and shall notify the provider of its findings. 30634

Audits shall be conducted by auditors under contract with or 30635
employed by the department. The decision whether to conduct an 30636
audit and the scope of the audit, which may be a desk or field 30637
audit, shall be determined based on prior performance of the 30638
provider and may be based on a risk analysis or other evidence 30639
that gives the department reason to believe that the provider has 30640
reported costs improperly. A desk or field audit may be performed 30641
annually, but is required whenever a provider does not pass the 30642
risk analysis tolerance factors. The department shall issue the 30643
audit report no later than three years after the cost report is 30644
filed, or upon the completion of a desk or field audit on the 30645

report or a report for a subsequent cost reporting period, 30646
whichever is earlier. During the time within which the department 30647
may issue an audit report, the provider may amend the cost report 30648
upon discovery of a material error or material additional 30649
information. The department shall review the amended cost report 30650
for accuracy and notify the provider of its determination. 30651

The department may establish a contract for the auditing of 30652
facilities by outside firms. Each contract entered into by bidding 30653
shall be effective for one to two years. The department shall 30654
establish an audit manual and program which shall require that all 30655
field audits, conducted either pursuant to a contract or by 30656
department employees: 30657

(1) Comply with the applicable rules prescribed pursuant to 30658
Titles XVIII and XIX; 30659

(2) Consider generally accepted auditing standards prescribed 30660
by the American institute of certified public accountants; 30661

(3) Include a written summary as to whether the costs 30662
included in the report examined during the audit are allowable and 30663
are presented fairly in accordance with generally accepted 30664
accounting principles and department rules, and whether, in all 30665
material respects, allowable costs are documented, reasonable, and 30666
related to patient care; 30667

(4) Are conducted by accounting firms or auditors who, during 30668
the period of the auditors' professional engagement or employment 30669
and during the period covered by the cost reports, do not have nor 30670
are committed to acquire any direct or indirect financial interest 30671
in the ownership, financing, or operation of a nursing facility or 30672
intermediate care facility for the mentally retarded in this 30673
state; 30674

(5) Are conducted by accounting firms or auditors who, as a 30675
condition of the contract or employment, shall not audit any 30676

facility that has been a client of the firm or auditor; 30677

(6) Are conducted by auditors who are otherwise independent 30678
as determined by the standards of independence established by the 30679
American institute of certified public accountants; 30680

(7) Are completed within the time period specified by the 30681
department; 30682

(8) Provide to the provider complete written interpretations 30683
that explain in detail the application of all relevant contract 30684
provisions, regulations, auditing standards, rate formulae, and 30685
departmental policies, with explanations and examples, that are 30686
sufficient to permit the provider to calculate with reasonable 30687
certainty those costs that are allowable and the rate to which the 30688
provider's facility is entitled. 30689

For the purposes of division (B)(4) of this section, 30690
employment of a member of an auditor's family by a nursing 30691
facility or intermediate care facility for the mentally retarded 30692
that the auditor does not review does not constitute a direct or 30693
indirect financial interest in the ownership, financing, or 30694
operation of the facility. 30695

(C) The department, pursuant to rules adopted under section 30696
~~5111.02~~ 5163.15 of the Revised Code, may conduct an exception 30697
review of assessment data submitted under section ~~5111.232~~ 30698
5164.051 or 5164.191 of the Revised Code. The department may 30699
conduct an exception review based on the findings of a 30700
certification survey conducted by the department of health, a risk 30701
analysis, or prior performance of the provider. 30702

Exception reviews shall be conducted at the facility by 30703
appropriate health professionals under contract with or employed 30704
by the department of ~~job and family services~~ health care 30705
administration. The professionals may review resident assessment 30706
forms and supporting documentation, conduct interviews, and 30707

observe residents to identify any patterns or trends of inaccurate 30708
assessments and resulting inaccurate case-mix scores. 30709

The rules shall establish an exception review program that 30710
requires that exception reviews do all of the following: 30711

(1) Comply with Titles XVIII and XIX; 30712

(2) Provide a written summary that states whether the 30713
resident assessment forms have been completed accurately; 30714

(3) Are conducted by health professionals who, during the 30715
period of their professional engagement or employment with the 30716
department, neither have nor are committed to acquire any direct 30717
or indirect financial interest in the ownership, financing, or 30718
operation of a nursing facility or intermediate care facility for 30719
the mentally retarded in this state; 30720

(4) Are conducted by health professionals who, as a condition 30721
of their engagement or employment with the department, shall not 30722
review any provider that has been a client of the professional. 30723

For the purposes of division (C)(3) of this section, 30724
employment of a member of a health professional's family by a 30725
nursing facility or intermediate care facility for the mentally 30726
retarded that the professional does not review does not constitute 30727
a direct or indirect financial interest in the ownership, 30728
financing, or operation of the facility. 30729

If an exception review is conducted before the effective date 30730
of the rate that is based on the case-mix data subject to the 30731
review and the review results in findings that exceed tolerance 30732
levels specified in the rules adopted under this division, the 30733
department, in accordance with those rules, may use the findings 30734
to recalculate individual resident case-mix scores, quarterly 30735
average facility case-mix scores, and annual average facility 30736
case-mix scores. The department may use the recalculated quarterly 30737
and annual facility average case-mix scores to calculate the 30738

facility's rate for direct care costs for the appropriate calendar 30739
quarter or quarters. 30740

(D) The department shall prepare a written summary of any 30741
audit disallowance or exception review finding that is made after 30742
the effective date of the rate that is based on the cost or 30743
case-mix data. Where the provider is pursuing judicial or 30744
administrative remedies in good faith regarding the disallowance 30745
or finding, the department shall not withhold from the provider's 30746
current payments any amounts the department claims to be due from 30747
the provider pursuant to section ~~5111.28~~ 5164.39 of the Revised 30748
Code. 30749

(E) The department shall not reduce rates calculated under 30750
sections ~~5111.20~~ 5164.01 to ~~5111.33~~ 5164.41 of the Revised Code on 30751
the basis that the provider charges a lower rate to any resident 30752
who is not eligible for the medicaid program. 30753

(F) The department shall adjust the rates calculated under 30754
sections ~~5111.20~~ 5164.01 to ~~5111.33~~ 5164.41 of the Revised Code to 30755
account for reasonable additional costs that must be incurred by 30756
intermediate care facilities for the mentally retarded to comply 30757
with requirements of federal or state statutes, rules, or policies 30758
enacted or amended after January 1, 1992, or with orders issued by 30759
state or local fire authorities. 30760

Sec. ~~5111.28~~ 5164.39. (A) If a provider properly amends its 30761
cost report under section ~~5111.27~~ 5164.38 of the Revised Code and 30762
the amended report shows that the provider received a lower rate 30763
under the original cost report than it was entitled to receive, 30764
the department of ~~job and family services~~ health care 30765
administration shall adjust the provider's rate prospectively to 30766
reflect the corrected information. The department shall pay the 30767
adjusted rate beginning two months after the first day of the 30768
month after the provider files the amended cost report. If the 30769

department finds, from an exception review of resident assessment 30770
information conducted after the effective date of the rate for 30771
direct care costs that is based on the assessment information, 30772
that inaccurate assessment information resulted in the provider 30773
receiving a lower rate than it was entitled to receive, the 30774
department prospectively shall adjust the provider's rate 30775
accordingly and shall make payments using the adjusted rate for 30776
the remainder of the calendar quarter for which the assessment 30777
information is used to determine the rate, beginning one month 30778
after the first day of the month after the exception review is 30779
completed. 30780

(B) If the provider properly amends its cost report under 30781
section ~~5111.27~~ 5164.38 of the Revised Code, the department makes 30782
a finding based on an audit under that section, or the department 30783
makes a finding based on an exception review of resident 30784
assessment information conducted under that section after the 30785
effective date of the rate for direct care costs that is based on 30786
the assessment information, any of which results in a 30787
determination that the provider has received a higher rate than it 30788
was entitled to receive, the department shall recalculate the 30789
provider's rate using the revised information. The department 30790
shall apply the recalculated rate to the periods when the provider 30791
received the incorrect rate to determine the amount of the 30792
overpayment. The provider shall refund the amount of the 30793
overpayment. 30794

In addition to requiring a refund under this division, the 30795
department may charge the provider interest at the applicable rate 30796
specified in this division from the time the overpayment was made. 30797

(1) If the overpayment resulted from costs reported for 30798
calendar year 1993, the interest shall be no greater than one and 30799
one-half times the average bank prime rate. 30800

(2) If the overpayment resulted from costs reported for 30801

subsequent calendar years: 30802

(a) The interest shall be no greater than two times the 30803
average bank prime rate if the overpayment was equal to or less 30804
than one per cent of the total medicaid payments to the provider 30805
for the fiscal year for which the incorrect information was used 30806
to establish a rate. 30807

(b) The interest shall be no greater than two and one-half 30808
times the current average bank prime rate if the overpayment was 30809
greater than one per cent of the total medicaid payments to the 30810
provider for the fiscal year for which the incorrect information 30811
was used to establish a rate. 30812

(C) The department also may impose the following penalties: 30813

(1) If a provider does not furnish invoices or other 30814
documentation that the department requests during an audit within 30815
sixty days after the request, no more than the greater of one 30816
thousand dollars per audit or twenty-five per cent of the 30817
cumulative amount by which the costs for which documentation was 30818
not furnished increased the total medicaid payments to the 30819
provider during the fiscal year for which the costs were used to 30820
establish a rate; 30821

(2) If an exiting operator or owner fails to provide notice 30822
of a facility closure, voluntary termination, or voluntary 30823
withdrawal of participation in the medicaid program as required by 30824
section ~~5111.66~~ 5164.83 of the Revised Code, or an exiting 30825
operator or owner and entering operator fail to provide notice of 30826
a change of operator as required by section ~~5111.67~~ 5164.84 of the 30827
Revised Code, no more than the current average bank prime rate 30828
plus four per cent of the last two monthly payments. 30829

(D) If the provider continues to participate in the medicaid 30830
program, the department shall deduct any amount that the provider 30831
is required to refund under this section, and the amount of any 30832

interest charged or penalty imposed under this section, from the 30833
next available payment from the department to the provider. The 30834
department and the provider may enter into an agreement under 30835
which the amount, together with interest, is deducted in 30836
installments from payments from the department to the provider. 30837

(E) The department shall transmit refunds and penalties to 30838
the treasurer of state for deposit in the general revenue fund. 30839

(F) For the purpose of this section, the department shall 30840
determine the average bank prime rate using statistical release 30841
H.15, "selected interest rates," a weekly publication of the 30842
federal reserve board, or any successor publication. If 30843
statistical release H.15, or its successor, ceases to contain the 30844
bank prime rate information or ceases to be published, the 30845
department shall request a written statement of the average bank 30846
prime rate from the federal reserve bank of Cleveland or the 30847
federal reserve board. 30848

Sec. ~~5111.221~~ 5164.40. The department of ~~job and family~~ 30849
~~services~~ health care administration shall make its best efforts 30850
each year to calculate rates under sections ~~5111.20~~ 5164.01 to 30851
~~5111.33~~ 5164.41 of the Revised Code in time to use them to make 30852
the payments due to providers by the fifteenth day of August. If 30853
the department is unable to calculate the rates so that they can 30854
be paid by that date, the department shall pay each provider the 30855
rate calculated for the provider's nursing facilities and 30856
intermediate care facilities for the mentally retarded under those 30857
sections at the end of the previous fiscal year. If the department 30858
also is unable to calculate the rates to make the payments due by 30859
the fifteenth day of September and the fifteenth day of October, 30860
the department shall pay the previous fiscal year's rate to make 30861
those payments. The department may increase by five per cent the 30862
previous fiscal year's rate paid for any facility pursuant to this 30863

section at the request of the provider. The department shall use 30864
rates calculated for the current fiscal year to make the payments 30865
due by the fifteenth day of November. 30866

If the rate paid to a provider for a facility pursuant to 30867
this section is lower than the rate calculated for the facility 30868
for the current fiscal year, the department shall pay the provider 30869
the difference between the two rates for the number of days for 30870
which the provider was paid for the facility pursuant to this 30871
section. If the rate paid for a facility pursuant to this section 30872
is higher than the rate calculated for it for the current fiscal 30873
year, the provider shall refund to the department the difference 30874
between the two rates for the number of days for which the 30875
provider was paid for the facility pursuant to this section. 30876

Sec. ~~5111.29~~ 5164.41. (A) The director of ~~job and family~~ 30877
~~services~~ health care administration shall adopt rules under 30878
section ~~5111.02~~ 5163.15 of the Revised Code that establish a 30879
process under which a provider, or a group or association of 30880
providers, may seek reconsideration of rates established under 30881
sections ~~5111.20~~ 5164.01 to ~~5111.33~~ 5164.41 of the Revised Code, 30882
including a rate for direct care costs recalculated before the 30883
effective date of the rate as a result of an exception review of 30884
resident assessment information conducted under section ~~5111.27~~ 30885
5164.38 of the Revised Code. 30886

(1) Except as provided in divisions (A)(2) to (4) of this 30887
section, the only issue that a provider, group, or association may 30888
raise in the rate reconsideration shall be whether the rate was 30889
calculated in accordance with sections ~~5111.20~~ 5164.01 to ~~5111.33~~ 30890
5164.41 of the Revised Code and the rules adopted under section 30891
~~5111.02~~ 5163.15 of the Revised Code. The rules shall permit a 30892
provider, group, or association to submit written arguments or 30893
other materials that support its position. The rules shall specify 30894

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 30928
request. 30929

(3) The rules shall provide that the department, through the 30930
rate reconsideration process, may increase an intermediate care 30931
facility for the mentally retarded's rate as calculated under 30932
sections ~~5111.20~~ 5164.01 to ~~5111.33~~ 5164.41 of the Revised Code if 30933
the department, in the department's sole discretion, determines 30934
that the rate as calculated under those sections works an extreme 30935
hardship on the facility. 30936

(4) The rules shall provide that when beds certified for the 30937
medicaid program are added to an existing intermediate care 30938
facility for the mentally retarded or replaced at the same site, 30939
the department, through the rate reconsideration process, shall 30940
increase the intermediate care facility for the mentally 30941
retarded's rate for capital costs proportionately, as limited by 30942
any applicable limitation under section ~~5111.251~~ 5164.08 of the 30943
Revised Code, to account for the costs of the beds that are added 30944
or replaced. The department shall make this increase one month 30945
after the first day of the month after the department receives 30946
sufficient documentation of the costs. Any rate increase granted 30947
under division (A)(4) of this section after June 30, 1993, shall 30948
remain in effect until the effective date of a rate calculated 30949
under section ~~5111.251~~ 5164.08 of the Revised Code that includes 30950
costs incurred for a full calendar year for the bed addition or 30951
bed replacement. The facility shall report double accumulated 30952
depreciation in an amount equal to the depreciation included in 30953
the rate adjustment on its cost report for the first year of 30954
operation. During the term of any loan used to finance a project 30955
for which a rate adjustment is granted under division (A)(4) of 30956
this section, if the facility is operated by the same provider, 30957
the provider shall subtract from the interest costs it reports on 30958
its cost report an amount equal to the difference between the 30959

following:	30960
(a) The actual, allowable interest costs for the loan during the calendar year for which the costs are being reported;	30961 30962
(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.	30963 30964 30965
(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.	30966 30967 30968 30969
(B) All of the following are subject to an adjudication conducted in accordance with Chapter 119. of the Revised Code:	30970 30971
(1) Any audit disallowance that the department makes as the result of an audit under section 5111.27 <u>5164.38</u> of the Revised Code;	30972 30973 30974
(2) Any adverse finding that results from an exception review of resident assessment information conducted under section 5111.27 <u>5164.38</u> of the Revised Code after the effective date of the facility's rate that is based on the assessment information;	30975 30976 30977 30978
(3) Any medicaid payment deemed an overpayment under section 5111.683 <u>5164.853</u> of the Revised Code;	30979 30980
(4) Any penalty the department imposes under division (C) of section 5111.28 <u>5164.39</u> of the Revised Code or section 5111.683 <u>5164.853</u> of the Revised Code.	30981 30982 30983
Sec. 5111.202 <u>5164.45</u>. (A) As used in this section:	30984
(1) "Dementia" includes Alzheimer's disease or a related disorder.	30985 30986
(2) "Serious mental illness" means "serious mental illness," as defined by the United States department of health and human	30987 30988

services in regulations adopted under ~~section 1919(e)(7)(G)(i) of~~ 30989
the "~~Social Security Act,~~" ~~49 Stat. 620 (1935),~~ 42 U.S.C.A. 301, 30990
~~as amended~~ 1396r(e)(7)(G)(i). 30991

(3) "Mentally ill individual" means an individual who has a 30992
serious mental illness other than either of the following: 30993

(a) A primary diagnosis of dementia; 30994

(b) A primary diagnosis that is not a primary diagnosis of 30995
dementia and a primary diagnosis of something other than a serious 30996
mental illness. 30997

(4) "Mentally retarded individual" means an individual who is 30998
mentally retarded or has a related condition, as described in 30999
~~section 1905(d) of the "Social Security Act~~ 42 U.S.C. 1396d(d)." 31000

(5) "Specialized services" means the services specified by 31001
the United States department of health and human services in 31002
regulations adopted under ~~section 1919(e)(7)(G)(iii) of the~~ 31003
~~"Social Security Act~~ 42 U.S.C. 1396r(e)(7)(G)(iii)." 31004

(B)(1) Except as provided in division (D) of this section, no 31005
nursing facility shall admit as a resident any mentally ill 31006
individual unless the facility has received evidence that the 31007
department of mental health has determined both of the following 31008
under section 5119.061 of the Revised Code: 31009

(a) That the individual requires the level of services 31010
provided by a nursing facility because of the individual's 31011
physical and mental condition; 31012

(b) Whether the individual requires specialized services for 31013
mental illness. 31014

(2) Except as provided in division (D) of this section, no 31015
nursing facility shall admit as a resident any mentally retarded 31016
individual unless the facility has received evidence that the 31017
department of mental retardation and developmental disabilities 31018

has determined both of the following under section 5123.021 of the Revised Code: 31019
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(a) That the individual requires the level of services provided by a nursing facility because of the individual's physical and mental condition; 31021
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(b) Whether the individual requires specialized services for mental retardation. 31024
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(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. 31026
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(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. 31033
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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 31041
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mental retardation and developmental disabilities under section 31050
5123.021 of the Revised Code. The hearing shall be conducted in 31051
the same manner as hearings conducted under section ~~5101.35~~ 31052
5160.34 of the Revised Code. Any decision made by the department 31053
of ~~job and family services~~ health care administration on the basis 31054
of the hearing is binding on the department of mental health and 31055
the department of mental retardation and developmental 31056
disabilities. 31057

Sec. ~~5111.204~~ 5164.47. (A) As used in this section, 31058
"representative" means a person acting on behalf of an applicant 31059
for or recipient of medicaid. A representative may be a family 31060
member, attorney, hospital social worker, or any other person 31061
chosen to act on behalf of an applicant or recipient. 31062

(B) The department of ~~job and family services~~ health care 31063
administration may require each applicant for or recipient of 31064
medicaid who applies or intends to apply for admission to a 31065
nursing facility or resides in a nursing facility to undergo an 31066
assessment to determine whether the applicant or recipient needs 31067
the level of care provided by a nursing facility. The assessment 31068
may be performed concurrently with a long-term care consultation 31069
provided under section 173.42 of the Revised Code. 31070

To the maximum extent possible, the assessment shall be based 31071
on information from the resident assessment instrument specified 31072
in rules adopted by the director of ~~job and family services~~ health 31073
care administration under division ~~(E)~~(D) of section ~~5111.232~~ 31074
5164.191 of the Revised Code. The assessment shall also be based 31075
on criteria and procedures established in rules adopted under 31076
division (F) of this section and information provided by the 31077
person being assessed or the person's representative. 31078

The department of ~~job and family services~~ health care 31079
administration, or if the assessment is performed by an agency 31080

under contract with the department pursuant to division (G) of 31081
this section, the agency, shall, not later than the time the level 31082
of care determination based on the assessment is required to be 31083
provided under division (C) of this section, give written notice 31084
of its conclusions and the basis for them to the person assessed 31085
and, if the department of ~~job and family services~~ health care 31086
administration or agency under contract with the department has 31087
been informed that the person has a representative, to the 31088
representative. 31089

(C) The department of ~~job and family services~~ health care 31090
administration or agency under contract with the department, 31091
whichever performs the assessment, shall provide a level of care 31092
determination based on the assessment as follows: 31093

(1) In the case of a person applying or intending to apply 31094
for admission to a nursing facility while hospitalized, not later 31095
than one of the following: 31096

(a) One working day after the person or the person's 31097
representative submits the application or notifies the department 31098
of the person's intention to apply and submits all information 31099
required for providing the level of care determination, as 31100
specified in rules adopted under division (F)(2) of this section; 31101

(b) A later date requested by the person or the person's 31102
representative. 31103

(2) In the case of a person applying or intending to apply 31104
for admission to a nursing facility who is not hospitalized, not 31105
later than one of the following: 31106

(a) Five calendar days after the person or the person's 31107
representative submits the application or notifies the department 31108
of the person's intention to apply and submits all information 31109
required for providing the level of care determination, as 31110
specified in rules adopted under division (F)(2) of this section; 31111

(b) A later date requested by the person or the person's representative. 31112
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(3) In the case of a person who resides in a nursing facility, not later than one of the following: 31114
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(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; 31116
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(b) A later date requested by the person or the person's representative. 31121
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(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. 31123
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(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. 31126
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(E) A nursing facility that admits or retains a person 31142

determined pursuant to an assessment required under this section 31143
not to need the level of care provided by the nursing facility 31144
shall not be reimbursed under the medicaid program for the 31145
person's care. 31146

(F) The director of ~~job and family services~~ health care 31147
administration shall adopt rules in accordance with Chapter 119. 31148
of the Revised Code to implement and administer this section. The 31149
rules shall include all of the following: 31150

(1) Criteria and procedures to be used in determining whether 31151
admission to a nursing facility or continued stay in a nursing 31152
facility is appropriate for the person being assessed; 31153

(2) Information the person being assessed or the person's 31154
representative must provide to the department or agency under 31155
contract with the department for purposes of the assessment and 31156
providing a level of care determination based on the assessment; 31157

(3) Circumstances under which a person is not required to be 31158
assessed; 31159

(4) Circumstances that constitute an emergency for purposes 31160
of division (C)(4) of this section and the number of days within 31161
which a level of care determination must be provided in the case 31162
of an emergency. 31163

(G) Pursuant to section ~~5111.91~~ 5161.05 of the Revised Code, 31164
the department of ~~job and family services~~ health care 31165
administration may enter into contracts in the form of interagency 31166
agreements with one or more other state agencies to perform the 31167
assessments required under this section. The interagency 31168
agreements shall specify the responsibilities of each agency in 31169
the performance of the assessments. 31170

Sec. ~~5111.35~~ 5164.50. As used in this section "a resident's 31171
rights" means the rights of a nursing facility resident under 31172

sections 3721.10 to 3721.17 of the Revised Code and subsection (c) 31173
of section 1819 or 1919 of the "Social Security Act," 49 Stat. 620 31174
(1935), 42 U.S.C.A. 301, as amended, and regulations issued under 31175
those subsections. 31176

As used in sections ~~5111.35~~ 5164.50 to ~~5111.62~~ 5164.78 of the 31177
Revised Code: 31178

(A) "Certification requirements" means the requirements for 31179
nursing facilities established under sections 1819 and 1919 of the 31180
"Social Security Act." 31181

(B) "Compliance" means substantially meeting all applicable 31182
certification requirements. 31183

(C) "Contracting agency" means a state agency that has 31184
entered into a contract with the department of ~~job and family~~ 31185
~~services~~ health care administration under section ~~5111.38~~ 5164.53 31186
of the Revised Code. 31187

(D)(1) "Deficiency" means a finding cited by the department 31188
of health during a survey, on the basis of one or more actions, 31189
practices, situations, or incidents occurring at a nursing 31190
facility, that constitutes a severity level three finding, 31191
severity level four finding, scope level three finding, or scope 31192
level four finding. Whenever the finding is a repeat finding, 31193
"deficiency" also includes any finding that is a severity level 31194
two and scope level one finding, a severity level two and scope 31195
level two finding, or a severity level one and scope level two 31196
finding. 31197

(2) "Cluster of deficiencies" means deficiencies that result 31198
from noncompliance with two or more certification requirements and 31199
are causing or resulting from the same action, practice, 31200
situation, or incident. 31201

(E) "Emergency" means either of the following: 31202

- (1) A deficiency or cluster of deficiencies that creates a condition of immediate jeopardy; 31203
31204
- (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: 31205
31206
31207
31208
- (a) A flood or other natural disaster, civil disaster, or similar event; 31209
31210
- (b) A labor strike that suddenly causes the number of staff members in a nursing facility to be below that necessary for resident care. 31211
31212
31213
- (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. 31214
31215
31216
- (G) "Immediate jeopardy" means that one or more residents of a nursing facility are in imminent danger of serious physical or life-threatening harm. 31217
31218
31219
- (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. 31220
31221
31222
31223
31224
- (I) "Noncompliance" means failure to substantially meet all applicable certification requirements. 31225
31226
- (J) "Nursing facility" has the same meaning as in section ~~5111.20~~ 5164.01 of the Revised Code. 31227
31228
- (K) "Provider" means a person, institution, or entity that furnishes nursing facility services under a ~~medical assistance program~~ medicaid provider agreement. 31229
31230
31231
- (L) "Repeat finding" or "repeat deficiency" means a finding 31232

or deficiency cited pursuant to a survey, to which both of the 31233
following apply: 31234

(1) The finding or deficiency involves noncompliance with the 31235
same certification requirement, and the same kind of actions, 31236
practices, situations, or incidents caused by or resulting from 31237
the noncompliance, as were cited in the immediately preceding 31238
standard survey or another survey conducted subsequent to the 31239
immediately preceding standard survey of the facility. For 31240
purposes of this division, actions, practices, situations, or 31241
incidents may be of the same kind even though they involve 31242
different residents, staff, or parts of the facility. 31243

(2) The finding or deficiency is cited subsequent to a 31244
determination by the department of health that the finding or 31245
deficiency cited on the immediately preceding standard survey, or 31246
another survey conducted subsequent to the immediately preceding 31247
standard survey, had been corrected. 31248

(M)(1) "Scope level one finding" means a finding of 31249
noncompliance by a nursing facility in which the actions, 31250
situations, practices, or incidents causing or resulting from the 31251
noncompliance affect one or a very limited number of facility 31252
residents and involve one or a very limited number of facility 31253
staff members. 31254

(2) "Scope level two finding" means a finding of 31255
noncompliance by a nursing facility in which the actions, 31256
situations, practices, or incidents causing or resulting from the 31257
noncompliance affect more than a limited number of facility 31258
residents or involve more than a limited number of facility staff 31259
members, but the number or percentage of facility residents 31260
affected or staff members involved and the number or frequency of 31261
the actions, situations, practices, or incidents in short 31262
succession does not establish any reasonable degree of 31263
predictability of similar actions, situations, practices, or 31264

incidents occurring in the future. 31265

(3) "Scope level three finding" means a finding of 31266
noncompliance by a nursing facility in which the actions, 31267
situations, practices, or incidents causing or resulting from the 31268
noncompliance affect more than a limited number of facility 31269
residents or involve more than a limited number of facility staff 31270
members, and the number or percentage of facility residents 31271
affected or staff members involved or the number or frequency of 31272
the actions, situations, practices, or incidents in short 31273
succession establishes a reasonable degree of predictability of 31274
similar actions, situations, practices, or incidents occurring in 31275
the future. 31276

(4) "Scope level four finding" means a finding of 31277
noncompliance by a nursing facility causing or resulting from 31278
actions, situations, practices, or incidents that involve a 31279
sufficient number or percentage of facility residents or staff 31280
members or occur with sufficient regularity over time that the 31281
noncompliance can be considered systemic or pervasive in the 31282
facility. 31283

(N)(1) "Severity level one finding" means a finding of 31284
noncompliance by a nursing facility that has not caused and, if 31285
continued, is unlikely to cause physical harm to a facility 31286
resident, mental or emotional harm to a resident, or a violation 31287
of a resident's rights that results in physical, mental, or 31288
emotional harm to the resident. 31289

(2) "Severity level two finding" means a finding of 31290
noncompliance by a nursing facility that, if continued over time, 31291
will cause, or is likely to cause, physical harm to a facility 31292
resident, mental or emotional harm to a resident, or a violation 31293
of a resident's rights that results in physical, mental, or 31294
emotional harm to the resident. 31295

(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, 31325
and procedures issued by the United States secretary of health and 31326
human services under ~~sections 1819 and 1919 of the "Social~~ 31327
~~Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended,~~ 31328
1395i-3 and 1396r and necessary for administration and enforcement 31329
of sections ~~5111.35~~ 5164.50 to ~~5111.62~~ 5164.78 of the Revised 31330
Code. If the secretary does not issue appropriate regulations for 31331
enforcement of ~~sections 1819 and 1919 of the "Social Security Act"~~ 31332
42 U.S.C. 1395i-3 and 1396r on or before December 13, 1990, the 31333
director of ~~job and family services~~ health care administration may 31334
adopt, under Chapter 119. of the Revised Code, rules that are 31335
consistent with those sections and with sections ~~5111.35~~ 5164.50 31336
to ~~5111.62~~ 5164.78 of the Revised Code. 31337

Sec. ~~5111.37~~ 5164.52. The department of ~~job and family~~ 31338
~~services~~ health care administration is hereby authorized to 31339
enforce sections ~~5111.35~~ 5164.50 to ~~5111.62~~ 5164.78 of the Revised 31340
Code. The department may enforce the sections directly or through 31341
contracting agencies. The department and agencies shall enforce 31342
the sections in accordance with the requirements of ~~sections 1819~~ 31343
~~and 1919 of the "Social Security Act," 49 Stat. 620 (1935), 42~~ 31344
~~U.S.C.A. 301, as amended, 1395i-3 and 1396r~~ that apply to nursing 31345
facilities; with regulations, guidelines, and procedures adopted 31346
by the United States secretary of health and human services for 31347
the enforcement of ~~sections 1819 and 1919 of the "Social Security~~ 31348
~~Act"~~ 42 U.S.C. 1395i-3 and 1396r; and with the rules adopted under 31349
section ~~5111.36~~ 5164.51 of the Revised Code. The department and 31350
agencies shall enforce sections ~~5111.35~~ 5164.50 to ~~5111.62~~ 5164.78 31351
of the Revised Code for purposes of the medicare program, ~~Title~~ 31352
~~XVIII of the "Social Security Act,"~~ only to the extent prescribed 31353
by the regulations, guidelines, and procedures issued by the 31354
secretary under ~~section 1819 of that act~~ 42 U.S.C. 1395i-3. 31355

Sec. ~~5111.38~~ 5164.53. The department of ~~job and family~~ 31356
~~services~~ health care administration may enter into contracts with 31357
other state agencies that authorize the agencies to perform all or 31358
part of the duties assigned to the department of ~~job and family~~ 31359
~~services~~ health care administration under sections ~~5111.35~~ 5164.50 31360
to ~~5111.62~~ 5164.78 of the Revised Code. Each contract shall 31361
specify the duties the agency is authorized to perform and the 31362
sections of the Revised Code under which the agency is authorized 31363
to perform those duties. 31364

Sec. ~~5111.39~~ 5164.54. (A) The department of health shall 31365
conduct a survey, titled a standard survey, of every nursing 31366
facility in this state on a statewide average of not more than 31367
once every twelve months. Each nursing facility shall undergo a 31368
standard survey at least once every fifteen months as a condition 31369
of meeting certification requirements. The department may extend a 31370
standard survey; such a survey is titled an extended survey. 31371

(B) The department may conduct surveys in addition to 31372
standard surveys when it considers them necessary. 31373

(C) The department shall conduct surveys in accordance with 31374
the regulations, guidelines, and procedures issued by the United 31375
States secretary of health and human services ~~under Titles XVIII~~ 31376
~~and XIX of the "Social Security Act," 49 Stat. 620 (1935), 42~~ 31377
~~U.S.C.A. 301, as amended~~ for the medicare and medicaid programs, 31378
sections ~~5111.40~~ 5164.55 to ~~5111.42~~ 5164.58 of the Revised Code, 31379
and rules adopted under section 3721.022 of the Revised Code. 31380

Sec. ~~5111.40~~ 5164.55. (A) At the conclusion of each survey, 31381
the department of health survey team shall conduct an exit 31382
interview with the administrator or other person in charge of the 31383
nursing facility and any other facility staff members designated 31384
by the administrator or person in charge of the facility. During 31385

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. 31416

(B) If the department of health determines both that the 31417
actions, practices, situations, or incidents cannot be justified 31418
by the factors identified in division (A) of this section and that 31419
one or more of the following are applicable, the department shall 31420
declare that the actions, practices, situations, or incidents 31421
constitute a finding: 31422

(1) The actions, practices, situations, or incidents could 31423
have been prevented by one or more persons involved in the 31424
facility's operation; 31425

(2) No person involved in the facility's operation identified 31426
the actions, practices, situations, or incidents prior to the 31427
survey; 31428

(3) Prior to the survey, no person involved in the facility's 31429
operation initiated action to correct the noncompliance caused by 31430
or resulting in the actions, practices, situations, or incidents; 31431

(4) The facility does not have in effect, if needed, a 31432
contingency plan that is reasonably calculated to prevent 31433
physical, mental, or emotional harm to residents while permanent 31434
corrective action is being taken. 31435

(C) The department of health shall determine the severity 31436
level and scope level of each finding. 31437

(D) A deficiency that is substantially corrected within the 31438
time limits specified in sections ~~5111.52~~ 5164.68 to ~~5111.56~~ 31439
5164.72 of the Revised Code and for which no remedy is imposed, 31440
shall be counted as a deficiency for the purpose of determining 31441
whether a deficiency is a repeat deficiency. 31442

(E) Whenever the department of health determines that during 31443
the period between two surveys a finding existed at the facility, 31444
but the facility substantially corrected it prior to the second 31445

survey, the department shall cite it. However, the department of 31446
~~job and family services~~ health care administration or a 31447
contracting agency shall impose a remedy only as provided in 31448
division (C) of section ~~5111.46~~ 5164.62 of the Revised Code. 31449

(F) Immediately upon determining the severity and scope of a 31450
finding at a nursing facility, the department of health shall 31451
notify the department of ~~job and family services~~ health care 31452
administration and any contracting agency of the finding, the 31453
severity and scope of the finding, and whether the finding creates 31454
immediate jeopardy. Immediately upon determining that an emergency 31455
exists at a facility that does not result from a deficiency that 31456
creates immediate jeopardy, the department of health shall notify 31457
the department of ~~job and family services~~ health care 31458
administration and any contracting agency. 31459

Sec. ~~5111.411~~ 5164.57. The results of a survey of a nursing 31460
facility that is conducted under section ~~5111.39~~ 5164.54 of the 31461
Revised Code, including any statement of deficiencies and all 31462
findings and deficiencies cited in the statement on the basis of 31463
the survey, shall be used solely to determine the nursing 31464
facility's compliance with certification requirements or with this 31465
chapter or another chapter of the Revised Code. Those results of a 31466
survey, that statement of deficiencies, and the findings and 31467
deficiencies cited in that statement shall not be used in any 31468
court or in any action or proceeding that is pending in any court 31469
and are not admissible in evidence in any action or proceeding 31470
unless that action or proceeding is an appeal of an administrative 31471
action by the department of ~~job and family services~~ health care 31472
administration or contracting agency under this chapter or is an 31473
action by any department or agency of the state to enforce this 31474
chapter or another chapter of the Revised Code. 31475

Nothing in this section prohibits the results of a survey, a 31476

statement of deficiencies, or the findings and deficiencies cited 31477
in that statement on the basis of the survey under this section 31478
from being used in a criminal investigation or prosecution. 31479

Sec. ~~5111.42~~ 5164.58. (A) Not later than ten days after an 31480
exit interview, the department of health shall deliver to the 31481
nursing facility a detailed statement, titled a statement of 31482
deficiencies, setting forth all findings and deficiencies cited on 31483
the basis of the survey, including any finding cited pursuant to 31484
division (E) of section ~~5111.41~~ 5164.56 of the Revised Code. The 31485
statement shall indicate the severity and scope level of each 31486
finding and fully describe the incidents or other facts that form 31487
the basis of the department's determination of the existence of 31488
each finding and deficiency. A failure by the survey team to 31489
completely disclose in the exit interview every finding that may 31490
result from the survey does not affect the validity of any finding 31491
or deficiency cited in the statement of deficiencies. On request 31492
of the facility, the department shall provide a copy of any 31493
written worksheet or other document produced by the survey team in 31494
making recommendations regarding scope and severity levels of 31495
findings and deficiencies. 31496

(B) At the same time the department of health delivers a 31497
statement of deficiencies, it also shall deliver to the facility a 31498
separate written notice that states all of the following: 31499

(1) That the department of ~~job and family services~~ health 31500
care administration or a contracting agency will issue an order 31501
under section ~~5111.57~~ 5164.73 of the Revised Code denying payment 31502
for any medicaid eligible residents admitted on and after the 31503
effective date of the order if the facility does not substantially 31504
correct, within ninety days after the exit interview, the 31505
deficiency or deficiencies cited in the statement of deficiencies 31506
in accordance with the plan of correction it submitted under 31507

section ~~5111.43~~ 5164.59 of the Revised Code; 31508

(2) If a condition of substandard care has been cited on the 31509
basis of a standard survey and a condition of substandard care was 31510
also cited on the immediately preceding standard survey, that the 31511
department of ~~job and family services~~ health care administration 31512
or a contracting agency will issue an order under section ~~5111.57~~ 31513
5164.73 of the Revised Code denying payment for any medicaid 31514
eligible residents admitted on and after the effective date of the 31515
order if a condition of substandard care is cited on the basis of 31516
the next standard survey; 31517

(3) That the department of ~~job and family services~~ health 31518
care administration or a contracting agency will issue an order 31519
under section ~~5111.58~~ 5164.74 of the Revised Code terminating the 31520
facility's participation in the ~~medical assistance~~ medicaid 31521
program if either of the following applies: 31522

(a) The facility does not substantially correct the 31523
deficiency or deficiencies in accordance with the plan of 31524
correction it submitted under section ~~5111.43~~ 5164.59 of the 31525
Revised Code within six months after the exit interview. 31526

(b) The facility substantially corrects the deficiency or 31527
deficiencies within the six-month period, but after correcting it, 31528
the department of health, based on a follow-up survey conducted 31529
during the remainder of the six-month period, determines that the 31530
facility has failed to maintain compliance with certification 31531
requirements. 31532

Sec. ~~5111.43~~ 5164.59. Whenever a nursing facility receives a 31533
statement of deficiencies under section ~~5111.42~~ 5164.58 of the 31534
Revised Code, the facility shall submit to the department of 31535
health for its approval a plan of correction for each finding 31536
cited in the statement. The plan shall describe the actions the 31537
facility will take to correct each finding and specify the date by 31538

which each finding will be corrected. In the case of a finding 31539
cited pursuant to division (E) of section ~~5111.41~~ 5164.56 of the 31540
Revised Code, the plan shall describe the actions the facility 31541
took to correct the finding and the date on which it was 31542
corrected. 31543

The department shall approve any plan that conforms to the 31544
requirements for approval of plans of corrections established in 31545
the regulations, guidelines, and procedures issued by the United 31546
States secretary of health and human services ~~under Titles XVIII~~ 31547
~~and XIX of the "Social Security Act," 49 Stat. 620 (1935), 42~~ 31548
~~U.S.C.A. 301, as amended~~ for the medicare and medicaid programs. 31549
The department also shall approve any modification of an existing 31550
plan submitted by a facility, if the plan as modified conforms to 31551
those regulations, guidelines, and procedures. The department 31552
shall not reject a facility's plan of correction or modification 31553
on the ground that the facility disputes the finding, if the plan 31554
is reasonably calculated to correct the finding. 31555

A facility that complies with this section shall not be 31556
considered to have admitted the existence of a finding cited by 31557
the department. 31558

Sec. ~~5111.44~~ 5164.60. The department of health may appoint 31559
employees of the department to conduct on-site monitoring of a 31560
nursing facility whenever a finding is cited, including any 31561
finding cited pursuant to division (E) of section ~~5111.41~~ 5164.56 31562
of the Revised Code, or an emergency is found to exist. 31563
Appointment of monitors under this section is not subject to 31564
appeal under section ~~5111.60~~ 5164.76 or any other section of the 31565
Revised Code. No employee of a facility for which monitors are 31566
appointed, no person employed by the facility within the previous 31567
two years, and no person who currently has a consulting or other 31568
contract with the department or the facility, shall be appointed 31569

as a monitor under this section. Every monitor appointed under 31570
this section shall have the professional qualifications necessary 31571
to monitor correction of the finding or elimination of the 31572
emergency. 31573

Sec. ~~5111.45~~ 5164.61. (A) If the department of health cites a 31574
deficiency or deficiencies that was not substantially corrected 31575
before a survey and that does not constitute a severity level four 31576
finding or create immediate jeopardy, the department of ~~job and~~ 31577
~~family services~~ health care administration or a contracting agency 31578
shall permit the nursing facility to continue participating in the 31579
~~medical assistance~~ medicaid program for up to six months after the 31580
exit interview, if all of the following apply: 31581

(1) The facility meets the requirements, established in 31582
regulations issued by the United States secretary of health and 31583
human services under ~~Title XIX of the "Social Security Act," 49~~ 31584
~~Stat. 620 (1935), 42 U.S.C.A. 301, as amended,~~ the medicaid 31585
program for certification of nursing facilities that have a 31586
deficiency. 31587

(2) The department of health has approved a plan of 31588
correction submitted by the facility under section ~~5111.43~~ 5164.59 31589
of the Revised Code for each deficiency. 31590

(3) The provider agrees to repay the department of ~~job and~~ 31591
~~family services~~ health care administration, in accordance with 31592
section ~~5111.58~~ 5164.74 of the Revised Code, the federal share of 31593
all payments made by the department to the facility during the 31594
six-month period following the exit interview if the facility does 31595
not within the six-month period substantially correct the 31596
deficiency or deficiencies in accordance with the plan of 31597
correction submitted under section ~~5111.43~~ 5164.59 of the Revised 31598
Code. 31599

(B) If any of the conditions in divisions (A)(1) to (3) of 31600

this section do not apply, the department of ~~job and family~~ 31601
~~services~~ health care administration or contracting agency shall 31602
issue an order terminating the facility's participation in the 31603
~~medical assistance~~ medicaid program. An order issued under this 31604
division is subject to appeal under Chapter 119. of the Revised 31605
Code. The order shall not take effect prior to the later of the 31606
thirtieth day after it is delivered to the facility or, if the 31607
order is appealed, the date on which a final adjudication order 31608
upholding the termination becomes effective pursuant to Chapter 31609
119. of the Revised Code. 31610

(C) At the time the department of ~~job and family services~~ 31611
health care administration or contracting agency issues an order 31612
under division (B) of this section terminating a nursing 31613
facility's participation in the ~~medical assistance~~ medicaid 31614
program, it may also impose, subject to section ~~5111.50~~ 5164.66 of 31615
the Revised Code, other remedies under sections ~~5111.46~~ 5164.62 to 31616
~~5111.48~~ 5164.64 of the Revised Code. 31617

Sec. ~~5111.46~~ 5164.62. (A) If the department of health cites a 31618
deficiency, or cluster of deficiencies, that was not substantially 31619
corrected before a survey and constitutes a severity level four 31620
finding, the department of ~~job and family services~~ health care 31621
administration or contracting agency shall, subject to sections 31622
~~5111.52~~ 5164.68 to ~~5111.56~~ 5164.72 of the Revised Code, impose a 31623
remedy for the deficiency or cluster of deficiencies. The 31624
department or agency may act under either division (A)(1) or (2) 31625
of this section: 31626

(1) The department or agency may impose one or more of the 31627
following remedies: 31628

(a) Issue an order terminating the nursing facility's 31629
participation in the ~~medical assistance~~ medicaid program. 31630

(b) Do either of the following: 31631

- (i) Regardless of whether the provider consents, appoint a temporary manager of the facility. 31632
31633
- (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. 31634
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- (c) Do either of the following: 31639
- (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; 31640
31641
31642
- (ii) Impose a fine. 31643
- (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. 31644
31645
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31648
- (2) The department or agency may impose one or more of the following remedies: 31649
31650
- (a) Appoint, subject to the continuing consent of the provider, a temporary manager of the facility; 31651
31652
- (b) Do either of the following: 31653
- (i) Regardless of whether the provider consents, appoint a temporary manager of the facility; 31654
31655
- (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. 31656
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- (c) Do either of the following: 31661

(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; 31662
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(ii) Impose a fine. 31665

(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; 31666
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(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. 31671
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(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 31675
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effect and the facility's participation shall terminate on the 31694
fifteenth day after the facility received the order. 31695

(C) If the department of health cites a deficiency or cluster 31696
of deficiencies pursuant to division (E) of section ~~5111.41~~ 31697
5164.56 of the Revised Code that constituted a severity level four 31698
finding, the department of ~~job and family services~~ health care 31699
administration or a contracting agency shall, subject to section 31700
~~5111.56~~ 5164.72 of the Revised Code, impose a fine. The fine shall 31701
be in effect for a period equal to the number of days the 31702
deficiency or cluster of deficiencies existed at the facility. 31703

Sec. ~~5111.47~~ 5164.63. If the department of health cites a 31704
deficiency, or cluster of deficiencies, that was not substantially 31705
corrected before a survey and constitutes a severity level three 31706
and scope level three or four finding, the department of ~~job and~~ 31707
~~family services~~ health care administration or a contracting agency 31708
may, subject to sections ~~5111.55~~ 5164.71 and ~~5111.56~~ 5164.72 of 31709
the Revised Code, impose one or more of the following remedies: 31710

(A) Do either of the following: 31711

(1) Issue an order denying payment to the facility under the 31712
~~medical assistance~~ medicaid program for all medicaid eligible 31713
residents admitted after the effective date of the order; 31714

(2) Impose a fine. 31715

(B) Issue an order denying payment to the facility under the 31716
~~medical assistance~~ medicaid program for medicaid eligible 31717
residents admitted after the effective date of the order who have 31718
certain diagnoses or special care needs specified by the 31719
department or agency; 31720

(C) Issue an order requiring the facility to correct the 31721
deficiency or cluster of deficiencies under the plan of correction 31722
submitted by the facility and approved by the department of health 31723

under section ~~5111.43~~ 5164.59 of the Revised Code. 31724

Sec. ~~5111.48~~ 5164.64. (A) If the department of health cites a 31725
deficiency, or cluster of deficiencies, that was not substantially 31726
corrected before a survey and constitutes a severity level three 31727
and scope level two finding, the department of ~~job and family~~ 31728
~~services~~ health care administration or a contracting agency may, 31729
subject to sections ~~5111.55~~ 5164.71 and ~~5111.56~~ 5164.72 of the 31730
Revised Code, impose one or more of the following remedies: 31731

(1) Do either of the following: 31732

(a) Issue an order denying payment to the facility under the 31733
~~medical assistance~~ medicaid program for all medicaid eligible 31734
residents admitted after the effective date of the order; 31735

(b) Impose a fine. 31736

(2) Issue an order denying payment to the facility under the 31737
~~medical assistance~~ medicaid program for medicaid eligible 31738
residents admitted after the effective date of the order who have 31739
certain diagnoses or special care needs specified by the 31740
department or agency; 31741

(3) Issue an order requiring the facility to correct the 31742
deficiency or cluster of deficiencies under the plan of correction 31743
proposed by the facility and approved by the department of health 31744
under section ~~5111.43~~ 5164.59 of the Revised Code. 31745

(B) If the department of health cites a deficiency, or 31746
cluster of deficiencies, that was not substantially corrected 31747
before a survey and constitutes a severity level three and scope 31748
level one finding, the department of ~~job and family services~~ 31749
health care administration or a contracting agency may, subject to 31750
sections ~~5111.55~~ 5164.71 and ~~5111.56~~ 5164.72 of the Revised Code, 31751
impose one or more of the following remedies: 31752

(1) Impose a fine; 31753

(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 31785
deficiency or cluster of deficiencies under the plan of correction 31786
submitted by the facility and approved by the department of health 31787
under section ~~5111.43~~ 5164.59 of the Revised Code. 31788

(E) If the department of health cites a deficiency, or 31789
cluster of deficiencies, that was not substantially corrected 31790
before a survey and constitutes a severity level one and scope 31791
level three or four finding, the department of ~~job and family~~
~~services~~ health care administration or a contracting agency may 31792
issue an order requiring the facility to correct the deficiency or 31793
cluster of deficiencies under the plan of correction submitted by 31794
the facility and approved by the department of health under 31795
section ~~5111.43~~ 5164.59 of the Revised Code. 31796
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(F) If the department of health cites a deficiency, or 31798
cluster of deficiencies, that was not substantially corrected 31799
before a survey, constitutes a severity level one and scope level 31800
two finding, and is a repeat finding, the department of ~~job and~~
~~family services~~ health care administration or a contracting agency 31801
may issue an order requiring the facility to correct the 31802
deficiency or cluster of deficiencies under the plan of correction 31803
submitted by the facility and approved by the department of health 31804
under section ~~5111.43~~ 5164.59 of the Revised Code. 31805
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Sec. ~~5111.49~~ 5164.65. (A) In determining which remedies to 31807
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 31808
imposed, the department of ~~job and family services~~ health care
administration or a contracting agency shall do both of the 31810
following: 31811
31812

(1) Impose the remedies that are most likely to achieve 31813
correction of deficiencies, encourage sustained compliance with 31814
certification requirements, and protect the health, safety, and 31815

rights of facility residents, but that are not directed at	31816
punishment of the facility;	31817
(2) Consider all of the following:	31818
(a) The presence or absence of immediate jeopardy;	31819
(b) The relationships of groups of deficiencies to each	31820
other;	31821
(c) The facility's history of compliance with certification	31822
requirements generally and in the specific area of the deficiency	31823
or deficiencies;	31824
(d) Whether the deficiency or deficiencies are directly	31825
related to resident care;	31826
(e) The corrective, long-term compliance, resident	31827
protective, and nonpunitive outcomes sought by the department or	31828
agency;	31829
(f) The nature, scope, and duration of the noncompliance with	31830
certification requirements;	31831
(g) The existence of repeat deficiencies;	31832
(h) The category of certification requirements with which the	31833
facility is out of compliance;	31834
(i) Any period of noncompliance with certification	31835
requirements that occurred between two certifications by the	31836
department of health that the facility was in compliance with	31837
certification requirements;	31838
(j) The facility's degree of culpability;	31839
(k) The accuracy, extent, and availability of facility	31840
records;	31841
(l) The facility's financial condition, exclusive of any	31842
moneys donated to a facility that is an organization described in	31843
subsection 501(c)(3) and is tax exempt under subsection 501(a) of	31844

the "Internal Revenue Code of 1986," 100 Stat. 2085, 26 U.S.C.A. 31845
1; 31846

(m) Any adverse effect that the action or fine would have on 31847
the health and safety of facility residents; 31848

(n) If the noncompliance that resulted in the citation of a 31849
deficiency or cluster of deficiencies existed before a change in 31850
ownership of the facility, whether the new owner or owners have 31851
had sufficient time to correct the noncompliance. 31852

(B) Whenever the department or agency imposes remedies under 31853
section ~~5111.46~~ 5164.62, ~~5111.47~~ 5164.63, or ~~5111.48~~ 5164.64 of 31854
the Revised Code, it shall provide a written statement to the 31855
nursing facility that specifies all of the following: 31856

(1) The effective date of each remedy; 31857

(2) The deficiency or cluster of deficiencies for which each 31858
remedy is imposed; 31859

(3) The severity and scope of the deficiency or cluster of 31860
deficiencies; 31861

(4) The rationale, including all applicable factors specified 31862
in division (A) of this section, for imposing the remedies. 31863

Sec. ~~5111.50~~ 5164.66. At the time the department of ~~job and~~ 31864
~~family services~~ health care administration or a contracting 31865
agency, under section ~~5111.45~~ 5164.61, ~~5111.46~~ 5164.62, or ~~5111.51~~ 31866
5164.67 of the Revised Code, issues an order terminating a nursing 31867
facility's participation in the ~~medical assistance~~ medicaid 31868
program, the department or agency may also impose a fine, in 31869
accordance with sections ~~5111.46~~ 5164.62 to ~~5111.48~~ 5164.64 and 31870
~~5111.56~~ 5164.72 of the Revised Code, to be collected in the event 31871
the termination order does not take effect. The department or 31872
agency shall not collect this fine if the termination order takes 31873
effect. 31874

Sec. ~~5111.51~~ 5164.67. (A) If the department of health finds 31875
during a survey that an emergency exists at a nursing facility, as 31876
the result of a deficiency or cluster of deficiencies that creates 31877
immediate jeopardy, the department of ~~job and family services~~ 31878
health care administration or a contracting agency shall impose 31879
one or more of the remedies described in division (A)(1) of this 31880
section and, in addition, may take one or both of the actions 31881
described in division (A)(2) of this section. 31882

(1) The department or agency shall impose one or more of the 31883
following remedies: 31884

(a) Appoint, subject to the continuing consent of the 31885
provider, a temporary manager of the facility; 31886

(b) Apply to the common pleas court of the county in which 31887
the facility is located for a temporary restraining order, 31888
preliminary injunction, or such other injunctive or equitable 31889
relief as is necessary to close the facility, transfer one or more 31890
residents to other nursing facilities or other appropriate care 31891
settings, or otherwise eliminate the condition of immediate 31892
jeopardy. If the court grants such an order, injunction, or 31893
relief, it may appoint a special master empowered to implement the 31894
court's judgment under the court's direct supervision. 31895

(c) Issue an order terminating the facility's participation 31896
in the medical assistance program; 31897

(d) Regardless of whether the provider consents, appoint a 31898
temporary manager of the facility. 31899

(2) The department or agency may do one or both of the 31900
following: 31901

(a) Issue an order denying payment to the facility for all 31902
medicaid eligible residents admitted after the effective date of 31903
the order; 31904

(b) Impose remedies under sections ~~5111.46~~ 5164.62 to ~~5111.48~~ 31905
5164.64 of the Revised Code appropriate to the severity and scope 31906
of the deficiency or cluster of deficiencies, except that the 31907
department or agency shall not impose a fine for the same 31908
deficiency for which the department or agency has issued an order 31909
under division (A)(2)(a) of this section. 31910

(B) If the department of health, department of ~~job and family~~ 31911
~~services~~ health care administration, or a contracting agency finds 31912
on the basis of a survey or other visit to the facility by 31913
representatives of that department or agency that an emergency 31914
exists at a facility that is not the result of a deficiency or 31915
cluster of deficiencies that constitutes immediate jeopardy, the 31916
department of ~~job and family services~~ health care administration 31917
or contracting agency may do either of the following: 31918

(1) Appoint, subject to the continuing consent of the 31919
provider, a temporary manager of the facility; 31920

(2) Apply to the common pleas court of the county in which 31921
the facility is located for a temporary restraining order, 31922
preliminary injunction, or such other injunctive or equitable 31923
relief as is necessary to close the facility, transfer one or more 31924
residents to other nursing facilities or other appropriate care 31925
settings, or otherwise eliminate the emergency. If the court 31926
grants such an order, injunction, or relief, it may appoint a 31927
special master empowered to implement the court's judgment under 31928
the court's direct supervision. 31929

(C)(1) Prior to acting under division (A)(1)(b), (c), (d), or 31930
(2), or (B)(2) of this section, the department of ~~job and family~~ 31931
~~services~~ health care administration or contracting agency shall 31932
give written notice to the facility specifying all of the 31933
following: 31934

(a) The nature of the emergency, including the nature of any 31935

deficiency or deficiencies that caused the emergency; 31936

(b) The nature of the action the department or agency intends 31937
to take unless the department of health determines that the 31938
facility, in the absence of state intervention, possesses the 31939
capacity to eliminate the emergency; 31940

(c) The rationale for taking the action. 31941

(2) If the department of health determines that the facility 31942
does not possess the capacity to eliminate the emergency in the 31943
absence of state intervention, the department of ~~job and family~~ 31944
~~services~~ health care administration or contracting agency may 31945
immediately take action under division (A) or (B) of this section. 31946
If the department of health determines that the facility possesses 31947
the capacity to eliminate the emergency, the department of ~~job and~~ 31948
~~family services~~ health care administration or contracting agency 31949
shall direct the facility to eliminate the emergency within five 31950
days after the facility's receipt of the notice. At the end of the 31951
five-day period, the department of health shall conduct a 31952
follow-up survey that focuses on the emergency. If the department 31953
of health determines that the facility has eliminated the 31954
emergency within the time period, the department of ~~job and family~~ 31955
~~services~~ health care administration or contracting agency shall 31956
not act under division (A)(1)(b), (c), (d), or (2)(a), or (B)(2) 31957
of this section. If the department of health determines that the 31958
facility has failed to eliminate the emergency within the five-day 31959
period, the department of job and family services or contracting 31960
agency shall take appropriate action under division (A)(1)(b), 31961
(c), (d), or (2), or (B)(2) of this section. 31962

(3) Until the written notice required by division (C)(1) of 31963
this section is actually delivered, no action taken by the 31964
department of ~~job and family services~~ health care administration 31965
or contracting agency under division (A)(1)(b), (c), (d), or (2), 31966
or (B)(2) of this section shall have any legal effect. In addition 31967

to the written notice, the department of health survey team shall 31968
give oral notice to the facility, at the time of the survey, 31969
concerning any recommendations the survey team intends to make 31970
that could form the basis of a determination that an emergency 31971
exists. 31972

(D) The department of ~~job and family services~~ health care 31973
administration or contracting agency shall deliver a written order 31974
issued under division (A)(1) of this section terminating a nursing 31975
facility's participation in the ~~medical assistance~~ medicaid 31976
program to the facility within five days after the exit interview. 31977
If the facility alleges, at any time prior to the later of the 31978
twentieth day after the exit interview or the fifteenth day after 31979
it receives the order, that the condition of immediate jeopardy 31980
for which the order was issued has been eliminated, the department 31981
of health shall conduct a follow-up survey to determine whether 31982
the immediate jeopardy has been eliminated. The order shall take 31983
effect and the facility's participation shall terminate on the 31984
twentieth day after the exit interview, unless the facility has 31985
eliminated the immediate jeopardy or did not receive notice from 31986
the department of ~~job and family services~~ health care 31987
administration or contracting agency within five days after the 31988
exit interview. In the latter case, the order shall take effect 31989
and the facility's participation shall terminate on the fifteenth 31990
day after the facility received the order. 31991

(E) Any action taken by the department of ~~job and family~~ 31992
~~services~~ health care administration or a contracting agency under 31993
division (A)(1)(c), (d), or (2)(a) of this section is subject to 31994
appeal under Chapter 119. of the Revised Code, except that the 31995
department or agency may take such action prior to and during the 31996
pendency of any proceeding under that chapter. No action taken by 31997
a facility under division (C) of this section to eliminate an 31998
emergency cited by the department of health shall be considered an 31999

admission by the facility of the existence of an emergency. 32000

Sec. ~~5111.52~~ 5164.68. (A) As used in this section: 32001

(1) "Provider agreement" means a contract between the 32002
department of ~~job and family services~~ health care administration 32003
and a nursing facility for the provision of nursing facility 32004
services under the ~~medical assistance~~ medicaid program. 32005

(2) "Terminating" includes not renewing. 32006

(B) A nursing facility's participation in the ~~medical~~ 32007
~~assistance~~ medicaid program shall be terminated under sections 32008
~~5111.35~~ 5164.50 to ~~5111.62~~ 5164.78 of the Revised Code as follows: 32009

(1) If the department of ~~job and family services~~ health care 32010
administration is terminating the facility's participation, it 32011
shall issue an order terminating the facility's provider 32012
agreement. 32013

(2) If the department of health, acting as a contracting 32014
agency, is terminating the facility's participation, it shall 32015
issue an order terminating certification of the facility's 32016
compliance with certification requirements. When the department of 32017
health terminates certification, the department of ~~job and family~~ 32018
~~services~~ health care administration shall terminate the facility's 32019
provider agreement. The department of ~~job and family services~~ 32020
health care administration is not required to provide an 32021
adjudication hearing when it terminates a provider agreement 32022
following termination of certification by the department of 32023
health. 32024

(3) If a state agency other than the department of health, 32025
acting as a contracting agency, is terminating the facility's 32026
participation, it shall notify the department of ~~job and family~~ 32027
~~services~~ health care administration, and the department of ~~job and~~ 32028
~~family services~~ health care administration shall issue an order 32029

terminating the facility's provider agreement. The contracting 32030
agency shall conduct any administrative proceedings concerning the 32031
order. 32032

(C) If the following conditions are met, the department of 32033
~~job and family services~~ health care administration may make 32034
~~medical assistance~~ medicaid payments to a nursing facility for a 32035
period not exceeding thirty days after the effective date of 32036
termination under sections ~~5111.35~~ 5164.50 to ~~5111.62~~ 5164.78 of 32037
the Revised Code of the facility's participation in the ~~medical~~ 32038
~~assistance~~ medicaid program: 32039

(1) The payments are for medicaid eligible residents admitted 32040
to the facility prior to the effective date of the termination; 32041

(2) The provider is making reasonable efforts to transfer 32042
medicaid eligible residents to other care settings. 32043

The period during which payments may be made under this 32044
division begins on the later of the effective date of the 32045
termination or, if the facility has appealed a termination order, 32046
the date of issuance of the adjudication order upholding 32047
termination. 32048

Sec. ~~5111.53~~ 5164.69. (A) Whenever a nursing facility is 32049
closed under sections ~~5111.35~~ 5164.50 to ~~5111.62~~ 5164.78 of the 32050
Revised Code, the department of ~~job and family services~~ health 32051
care administration or contracting agency shall arrange for the 32052
safe and orderly transfer of all residents, including residents 32053
who are not medicaid eligible residents, to other appropriate care 32054
settings. Whenever a facility's participation in the ~~medical~~ 32055
~~assistance~~ medicaid program is terminated under sections ~~5111.35~~ 32056
5164.50 to ~~5111.62~~ 5164.78 of the Revised Code, the department or 32057
agency shall arrange for the safe and orderly transfer of all 32058
medicaid eligible residents or, if the termination results in the 32059
closure of the facility, of all residents. The provider and all 32060

persons involved in the facility's operation shall cooperate with 32061
and assist in the transfer of residents. 32062

(B) After a nursing facility's participation in the ~~medical~~ 32063
~~assistance~~ medicaid program is terminated under section ~~5111.45~~ 32064
~~5164.61~~, ~~5111.46~~ 5164.62, ~~5111.51~~ 5164.67, or ~~5111.58~~ 5164.74 of 32065
the Revised Code, the department of ~~job and family services~~ health 32066
care administration or contracting agency may appoint a temporary 32067
manager subject to the continuing consent of the provider, or may 32068
apply to the common pleas court of the county in which the 32069
facility is located for such injunctive relief as is necessary for 32070
the appointment of a special master, to ensure the transfer of 32071
medicaid eligible residents to other appropriate care settings 32072
and, if applicable, the orderly closure of the facility. 32073

Sec. ~~5111.54~~ 5164.70. (A) A temporary manager of a nursing 32074
facility appointed by the department of ~~job and family services~~ 32075
health care administration or a contracting agency under sections 32076
~~5111.35~~ 5164.50 to ~~5111.62~~ 5164.78 of the Revised Code shall meet 32077
all of the following qualifications: 32078

(1) Be licensed as a nursing home administrator under Chapter 32079
4751. of the Revised Code; 32080

(2) Have demonstrated competence as a nursing home 32081
administrator; 32082

(3) Have had no disciplinary action taken against the 32083
temporary manager by any licensing board or professional society 32084
in this state. 32085

(B) The salary of a temporary manager or special master 32086
appointed under sections ~~5111.35~~ 5164.50 to ~~5111.62~~ 5164.78 of the 32087
Revised Code shall be paid by the facility and set by the 32088
department of ~~job and family services~~ health care administration 32089
or contracting agency, in the case of a temporary manager, or by 32090

the court, in the case of a special master, at a rate not to 32091
exceed the maximum allowable compensation for an administrator 32092
under the ~~medical assistance~~ medicaid program. The extent to which 32093
this compensation is allowable under the ~~medical assistance~~ 32094
medicaid program is subject to and limited by this chapter and 32095
rules of the department. 32096

Subject to division (C) of this section, any costs incurred 32097
on behalf of a nursing facility by a temporary manager or special 32098
master appointed under sections ~~5111.35~~ 5164.50 to ~~5111.62~~ 5164.78 32099
of the Revised Code shall be paid by the facility. The 32100
allowability of these costs under the ~~medical assistance~~ medicaid 32101
program shall be subject to and governed by this chapter and the 32102
rules of the department. This division does not prohibit a 32103
facility from applying for or receiving any waiver of cost 32104
ceilings available under rules of the department. 32105

(C) No temporary manager or special master appointed under 32106
sections ~~5111.35~~ 5164.50 to ~~5111.62~~ 5164.78 of the Revised Code 32107
shall enter into any employment contract on behalf of a facility, 32108
or purchase any capital goods using facility funds totaling more 32109
than ten thousand dollars, unless the temporary manager or special 32110
master has obtained prior approval for the contract or purchase 32111
from either the provider or the court. 32112

(D)(1) A temporary manager appointed for a nursing facility 32113
under section ~~5111.46~~ 5164.62 of the Revised Code is hereby 32114
vested, subject to division (C) of this section, with the legal 32115
authority necessary to correct any deficiency or cluster of 32116
deficiencies at a facility, bring the facility into compliance 32117
with certification requirements, and otherwise ensure the health 32118
and safety of the residents. 32119

(2) A temporary manager appointed under section ~~5111.51~~ 32120
5164.67 of the Revised Code is hereby vested, subject to division 32121
(C) of this section, with the authority necessary to eliminate the 32122

emergency, bring the facility into compliance with certification 32123
requirements, and otherwise ensure the health and safety of the 32124
residents. 32125

(3) A temporary manager appointed under section ~~5111.53~~ 32126
5164.69 of the Revised Code is hereby vested, subject to division 32127
(C) of this section, with the authority necessary to ensure the 32128
transfer of medicaid eligible residents to other appropriate care 32129
settings and, if applicable, the orderly closure of the facility, 32130
and to otherwise ensure the health and safety of the residents. 32131

(E) Prior to acting under division (A)(1)(b) or (2)(b) of 32132
section ~~5111.46~~ 5164.62 of the Revised Code to appoint a temporary 32133
manager or apply for a special master, the department of ~~job and~~ 32134
~~family services~~ health care administration or contracting agency 32135
shall order the facility to substantially correct the deficiency 32136
or deficiencies within five days after receiving the statement and 32137
inform the facility, in the statement it provides pursuant to 32138
division (B) of section ~~5111.49~~ 5164.65 of the Revised Code, of 32139
the order and that it will not take that action unless the 32140
facility fails to substantially correct the deficiency or 32141
deficiencies within that five-day period. At the end of the 32142
five-day period, the department of health shall conduct a 32143
follow-up survey that focuses on the deficiency or deficiencies. 32144
If the department of health determines that the facility has 32145
substantially corrected the deficiency or deficiencies within that 32146
time, the department of ~~job and family services~~ health care 32147
administration or contracting agency shall not appoint a temporary 32148
manager or apply for a special master. If the department of health 32149
determines that the facility has failed to substantially correct 32150
the deficiency or deficiencies within that time, the department of 32151
~~job and family services~~ health care administration or contracting 32152
agency may proceed with appointment of the temporary manager or 32153
application for a special master. Until the statement required 32154

under division (B) of section ~~5111.49~~ 5164.65 of the Revised Code 32155
is actually delivered, no action taken by the department or agency 32156
to appoint a temporary manager or apply for a temporary manager 32157
under division (A)(1)(b) or (2)(b) of section ~~5111.46~~ 5164.62 of 32158
the Revised Code shall have any legal effect. No action taken by a 32159
facility under this division to substantially correct a deficiency 32160
or deficiencies shall be considered an admission by the facility 32161
of the existence of a deficiency or deficiencies. 32162

(F) Appointment of a temporary manager under division 32163
(A)(1)(b) or (2)(b) of section ~~5111.46~~ 5164.62 or division 32164
(A)(1)(d) of section ~~5111.51~~ 5164.67 of the Revised Code shall 32165
expire at the end of the seventh day following the appointment. If 32166
the department of ~~job and family services~~ health care 32167
administration or contracting agency finds that the deficiency or 32168
deficiencies that prompted the appointment under division 32169
(A)(1)(b) or (2)(b) of section ~~5111.46~~ 5164.62 of the Revised Code 32170
cannot be substantially corrected, or the condition of immediate 32171
jeopardy that prompted the appointment under division (A)(1)(d) of 32172
section ~~5111.51~~ 5164.67 of the Revised Code cannot be eliminated, 32173
prior to the expiration of the appointment, it may take one of the 32174
following actions: 32175

(1) Appoint, subject to the continuing consent of the 32176
provider, a temporary manager for the facility; 32177

(2) Apply to the common pleas court of the county in which 32178
the facility is located for an order appointing a special master 32179
who, under the authority and direct supervision of the court and 32180
subject to divisions (B) and (C) of this section, may take such 32181
additional actions as are necessary to correct the deficiency or 32182
deficiencies or eliminate the condition of immediate jeopardy and 32183
bring the facility into compliance with certification 32184
requirements. 32185

(G) The court, on finding that the deficiency or deficiencies 32186

for which a special master was appointed under division (F)(2) of 32187
this section or division (A)(1)(b) or (2)(b) of section ~~5111.46~~ 32188
5164.62 of the Revised Code has been substantially corrected, or 32189
the emergency for which a special master was appointed under 32190
division (F)(2) of this section or division (A)(1)(b) or (B)(2) of 32191
section ~~5111.51~~ 5164.67 of the Revised Code has been eliminated, 32192
that the facility has been brought into compliance with 32193
certification requirements, and that the provider has established 32194
the management capability to ensure continued compliance with the 32195
certification requirements, shall immediately terminate its 32196
jurisdiction over the facility and return control and management 32197
of the facility to the provider. If the deficiency or deficiencies 32198
cannot be substantially corrected, or the emergency cannot be 32199
eliminated practicably within a reasonable time following 32200
appointment of the special master, the court may order the special 32201
master to close the facility and transfer all residents to other 32202
nursing facilities or other appropriate care settings. 32203

Sec. ~~5111.55~~ 5164.71. (A) An order issued under section 32204
~~5111.46~~ 5164.62, ~~5111.47~~ 5164.63, ~~5111.48~~ 5164.64, ~~5111.51~~ 32205
5164.67, or ~~5111.57~~ 5164.73 of the Revised Code denying payment to 32206
a nursing facility for all medicaid eligible residents admitted 32207
after its effective date, or an order issued under section ~~5111.46~~ 32208
5164.62, ~~5111.47~~ 5164.63, or ~~5111.48~~ 5164.64 of the Revised Code 32209
denying payment to a nursing facility for medicaid eligible 32210
residents admitted after the effective date of the order who have 32211
specified diagnoses or special care needs, shall also apply to 32212
individuals admitted to the facility on and after the effective 32213
date of the order who are not medicaid eligible residents but 32214
become medicaid eligible residents after admission. Such an order 32215
shall not apply to any of the following: 32216

(1) An individual who was a medicaid eligible resident of the 32217
facility on the day immediately preceding the effective date of 32218

the order and continues to be a medicaid eligible resident on and 32219
after that date; 32220

(2) An individual who was a resident of the facility on the 32221
day immediately preceding the effective date of the order, 32222
continues to be a resident on and after that date, and becomes 32223
medicaid eligible on or after that date; 32224

(3) An individual who was a medicaid eligible resident of the 32225
facility prior to the effective date of the order, is temporarily 32226
absent from the facility on that or a subsequent date due to 32227
hospitalization or participation in therapeutic programs outside 32228
the facility, and chooses to return to the facility; 32229

(4) An individual who was a resident of the facility prior to 32230
the effective date of the order, is temporarily absent from the 32231
facility on that or a subsequent date due to hospitalization or 32232
participation in therapeutic programs outside the facility, 32233
becomes medicaid eligible on or after that date, and chooses to 32234
return to the facility. 32235

(B) An order issued under section ~~5111.46~~ 5164.62 of the 32236
Revised Code denying payment to a nursing facility for all 32237
medicaid eligible residents admitted after its effective date, or 32238
denying payment to a facility for medicaid eligible residents 32239
admitted after the effective date of the order who have specified 32240
diagnoses or special care needs shall not take effect prior to the 32241
fifth day after the order is delivered to the facility. Such an 32242
order issued under section ~~5111.47~~ 5164.63 or ~~5111.48~~ 5164.64 of 32243
the Revised Code shall not take effect prior to the twentieth day 32244
after it is delivered to the facility. 32245

(C) No nursing facility that has received an order under 32246
section ~~5111.46~~ 5164.62, ~~5111.47~~ 5164.63, ~~5111.48~~ 5164.64, ~~5111.51~~ 32247
5164.67, or ~~5111.57~~ 5164.73 of the Revised Code denying payment 32248
for all new admissions of medicaid eligible residents shall admit 32249

a medicaid eligible resident on or after the effective date of the 32250
order, unless the resident is described in division (A)(3) or (4) 32251
of this section, until the order is terminated pursuant to this 32252
section. No nursing facility that has received an order under 32253
section ~~5111.46~~ 5164.62, ~~5111.47~~ 5164.63, or ~~5111.48~~ 5164.64 of 32254
the Revised Code denying payment to a nursing facility for new 32255
admissions of medicaid eligible residents with specified diagnoses 32256
or special care needs shall admit such a resident on or after the 32257
effective date of the order, unless the resident is described in 32258
division (A)(3) or (4) of this section, until the order is 32259
terminated pursuant to this section. 32260

(D) In the case of an order imposed under division (B) of 32261
section ~~5111.57~~ 5164.73 of the Revised Code, the department of 32262
health care administration or contracting agency shall appoint 32263
monitors in accordance with section ~~5111.44~~ 5164.60 of the Revised 32264
Code to conduct on-site monitoring. 32265

(E)(1) A facility may give written notice to the department 32266
of health whenever any of the following apply: 32267

(a) With respect to an order denying payment issued under 32268
section ~~5111.46~~ 5164.62, ~~5111.47~~ 5164.63, or ~~5111.48~~ 5164.64 of 32269
the Revised Code, either of the following is the case: 32270

(i) The facility has completed implementation of the plan of 32271
correction it submitted under section ~~5111.43~~ 5164.59 of the 32272
Revised Code and substantially corrected all deficiencies for 32273
which the order was issued. 32274

(ii) The facility has reduced the severity or scope of all of 32275
the deficiencies to a level at which sections ~~5111.46~~ 5164.62 to 32276
~~5111.48~~ 5164.64 of the Revised Code do not authorize the order. 32277

(b) With respect to an order denying payment issued under 32278
section ~~5111.51~~ 5164.67 of the Revised Code, the facility has 32279
eliminated the immediate jeopardy. 32280

(c) With respect to an order denying payment issued under 32281
division (A) of section ~~5111.57~~ 5164.73 of the Revised Code, the 32282
facility has completed implementation of the plan of correction it 32283
submitted under section ~~5111.43~~ 5164.59 of the Revised Code and 32284
substantially corrected all deficiencies for which the order was 32285
issued. 32286

(d) With respect to an order denying payment issued under 32287
division (B) of section ~~5111.57~~ 5164.73 of the Revised Code, both 32288
of the following are the case: 32289

(i) The facility has completed implementation of the plan of 32290
correction it submitted under section ~~5111.43~~ 5164.59 of the 32291
Revised Code and substantially corrected all deficiencies for 32292
which the order was issued. 32293

(ii) The facility is in compliance with certification 32294
requirements and has provided adequate assurance that it will 32295
remain in compliance with them. 32296

(2) Within ten working days after it receives the notice 32297
under division (E)(1) of this section, the department of health 32298
shall conduct a follow-up survey that focuses on the cited 32299
deficiency or deficiencies, unless the department is able to 32300
determine, on the basis of documentation provided by the facility, 32301
that the facility has completed the applicable action described in 32302
divisions (E)(1)(a) to (d) of this section. If the department of 32303
health makes that determination on the basis of the documentation, 32304
the department of ~~job and family services~~ health care 32305
administration or contracting agency shall terminate the order 32306
denying payment as of the date the facility completed the 32307
applicable action, as subsequently verified by the department of 32308
health. If the department of health conducts a follow-up survey, 32309
the department of ~~job and family services~~ health care 32310
administration or contracting agency shall terminate the order 32311
denying payment as of the date the department of health makes the 32312

determination that the facility completed the applicable action. 32313

(F) The department of ~~job and family services~~ health care 32314
administration or contracting agency shall provide public notice 32315
implementing an order under section ~~5111.46~~ 5164.62, ~~5111.47~~ 32316
5164.63, ~~5111.48~~ 5164.64, ~~5111.51~~ 5164.67, or ~~5111.57~~ 5164.73 of 32317
the Revised Code denying payment to a nursing facility under the 32318
~~medical assistance~~ medicaid program for all medicaid eligible 32319
residents by publishing in a newspaper of general circulation in 32320
the county in which the facility is located an announcement 32321
stating: "By order of the (Ohio Department of ~~Job and Family~~ 32322
~~Services~~ Health Care Administration or name of contracting 32323
agency), effective on and after (effective date of order), (name 32324
of facility) is no longer authorized to admit Medicaid eligible 32325
residents." Immediately following termination of any such order, 32326
the department or agency shall publish in a newspaper of general 32327
circulation in the county in which the facility is located an 32328
announcement stating: "By order of the (Ohio Department of ~~Job and~~ 32329
~~Family Services~~ Health Care Administration or name of contracting 32330
agency), effective on and after (effective date of termination), 32331
(name of facility) is hereby authorized to admit Medicaid eligible 32332
residents." Neither the department nor the contracting agency 32333
shall issue public notice of an order under section ~~5111.46~~ 32334
5164.62, ~~5111.47~~ 5164.63, or ~~5111.48~~ 5164.64 of the Revised Code 32335
denying payment to a nursing facility for medicaid eligible 32336
residents with specified diagnoses or special care needs; public 32337
notice is not required for such an order to take effect. 32338

(G) A facility that complies with division (E) of this 32339
section shall not be considered to have admitted to the existence 32340
of the deficiency that constitutes the basis of the department's 32341
or agency's order. 32342

Sec. ~~5111.56~~ 5164.72. (A) As used in this section, "certified 32343

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	32375
finding;	32376
(7) Seventy per cent of the amount calculated under division	32377
(C) of this section for any deficiency or cluster of deficiencies	32378
that constitutes a severity level three and scope level one	32379
finding;	32380
(8) Fifty per cent of the amount calculated under division	32381
(C) of this section for any deficiency or cluster of deficiencies	32382
that constitutes a severity level two and scope level four	32383
finding;	32384
(9) Forty per cent of the amount calculated under division	32385
(C) of this section for any deficiency or cluster of deficiencies	32386
that constitutes a severity level two and scope level three	32387
finding.	32388
(C) The amount subject to division (B) of this section shall	32389
be the product of multiplying two dollars and fifty cents for each	32390
day the fine is in effect by the total number of licensed nursing	32391
home beds or certified beds, whichever is greater, in the facility	32392
as of the date the deficiency or cluster of deficiencies that is	32393
the reason for the fine was cited.	32394
(D)(1) The department of job and family services <u>health care</u>	32395
<u>administration</u> or contracting agency shall not impose on a	32396
facility, at any one time, more than four fines as a result of any	32397
one survey.	32398
(2) The department of job and family services <u>health care</u>	32399
<u>administration</u> or contracting agency shall not impose more than	32400
one fine based on a deficiency or cluster of deficiencies.	32401
However, if the department of health, in a follow-up or other	32402
subsequent survey, finds a change in the scope or severity of the	32403
deficiency or cluster of deficiencies, the department of job and	32404
family services <u>health care administration</u> or contracting agency	32405

may increase or decrease the fine in accordance with division (B) 32406
of this section to reflect the change in scope or severity. The 32407
department or agency shall give the facility written notice of the 32408
change in the amount of the fine. The change shall take effect on 32409
the date the follow-up or other subsequent survey is completed. 32410

If the department of health finds that a deficiency is a 32411
repeat deficiency, the department of ~~job and family services~~ 32412
health care administration or contracting agency may impose a fine 32413
that is one hundred per cent greater than the fine specified in 32414
division (B) of this section for the deficiency. 32415

(E) The total amount of fines the department of ~~job and~~ 32416
~~family services~~ health care administration or contracting agency 32417
may impose on a facility in a single calendar year shall not 32418
exceed five hundred dollars for each licensed nursing home bed or 32419
certified bed, whichever is greater in number, in the facility. 32420

(F)(1) Except as provided in division (F)(2) of this section, 32421
the department of ~~job and family services~~ health care 32422
administration or contracting agency shall not impose a fine under 32423
section ~~5111.46~~ 5164.62, ~~5111.47~~ 5164.63, or ~~5111.48~~ 5164.64 of 32424
the Revised Code if the deficiency or cluster of deficiencies is 32425
substantially corrected within twenty days after the nursing 32426
facility receives the statement provided under division (B) of 32427
section ~~5111.49~~ 5164.65 of the Revised Code. The department or 32428
agency shall inform the nursing facility in that statement that 32429
the fine will not be imposed if the deficiency or cluster of 32430
deficiencies is substantially corrected within the twenty-day 32431
period. 32432

(2) If a nursing facility has substantially corrected a 32433
deficiency or cluster of deficiencies within six months after the 32434
exit interview of a survey that was the basis for citing a 32435
deficiency or cluster of deficiencies, but after correcting it has 32436
been cited for the same deficiency or cluster of deficiencies by 32437

the department of health on the basis of a subsequent survey 32438
conducted during the remainder of the six-month period, the 32439
department of ~~job and family services~~ health care administration 32440
or contracting agency may impose a fine beginning on the date of 32441
the exit interview of the subsequent survey. 32442

(G) Whenever a facility believes that it has completed 32443
implementation of the plan of correction it submitted under 32444
section ~~5111.43~~ 5164.59 of the Revised Code and substantially 32445
corrected the cited deficiency or cluster of deficiencies that is 32446
the basis for a fine, it may give written notice to that effect to 32447
the department of health. After receiving the notice, the 32448
department shall conduct a follow-up survey of the facility that 32449
focuses on the deficiency or cluster, unless the department is 32450
able to determine, on the basis of documentation provided by the 32451
facility, that the facility has substantially corrected the 32452
deficiency or cluster. If, based on the follow-up survey, the 32453
department establishes that the facility had not completed 32454
implementation of the plan of correction at the time the 32455
department received the notice, any fine based on the deficiency 32456
or cluster shall be doubled effective from the date the department 32457
received the notice. A facility that complies with this division 32458
shall not be considered to have admitted the existence of the 32459
deficiency or cluster that is the basis for the fine. 32460

(H) Except for a fine imposed under division (C) of section 32461
~~5111.46~~ 5164.62 of the Revised Code and as provided in division 32462
(F)(2) of this section, the department of ~~job and family services~~ 32463
health care administration or contracting agency shall impose a 32464
fine only if the facility fails to give notice under division (G) 32465
of this section within twenty days after it receives the statement 32466
required by division (B) of section ~~5111.49~~ 5164.65 of the Revised 32467
Code or if the department of health determines, based on a 32468
follow-up survey, that the deficiency or cluster of deficiencies 32469

for which the fine is proposed has not been substantially 32470
corrected within the twenty-day period. The fine shall be imposed 32471
effective on the twenty-first day after the facility receives the 32472
statement under division (B) of section ~~5111.49~~ 5164.65 of the 32473
Revised Code. The fine shall remain in effect until the earliest 32474
of the following: 32475

(1) The date the department of health receives notice under 32476
division (G) of this section, unless the department determines, on 32477
the basis of a follow-up survey, that the deficiency or cluster of 32478
deficiencies that is the basis for the fine has not been 32479
substantially corrected as of that date; 32480

(2) The date on which the department of health makes a 32481
determination, on the basis of a follow-up survey, that the 32482
deficiency or cluster of deficiencies has been substantially 32483
corrected; 32484

(3) The date the facility substantially corrected the 32485
deficiency or cluster, as subsequently determined by the 32486
department of health on the basis of documentation provided by the 32487
facility. 32488

(I) Any fine imposed by the department of ~~job and family~~ 32489
~~services~~ health care administration or contracting agency under 32490
this section is subject to appeal under Chapter 119. of the 32491
Revised Code. If the facility does not request a hearing under 32492
Chapter 119. of the Revised Code and either pays or agrees in 32493
writing to pay the fine when payment becomes due under division 32494
(J) of this section, the department or agency shall reduce the 32495
fine by fifty per cent. The department or agency may compromise 32496
any claim for payment of a fine under sections ~~5111.35~~ 5164.50 to 32497
~~5111.62~~ 5164.78 of the Revised Code. 32498

(J) The department of ~~job and family services~~ health care 32499
administration or contracting agency shall collect interest on 32500

32501 fines, at the rate per calendar month that equals one-twelfth of
32502 the rate per year prescribed by section 5703.47 of the Revised
32503 Code for the calendar year that includes the month for which the
32504 interest charge accrues. Payment of a fine is due, and interest
32505 begins to accrue on the unpaid fine or balance, on the
32506 thirty-first day after the department or agency issues a final
32507 adjudication order imposing the fine. If the deficiency or
32508 deficiencies on which the fine is based have not been corrected
32509 when the final adjudication order is issued, the payment is due,
32510 and interest begins to accrue on the unpaid fine or balance, on
32511 the thirty-first day after the deficiency or deficiencies are
32512 corrected and the department or agency mails a notice specifying
32513 the amount of the fine to the facility.

32514 (K) The department of ~~job and family services~~ health care
32515 administration or contracting agency shall collect fines and
32516 interest imposed under this section through one of the following
32517 means:

32518 (1) A lump sum payment from the provider;

32519 (2) Periodic payments for a period not to exceed twelve
32520 months, in accordance with a schedule approved by the department
32521 or agency;

32522 (3) Appropriately reducing the amounts of payments made to
32523 the facility for care provided to medicaid eligible residents for
32524 a period not to exceed twelve months following the date on which
32525 payment of the fine becomes due under division (J) of this
32526 section. An amount equal to the amount by which each payment is
32527 reduced shall be deposited to the credit of the residents
32528 protection fund in accordance with section ~~5111.62~~ 5164.78 of the
32529 Revised Code.

32530 **Sec. ~~5111.57~~ 5164.73.** (A) The department of ~~job and family~~
32531 ~~services~~ health care administration or a contracting agency shall

issue an order denying payment to a nursing facility for all 32532
medicaid eligible residents admitted to the facility on or after 32533
the effective date of the order, if the facility has failed to 32534
substantially correct within ninety days after the exit interview 32535
a deficiency or cluster of deficiencies in accordance with the 32536
plan of correction it submitted under section ~~5111.43~~ 5164.59 of 32537
the Revised Code, as determined by the department of health on the 32538
basis of a follow-up survey. 32539

(B) The department of ~~job and family services~~ health care 32540
administration or contracting agency shall issue an order denying 32541
payment to a nursing facility for all medicaid eligible residents 32542
admitted to the facility on or after the effective date of the 32543
order, if during three consecutive standard surveys conducted 32544
after December 13, 1990, the department of health has found a 32545
condition of substandard care in a facility. 32546

(C) An order issued under division (A) or (B) of this section 32547
shall take effect on the later of the date the facility receives 32548
the order or the date the public notice required under division 32549
(F) of section ~~5111.55~~ 5164.71 of the Revised Code is published. 32550
The order is subject to appeal under Chapter 119. of the Revised 32551
Code; however the order may take effect prior to or during the 32552
pendency of any hearing under that chapter. In that case, the 32553
department or agency shall provide the facility an opportunity for 32554
a hearing in accordance with section ~~5111.60~~ 5164.76 of the 32555
Revised Code. 32556

Sec. ~~5111.58~~ 5164.74. (A) If a nursing facility notifies the 32557
department of ~~job and family services~~ health care administration 32558
or a contracting agency, at any time during the six-month period 32559
following the exit interview of a survey that was the basis for 32560
citing a deficiency or deficiencies, that the deficiency or 32561
deficiencies have been substantially corrected in accordance with 32562

the plan of correction submitted and approved under section 32563
~~5111.43~~ 5164.59 of the Revised Code, the department of health 32564
shall conduct a follow-up survey to determine whether the 32565
deficiency or deficiencies have been substantially corrected in 32566
accordance with the plan. 32567

(B) The department of ~~job and family services~~ health care 32568
administration or a contracting agency shall terminate a nursing 32569
facility's participation in the ~~medical assistance~~ medicaid 32570
program whenever the facility has not substantially corrected, 32571
within six months after the exit interview of the survey on the 32572
basis of which it was cited, a deficiency or deficiencies in 32573
accordance with the plan of correction submitted under section 32574
~~5111.43~~ 5164.59 of the Revised Code, as determined by the 32575
department of health on the basis of a follow-up survey. 32576

(C) Unless the facility has substantially corrected the 32577
deficiency or deficiencies in accordance with the plan of 32578
correction, as determined by the department of health on the basis 32579
of a follow-up survey, the department of ~~job and family services~~ 32580
health care administration or contracting agency shall deliver to 32581
the facility, at least thirty days prior to the day that is six 32582
months after the exit interview, a written order terminating the 32583
facility's participation in the ~~medical assistance~~ medicaid 32584
program. The order shall take effect and the facility's 32585
participation shall terminate on the day that is six months after 32586
the exit interview. The order shall not take effect if, after it 32587
is delivered to the facility and prior to the effective date of 32588
the order, the department of health determines on the basis of a 32589
follow-up survey that the facility has corrected the deficiency or 32590
deficiencies. 32591

An order issued under this section is subject to appeal under 32592
Chapter 119. of the Revised Code; however, the order may take 32593
effect prior to or during the pendency of any hearing under that 32594

chapter. In that case, the department of ~~job and family services~~ 32595
health care administration or contracting agency shall provide the 32596
facility an opportunity for a hearing in accordance with section 32597
~~5111.60~~ 5164.76 of the Revised Code. 32598

(D) Except as provided in division (E) of this section, 32599
whenever the department of ~~job and family services~~ health care 32600
administration or a contracting agency terminates a facility's 32601
participation in the ~~medical assistance~~ medicaid program pursuant 32602
to this section, the provider shall repay the department the 32603
federal share of all payments made by the department to the 32604
facility under the ~~medical assistance~~ medicaid program during the 32605
six-month period following the exit interview of the survey that 32606
was the basis for citing the deficiency or cluster of 32607
deficiencies. The provider shall repay the department within 32608
thirty days after the department repays to the federal government 32609
the federal share of payments made to the facility during that 32610
six-month period. 32611

(E) A provider is not required to repay the department of ~~job~~ 32612
~~and family services~~ health care administration if either of the 32613
following is the case: 32614

(1) The facility has brought an appeal under Chapter 119. of 32615
the Revised Code of termination of its participation in the 32616
~~medical assistance~~ medicaid program, except that the provider 32617
shall repay the department of ~~job and family services~~ health care 32618
administration within thirty days after the facility exhausts its 32619
right to appeal under that chapter. 32620

(2) The facility complied with the plan of correction 32621
approved by the department of health and the obligation to repay 32622
resulted from the department's failure to provide timely 32623
verification to the United States department of health and human 32624
services of the facility's compliance with the plan of correction. 32625

(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 32686
medicaid eligible residents admitted after the effective date of 32687
the order who have certain diagnoses or special care needs 32688
specified by the department or agency; 32689

(5) A fine imposed under section ~~5111.46~~ 5164.62, ~~5111.47~~ 32690
5164.63, or ~~5111.48~~ 5164.64 of the Revised Code. 32691

(B) The department of ~~job and family services~~ health care 32692
administration or contracting agency may do any of the following 32693
prior to or during the pendency of any proceeding under Chapter 32694
119. of the Revised Code: 32695

(1) Issue and execute an order under section ~~5111.46~~ 5164.62, 32696
~~5111.51~~ 5164.67, or ~~5111.58~~ 5164.74 of the Revised Code 32697
terminating a nursing facility's participation in the ~~medical~~ 32698
~~assistance~~ medicaid program; 32699

(2) Appoint a temporary manager under division (A)(1)(b) or 32700
(2)(b) of section ~~5111.46~~ 5164.62 or division (A)(1)(d) of section 32701
~~5111.51~~ 5164.67 of the Revised Code; 32702

(3) Issue and execute an order under section ~~5111.46~~ 5164.62, 32703
~~5111.47~~ 5164.63, ~~5111.51~~ 5164.67, or ~~5111.57~~ 5164.73 of the 32704
Revised Code denying payment to a facility for all medicaid 32705
eligible residents admitted after the effective date of the order; 32706

(4) Issue and execute an order under section ~~5111.46~~ 5164.62 32707
or ~~5111.47~~ 5164.63 or division (A), (B), or (C) of section ~~5111.48~~ 32708
5164.64 of the Revised Code denying payment to a facility for 32709
medicaid eligible residents admitted after the effective date of 32710
the order who have specified diagnoses or special care needs. 32711

(C) Whenever the department or agency imposes a remedy listed 32712
in division (B) of this section prior to or during the pendency of 32713
a proceeding, all of the following apply: 32714

(1) The provider against whom the action is taken shall have 32715

ten days after the date the facility actually receives the notice 32716
specified in section 119.07 of the Revised Code to request a 32717
hearing. 32718

(2) The hearing shall commence within thirty days after the 32719
date the department or agency receives the provider's request for 32720
a hearing. 32721

(3) The hearing shall continue uninterrupted from day to day, 32722
except for Saturdays, Sundays, and legal holidays, unless other 32723
interruptions are agreed to by the provider and the department or 32724
agency. 32725

(4) If the hearing is conducted by a hearing examiner, the 32726
hearing examiner shall file a report and recommendations within 32727
ten days after the close of the hearing. 32728

(5) The provider shall have five days after the date the 32729
hearing officer files the report and recommendations within which 32730
to file objections to the report and recommendations. 32731

(6) Not later than fifteen days after the date the hearing 32732
officer files the report and recommendations, the director of ~~job~~ 32733
~~and family services~~ health care administration or the director of 32734
the contracting agency shall issue an order approving, modifying, 32735
or disapproving the report and recommendations of the hearing 32736
examiner. 32737

(D) If the department or agency imposes more than one remedy 32738
as the result of deficiencies cited in a single survey, the 32739
proceedings for all of the remedies shall be consolidated. If any 32740
of the remedies are imposed during the pendency of a hearing, as 32741
permitted by division (B) of this section, the consolidated 32742
hearing shall be conducted in accordance with division (C) of this 32743
section. The consolidation of the remedies for purposes of a 32744
hearing does not affect the effective dates prescribed in sections 32745
~~5111.35~~ 5164.50 to ~~5111.58~~ 5164.74 of the Revised Code. 32746

(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. 32777
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(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. 32779
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(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. 32785
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(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. 32798
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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, 32803
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collected under section 173.42 of the Revised Code shall be 32808
deposited in the state treasury to the credit of the residents 32809
protection fund. 32810

Moneys in the fund shall be used for the protection of the 32811
health or property of residents of nursing facilities in which the 32812
department of health finds deficiencies, including payment for the 32813
costs of relocation of residents to other facilities, maintenance 32814
of operation of a facility pending correction of deficiencies or 32815
closure, and reimbursement of residents for the loss of money 32816
managed by the facility under section 3721.15 of the Revised Code. 32817

The fund shall be maintained and administered by the 32818
department of ~~job and family services~~ health care administration 32819
under rules developed in consultation with the departments of 32820
health and aging and adopted by the director of ~~job and family~~ 32821
~~services~~ health care administration under Chapter 119. of the 32822
Revised Code. 32823

Sec. ~~5111.63~~ 5164.79. For the purposes of this section, 32824
"facility," "~~medicare,~~" and "~~medicaid~~" have has the same meanings 32825
meaning as in section 3721.10 of the Revised Code. 32826

The department of health shall be the designee of the 32827
department of ~~job and family services~~ health care administration 32828
for the purpose of conducting a hearing pursuant to section 32829
3721.162 of the Revised Code concerning a facility's decision to 32830
transfer or discharge a resident if the resident is a medicaid 32831
recipient or medicare beneficiary. 32832

Sec. ~~5111.65~~ 5164.82. As used in sections ~~5111.65~~ 5164.82 to 32833
~~5111.688~~ 5164.858 of the Revised Code: 32834

(A) "Change of operator" means an entering operator becoming 32835
the operator of a nursing facility or intermediate care facility 32836
for the mentally retarded in the place of the exiting operator. 32837

(1) Actions that constitute a change of operator include the following:	32838 32839
(a) A change in an exiting operator's form of legal organization, including the formation of a partnership or corporation from a sole proprietorship;	32840 32841 32842
(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;	32843 32844 32845 32846 32847
(c) A lease of the facility to the entering operator or the exiting operator's termination of the exiting operator's lease;	32848 32849
(d) If the exiting operator is a partnership, dissolution of the partnership;	32850 32851
(e) If the exiting operator is a partnership, a change in composition of the partnership unless both of the following apply:	32852 32853
(i) The change in composition does not cause the partnership's dissolution under state law.	32854 32855
(ii) The partners agree that the change in composition does not constitute a change in operator.	32856 32857
(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.	32858 32859 32860 32861
(2) The following, alone, do not constitute a change of operator:	32862 32863
(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;	32864 32865 32866 32867

(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 32898
retarded on the effective date of a change of operator; 32899

(2) An operator that will cease to be the operator of a 32900
nursing facility or intermediate care facility for the mentally 32901
retarded on the effective date of a facility closure; 32902

(3) An operator of an intermediate care facility for the 32903
mentally retarded that is undergoing or has undergone a voluntary 32904
termination; 32905

(4) An operator of a nursing facility that is undergoing or 32906
has undergone a voluntary withdrawal of participation. 32907

(H)(1) "Facility closure" means discontinuance of the use of 32908
the building, or part of the building, that houses the facility as 32909
a nursing facility or intermediate care facility for the mentally 32910
retarded that results in the relocation of all of the facility's 32911
residents. A facility closure occurs regardless of any of the 32912
following: 32913

(a) The operator completely or partially replacing the 32914
facility by constructing a new facility or transferring the 32915
facility's license to another facility; 32916

(b) The facility's residents relocating to another of the 32917
operator's facilities; 32918

(c) Any action the department of health takes regarding the 32919
facility's certification ~~under Title XIX of the "Social Security~~ 32920
~~Act," 79 Stat. 286 (1965), 42 U.S.C. 1396, as amended, for~~ 32921
participation in the medicaid program that may result in the 32922
transfer of part of the facility's survey findings to another of 32923
the operator's facilities; 32924

(d) Any action the department of health takes regarding the 32925
facility's license under Chapter 3721. of the Revised Code; 32926

(e) Any action the department of mental retardation and 32927

developmental disabilities takes regarding the facility's license 32928
under section 5123.19 of the Revised Code. 32929

(2) A facility closure does not occur if all of the 32930
facility's residents are relocated due to an emergency evacuation 32931
and one or more of the residents return to a medicaid-certified 32932
bed in the facility not later than thirty days after the 32933
evacuation occurs. 32934

(I) "Fiscal year," "intermediate care facility for the 32935
mentally retarded," "nursing facility," "operator," "owner," and 32936
"provider agreement" have the same meanings as in section ~~5111.20~~ 32937
5164.01 of the Revised Code. 32938

(J) "Voluntary termination" means an operator's voluntary 32939
election to terminate the participation of an intermediate care 32940
facility for the mentally retarded in the medicaid program but to 32941
continue to provide service of the type provided by a residential 32942
facility as defined in section 5123.19 of the Revised Code. 32943

(K) "Voluntary withdrawal of participation" means an 32944
operator's voluntary election to terminate the participation of a 32945
nursing facility in the medicaid program but to continue to 32946
provide service of the type provided by a nursing facility. 32947

Sec. ~~5111.651~~ 5164.821. Sections ~~5111.65~~ 5164.82 to ~~5111.688~~ 32948
5164.858 of the Revised Code do not apply to a nursing facility or 32949
intermediate care facility for the mentally retarded that 32950
undergoes a facility closure, voluntary termination, voluntary 32951
withdrawal of participation, or change of operator on or before 32952
September 30, 2005, if the exiting operator provided written 32953
notice of the facility closure, voluntary termination, voluntary 32954
withdrawal of participation, or change of operator to the 32955
department of job and family services on or before June 30, 2005. 32956

Sec. ~~5111.66~~ 5164.83. An exiting operator or owner of a 32957

nursing facility or intermediate care facility for the mentally 32958
retarded participating in the medicaid program shall provide the 32959
department of ~~job and family services~~ health care administration 32960
written notice of a facility closure, voluntary termination, or 32961
voluntary withdrawal of participation not less than ninety days 32962
before the effective date of the facility closure, voluntary 32963
termination, or voluntary withdrawal of participation. The written 32964
notice shall include all of the following: 32965

(A) The name of the exiting operator and, if any, the exiting 32966
operator's authorized agent; 32967

(B) The name of the nursing facility or intermediate care 32968
facility for the mentally retarded that is the subject of the 32969
written notice; 32970

(C) The exiting operator's medicaid provider agreement number 32971
for the facility that is the subject of the written notice; 32972

(D) The effective date of the facility closure, voluntary 32973
termination, or voluntary withdrawal of participation; 32974

(E) The signature of the exiting operator's or owner's 32975
representative. 32976

Sec. ~~5111.67~~ 5164.84. (A) An exiting operator or owner and 32977
entering operator shall provide the department of ~~job and family~~ 32978
~~services~~ health care administration written notice of a change of 32979
operator if the nursing facility or intermediate care facility for 32980
the mentally retarded participates in the medicaid program and the 32981
entering operator seeks to continue the facility's participation. 32982
The written notice shall be provided to the department not later 32983
than forty-five days before the effective date of the change of 32984
operator if the change of operator does not entail the relocation 32985
of residents. The written notice shall be provided to the 32986
department not later than ninety days before the effective date of 32987

the change of operator if the change of operator entails the	32988
relocation of residents. The written notice shall include all of	32989
the following:	32990
(1) The name of the exiting operator and, if any, the exiting	32991
operator's authorized agent;	32992
(2) The name of the nursing facility or intermediate care	32993
facility for the mentally retarded that is the subject of the	32994
change of operator;	32995
(3) The exiting operator's medicaid provider agreement number	32996
for the facility that is the subject of the change of operator;	32997
(4) The name of the entering operator;	32998
(5) The effective date of the change of operator;	32999
(6) The manner in which the entering operator becomes the	33000
facility's operator, including through sale, lease, merger, or	33001
other action;	33002
(7) If the manner in which the entering operator becomes the	33003
facility's operator involves more than one step, a description of	33004
each step;	33005
(8) Written authorization from the exiting operator or owner	33006
and entering operator for the department to process a provider	33007
agreement for the entering operator;	33008
(9) The signature of the exiting operator's or owner's	33009
representative.	33010
(B) The entering operator shall include a completed	33011
application for a provider agreement with the written notice to	33012
the department. The entering operator shall attach to the	33013
application the following:	33014
(1) If the written notice is provided to the department	33015
before the date the exiting operator or owner and entering	33016
operator complete the transaction for the change of operator, all	33017

the proposed leases, management agreements, merger agreements and 33018
supporting documents, and sales contracts and supporting documents 33019
relating to the facility's change of operator; 33020

(2) If the written notice is provided to the department on or 33021
after the date the exiting operator or owner and entering operator 33022
complete the transaction for the change of operator, copies of all 33023
the executed leases, management agreements, merger agreements and 33024
supporting documents, and sales contracts and supporting documents 33025
relating to the facility's change of operator. 33026

Sec. ~~5111.671~~ 5164.841. The department of ~~job and family~~ 33027
~~services~~ health care administration may enter into a provider 33028
agreement with an entering operator that goes into effect at 12:01 33029
a.m. on the effective date of the change of operator if all of the 33030
following requirements are met: 33031

(A) The department receives a properly completed written 33032
notice required by section ~~5111.67~~ 5164.84 of the Revised Code on 33033
or before the date required by that section. 33034

(B) The entering operator furnishes to the department copies 33035
of all the fully executed leases, management agreements, merger 33036
agreements and supporting documents, and sales contracts and 33037
supporting documents relating to the change of operator not later 33038
than ten days after the effective date of the change of operator. 33039

(C) The entering operator is eligible for medicaid payments 33040
as provided in section ~~5111.21~~ 5164.02 of the Revised Code. 33041

Sec. ~~5111.672~~ 5164.842. (A) The department of ~~job and family~~ 33042
~~services~~ health care administration may enter into a provider 33043
agreement with an entering operator that goes into effect at 12:01 33044
a.m. on the date determined under division (B) of this section if 33045
all of the following are the case: 33046

(1) The department receives a properly completed written 33047

notice required by section ~~5111.67~~ 5164.84 of the Revised Code. 33048

(2) The entering operator furnishes to the department copies 33049
of all the fully executed leases, management agreements, merger 33050
agreements and supporting documents, and sales contracts and 33051
supporting documents relating to the change of operator. 33052

(3) The requirement of division (A)(1) of this section is met 33053
after the time required by section ~~5111.67~~ 5164.84 of the Revised 33054
Code, the requirement of division (A)(2) of this section is met 33055
more than ten days after the effective date of the change of 33056
operator, or both. 33057

(4) The entering operator is eligible for medicaid payments 33058
as provided in section ~~5111.21~~ 5164.02 of the Revised Code. 33059

(B) The department shall determine the date a provider 33060
agreement entered into under this section is to go into effect as 33061
follows: 33062

(1) The effective date shall give the department sufficient 33063
time to process the change of operator, assure no duplicate 33064
payments are made, make the withholding required by section 33065
~~5111.681~~ 5164.851 of the Revised Code, and withhold the final 33066
payment to the exiting operator until one hundred eighty days 33067
after either of the following: 33068

(a) The date that the exiting operator submits to the 33069
department a properly completed cost report under section ~~5111.682~~ 33070
5164.852 of the Revised Code; 33071

(b) The date that the department waives the cost report 33072
requirement of section ~~5111.682~~ 5164.852 of the Revised Code. 33073

(2) The effective date shall be not earlier than the later of 33074
the effective date of the change of operator or the date that the 33075
exiting operator or owner and entering operator comply with 33076
section ~~5111.67~~ 5164.84 of the Revised Code. 33077

(3) The effective date shall be not later than the following 33078
after the later of the dates specified in division (B)(2) of this 33079
section: 33080

(a) Forty-five days if the change of operator does not entail 33081
the relocation of residents; 33082

(b) Ninety days if the change of operator entails the 33083
relocation of residents. 33084

Sec. ~~5111.673~~ 5164.843. A provider that enters into a 33085
provider agreement with the department of ~~job and family services~~ 33086
health care administration under section ~~5111.671~~ 5164.841 or 33087
~~5111.672~~ 5164.842 of the Revised Code shall do all of the 33088
following: 33089

(A) Comply with all applicable federal statutes and 33090
regulations; 33091

(B) Comply with section ~~5111.22~~ 5164.03 of the Revised Code 33092
and all other applicable state statutes and rules; 33093

(C) Comply with all the terms and conditions of the exiting 33094
operator's provider agreement, including, but not limited to, all 33095
of the following: 33096

(1) Any plan of correction; 33097

(2) Compliance with health and safety standards; 33098

(3) Compliance with the ownership and financial interest 33099
disclosure requirements of 42 C.F.R. 455.104, 455.105, and 1002.3; 33100

(4) Compliance with the civil rights requirements of 45 33101
C.F.R. parts 80, 84, and 90; 33102

(5) Compliance with additional requirements imposed by the 33103
department; 33104

(6) Any sanctions relating to remedies for violation of the 33105
provider agreement, including deficiencies, compliance periods, 33106

accountability periods, monetary penalties, notification for 33107
correction of contract violations, and history of deficiencies. 33108

Sec. ~~5111.674~~ 5164.844. In the case of a change of operator, 33109
the exiting operator shall be considered to be the operator of the 33110
nursing facility or intermediate care facility for the mentally 33111
retarded for purposes of the medicaid program, including medicaid 33112
payments, until the effective date of the entering operator's 33113
provider agreement if the provider agreement is entered into under 33114
section ~~5111.671~~ 5164.841 or ~~5111.672~~ 5164.842 of the Revised 33115
Code. 33116

Sec. ~~5111.675~~ 5164.845. The department of ~~job and family~~ 33117
~~services~~ health care administration may enter into a provider 33118
agreement as provided in section ~~5111.22~~ 5164.03 of the Revised 33119
Code, rather than section ~~5111.671~~ 5164.841 or ~~5111.672~~ 5164.842 33120
of the Revised Code, with an entering operator if the entering 33121
operator does not agree to a provider agreement that satisfies the 33122
requirements of division (C) of section ~~5111.673~~ 5164.843 of the 33123
Revised Code. The department may not enter into the provider 33124
agreement unless the department of health certifies the nursing 33125
facility or intermediate care facility for the mentally retarded 33126
~~under Title XIX of the "Social Security Act," 79 Stat. 286 (1965),~~ 33127
~~42 U.S.C. 1396, as amended~~ for participation in the medicaid 33128
program. The effective date of the provider agreement shall not 33129
precede any of the following: 33130

(A) The date that the department of health certifies the 33131
facility; 33132

(B) The effective date of the change of operator; 33133

(C) The date the requirement of section ~~5111.67~~ 5164.84 of 33134
the Revised Code is satisfied. 33135

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~~ 33166
~~and family services~~ health care administration shall determine the 33167
amount of any overpayments made under the medicaid program to the 33168
exiting operator, including overpayments the exiting operator 33169
disputes, and other actual and potential debts the exiting 33170
operator owes or may owe to the department and United States 33171
centers for medicare and medicaid services under the medicaid 33172
program. In determining the exiting operator's other actual and 33173
potential debts to the department under the medicaid program, the 33174
department shall include all of the following that the department 33175
determines is applicable: 33176

(1) Refunds due the department under section ~~5111.27~~ 5164.38 33177
of the Revised Code; 33178

(2) Interest owed to the department and United States centers 33179
for medicare and medicaid services; 33180

(3) Final civil monetary and other penalties for which all 33181
right of appeal has been exhausted; 33182

(4) Money owed the department and United States centers for 33183
medicare and medicaid services from any outstanding final fiscal 33184
audit, including a final fiscal audit for the last fiscal year or 33185
portion thereof in which the exiting operator participated in the 33186
medicaid program. 33187

(B) If the department is unable to determine the amount of 33188
the overpayments and other debts for any period before the 33189
effective date of the entering operator's provider agreement or 33190
the effective date of the facility closure, voluntary termination, 33191
or voluntary withdrawal of participation, the department shall 33192
make a reasonable estimate of the overpayments and other debts for 33193
the period. The department shall make the estimate using 33194
information available to the department, including prior 33195
determinations of overpayments and other debts. 33196

Sec. ~~5111.681~~ 5164.851. (A) Except as provided in division 33197
(B) of this section, the department of ~~job and family services~~ 33198
health care administration shall withhold the greater of the 33199
following from payment due an exiting operator under the medicaid 33200
program: 33201

(1) The total amount of any overpayments made under the 33202
medicaid program to the exiting operator, including overpayments 33203
the exiting operator disputes, and other actual and potential 33204
debts, including any unpaid penalties, the exiting operator owes 33205
or may owe to the department and United States centers for 33206
medicare and medicaid services under the medicaid program; 33207

(2) An amount equal to the average amount of monthly payments 33208
to the exiting operator under the medicaid program for the 33209
twelve-month period immediately preceding the month that includes 33210
the last day the exiting operator's provider agreement is in 33211
effect or, in the case of a voluntary withdrawal of participation, 33212
the effective date of the voluntary withdrawal of participation. 33213

(B) The department may choose not to make the withholding 33214
under division (A) of this section if an entering operator does 33215
both of the following: 33216

(1) Enters into a nontransferable, unconditional, written 33217
agreement with the department to pay the department any debt the 33218
exiting operator owes the department under the medicaid program; 33219

(2) Provides the department a copy of the entering operator's 33220
balance sheet that assists the department in determining whether 33221
to make the withholding under division (A) of this section. 33222

Sec. ~~5111.682~~ 5164.852. (A) Except as provided in division 33223
(B) of this section, an exiting operator shall file with the 33224
department of ~~job and family services~~ health care administration a 33225
cost report not later than ninety days after the last day the 33226

exiting operator's provider agreement is in effect or, in the case 33227
of a voluntary withdrawal of participation, the effective date of 33228
the voluntary withdrawal of participation. The cost report shall 33229
cover the period that begins with the day after the last day 33230
covered by the operator's most recent previous cost report 33231
required by section ~~5111.26~~ 5164.37 of the Revised Code and ends 33232
on the last day the exiting operator's provider agreement is in 33233
effect or, in the case of a voluntary withdrawal of participation, 33234
the effective date of the voluntary withdrawal of participation. 33235
The cost report shall include, as applicable, all of the 33236
following: 33237

(1) The sale price of the nursing facility or intermediate 33238
care facility for the mentally retarded; 33239

(2) A final depreciation schedule that shows which assets are 33240
transferred to the buyer and which assets are not transferred to 33241
the buyer; 33242

(3) Any other information the department requires. 33243

(B) The department, at its sole discretion, may waive the 33244
requirement that an exiting operator file a cost report in 33245
accordance with division (A) of this section. 33246

Sec. ~~5111.683~~ 5164.853. If an exiting operator required by 33247
section ~~5111.682~~ 5164.852 of the Revised Code to file a cost 33248
report with the department of ~~job and family services~~ health care
administration fails to file the cost report in accordance with 33249
that section, all payments under the medicaid program for the 33250
period the cost report is required to cover are deemed 33251
overpayments until the date the department receives the properly 33252
completed cost report. The department may impose on the exiting 33253
operator a penalty of one hundred dollars for each calendar day 33254
the properly completed cost report is late. 33255
33256

Sec. ~~5111.684~~ 5164.854. The department of ~~job and family~~ 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~~ 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~~ 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: 33287

(A) Ninety-one days after the date the exiting operator files 33288
a properly completed cost report required by section ~~5111.682~~ 33289
5164.852 of the Revised Code unless the department issues the 33290
report required by section ~~5111.685~~ 5164.855 of the Revised Code 33291
not later than ninety days after the date the exiting operator 33292
files the properly completed cost report; 33293

(B) Not later than thirty days after the exiting operator 33294
agrees to a final fiscal audit resulting from the report required 33295
by section ~~5111.685~~ 5164.855 of the Revised Code if the department 33296
issues the report not later than ninety days after the date the 33297
exiting operator files a properly completed cost report required 33298
by section ~~5111.682~~ 5164.852 of the Revised Code; 33299

(C) Ninety-one days after the date the department waives the 33300
cost report requirement of section ~~5111.682~~ 5164.852 of the 33301
Revised Code unless the department issues the report required by 33302
section ~~5111.685~~ 5164.855 of the Revised Code not later than 33303
ninety days after the date the department waives the cost report 33304
requirement; 33305

(D) Not later than thirty days after the exiting operator 33306
agrees to a final fiscal audit resulting from the report required 33307
by section ~~5111.685~~ 5164.855 of the Revised Code if the department 33308
issues the report not later than ninety days after the date the 33309
department waives the cost report requirement of section ~~5111.682~~ 33310
5164.852 of the Revised Code. 33311

Sec. ~~5111.687~~ 5164.857. The department of ~~job and family~~ 33312
~~services~~ health care administration, at its sole discretion, may 33313
release the amount withheld under division (A) of section ~~5111.681~~ 33314
5164.851 of the Revised Code if the exiting operator submits to 33315
the department written notice of a postponement of a change of 33316
operator, facility closure, voluntary termination, or voluntary 33317

withdrawal of participation and the transactions leading to the 33318
change of operator, facility closure, voluntary termination, or 33319
voluntary withdrawal of participation are postponed for at least 33320
thirty days but less than ninety days after the date originally 33321
proposed for the change of operator, facility closure, voluntary 33322
termination, or voluntary withdrawal of participation as reported 33323
in the written notice required by section ~~5111.66~~ 5164.83 or 33324
~~5111.67~~ 5164.84 of the Revised Code. The department shall release 33325
the amount withheld if the exiting operator submits to the 33326
department written notice of a cancellation or postponement of a 33327
change of operator, facility closure, voluntary termination, or 33328
voluntary withdrawal of participation and the transactions leading 33329
to the change of operator, facility closure, voluntary 33330
termination, or voluntary withdrawal of participation are canceled 33331
or postponed for more than ninety days after the date originally 33332
proposed for the change of operator, facility closure, voluntary 33333
termination, or voluntary withdrawal of participation as reported 33334
in the written notice required by section ~~5111.66~~ 5164.83 or 33335
~~5111.67~~ 5164.84 of the Revised Code. 33336

After the department receives a written notice regarding a 33337
cancellation or postponement of a facility closure, voluntary 33338
termination, or voluntary withdrawal of participation, the exiting 33339
operator or owner shall provide new written notice to the 33340
department under section ~~5111.66~~ 5164.83 of the Revised Code 33341
regarding any transactions leading to a facility closure, 33342
voluntary termination, or voluntary withdrawal of participation at 33343
a future time. After the department receives a written notice 33344
regarding a cancellation or postponement of a change of operator, 33345
the exiting operator or owner and entering operator shall provide 33346
new written notice to the department under section ~~5111.67~~ 5164.84 33347
of the Revised Code regarding any transactions leading to a change 33348
of operator at a future time. 33349

Sec. ~~5111.688~~ 5164.858. The director of ~~job and family~~ 33350
~~services~~ health care administration may adopt rules under section 33351
~~5111.02~~ 5163.15 of the Revised Code to implement sections ~~5111.65~~ 33352
5164.82 to ~~5111.688~~ 5164.858 of the Revised Code, including rules 33353
applicable to an exiting operator that provides written 33354
notification under section ~~5111.66~~ 5164.83 of the Revised Code of 33355
a voluntary withdrawal of participation. Rules adopted under this 33356
section shall comply with ~~section 1919(c)(2)(F) of the "Social~~ 33357
~~Security Act," 79 Stat. 286 (1965),~~ 42 U.S.C. 1396r(c)(2)(F), 33358
regarding restrictions on transfers or discharges of nursing 33359
facility residents in the case of a voluntary withdrawal of 33360
participation. The rules may prescribe a medicaid reimbursement 33361
methodology and other procedures that are applicable after the 33362
effective date of a voluntary withdrawal of participation that 33363
differ from the reimbursement methodology and other procedures 33364
that would otherwise apply. 33365

Sec. ~~5111.99~~ 5164.99. (A) Whoever violates division (B) of 33366
section ~~5111.26~~ 5164.37 or division (E) of section ~~5111.31~~ 33367
5164.033 of the Revised Code shall be fined not less than five 33368
hundred dollars nor more than one thousand dollars for the first 33369
offense and not less than one thousand dollars nor more than five 33370
thousand dollars for each subsequent offense. Fines paid under 33371
this section shall be deposited in the state treasury to the 33372
credit of the general revenue fund. 33373

(B) Whoever violates division (D) of section ~~5111.61~~ 5164.77 33374
of the Revised Code is guilty of registering a false complaint, a 33375
misdemeanor of the first degree. 33376

Sec. 5165.01. As used in this chapter: 33377

"Care management system" means the medicaid managed care 33378
program established under section 5165.02 of the Revised Code. 33379

"Emergency services" has the same meaning as in 42 U.S.C. 1396u-2(b)(2). 33380
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"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. 33382
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"Provider" has the same meaning as in section 5163.01 of the Revised Code. 33386
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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. 33388
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~~**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.~~ 33394
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~~(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: 33400
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~~(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 33406
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individuals included in the category shall be designated for 33410
participation, except for ~~individuals~~ individuals included in one 33411
or more of the medicaid recipient groups specified in 42 C.F.R. 33412
438.50(d). The department shall designate the participants not 33413
later than January 1, 2006. Beginning not later than December 31, 33414
2006, the department shall ensure that all participants are 33415
enrolled in health insuring corporations under contract with the 33416
department pursuant to section ~~5111.17~~ 5165.05 of the Revised 33417
Code. 33418

~~(2)~~(B) In the case of individuals who receive medicaid on the 33419
basis of being aged, blind, or disabled, as specified in division 33420
~~(A)~~~~(2)~~(B) of section ~~5111.01~~ 5162.01 of the Revised Code, the 33421
department shall implement the care management system in all 33422
counties. All individuals included in the category shall be 33423
designated for participation, except for the individuals specified 33424
in divisions ~~(B)~~~~(2)~~~~(a)~~ ~~to~~ ~~(e)~~ of this section. Beginning not later 33425
than December 31, 2006, the department shall ensure that all 33426
participants are enrolled in health insuring corporations under 33427
contract with the department pursuant to section ~~5111.17~~ 5165.05 33428
of the Revised Code. 33429

In designating participants who receive medicaid on the basis 33430
of being aged, blind, or disabled, the department shall not 33431
include any of the following: 33432

~~(a)~~(1) Individuals who are under twenty-one years of age; 33433

~~(b)~~(2) Individuals who are institutionalized; 33434

~~(e)~~(3) Individuals who become eligible for medicaid by 33435
spending down their income or resources to a level that meets the 33436
medicaid program's financial eligibility requirements; 33437

~~(d)~~(4) Individuals who are dually eligible under the medicaid 33438
program and the medicare program ~~established under Title XVIII of~~ 33439
~~the "Social Security Act," 79 Stat. 286 (1965), 42 U.S.C. 1395, as~~ 33440

amended; 33441

~~(e)(5)~~ Individuals to the extent that they are receiving 33442
medicaid services through a medicaid waiver component, as defined 33443
in section ~~5111.85~~ 5163.50 of the Revised Code. 33444

~~(3)(C)~~ Alcohol, drug addiction, and mental health services 33445
covered by medicaid shall not be included in any component of the 33446
care management system when the nonfederal share of the cost of 33447
those services is provided by a board of alcohol, drug ~~addiction~~ 33448
addiction, and mental health services or a state agency other than 33449
the department of ~~job and family services~~ health care 33450
administration, but the recipients of those services may otherwise 33451
be designated for participation in the system. 33452

~~(C)~~ Subject to division (B) of this section, the department 33453
may do both of the following under the care management system: 33454

~~(1)~~ Require or permit participants in the system to obtain 33455
health care services from providers designated by the department; 33456

~~(2)~~ Require or permit participants in the system to obtain 33457
health care services through managed care organizations under 33458
contract with the department pursuant to section 5111.17 of the 33459
Revised Code. 33460

~~(D)(1)~~ The department shall prepare an annual report on the 33461
care management system. The report shall address the department's 33462
ability to implement the system, including all of the following 33463
components: 33464

~~(a)~~ The required designation of participants included in the 33465
category identified by the department as covered families and 33466
children; 33467

~~(b)~~ The required designation of participants included in the 33468
aged, blind, or disabled category of medicaid recipients; 33469

~~(c)~~ The conduct of the pilot program for chronically ill 33470

~~children established under section 5111.163 of the Revised Code;~~ 33471

~~(d) The use of any programs for enhanced care management.~~ 33472

~~(2) The department shall submit each annual report to the 33473
general assembly. The first report shall be submitted not later 33474
than October 1, 2007.~~ 33475

~~(E) The director of job and family services may adopt rules 33476
in accordance with Chapter 119. of the Revised Code to implement 33477
this section.~~ 33478

Sec. 5165.04. Subject to section 5165.03 of the Revised Code, 33479
the department of health care administration may do both of the 33480
following under the care management system: 33481

(A) Require or permit participants in the system to obtain 33482
health care services from providers designated by the department; 33483

(B) Require or permit participants in the system to obtain 33484
health care services through managed care organizations under 33485
contract with the department pursuant to section 5165.05 of the 33486
Revised Code. 33487

Sec. ~~5111.17~~ 5165.05. ~~(A)~~ The department of ~~job and family 33488
services~~ health care administration may enter into contracts with 33489
managed care organizations, including health insuring 33490
corporations, under which the organizations are authorized to 33491
provide, or arrange for the provision of, health care services to 33492
~~medical assistance~~ medicaid recipients who are required or 33493
permitted to obtain health care services through managed care 33494
organizations as part of the care management system ~~established 33495
under section 5111.16 of the Revised Code.~~ 33496

~~(B) The department shall develop and implement a financial 33497
incentive program to improve and reward positive health outcomes 33498
through the managed care organization contracts entered into under 33499~~

~~this section. In developing and implementing the program, the 33500
department may take into consideration the recommendations 33501
regarding the program made by the medicaid care management working 33502
group created under section 5111.161 of the Revised Code. 33503~~

~~(C) The director of job and family services may adopt rules 33504
in accordance with Chapter 119. of the Revised Code to implement 33505
this section. 33506~~

Sec. 5165.06. The department of health care administration 33507
shall develop and implement a financial incentive program to 33508
improve and reward positive health outcomes through the managed 33509
care organization contracts entered into under section 5165.05 of 33510
the Revised Code. In developing and implementing the program, the 33511
department may take into consideration the recommendations 33512
regarding the program made by the medicaid care management working 33513
group created under section 5165.19 of the Revised Code. 33514

Sec. ~~5111.171~~ 5165.07. ~~(A)~~ The department of job and family 33515
services health care administration may provide financial 33516
incentive awards to medicaid managed care organizations ~~under~~ 33517
~~contract with the department pursuant to section 5111.17 of the~~ 33518
~~Revised Code~~ that meet or exceed performance standards specified 33519
in provider agreements or rules adopted ~~by the department~~ under 33520
section 5165.18 of the Revised Code. The department may specify in 33521
a contract with a managed care organization the amounts of 33522
financial incentive awards, methodology for distributing awards, 33523
types of awards, and standards for administration by the 33524
department. 33525

~~(B) There is hereby created in the state treasury the health 33526
care compliance fund. The fund shall consist of all fines imposed 33527
on and collected from managed care organizations for failure to 33528
meet performance standards or other requirements specified in 33529~~

~~provider agreements or rules adopted by the department. All 33530
investment earnings of the fund shall be credited to the fund. 33531
Moneys credited to the fund shall be used solely for the following 33532
purposes: 33533~~

~~(1) To reimburse managed care organizations that have paid 33534
fines for failures to meet performance standards or other 33535
requirements and that have come into compliance by meeting 33536
requirements as specified by the department; 33537~~

~~(2) To provide financial incentive awards established 33538
pursuant to division (A) of this section and specified in 33539
contracts between managed care organizations and the department. 33540~~

Sec. 5165.08. There is hereby created in the state treasury 33541
the health care compliance fund. The fund shall consist of all 33542
fines imposed on and collected from medicaid managed care 33543
organizations for failure to meet performance standards or other 33544
requirements specified in provider agreements or rules under 33545
section 5165.18 of the Revised Code. All investment earnings of 33546
the fund shall be credited to the fund. Moneys credited to the 33547
fund shall be used solely for the following purposes: 33548

(A) To reimburse medicaid managed care organizations that 33549
have paid fines for failures to meet performance standards or 33550
other requirements and that have come into compliance by meeting 33551
requirements as specified by the department; 33552

(B) To provide financial incentive awards established 33553
pursuant to section 5165.06 of the Revised Code and specified in 33554
contracts between medicaid managed care organizations and the 33555
department. 33556

Sec. ~~5111.172~~ 5165.09. When contracting under section ~~5111.17~~ 33557
~~5165.05~~ of the Revised Code with a managed care organization that 33558
is a health insuring corporation, the department of ~~job and family~~ 33559

~~services~~ health care administration may require the health 33560
insuring corporation to provide coverage of prescription drugs for 33561
medicaid recipients enrolled in the health insuring corporation. 33562
In providing the required coverage, the health insuring 33563
corporation may, subject to the department's approval, use 33564
strategies for the management of drug utilization. 33565

Sec. ~~5111.173~~ 5165.10. The department of ~~job and family~~ 33566
~~services~~ health care administration shall appoint a temporary 33567
manager for a medicaid managed care organization ~~under contract~~ 33568
~~with the department pursuant to section 5111.17 of the Revised~~ 33569
~~Code~~ if the department determines that the medicaid managed care 33570
organization has repeatedly failed to meet substantive 33571
requirements specified in ~~section 1903(m) of the "Social Security~~ 33572
~~Act," 79 Stat. 286 (1965), 42 U.S.C. 1396b(m), as amended; section~~ 33573
~~1932 of the Social Security Act, 42 U.S.C. 1396u-2, as amended; or~~ 33574
42 C.F.R. 438 Part I. The appointment of a temporary manager does 33575
not preclude the department from imposing other sanctions 33576
available to the department against the medicaid managed care 33577
organization. 33578

The medicaid managed care organization shall pay all costs of 33579
having the temporary manager perform the temporary manager's 33580
duties, including all costs the temporary manager incurs in 33581
performing those duties. If the temporary manager incurs costs or 33582
liabilities on behalf of the medicaid managed care organization, 33583
the medicaid managed care organization shall pay those costs and 33584
be responsible for those liabilities. 33585

The appointment of a temporary manager is not subject to 33586
Chapter 119. of the Revised Code, but the medicaid managed care 33587
organization may request a reconsideration of the appointment. 33588
Reconsiderations shall be requested and conducted in accordance 33589
with rules ~~the director of job and family services shall adopt in~~ 33590

~~accordance with Chapter 119. adopted under section 5165.18 of the~~ 33591
Revised Code. 33592

The appointment of a temporary manager does not cause the 33593
medicaid managed care organization to lose the right to appeal, in 33594
accordance with Chapter 119. of the Revised Code, any proposed 33595
termination or any decision not to renew the medicaid managed care 33596
organization's medicaid provider agreement or the right to 33597
initiate the sale of the medicaid managed care organization or its 33598
assets. 33599

~~In addition to the rules required to be adopted under this~~ 33600
~~section, the director may adopt any other rules necessary to~~ 33601
~~implement this section. The rules shall be adopted in accordance~~ 33602
~~with Chapter 119. of the Revised Code.~~ 33603

Sec. ~~5111.177~~ 5165.11. When contracting under section ~~5111.17~~ 33604
5165.05 of the Revised Code with a health insuring corporation 33605
that holds a certificate of authority under Chapter 1751. of the 33606
Revised Code, the department of ~~job and family services~~ health 33607
care administration shall require the health insuring corporation 33608
to provide a grievance process for medicaid recipients in 33609
accordance with 42 C.F.R. 438, subpart F. 33610

Sec. ~~5111.174~~ 5165.12. The department of ~~job and family~~ 33611
~~services~~ health care administration may disenroll some or all 33612
medicaid recipients enrolled in a medicaid managed care 33613
organization ~~under contract with the department pursuant to~~ 33614
~~section 5111.17 of the Revised Code~~ if the department proposes to 33615
terminate or not to renew the contract and determines that the 33616
recipients' access to medically necessary services is jeopardized 33617
by the proposal to terminate or not to renew the contract. The 33618
disenrollment is not subject to Chapter 119. of the Revised Code, 33619
but the medicaid managed care organization may request a 33620

reconsideration of the disenrollment. Reconsiderations shall be 33621
requested and conducted in accordance with rules ~~the director of~~ 33622
~~job and family services shall adopt in accordance with Chapter~~ 33623
~~119.~~ adopted under section 5165.18 of the Revised Code. The 33624
request for, or conduct of, a reconsideration regarding a proposed 33625
disenrollment shall not delay the disenrollment. 33626

~~In addition to the rules required to be adopted under this~~ 33627
~~section, the director may adopt any other rules necessary to~~ 33628
~~implement this section. The rules shall be adopted in accordance~~ 33629
~~with Chapter 119. of the Revised Code.~~ 33630

Sec. ~~5111.175~~ 5165.13. For the purpose of determining the 33631
amount the department of ~~job and family services~~ health care 33632
administration pays hospitals under section ~~5112.08~~ 5166.07 of the 33633
Revised Code and the amount of disproportionate share hospital 33634
payments paid by the medicare program ~~established under Title~~ 33635
~~XVIII of the "Social Security Act," 79 Stat. 286 (1965), 42 U.S.C.~~ 33636
~~1396n, as amended, a~~ medicaid managed care organization ~~under~~ 33637
~~contract with the department pursuant to section 5111.17 of the~~ 33638
~~Revised Code authorizing the organization~~ authorized to provide, 33639
or arrange for the provision of, hospital services to medicaid 33640
recipients shall keep detailed records for each hospital with 33641
which it contracts about the cost to the hospital of providing the 33642
services, payments made by the organization to the hospital for 33643
the services, utilization of hospital services by medicaid 33644
recipients enrolled in the organization, and other utilization 33645
data required by the department. 33646

Sec. ~~5111.162~~ 5165.14. (A) ~~As used in this section:~~ 33647

~~(1) "Emergency services" has the same meaning as in section~~ 33648
~~1932(b)(2) of the "Social Security Act," 79 Stat. 286 (1965), 42~~ 33649
~~U.S.C. 1396u-2(b)(2), as amended.~~ 33650

~~(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.~~ 33651
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~~(B)~~ Except as provided in division ~~(C)~~(B) of this section, 33655
when a participant in the care management system ~~established under~~ 33656
~~section 5111.16 of the Revised Code~~ is enrolled in a medicaid 33657
managed care organization and the organization refers the 33658
participant to receive services, other than emergency services 33659
provided on or after January 1, 2007, at a hospital that 33660
participates in the medicaid program but is not under contract 33661
with the organization, the hospital shall provide the service for 33662
which the referral was made and shall accept from the 33663
organization, as payment in full, the amount derived from the 33664
reimbursement rate used by the department to reimburse other 33665
hospitals of the same type for providing the same service to a 33666
medicaid recipient who is not enrolled in a medicaid managed care 33667
organization. 33668

~~(C)~~(B) A hospital is not subject to division ~~(B)~~(A) of this 33669
section if all of the following are the case: 33670

(1) The hospital is located in a county in which participants 33671
in the care management system are required before January 1, 2006, 33672
to be enrolled in a medicaid managed care organization that is a 33673
health insuring corporation; 33674

(2) The hospital has entered into a contract before January 33675
1, 2006, with at least one health insuring corporation serving the 33676
participants specified in division ~~(C)~~(B)(1) of this section; 33677

(3) The hospital remains under contract with at least one 33678
health insuring corporation serving participants in the care 33679
management system who are required to be enrolled in a health 33680
insuring corporation. 33681

~~(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~~ 33712
~~and family services~~ health care administration shall apply to the 33713
United States secretary of health and human services for the 33714
waiver. 33715

(B)(1) If the director determines that section 3901.3814 of 33716
the Revised Code can be implemented without a waiver or a waiver 33717
is granted, the department shall notify the department of 33718
insurance that the section can be implemented. Implementation of 33719
the section shall be effective eighteen months after the notice is 33720
sent. 33721

(2) At the time the notice is given under division (B)(1) of 33722
this section, the department shall also give notice to each health 33723
insuring corporation that provides coverage to medicaid 33724
recipients. The notice shall inform the corporation that sections 33725
3901.38 and 3901.381 to 3901.3814 of the Revised Code apply to 33726
claims for services rendered to recipients on the date determined 33727
under division (B)(1) of this section, instead of the prompt 33728
payment requirements of 42 C.F.R. 447.46. That date shall be 33729
specified in the notice. 33730

Sec. 5165.17. (A) The department of health care 33731
administration shall prepare an annual report on the care 33732
management system. The report shall address the department's 33733
ability to implement the system, including all of the following 33734
components: 33735

(1) The required designation of participants included in the 33736
category identified by the department as covered families and 33737
children; 33738

(2) The required designation of participants included in the 33739
aged, blind, or disabled category of medicaid recipients; 33740

(3) The use of any programs for enhanced care management. 33741

(B) The department shall submit each annual report to the 33742
general assembly. The first report shall be submitted not later 33743
than October 1, 2007. 33744

Sec. 5165.18. The director of health care administration 33745
shall adopt rules in accordance with Chapter 119. of the Revised 33746
Code to implement care management system, including rules that do 33747
all of the following: 33748

(A) Specify the circumstances under which a medicaid managed 33749
care organization is permitted to refer a participant in the care 33750
management system to a hospital that is not under contract with 33751
the organization; 33752

(B) Specify performance standards for medicaid managed care 33753
organizations; 33754

(C) The method by which a medicaid managed care organization 33755
may request a reconsideration of the appointment of a temporary 33756
manager under section 5165.10 of the Revised Code and the method 33757
by which the reconsideration is to be conducted; 33758

(D) The method by which a medicaid managed care organization 33759
may request a reconsideration of a disenrollment under section 33760
5165.12 of the Revised Code and the method by which the 33761
reconsideration is to be conducted. 33762

Sec. ~~5111.161~~ 5165.19. (A) There is hereby created the 33763
medicaid care management working group, consisting of the 33764
following members: 33765

(1) Three individuals representing medicaid health insuring 33766
corporations, as defined in section ~~5111.176~~ 5166.60 of the 33767
Revised Code, one appointed by the president of the senate, one 33768
appointed by the speaker of the house of representatives, and one 33769
appointed by the governor; 33770

(2) One individual representing programs that provide enhanced care management services, appointed by the governor;	33771 33772
(3) Four individuals representing health care professional and trade associations, appointed as follows:	33773 33774
(a) One representative of the American academy of pediatrics, appointed by the president of the senate;	33775 33776
(b) One representative of the American academy of family physicians, appointed by the speaker of the house of representatives;	33777 33778 33779
(c) One representative of the Ohio state medical association, appointed by the president of the senate;	33780 33781
(d) One representative of the Ohio hospital association, appointed by the speaker of the house of representatives.	33782 33783
(4) One individual representing behavioral health professional and trade associations, appointed by the speaker of the house of representatives;	33784 33785 33786
(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;	33787 33788 33789
(6) One individual representing county departments of job and family services, appointed by the president of the senate;	33790 33791
(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;	33792 33793 33794 33795
(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	33796 33797 33798 33799 33800

medical association. 33801

(9) The director of ~~job and family services~~ health care administration or the director's designee; 33802
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(10) The director of health or the director's designee; 33804

(11) The director of aging or the director's designee. 33805

(B) The members of the working group shall serve at the 33806
pleasure of their appointing authorities. Vacancies shall be 33807
filled in the manner provided for original appointments. 33808

(C) The working group shall develop guidelines that the 33809
department of ~~job and family services~~ health care administration 33810
may consider when entering into contracts under section ~~5111.17~~ 33811
5165.05 of the Revised Code with managed care organizations for 33812
purposes of the care management system established under section 33813
~~5111.16~~ 5165.03 of the Revised Code. The working group shall 33814
consult regularly with the departments of insurance, alcohol and 33815
drug addiction services, mental health, and mental retardation and 33816
developmental disabilities and the rehabilitation services 33817
commission. 33818

In developing the guidelines, the working group shall do all 33819
of the following: 33820

(1) Examine the best practice standards used in managed care 33821
programs and other health care and related systems to maximize 33822
patient and provider satisfaction, maintain quality of care, and 33823
obtain cost-effectiveness; 33824

(2) Consider the most effective means of facilitating the 33825
expansion of the care management system and increasing consistency 33826
within the system; 33827

(3) Make recommendations for coordinating the regulatory 33828
relationships involved in the medicaid care management system; 33829

(4) Make recommendations for improving the resolution of 33830

contracting issues among the providers involved in the care management system; 33831
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(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: 33833
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(a) Standards and procedures by which care management contractors may receive financial incentives for positive health outcomes measured on an individual basis; 33839
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(b) Specific measures of positive health outcomes, particularly among individuals with high-risk health conditions; 33842
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(c) Criteria for determining what constitutes a completed health outcome; 33844
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(d) Methods of funding the program without requiring an increase in appropriations. 33846
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(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. 33848
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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. 33856
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(B) The department of ~~job and family services~~ health care 33861
administration, pursuant to guidelines issued by the United States 33862
secretary of health and human services, shall identify cases in 33863
which enrollment of an individual otherwise eligible for ~~medical~~ 33864
~~assistance under this chapter~~ the medicaid program in a group 33865
health plan in which the individual is eligible to enroll and 33866
payment of the individual's premiums, deductibles, coinsurance, 33867
and other cost-sharing expenses is cost effective. 33868

The department shall require, as a condition of eligibility 33869
for ~~medical assistance~~ the medicaid program, individuals 33870
identified under this division, or in the case of a child, the 33871
child's parent, to apply for enrollment in the group health plan, 33872
except that the failure of a parent to enroll self or the parent's 33873
child in a group health plan does not affect the child's 33874
eligibility under the ~~medical assistance~~ medicaid program. 33875

The department shall pay enrollee premiums and deductibles, 33876
coinsurance, and other cost-sharing obligations for services and 33877
items otherwise covered under the ~~medical assistance~~ medicaid 33878
program. The department shall treat coverage under the group 33879
health plan in the same manner as any other third-party liability 33880
under the program. If not all members of a family are eligible for 33881
~~medical assistance~~ the medicaid program and enrollment of the 33882
eligible members in a group health plan is not possible without 33883
also enrolling the members who are ineligible for ~~medical~~ 33884
~~assistance~~ the medicaid program, the department shall pay the 33885
premiums for the ineligible members if the payments are cost 33886
effective. The department shall not pay deductibles, coinsurance, 33887
or other cost-sharing obligations of enrolled members who are not 33888
eligible for ~~medical assistance~~ the medicaid program. 33889

The department may make payments under this section to 33890
employers, insurers, or other entities. The department may make 33891
the payments without entering into a contract with employers, 33892

insurers, or other entities. 33893

(C) To the extent permitted by federal law and regulations, 33894
the department of ~~job and family services~~ health care 33895
administration shall coordinate the ~~medical assistance~~ medicaid 33896
program with group health plans in such a manner that the ~~medical~~ 33897
~~assistance~~ medicaid program serves as a supplement to the group 33898
health plans. In its coordination efforts, the department shall 33899
consider cost-effectiveness and quality of care. The department 33900
may enter into agreements with group health plans as necessary to 33901
implement this division. 33902

(D) The director of ~~job and family services~~ health care 33903
administration shall adopt rules in accordance with Chapter 119. 33904
of the Revised Code to implement this section. 33905

Sec. ~~5112.01~~ 5166.01. As used in sections ~~5112.03~~ 5166.02 to 33906
~~5112.21~~ 5166.14 of the Revised Code: 33907

(A)(1) "Hospital" means a nonfederal hospital to which either 33908
of the following applies: 33909

(a) The hospital is registered under section 3701.07 of the 33910
Revised Code as a general medical and surgical hospital or a 33911
pediatric general hospital, and provides inpatient hospital 33912
services, as defined in 42 C.F.R. 440.10; 33913

(b) The hospital is recognized under the medicare program 33914
~~established by Title XVIII of the "Social Security Act," 49 Stat.~~ 33915
~~620 (1935), 42 U.S.C.A. 301, as amended,~~ as a cancer hospital and 33916
is exempt from the medicare prospective payment system. 33917

"Hospital" does not include a hospital operated by a health 33918
insuring corporation that has been issued a certificate of 33919
authority under section 1751.05 of the Revised Code or a hospital 33920
that does not charge patients for services. 33921

(2) "Disproportionate share hospital" means a hospital that 33922

meets the definition of a disproportionate share hospital in rules 33923
adopted under section ~~5112.03~~ 5166.02 of the Revised Code. 33924

(B) "Bad debt," "charity care," "courtesy care," and 33925
"contractual allowances" have the same meanings given these terms 33926
in regulations ~~adopted under Title XVIII of the "Social Security~~ 33927
~~Act governing the medicare program."~~ 33928

(C) "Cost reporting period" means the twelve-month period 33929
used by a hospital in reporting costs for purposes of ~~Title XVIII~~ 33930
~~of the "Social Security Act the medicare program."~~ 33931

(D) "Governmental hospital" means a county hospital with more 33932
than five hundred registered beds or a state-owned and -operated 33933
hospital with more than five hundred registered beds. 33934

(E) "Indigent care pool" means the sum of the following: 33935

(1) The total of assessments to be paid in a program year by 33936
all hospitals under section ~~5112.06~~ 5166.05 of the Revised Code, 33937
less the assessments deposited into the legislative budget 33938
services fund under section ~~5112.19~~ 5166.13 of the Revised Code 33939
and into the health care services administration fund created 33940
under section ~~5111.94~~ 5161.15 of the Revised Code; 33941

(2) The total amount of intergovernmental transfers required 33942
to be made in the same program year by governmental hospitals 33943
under section ~~5112.07~~ 5166.06 of the Revised Code, less the amount 33944
of transfers deposited into the legislative budget services fund 33945
under section ~~5112.19~~ 5166.13 of the Revised Code and into the 33946
health care services administration fund created under section 33947
~~5111.94~~ 5161.15 of the Revised Code; 33948

(3) The total amount of federal matching funds that will be 33949
made available in the same program year as a result of funds 33950
distributed by the department of ~~job and family services~~ health 33951
care administration to hospitals under section ~~5112.08~~ 5166.07 of 33952
the Revised Code. 33953

(F) "Intergovernmental transfer" means any transfer of money 33954
by a governmental hospital under section ~~5112.07~~ 5166.06 of the 33955
Revised Code. 33956

~~(G) "Medical assistance program" means the program of medical 33957
assistance established under section 5111.01 of the Revised Code 33958
and Title XIX of the "Social Security Act." 33959~~

~~(H)~~ "Program year" means a period beginning the first day of 33960
October, or a later date designated in rules adopted under section 33961
~~5112.03~~ 5166.02 of the Revised Code, and ending the thirtieth day 33962
of September, or an earlier date designated in rules adopted under 33963
that section. 33964

~~(I)~~(H) "Registered beds" means the total number of hospital 33965
beds registered with the department of health, as reported in the 33966
most recent "directory of registered hospitals" published by the 33967
department of health. 33968

~~(J)~~(I) "Total facility costs" means the total costs for all 33969
services rendered to all patients, including the direct, indirect, 33970
and overhead cost to the hospital of all services, supplies, 33971
equipment, and capital related to the care of patients, regardless 33972
of whether patients are enrolled in a health insuring corporation, 33973
excluding costs associated with providing skilled nursing services 33974
in distinct-part nursing facility units, as shown on the 33975
hospital's cost report filed under section ~~5112.04~~ 5166.03 of the 33976
Revised Code. Effective October 1, 1993, if rules adopted under 33977
section ~~5112.03~~ 5166.02 of the Revised Code so provide, "total 33978
facility costs" may exclude costs associated with providing care 33979
to recipients of any of the governmental programs listed in 33980
division (B) of that section. 33981

~~(K)~~(J) "Uncompensated care" means bad debt and charity care. 33982

Sec. ~~5112.03~~ 5166.02. (A) The director of ~~job and family~~ 33983

~~services~~ health care administration shall adopt, and may amend and 33984
rescind, rules in accordance with Chapter 119. of the Revised Code 33985
for the purpose of administering sections ~~5112.01~~ 5166.01 to 33986
~~5112.21~~ 5166.14 of the Revised Code, including rules that do all 33987
of the following: 33988

(1) Define as a "disproportionate share hospital" any 33989
hospital included under subsection (b) of section 1923 of the 33990
"Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 33991
1396r-4(b), as amended, and any other hospital the director 33992
determines appropriate; 33993

(2) Prescribe the form for submission of cost reports under 33994
section ~~5112.04~~ 5166.03 of the Revised Code; 33995

(3) Establish, in accordance with division (A) of section 33996
~~5112.06~~ 5166.05 of the Revised Code, the assessment rate or rates 33997
to be applied to hospitals under that section; 33998

(4) Establish schedules for hospitals to pay installments on 33999
their assessments under section ~~5112.06~~ 5166.05 of the Revised 34000
Code and for governmental hospitals to pay installments on their 34001
intergovernmental transfers under section ~~5112.07~~ 5166.06 of the 34002
Revised Code; 34003

(5) Establish procedures to notify hospitals of adjustments 34004
made under division (B)(2)(b) of section ~~5112.06~~ 5166.05 of the 34005
Revised Code in the amount of installments on their assessment; 34006

(6) Establish procedures to notify hospitals of adjustments 34007
made under division (D) of section ~~5112.09~~ 5166.08 of the Revised 34008
Code in the total amount of their assessment and to adjust for the 34009
remainder of the program year the amount of the installments on 34010
the assessments; 34011

(7) Establish, in accordance with section ~~5112.08~~ 5166.07 of 34012
the Revised Code, the methodology for paying hospitals under that 34013
section. 34014

The director shall consult with hospitals when adopting the 34015
rules required by divisions (A)(4) and (5) of this section in 34016
order to minimize hospitals' cash flow difficulties. 34017

(B) Rules adopted under this section may provide that "total 34018
facility costs" excludes costs associated with any of the 34019
following: 34020

(1) Recipients of the ~~medical assistance~~ medicaid program; 34021

(2) Recipients of financial assistance provided under Chapter 34022
5115. of the Revised Code; 34023

(3) Recipients of the disability medical assistance ~~provided~~ 34024
~~under Chapter 5115. of the Revised Code~~ program; 34025

(4) Recipients of the program for medically handicapped 34026
children established under section 3701.023 of the Revised Code; 34027

(5) Recipients of the medicare program ~~established under~~ 34028
~~Title XVIII of the "Social Security Act," 49 Stat. 620 (1935), 42~~ 34029
~~U.S.C.A. 301, as amended:~~ 34030

(6) Recipients of Title V of the "Social Security Act of 34031
1935"; 34032

(7) Any other category of costs deemed appropriate by the 34033
director in accordance with ~~Title XIX of the "Social Security Act"~~ 34034
~~and the rules adopted under that title~~ federal law, including 34035
administrative regulations, governing the medicaid program. 34036

Sec. 5112.04 5166.03. (A) Except as provided in division (C) 34037
of this section, each hospital, on or before the first day of July 34038
of each year or at a later date approved by the director of ~~job~~ 34039
~~and family services~~ health care administration, shall submit to 34040
the department of ~~job and family services~~ health care 34041
administration a financial statement for the preceding calendar 34042
year that accurately reflects the income, expenses, assets, 34043
liabilities, and net worth of the hospital, and accompanying 34044

notes. A hospital that has a fiscal year different from the 34045
calendar year shall file its financial statement within one 34046
hundred eighty days of the end of its fiscal year or at a later 34047
date approved by the director of ~~job and family services~~ health 34048
care administration. The financial statement shall be prepared by 34049
an independent certified public accountant and reflect an official 34050
audit report prepared in a manner consistent with generally 34051
accepted accounting principles. The financial statement shall, to 34052
the extent that the hospital has sufficient financial records, 34053
show bad debt and charity care separately from courtesy care and 34054
contractual allowances. 34055

(B) Except as provided in division (C) of this section, each 34056
hospital, within one hundred eighty days after the end of the 34057
hospital's cost reporting period, shall submit to the department a 34058
cost report in a format prescribed in rules adopted ~~by the~~ 34059
~~director of job and family services~~ under section ~~5112.03~~ 5166.02 34060
of the Revised Code. The department shall grant a hospital an 34061
extension of the one hundred eighty day period if the health care 34062
financing administration of the United States department of health 34063
and human services extends the date by which the hospital must 34064
submit its cost report for the hospital's cost reporting period. 34065

(C) The director of ~~job and family services~~ health care 34066
administration may adopt rules under section ~~5112.03~~ 5166.02 of 34067
the Revised Code specifying financial information that must be 34068
submitted by hospitals for which no financial statement or cost 34069
report is available. The rules shall specify deadlines for 34070
submitting the information. Each such hospital shall submit the 34071
information specified in the rules not later than the deadline 34072
specified in the rules. 34073

Sec. ~~5112.05~~ 5166.04. The requirements of sections ~~5112.06~~ 34074
5166.05 to ~~5112.09~~ 5166.08 of the Revised Code apply only as long 34075

as the United States ~~health care financing administration~~ 34076
department of health and human services determines that the 34077
assessment imposed under section ~~5112.06~~ 5166.05 of the Revised 34078
Code is a permissible health care-related tax pursuant to ~~section~~ 34079
~~1903(w) of the "Social Security Act," 49 Stat. 620 (1935), 42~~ 34080
~~U.S.C.A. 1396b(w), as amended.~~ Whenever the department of ~~job and~~ 34081
~~family services~~ health care administration is informed that the 34082
assessment is an impermissible health care-related tax, the 34083
department shall promptly refund to each hospital the amount of 34084
money currently in the hospital care assurance program fund 34085
created by section ~~5112.18~~ 5166.12 of the Revised Code that has 34086
been paid by the hospital under section ~~5112.06~~ 5166.05 or ~~5112.07~~ 34087
5166.06 of the Revised Code, plus any investment earnings on that 34088
amount. 34089

Sec. ~~5112.06~~ 5166.05. (A) For the purpose of distributing 34090
funds to hospitals under the ~~medical assistance~~ medicaid program 34091
pursuant to sections ~~5112.01~~ 5166.01 to ~~5112.21~~ 5166.14 of the 34092
Revised Code and depositing funds into the legislative budget 34093
services fund under section ~~5112.19~~ 5166.13 of the Revised Code 34094
and into the health care services administration fund created 34095
under section ~~5111.94~~ 5161.15 of the Revised Code, there is hereby 34096
imposed an assessment on all hospitals. Each hospital's assessment 34097
shall be based on total facility costs. All hospitals shall be 34098
assessed according to the rate or rates established each program 34099
year by the department of ~~job and family services~~ health care 34100
administration in rules adopted under section ~~5112.03~~ 5166.02 of 34101
the Revised Code. The department shall assess all hospitals 34102
uniformly and in a manner consistent with federal statutes and 34103
regulations. During any program year, the department shall not 34104
assess any hospital more than two per cent of the hospital's total 34105
facility costs. 34106

The department shall establish an assessment rate or rates 34107

each program year that will do both of the following: 34108

(1) Yield funds that, when combined with intergovernmental 34109
transfers and federal matching funds, will produce a program of 34110
sufficient size to pay a substantial portion of the indigent care 34111
provided by hospitals; 34112

(2) Yield funds that, when combined with intergovernmental 34113
transfers and federal matching funds, will produce amounts for 34114
distribution to disproportionate share hospitals that do not 34115
exceed, in the aggregate, the limits prescribed by the United 34116
States ~~health care financing administration~~ department of health 34117
and human services under ~~subsection (f) of section 1923 of the~~ 34118
~~"Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A.~~ 34119
~~1396r-4(f), as amended.~~ 34120

(B)(1) Except as provided in division (B)(3) of this section, 34121
each hospital shall pay its assessment in periodic installments in 34122
accordance with a schedule established by the director of ~~job and~~ 34123
~~family services~~ health care administration in rules adopted under 34124
section ~~5112.03~~ 5166.02 of the Revised Code. 34125

(2) The installments shall be equal in amount, unless either 34126
of the following applies: 34127

(a) The department makes adjustments during a program year 34128
under division (D) of section ~~5112.09~~ 5166.08 of the Revised Code 34129
in the total amount of hospitals' assessments; 34130

(b) The director of ~~job and family services~~ health care 34131
administration determines that adjustments in the amounts of 34132
installments are necessary for the administration of sections 34133
~~5112.01~~ 5166.01 to ~~5112.21~~ 5166.14 of the Revised Code and that 34134
unequal installments will not create cash flow difficulties for 34135
hospitals. 34136

(3) The director may adopt rules under section ~~5112.03~~ 34137
5166.02 of the Revised Code establishing alternate schedules for 34138

hospitals to pay assessments under this section in order to reduce 34139
hospitals' cash flow difficulties. 34140

Sec. ~~5112.07~~ 5166.06. (A) The department of ~~job and family~~ 34141
~~services~~ health care administration may require governmental 34142
hospitals to make intergovernmental transfers each program year 34143
for the purpose of distributing funds to hospitals under the 34144
~~medical assistance~~ medicaid program pursuant to sections ~~5112.01~~ 34145
~~5166.01~~ to ~~5112.21~~ 5166.14 of the Revised Code and depositing 34146
funds into the legislative budget services fund under section 34147
~~5112.19~~ 5166.13 of the Revised Code and into the health care 34148
services administration fund created under section ~~5111.94~~ 5161.15 34149
of the Revised Code. The department shall not require transfers in 34150
an amount that, when combined with hospital assessments paid under 34151
section ~~5112.06~~ 5166.05 of the Revised Code and federal matching 34152
funds, produce amounts for distribution to disproportionate share 34153
hospitals that, in the aggregate, exceed limits prescribed by the 34154
United States ~~health care financing administration~~ department of 34155
health and human services under ~~subsection (f) of section 1923 of~~ 34156
~~the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A.~~ 34157
~~1396r-4(f), as amended.~~ 34158

(B) Before or during each program year, the department shall 34159
notify each governmental hospital of the amount of the 34160
intergovernmental transfer it is required to make during the 34161
program year. Each governmental hospital shall make 34162
intergovernmental transfers as required by the department under 34163
this section in periodic installments, executed by electronic fund 34164
transfer, in accordance with a schedule established in rules 34165
adopted under section ~~5112.03~~ 5166.02 of the Revised Code. 34166

Sec. ~~5112.08~~ 5166.07. The director of ~~job and family services~~ 34167
health care administration shall adopt rules under section ~~5112.03~~ 34168
5166.02 of the Revised Code establishing a methodology to pay 34169

hospitals that is sufficient to expend all money in the indigent care pool. Under the rules: 34170
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(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. 34172
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(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: 34175
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(1) Total costs, volume, or proportion of services to medicaid recipients ~~of the medical assistance program~~, including recipients enrolled in health insuring corporations; 34181
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(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;~~ 34184
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(3) The amount of uncompensated care provided by the hospital or group of hospitals; 34191
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(4) Other factors that the director considers to be appropriate indicators of indigent care. 34193
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(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 34195
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of the funds. The formula shall be consistent with ~~section 1923 of~~ 34201
the "~~Social Security Act,~~" 42 U.S.C.A. 1396r-4, ~~as amended,~~ shall 34202
be and based on any combination of the indicators of indigent care 34203
listed in division (B) of this section that the director considers 34204
appropriate. 34205

(D) The department shall distribute funds to each hospital in 34206
installments not later than ten working days after the deadline 34207
established in rules for each hospital to pay an installment on 34208
its assessment under section ~~5112.06~~ 5166.05 of the Revised Code. 34209
In the case of a governmental hospital that makes 34210
intergovernmental transfers, the department shall pay an 34211
installment under this section not later than ten working days 34212
after the earlier of that deadline or the deadline established in 34213
rules for the governmental hospital to pay an installment on its 34214
intergovernmental transfer. If the amount in the hospital care 34215
assurance program fund created under section ~~5112.18~~ 5166.12 of 34216
the Revised Code and the portion of the health care - federal fund 34217
created under section ~~5111.943~~ 5161.18 of the Revised Code that is 34218
credited to that fund pursuant to division (B) of section ~~5112.18~~ 34219
5166.12 of the Revised Code are insufficient to make the total 34220
distributions for which hospitals are eligible to receive in any 34221
period, the department shall reduce the amount of each 34222
distribution by the percentage by which the amount and portion are 34223
insufficient. The department shall distribute to hospitals any 34224
amounts not distributed in the period in which they are due as 34225
soon as moneys are available in the funds. 34226

Sec. ~~5112.09~~ 5166.08. (A) Before or during each program year, 34227
the department of ~~job and family services~~ health care 34228
administration shall mail to each hospital by certified mail, 34229
return receipt requested, the preliminary determination of the 34230
amount that the hospital is assessed under section ~~5112.06~~ 5166.05 34231
of the Revised Code during the program year. The preliminary 34232

determination of a hospital's assessment shall be calculated for a 34233
cost-reporting period that is specified in rules adopted under 34234
section ~~5112.03~~ 5166.02 of the Revised Code. 34235

The department shall consult with hospitals each year when 34236
determining the date on which it will mail the preliminary 34237
determinations in order to minimize hospitals' cash flow 34238
difficulties. 34239

If no hospital submits a request for reconsideration under 34240
division (B) of this section, the preliminary determination 34241
constitutes the final reconciliation of each hospital's assessment 34242
under section ~~5112.06~~ 5166.05 of the Revised Code. The final 34243
reconciliation is subject to adjustments under division (D) of 34244
this section. 34245

(B) Not later than fourteen days after the preliminary 34246
determinations are mailed, any hospital may submit to the 34247
department a written request to reconsider the preliminary 34248
determinations. The request shall be accompanied by written 34249
materials setting forth the basis for the reconsideration. If one 34250
or more hospitals submit a request, the department shall hold a 34251
public hearing not later than thirty days after the preliminary 34252
determinations are mailed to reconsider the preliminary 34253
determinations. The department shall mail to each hospital a 34254
written notice of the date, time, and place of the hearing at 34255
least ten days prior to the hearing. On the basis of the evidence 34256
submitted to the department or presented at the public hearing, 34257
the department shall reconsider and may adjust the preliminary 34258
determinations. The result of the reconsideration is the final 34259
reconciliation of the hospital's assessment under section ~~5112.06~~ 34260
5166.05 of the Revised Code. The final reconciliation is subject 34261
to adjustments under division (D) of this section. 34262

(C) The department shall mail to each hospital a written 34263
notice of its assessment for the program year under the final 34264

reconciliation. A hospital may appeal the final reconciliation of 34265
its assessment to the court of common pleas of Franklin county. 34266
While a judicial appeal is pending, the hospital shall pay, in 34267
accordance with the schedules required by division (B) of section 34268
~~5112.06~~ 5166.05 of the Revised Code, any amount of its assessment 34269
that is not in dispute into the hospital care assurance program 34270
fund created in section ~~5112.18~~ 5166.12 of the Revised Code. 34271

(D) In the course of any program year, the department may 34272
adjust the assessment rate or rates established in rules pursuant 34273
to section ~~5112.06~~ 5166.05 of the Revised Code or adjust the 34274
amounts of intergovernmental transfers required under section 34275
~~5112.07~~ 5166.06 of the Revised Code and, as a result of the 34276
adjustment, adjust each hospital's assessment and 34277
intergovernmental transfer, to reflect refinements made by the 34278
United States ~~health care financing administration~~ department of 34279
health and human services during that program year to the limits 34280
it prescribed under ~~subsection (f) of section 1923 of the "Social~~ 34281
~~Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 1396r-4(f), as~~ 34282
~~amended~~. When adjusted, the assessment rate or rates must comply 34283
with division (A) of section ~~5112.06~~ 5166.05 of the Revised Code. 34284
An adjusted intergovernmental transfer must comply with division 34285
(A) of section ~~5112.07~~ 5166.06 of the Revised Code. The department 34286
shall notify hospitals of adjustments made under this division and 34287
adjust for the remainder of the program year the installments paid 34288
by hospitals under sections ~~5112.06~~ 5166.05 and ~~5112.07~~ 5166.06 of 34289
the Revised Code in accordance with rules adopted under section 34290
~~5112.03~~ 5166.02 of the Revised Code. 34291

Sec. ~~5112.10~~ 5166.09. The department of ~~job and family~~ 34292
~~services~~ health care administration shall operate the hospital 34293
care assurance program established by sections ~~5112.01~~ 5166.01 to 34294
~~5112.21~~ 5166.14 of the Revised Code on a program year basis. The 34295
department shall complete all program requirements on or before 34296

the thirtieth day of September each year. 34297

Sec. ~~5112.11~~ 5166.10. Except for moneys deposited into the 34298
legislative budget services fund under section ~~5112.19~~ 5166.13 of 34299
the Revised Code and the health care services administration fund 34300
created under section ~~5111.94~~ 5161.15 of the Revised Code, the 34301
department of ~~job and family services~~ health care administration 34302
shall not use money paid to the department under sections ~~5112.06~~ 34303
5166.05 and ~~5112.07~~ 5166.06 of the Revised Code or money that the 34304
department pays to hospitals under section ~~5112.08~~ 5166.07 of the 34305
Revised Code to replace any funds appropriated by the general 34306
assembly for the ~~medical assistance~~ medicaid program. 34307

Sec. ~~5112.17~~ 5166.11. (A) As used in this section: 34308

(1) "Federal poverty guideline" means the official poverty 34309
guideline as revised annually by the United States secretary of 34310
health and human services in accordance with section 673 of the 34311
"Community Service Block Grant Act," 95 Stat. 511 (1981), 42 34312
U.S.C.A. 9902, as amended, for a family size equal to the size of 34313
the family of the person whose income is being determined. 34314

(2) "Third-party payer" means any private or public entity or 34315
program that may be liable by law or contract to make payment to 34316
or on behalf of an individual for health care services. 34317
"Third-party payer" does not include a hospital. 34318

(B) Each hospital that receives funds distributed under 34319
sections ~~5112.01~~ 5166.01 to ~~5112.21~~ 5166.14 of the Revised Code 34320
shall provide, without charge to the individual, basic, medically 34321
necessary hospital-level services to individuals who are residents 34322
of this state, are not recipients of the ~~medical assistance~~ 34323
medicaid program, and whose income is at or below the federal 34324
poverty guideline. Recipients of disability financial assistance 34325
~~and recipients of disability medical assistance~~ provided under 34326

Chapter 5115. of the Revised Code and recipients of the disability 34327
medical assistance program qualify for services under this 34328
section. The director of ~~job and family services~~ health care 34329
administration shall adopt rules under section ~~5112.03~~ 5166.02 of 34330
the Revised Code specifying the hospital services to be provided 34331
under this section. 34332

(C) Nothing in this section shall be construed to prevent a 34333
hospital from requiring an individual to apply for eligibility 34334
under the ~~medical assistance~~ medicaid program before the hospital 34335
processes an application under this section. Hospitals may bill 34336
any third-party payer for services rendered under this section. 34337
Hospitals may bill the ~~medical assistance~~ medicaid program, in 34338
accordance with Chapter ~~5111.~~ 5163. of the Revised Code and the 34339
rules adopted under ~~that chapter~~ section 5163.15 of the Revised 34340
Code, for services rendered under this section if the individual 34341
becomes a recipient of the program. Hospitals may bill individuals 34342
for services under this section if all of the following apply: 34343

(1) The hospital has an established post-billing procedure 34344
for determining the individual's income and canceling the charges 34345
if the individual is found to qualify for services under this 34346
section. 34347

(2) The initial bill, and at least the first follow-up bill, 34348
is accompanied by a written statement that does all of the 34349
following: 34350

(a) Explains that individuals with income at or below the 34351
federal poverty guideline are eligible for services without 34352
charge; 34353

(b) Specifies the federal poverty guideline for individuals 34354
and families of various sizes at the time the bill is sent; 34355

(c) Describes the procedure required by division (C)(1) of 34356
this section. 34357

(3) The hospital complies with any additional rules the 34358
department adopts under section ~~5112.03~~ 5166.02 of the Revised 34359
Code. 34360

Notwithstanding division (B) of this section, a hospital 34361
providing care to an individual under this section is subrogated 34362
to the rights of any individual to receive compensation or 34363
benefits from any person or governmental entity for the hospital 34364
goods and services rendered. 34365

(D) Each hospital shall collect and report to the department, 34366
in the form and manner prescribed by the department, information 34367
on the number and identity of patients served pursuant to this 34368
section. 34369

(E) This section applies beginning May 22, 1992, regardless 34370
of whether the department has adopted rules specifying the 34371
services to be provided. Nothing in this section alters the scope 34372
or limits the obligation of any governmental entity or program, 34373
including the program awarding reparations to victims of crime 34374
under sections 2743.51 to 2743.72 of the Revised Code and the 34375
program for medically handicapped children established under 34376
section 3701.023 of the Revised Code, to pay for hospital services 34377
in accordance with state or local law. 34378

Sec. ~~5112.18~~ 5166.12. (A) Except as provided in section 34379
~~5112.19~~ 5166.13 of the Revised Code, all payments of assessments 34380
by hospitals under section ~~5112.06~~ 5166.05 of the Revised Code and 34381
all intergovernmental transfers under section ~~5112.07~~ 5166.06 of 34382
the Revised Code shall be deposited in the state treasury to the 34383
credit of the hospital care assurance program fund, hereby 34384
created. All investment earnings of the hospital care assurance 34385
program fund shall be credited to the fund. The department of ~~job~~ 34386
~~and family services~~ health care administration shall maintain 34387
records that show the amount of money in the hospital care 34388

assurance program fund at any time that has been paid by each 34389
hospital and the amount of any investment earnings on that amount. 34390
All moneys credited to the hospital care assurance program fund 34391
shall be used solely to make payments to hospitals under division 34392
(D) of this section and section ~~5112.08~~ 5166.07 of the Revised 34393
Code. 34394

(B) All federal matching funds received as a result of the 34395
department distributing funds from the hospital care assurance 34396
program fund to hospitals under section ~~5112.08~~ 5166.07 of the 34397
Revised Code shall be credited to the health care - federal fund 34398
created under section ~~5111.943~~ 5161.18 of the Revised Code. 34399

(C) All distributions of funds to hospitals under section 34400
~~5112.08~~ 5166.07 of the Revised Code are conditional on: 34401

(1) Expiration of the time for appeals under section ~~5112.09~~ 34402
5166.08 of the Revised Code without the filing of an appeal, or on 34403
court determinations, in the event of appeals, that the hospital 34404
is entitled to the funds; 34405

(2) The sum of the following being sufficient to distribute 34406
the funds after the final determination of any appeals: 34407

(a) The available money in the hospital care assurance 34408
program fund; 34409

(b) The available portion of the money in the health care - 34410
federal fund that is credited to that fund pursuant to division 34411
(B) of this section. 34412

(3) The hospital's compliance with section ~~5112.17~~ 5166.11 of 34413
the Revised Code. 34414

(D) If an audit conducted by the department of the amounts of 34415
payments made and funds received by hospitals under sections 34416
~~5112.06, 5112.07, and 5112.08~~ 5166.05, 5166.06, and 5166.07 of the 34417
Revised Code identifies amounts that, due to errors by the 34418

department, a hospital should not have been required to pay but 34419
did pay, should have been required to pay but did not pay, should 34420
not have received but did receive, or should have received but did 34421
not receive, the department shall: 34422

(1) Make payments to any hospital that the audit reveals paid 34423
amounts it should not have been required to pay or did not receive 34424
amounts it should have received; 34425

(2) Take action to recover from a hospital any amounts that 34426
the audit reveals it should have been required to pay but did not 34427
pay or that it should not have received but did receive. 34428

Payments made under division (D)(1) of this section shall be 34429
made from the hospital care assurance program fund. Amounts 34430
recovered under division (D)(2) of this section shall be deposited 34431
to the credit of that fund. Any hospital may appeal the amount the 34432
hospital is to be paid under division (D)(1) or the amount that is 34433
to be recovered from the hospital under division (D)(2) of this 34434
section to the court of common pleas of Franklin county. 34435

Sec. ~~5112.19~~ 5166.13. From the first installment of 34436
assessments paid under section ~~5112.06~~ 5166.05 of the Revised Code 34437
and intergovernmental transfers made under section ~~5112.07~~ 5166.06 34438
of the Revised Code during each program year beginning in an 34439
odd-numbered calendar year, the department of ~~job and family~~ 34440
~~services~~ health care administration shall deposit into the state 34441
treasury to the credit of the legislative budget services fund, 34442
which is hereby created, a total amount equal to the amount by 34443
which the biennial appropriation from that fund exceeds the amount 34444
of unexpended, unencumbered moneys in that fund. All investment 34445
earnings of the legislative budget services fund shall be credited 34446
to that fund. Money in the legislative budget services fund shall 34447
be used solely to pay the expenses of the legislative budget 34448
office of the legislative service commission. 34449

Sec. ~~5112.21~~ 5166.14. Except as specifically required by 34450
sections ~~5112.01~~ 5166.01 to ~~5112.19~~ 5166.13 of the Revised Code, 34451
information filed under those sections shall not include any 34452
patient-identifying material. Information that includes 34453
patient-identifying material is not a public record under section 34454
149.43 of the Revised Code, and no patient-identifying material 34455
shall be released publicly by the department of ~~job and family~~ 34456
~~services~~ health care administration or by any person under 34457
contract with the department who has access to such information. 34458

Sec. ~~3721.50~~ 5166.20. As used in sections ~~3721.50~~ 5166.20 to 34459
~~3721.58~~ 5166.30 of the Revised Code: 34460

(A) "Hospital" has the same meaning as in section 3727.01 of 34461
the Revised Code. 34462

(B) "Inpatient days" means all days during which a resident 34463
of a nursing facility, regardless of payment source, occupies a 34464
bed in the nursing facility that is included in the facility's 34465
certified capacity under ~~Title XIX~~ the medicaid program. 34466
Therapeutic or hospital leave days for which payment is made under 34467
section ~~5111.26~~ 5164.37 of the Revised Code are considered 34468
inpatient days proportionate to the percentage of the facility's 34469
per resident per day rate paid for those days. 34470

(C) ~~"Medicaid" has the same meaning as in section 5111.01 of~~ 34471
~~the Revised Code.~~ 34472

~~(D)~~ "Medicaid day" means all days during which a resident who 34473
is a medicaid recipient occupies a bed in a nursing facility that 34474
is included in the facility's certified capacity under ~~Title XIX~~ 34475
the medicaid program. Therapeutic or hospital leave days for which 34476
payment is made under section ~~5111.26~~ 5164.37 of the Revised Code 34477
are considered medicaid days proportionate to the percentage of 34478
the nursing facility's per resident per day rate for those days. 34479

~~(E)~~(D) "Nursing facility" has the same meaning as in section 34480
~~5111.20~~ 5164.01 of the Revised Code. 34481

~~(F)~~(E)(1) "Nursing home" means all of the following: 34482

(a) A nursing home licensed under section 3721.02 or 3721.09 34483
of the Revised Code, including any part of a home for the aging 34484
licensed as a nursing home; 34485

(b) A facility or part of a facility, other than a hospital, 34486
that is certified as a skilled nursing facility under ~~Title XVIII~~ 34487
the medicare program; 34488

(c) A nursing facility, other than a portion of a hospital 34489
certified as a nursing facility. 34490

(2) "Nursing home" does not include any of the following: 34491

(a) A county home, county nursing home, or district home 34492
operated pursuant to Chapter 5155. of the Revised Code; 34493

(b) A nursing home maintained and operated by the Ohio 34494
veterans' home agency under section 5907.01 of the Revised Code; 34495

(c) A nursing home or part of a nursing home licensed under 34496
section 3721.02 or 3721.09 of the Revised Code that is certified 34497
as an intermediate care facility for the mentally retarded under 34498
~~Title XIX~~ the medicaid program. 34499

~~(G) "Title XIX" means Title XIX of the "Social Security Act,"~~ 34500
~~79 Stat. 286 (1965), 42 U.S.C. 1396, as amended.~~ 34501

~~(H) "Title XVIII" means Title XVIII of the "Social Security~~ 34502
~~Act," 79 Stat. 286 (1965), 42 U.S.C. 1395, as amended.~~ 34503

Sec. ~~3721.51~~ 5166.21. The department of ~~job and family~~ 34504
~~services~~ health care administration shall do all of the following: 34505

(A) Subject to division (C) of this section and for the 34506
purposes specified in sections ~~3721.56~~ 5166.27 and ~~3721.561~~ 34507
5166.28 of the Revised Code, determine an annual franchise permit 34508

fee on each nursing home in an amount equal to six dollars and 34509
twenty-five cents for fiscal years 2006 and 2007 and one dollar 34510
for each fiscal year thereafter, multiplied by the product of the 34511
following: 34512

(1) The number of beds licensed as nursing home beds, plus 34513
any other beds certified as skilled nursing facility beds under 34514
~~Title XVIII~~ the medicare program or nursing facility beds under 34515
~~Title XIX~~ the medicaid program on the first day of May of the 34516
calendar year in which the fee is determined pursuant to division 34517
(A) of section ~~3721.53~~ 5166.23 of the Revised Code; 34518

(2) The number of days in the fiscal year beginning on the 34519
first day of July of the calendar year in which the fee is 34520
determined pursuant to division (A) of section ~~3721.53~~ 5166.23 of 34521
the Revised Code. 34522

(B) Subject to division (C) of this section and for the 34523
purposes specified in sections ~~3721.56~~ 5166.27 and ~~3721.561~~ 34524
5166.28 of the Revised Code, determine an annual franchise permit 34525
fee on each hospital in an amount equal to six dollars and 34526
twenty-five cents for fiscal years 2006 and 2007 and one dollar 34527
for each fiscal year thereafter, multiplied by the product of the 34528
following: 34529

(1) The number of beds registered pursuant to section 3701.07 34530
of the Revised Code as skilled nursing facility beds or long-term 34531
care beds, plus any other beds licensed as nursing home beds under 34532
section 3721.02 or 3721.09 of the Revised Code, on the first day 34533
of May of the calendar year in which the fee is determined 34534
pursuant to division (A) of section ~~3721.53~~ 5166.23 of the Revised 34535
Code; 34536

(2) The number of days in the fiscal year beginning on the 34537
first day of July of the calendar year in which the fee is 34538
determined pursuant to division (A) of section ~~3721.53~~ 5166.23 of 34539

the Revised Code. 34540

(C) If the United States centers for medicare and medicaid 34541
services determines that the franchise permit fee established by 34542
sections ~~3721.50~~ 5166.20 to ~~3721.58~~ 5166.30 of the Revised Code is 34543
an impermissible health care related tax under ~~section 1903(w) of~~ 34544
the "~~Social Security Act,~~" ~~49 Stat. 620 (1935),~~ 42 U.S.C. 34545
1396b(w), ~~as amended,~~ take all necessary actions to cease 34546
implementation of sections ~~3721.50~~ 5166.20 to ~~3721.58~~ 5166.30 of 34547
the Revised Code in accordance with rules adopted under section 34548
~~3721.58~~ 5166.30 of the Revised Code. 34549

Sec. ~~3721.52~~ 5166.22. (A) For the purpose of the fee under 34550
division (A) of section ~~3721.51~~ 5166.21 of the Revised Code, the 34551
department of health shall, not later than the first day of each 34552
June, report to the department of ~~job and family services~~ health
care administration the number of beds in each nursing home 34553
licensed on the preceding first day of May under section 3721.02 34554
or 3721.09 of the Revised Code or certified on that date under 34555
~~Title XVIII or XIX~~ the medicare or medicaid program. 34556
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(B) For the purpose of the fee under division (B) of section 34558
~~3721.51~~ 5166.21 of the Revised Code, the department of health 34559
shall, not later than the first day of each June, report to the 34560
department of ~~job and family services~~ health care administration 34561
the number of beds in each hospital registered on the preceding 34562
first day of May pursuant to section 3701.07 of the Revised Code 34563
as skilled nursing facility or long-term care beds or licensed on 34564
that date under section 3721.02 or 3721.09 of the Revised Code as 34565
nursing home beds. 34566

Sec. ~~3721.53~~ 5166.23. (A) Not later than the fifteenth day of 34567
August of each year, the department of ~~job and family services~~ 34568
health care administration shall determine the annual franchise 34569

permit fee for each nursing home in accordance with division (A) 34570
of section ~~3721.51~~ 5166.21 of the Revised Code and the annual 34571
franchise permit fee for each hospital in accordance with division 34572
(B) of that section. 34573

(B) Not later than the first day of September of each year, 34574
the department shall mail to each nursing home and hospital notice 34575
of the amount of the franchise permit fee that has been determined 34576
for the nursing home or hospital. 34577

(C) Each nursing home and hospital shall pay its fee under 34578
section ~~3721.51~~ 5166.21 of the Revised Code to the department in 34579
quarterly installment payments not later than forty-five days 34580
after the last day of each September, December, March, and June. 34581

(D) No nursing home or hospital shall directly bill its 34582
residents for the fee paid under this section, or otherwise 34583
directly pass the fee through to its residents. 34584

Sec. ~~3721.54~~ 5166.24. If a nursing home or hospital fails to 34585
pay the full amount of a franchise permit fee installment when 34586
due, the department of ~~job and family services~~ health care 34587
administration may assess a five per cent penalty on the amount 34588
due for each month or fraction thereof the installment is overdue. 34589

Sec. ~~3721.541~~ 5166.25. (A) In addition to assessing a penalty 34590
pursuant to section ~~3721.54~~ 5166.24 of the Revised Code, the 34591
department of ~~job and family services~~ health care administration 34592
may do either of the following if a nursing facility or hospital 34593
fails to pay the full amount of a franchise permit fee installment 34594
when due: 34595

(1) Withhold an amount equal to the installment and penalty 34596
assessed under section ~~3721.54~~ 5166.24 of the Revised Code from a 34597
medicaid payment due the nursing facility or hospital until the 34598
nursing facility or hospital pays the installment and penalty; 34599

(2) Terminate the nursing facility or hospital's medicaid provider agreement. 34600
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(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. 34602
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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. 34606
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(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. 34615
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(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. 34625
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Sec. ~~3721.56~~ 5166.27. There is hereby created in the state treasury the home- and community-based services for the aged fund. 34628
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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 34660
its duties under sections ~~3721.50~~ 5166.20 to ~~3721.58~~ 5166.30 of 34661
the Revised Code. At the request of the department, the attorney 34662
general shall aid in any such investigations. The attorney general 34663
shall institute and prosecute all necessary actions for the 34664
enforcement of sections ~~3721.50~~ 5166.20 to ~~3721.58~~ 5166.30 of the 34665
Revised Code, except that at the request of the attorney general, 34666
the county prosecutor of the county in which a nursing home or 34667
hospital that has failed to comply with sections ~~3721.50~~ 5166.20 34668
to ~~3721.58~~ 5166.30 of the Revised Code is located shall institute 34669
and prosecute any necessary action against the nursing home or 34670
hospital. 34671

Sec. ~~3721.58~~ 5166.30. The director of ~~job and family services~~ 34672
health care administration shall adopt rules in accordance with 34673
Chapter 119. of the Revised Code to do all of the following: 34674
34675

(A) Prescribe the actions the department of ~~job and family~~ 34676
~~services~~ health care administration will take to cease 34677
implementation of sections ~~3721.50~~ 5166.20 through ~~3721.57~~ 5166.29 34678
of the Revised Code if the United States centers for medicare and 34679
medicaid services determines that the franchise permit fee 34680
established by those sections is an impermissible health-care 34681
related tax under ~~section 1903(w) of the "Social Security Act," 49~~ 34682
~~Stat. 620 (1935),~~ 42 U.S.C. 1396b(w), ~~as amended;~~ 34683

(B) Establish the method of distributing moneys in the home 34684
and community-based services for the aged fund created under 34685
section ~~3721.56~~ 5166.27 of the Revised Code; 34686

(C) Establish any requirements or procedures the director 34687
considers necessary to implement sections ~~3721.50~~ 5166.20 to 34688
~~3721.58~~ 5166.30 of the Revised Code. 34689

~~Sec. 5112.30~~ 5166.40. As used in sections ~~5112.30~~ 5166.40 to 34690
~~5112.39~~ 5166.50 of the Revised Code+ 34691

~~(A) "Intermediate, "~~intermediate care facility for the 34692
mentally retarded" has the same meaning as in section ~~5111.20~~ 34693
5164.01 of the Revised Code, except that it does not include any 34694
such facility operated by the department of mental retardation and 34695
developmental disabilities. 34696

~~(B) "Medicaid" has the same meaning as in section 5111.01 of~~ 34697
~~the Revised Code.~~ 34698

~~Sec. 5112.31~~ 5166.41. The department of ~~job and family~~ 34699
~~services~~ health care administration shall do all of the following: 34700

(A) For the purpose of providing home and community-based 34701
services for mentally retarded and developmentally disabled 34702
persons, annually assess each intermediate care facility for the 34703
mentally retarded a franchise permit fee equal to nine dollars and 34704
sixty-three cents multiplied, except as adjusted under section 34705
~~5112.311~~ 5166.42 of the Revised Code, by the product of the 34706
following: 34707

(1) The number of beds certified ~~under Title XIX of the~~ 34708
~~"Social Security Act"~~ for the medicaid program on the first day of 34709
May of the calendar year in which the assessment is determined 34710
pursuant to division (A) of section ~~5112.33~~ 5166.44 of the Revised 34711
Code; 34712

(2) The number of days in the fiscal year beginning on the 34713
first day of July of the same calendar year. 34714

(B) Beginning July 1, 2007, and the first day of each July 34715
thereafter, adjust fees determined under division (A) of this 34716
section in accordance with the composite inflation factor 34717
established in rules adopted under section ~~5112.39~~ 5166.50 of the 34718
Revised Code. 34719

(C) If the United States secretary of health and human 34720
services determines that the franchise permit fee established by 34721
sections ~~5112.30~~ 5166.40 to ~~5112.39~~ 5166.50 of the Revised Code 34722
would be an impermissible health care-related tax under ~~section~~ 34723
~~1903(w) of the "Social Security Act,"~~ 42 U.S.C.A. 1396b(w), ~~as~~ 34724
~~amended,~~ take all necessary actions to cease implementation of 34725
those sections in accordance with rules adopted under section 34726
~~5112.39~~ 5166.50 of the Revised Code. 34727

Sec. ~~5112.311~~ 5166.42. If, under section ~~5111.8816~~ 5163.6616 34728
of the Revised Code, the certified capacity of an intermediate 34729
care facility for the mentally retarded is reduced, the department 34730
of ~~job and family services~~ health care administration shall adjust 34731
the franchise permit fee the facility was assessed under section 34732
~~5112.31~~ 5166.41 of the Revised Code accordingly. If, under section 34733
~~5111.8811~~ 5163.6611 of the Revised Code, the certified capacity of 34734
an intermediate care facility for the mentally retarded is 34735
increased, the department may adjust the franchise permit fee the 34736
facility was assessed under section ~~5112.31~~ 5166.41 of the Revised 34737
Code accordingly. 34738

Sec. ~~5112.32~~ 5166.43. For the purpose of the franchise permit 34739
fee imposed under section ~~5112.31~~ 5166.41 of the Revised Code, the 34740
department of mental retardation and developmental disabilities 34741
shall: 34742

(A) Not later than August 1, 1993, report to the department 34743
of ~~job and family services~~ health care administration the number 34744
of beds in each intermediate care facility for the mentally 34745
retarded certified on July 1, 1993, ~~under Title XIX of the "Social~~ 34746
~~Security Act,"~~ 49 Stat. 620 (1935), 42 U.S.C.A. 301, ~~as amended~~ 34747
for the medicaid program; 34748

(B) Not later than June 1, 1994, and the first day of each 34749

June thereafter, report to the department of ~~job and family~~ 34750
~~services~~ health care administration the number of beds in each 34751
such facility certified on the preceding first day of May under 34752
that title. 34753

Sec. ~~5112.33~~ 5166.44. (A) Not later than the fifteenth day of 34754
August of each year, the department of ~~job and family services~~ 34755
health care administration shall determine the annual franchise 34756
permit fee for each intermediate care facility for the mentally 34757
retarded in accordance with section ~~5112.31~~ 5166.41 of the Revised 34758
Code. 34759

(B) Not later than the first day of September of each year, 34760
the department shall mail to each intermediate care facility for 34761
the mentally retarded notice of the amount of the franchise permit 34762
fee the facility has been assessed under section ~~5112.31~~ 5166.41 34763
of the Revised Code. 34764

(C) Each intermediate care facility for the mentally retarded 34765
shall pay its fee under section ~~5112.31~~ 5166.41 of the Revised 34766
Code to the department in quarterly installment payments not later 34767
than forty-five days after the last day of each September, 34768
December, March, and June. 34769

Sec. ~~5112.34~~ 5166.45. If an intermediate care facility for 34770
the mentally retarded fails to pay the full amount of an 34771
installment when due, the department of ~~job and family services~~ 34772
health care administration may assess a five per cent penalty on 34773
the amount due for each month or fraction thereof the installment 34774
is overdue. 34775

Sec. ~~5112.341~~ 5166.46. (A) In addition to assessing a penalty 34776
pursuant to section ~~5112.34~~ 5166.45 of the Revised Code, the 34777
department of ~~job and family services~~ health care administration 34778
may do either of the following if an intermediate care facility 34779

for the mentally retarded fails to pay the full amount of a 34780
franchise permit fee installment when due: 34781

(1) Withhold an amount equal to the installment and penalty 34782
assessed under section ~~5112.34~~ 5166.45 of the Revised Code from a 34783
medicaid payment due the facility until the facility pays the 34784
installment and penalty; 34785

(2) Terminate the facility's medicaid provider agreement. 34786

(B) The department may withhold a medicaid payment under 34787
division (A)(1) of this section without providing notice to the 34788
intermediate care facility for the mentally retarded and without 34789
conducting an adjudication under Chapter 119. of the Revised Code. 34790

Sec. ~~5112.35~~ 5166.47. (A) An intermediate care facility for 34791
the mentally retarded may appeal the franchise permit fee imposed 34792
under section ~~5112.31~~ 5166.41 of the Revised Code solely on the 34793
grounds that the department of ~~job and family services~~ health care 34794
administration committed a material error in determining the 34795
amount of the fee. A request for an appeal must be received by the 34796
department not later than fifteen days after the date the 34797
department mails the notice of the fee and must include written 34798
materials setting forth the basis for the appeal. 34799

(B) If an intermediate care facility for the mentally 34800
retarded submits a request for an appeal within the time required 34801
under division (A) of this section, the department shall hold a 34802
public hearing in Columbus not later than thirty days after the 34803
date the department receives the request for an appeal. The 34804
department shall, not later than ten days before the date of the 34805
hearing, mail a notice of the date, time, and place of the hearing 34806
to the facility. The department may hear all requested appeals in 34807
one public hearing. 34808

(C) On the basis of the evidence presented at the hearing or 34809

any other evidence submitted by the intermediate care facility for 34810
the mentally retarded, the department may adjust a fee. The 34811
department's decision is final. 34812

Sec. ~~5112.37~~ 5166.48. All installment payments and penalties 34813
paid by an intermediate care facility for the mentally retarded 34814
under sections ~~5112.33~~ 5166.44 and ~~5112.34~~ 5166.45 of the Revised 34815
Code shall be deposited into the "home and community-based 34816
services for the mentally retarded and developmentally disabled 34817
fund," which is hereby created in the state treasury. The 34818
department of ~~job and family services~~ health care administration 34819
shall distribute the money in the fund in accordance with rules 34820
adopted under section ~~5112.39~~ 5166.50 of the Revised Code. The 34821
departments of ~~job and family services~~ health care administration 34822
and mental retardation and developmental disabilities shall use 34823
the money for the ~~medical assistance~~ medicaid program ~~established~~ 34824
~~under Chapter 5111. of the Revised Code and, including~~ home and 34825
community-based services to ~~mentally retarded and developmentally~~ 34826
~~disabled~~ persons with mental retardation or a developmental 34827
disability. 34828

Sec. ~~5112.38~~ 5166.49. The department of ~~job and family~~ 34829
~~services~~ health care administration may make any investigation it 34830
considers appropriate to obtain information necessary to fulfill 34831
its duties under sections ~~5112.30~~ 5166.40 to ~~5112.39~~ 5166.50 of 34832
the Revised Code. At the request of the department, the attorney 34833
general shall aid in any such investigations. The attorney general 34834
shall institute and prosecute all necessary actions for the 34835
enforcement of sections ~~5112.30~~ 5166.40 to ~~5112.39~~ 5166.50 of the 34836
Revised Code, except that at the request of the attorney general, 34837
the county prosecutor of the county in which an intermediate care 34838
facility for the mentally retarded that has failed to comply with 34839
those sections is located shall institute and prosecute any 34840

necessary action against the facility. 34841

Sec. ~~5112.39~~ 5166.50. The director of ~~job and family services~~ 34842
health care administration shall adopt rules in accordance with 34843
Chapter 119. of the Revised Code to do all of the following: 34844

(A) Establish a composite inflation factor with which to 34846
adjust franchise permit fees under section ~~5112.31~~ 5166.41 of the 34847
Revised Code; 34848

(B) Prescribe the actions the department will take to cease 34849
implementation of sections ~~5112.30~~ 5166.40 to ~~5112.39~~ 5166.50 of 34850
the Revised Code if the United States secretary of health and 34851
human services determines that the franchise permit fee imposed 34852
under section ~~5112.31~~ 5166.41 of the Revised Code is an 34853
impermissible health care-related tax under ~~section 1903(w) of the~~ 34854
~~"Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 1396b(w),~~ 34855
~~as amended;~~ 34856

(C) Establish the method of distributing the money in the 34857
home and community-based services for the mentally retarded and 34858
developmentally disabled fund created by section ~~5112.37~~ 5166.48 34859
of the Revised Code; 34860

(D) Establish any other requirements or procedures the 34861
director considers necessary to implement sections ~~5112.30~~ 5166.40 34862
to ~~5112.39~~ 5166.50 of the Revised Code. 34863

Sec. ~~5111.176~~ 5166.60. (A) As used in this section: 34864

(1) "Medicaid health insuring corporation" means a health 34865
insuring corporation that holds a certificate of authority under 34866
Chapter 1751. of the Revised Code and has entered into a contract 34867
with the department of ~~job and family services~~ health care 34868
administration pursuant to section ~~5111.17~~ 5165.05 of the Revised 34869
Code. 34870

(2) "Managed care premium" means any premium payment, 34871
capitation payment, or other payment a medicaid health insuring 34872
corporation receives for providing, or arranging for the provision 34873
of, health care services to its members or enrollees residing in 34874
this state. 34875

(B) Except as provided in division (C) of this section, all 34876
of the following apply: 34877

(1) Each medicaid health insuring corporation shall pay to 34878
the department of ~~job and family services~~ health care 34879
administration a franchise permit fee for the period December 1, 34880
2005, through December 31, 2005, and each calendar quarter 34881
occurring thereafter. 34882

(2) The fee to be paid is an amount that is equal to a 34883
percentage of the managed care premiums the medicaid health 34884
insuring corporation received in the period December 1, 2005, 34885
through December 31, 2005, and in the subsequent quarter to which 34886
the fee applies, excluding the amount of any managed care premiums 34887
the corporation returned or refunded to enrollees, members, or 34888
premium payers during the period December 1, 2005, through 34889
December 31, 2005, or the subsequent quarter to which the fee 34890
applies. 34891

(3) The percentage to be used in calculating the fee shall be 34892
four and one-half per cent, unless the department adopts rules 34893
under division (L) of this section decreasing the percentage below 34894
four and one-half per cent or increasing the percentage to not 34895
more than six per cent. 34896

(C) The department shall reduce the franchise permit fee 34897
imposed under this section or terminate its collection of the fee 34898
if the department determines either of the following: 34899

(1) That the reduction or termination is required to comply 34900
with federal statutes or regulations; 34901

(2) That the fee does not qualify as a state share of 34902
medicaid expenditures eligible for federal financial 34903
participation. 34904

(D) The franchise permit fee shall be paid on or before the 34905
thirtieth day following the end of the period December 1, 2005, 34906
through December 31, 2005, or the calendar quarter to which the 34907
fee applies. At the time the fee is submitted, the medicaid health 34908
insuring corporation shall file with the department a report on a 34909
form prescribed by the department. The corporation shall provide 34910
on the form all information required by the department and shall 34911
include with the form any necessary supporting documentation. 34912

(E) The department may audit the records of any medicaid 34913
health insuring corporation to determine whether the corporation 34914
is in compliance with this section. The department may audit the 34915
records that pertain to the period December 1, 2005, through 34916
December 31, 2005, or a particular calendar quarter, at any time 34917
during the five years following the date the franchise permit fee 34918
payment for that period or quarter was due. 34919

(F)(1) A medicaid health insuring corporation that does not 34920
pay the franchise permit fee in full by the date the payment is 34921
due is subject to any or all of the following: 34922

(a) A monetary penalty in the amount of five hundred dollars 34923
for each day any part of the fee remains unpaid, except that the 34924
penalty shall not exceed an amount equal to five per cent of the 34925
total fee that was due; 34926

(b) Withholdings from future managed care premiums pursuant 34927
to division (G) of this section; 34928

(c) Termination of the corporation's medicaid provider 34929
agreement pursuant to division (H) of this section. 34930

(2) Penalties imposed under division (F)(1)(a) of this 34931
section are in addition to and not in lieu of the franchise permit 34932

fee. 34933

(G) If a medicaid health insuring corporation fails to pay 34934
the full amount of its franchise permit fee when due, or the full 34935
amount of a penalty imposed under division (F)(1)(a) of this 34936
section, the department may withhold an amount equal to the 34937
remaining amount due from any future managed care premiums to be 34938
paid to the corporation under the medicaid program. The department 34939
may withhold amounts under this division without providing notice 34940
to the corporation. The amounts may be withheld until the amount 34941
due has been paid. 34942

(H) The department may commence actions to terminate a 34943
medicaid health insuring corporation's medicaid provider 34944
agreement, and may terminate the agreement subject to division (I) 34945
of this section, if the corporation does any of the following: 34946

(1) Fails to pay its franchise permit fee or fails to pay the 34947
fee promptly; 34948

(2) Fails to pay a penalty imposed under division (F)(1)(a) 34949
of this section or fails to pay the penalty promptly; 34950

(3) Fails to cooperate with an audit conducted under division 34951
(E) of this section. 34952

(I) At the request of a medicaid health insuring corporation, 34953
the department shall grant the corporation a hearing in accordance 34954
with Chapter 119. of the Revised Code, if either of the following 34955
is the case: 34956

(1) The department has determined that the corporation owes 34957
an additional franchise permit fee or penalty as the result of an 34958
audit conducted under division (E) of this section. 34959

(2) The department is proposing to terminate the 34960
corporation's medicaid provider agreement and the provisions of 34961
section ~~5111.06~~ 5163.01 of the Revised Code requiring an 34962

adjudication in accordance with Chapter 119. of the Revised Code 34963
are applicable. 34964

(J)(1) At the request of a medicaid corporation, the 34965
department shall grant the corporation a reconsideration of any 34966
issue that arises out of the provisions of this section and is not 34967
subject to division (I) of this section. The department's decision 34968
at the conclusion of the reconsideration is not subject to appeal 34969
under Chapter 119. of the Revised Code or any other provision of 34970
the Revised Code. 34971

(2) In conducting a reconsideration, the department shall do 34972
at least the following: 34973

(a) Specify the time frames within which a corporation must 34974
act in order to exercise its opportunity for a reconsideration; 34975

(b) Permit the corporation to present written arguments or 34976
other materials that support the corporation's position. 34977

(K) There is hereby created in the state treasury the managed 34978
care assessment fund. Money collected from the franchise permit 34979
fees and penalties imposed under this section shall be credited to 34980
the fund. The department shall use the money in the fund to pay 34981
for medicaid services, the department's administrative costs, and 34982
contracts with medicaid health insuring corporations. 34983

(L) The director of ~~job and family services~~ health care 34984
administration may adopt rules to implement and administer this 34985
section. The rules shall be adopted in accordance with Chapter 34986
119. of the Revised Code. 34987

Sec. ~~5112.99~~ 5166.99. (A) The director of ~~job and family~~ 34988
~~services~~ health care administration shall impose a penalty for 34989
each day that a hospital fails to report the information required 34990
under section ~~5112.04~~ 5166.03 of the Revised Code on or before the 34991
dates specified in that section. The amount of the penalty shall 34992

be established by the director in rules adopted under section 34993
~~5112.03~~ 5166.02 of the Revised Code. 34994

(B) In addition to any other remedy available to the 34995
department of ~~job and family services~~ health care administration 34996
under law to collect unpaid assessments and transfers, the 34997
director shall impose a penalty of ten per cent of the amount due 34998
on any hospital that fails to pay assessments or make 34999
intergovernmental transfers by the dates required by rules adopted 35000
under section ~~5112.03~~ 5166.02 of the Revised Code. 35001

(C) The director shall waive the penalties provided for in 35002
divisions (A) and (B) of this section for good cause shown by the 35003
hospital. 35004

(D) All penalties imposed under this section shall be 35005
deposited into the health care administration fund created by 35006
section ~~5111.94~~ 5161.15 of the Revised Code. 35007

Sec. 5167.01. As used in this chapter, "federal poverty 35008
guidelines" has the same meaning as in section 5101.46 of the 35009
Revised Code. 35010

Sec. ~~5101.50~~ 5167.05. ~~(A) As used in this section and in~~ 35011
~~sections 5101.51 to 5101.5110 of the Revised Code:~~ 35012

~~(1) "Children's health insurance program" means the program~~ 35013
~~authorized by Title XXI of the "Social Security Act," 111 Stat.~~ 35014
~~552 (1997), 42 U.S.C.A. 1397aa.~~ 35015

~~(2) "Federal poverty guidelines" has the same meaning as in~~ 35016
~~section 5101.46 of the Revised Code.~~ 35017

~~(B)~~ The director of ~~job and family services~~ health care 35018
administration may continue to operate the children's health 35019
insurance program initially authorized by an executive order 35020
issued under section 107.17 of the Revised Code as long as federal 35021

financial participation is available for the program. If operated, 35022
the program shall provide health assistance to uninsured 35023
individuals under nineteen years of age with family incomes not 35024
exceeding one hundred fifty per cent of the federal poverty 35025
guidelines. In accordance with 42 U.S.C.A. 1397aa, the director 35026
may provide for the health assistance to meet the requirements of 35027
42 U.S.C.A. 1397cc, to be provided under the medicaid program 35028
~~established under Chapter 5111. of the Revised Code~~, or to be a 35029
combination of both. 35030

Sec. ~~5101.501~~ 5167.06. Health assistance provided under 35031
section ~~5101.50~~ 5167.05 of the Revised Code shall be known as the 35032
children's health insurance program part I. 35033

Sec. ~~5101.502~~ 5167.07. The director of ~~job and family~~ 35034
~~services~~ health care administration may adopt rules in accordance 35035
with Chapter 119. of the Revised Code as necessary for the 35036
efficient administration of the children's health insurance 35037
program part I, including rules that establish all of the 35038
following: 35039

(A) The conditions under which health assistance services 35040
will be reimbursed; 35041

(B) The method of reimbursement applicable to services 35042
reimbursable under the program; 35043

(C) The amount of reimbursement, or the method by which the 35044
amount is to be determined, for each reimbursable service. 35045

Sec. ~~5101.503~~ 5167.08. A completed application for ~~medical~~ 35046
~~assistance under Chapter 5111. of the Revised Code~~ the medicaid 35047
program shall be treated as an application for health assistance 35048
under the children's health insurance program part I if the 35049
application is for an assistance group that includes a child under 35050

nineteen years of age and is denied. 35051

Sec. ~~5101.51~~ 5167.10. In accordance with federal law 35052
governing the children's health insurance program, the director of 35053
~~job and family services~~ health care administration may submit a 35054
state child health plan to the United States secretary of health 35055
and human services to provide, except as provided in section 35056
~~5101.516~~ 5167.16 of the Revised Code, health assistance to 35057
uninsured individuals under nineteen years of age with family 35058
incomes above one hundred fifty per cent of the federal poverty 35059
guidelines but not exceeding two hundred per cent of the federal 35060
poverty guidelines. If the director submits the plan, the director 35061
shall include both of the following in the plan: 35062

(A) The health assistance will not begin before January 1, 35063
2000. 35064

(B) The health assistance will be available only while 35065
federal financial participation is available for it. 35066

Sec. ~~5101.511~~ 5167.11. Health assistance provided under 35067
section ~~5101.51~~ 5167.10 of the Revised Code shall be known as the 35068
children's health insurance program part II. 35069

Sec. ~~5101.512~~ 5167.12. If the director of ~~job and family~~ 35070
~~services~~ health care administration submits a state child health 35071
plan to the United States secretary of health and human services 35072
under section ~~5101.51~~ 5167.10 of the Revised Code and the 35073
secretary approves the plan, the director shall implement the 35074
children's health insurance program part II in accordance with the 35075
plan. The director may adopt rules in accordance with Chapter 119. 35076
of the Revised Code as necessary for the efficient administration 35077
of the program, including rules that establish all of the 35078
following: 35079

(A) The conditions under which health assistance services will be reimbursed; 35080
35081

(B) The method of reimbursement applicable to services reimbursable under the program; 35082
35083

(C) The amount of reimbursement, or the method by which the amount is to be determined, for each reimbursable service. 35084
35085

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. 35086
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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. 35094
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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: 35100
35101
35102
35103

(A) Using employees of the department of ~~job and family services~~ health care administration; 35104
35105

(B) Assigning the duty to county departments of job and family services; 35106
35107

(C) Contracting with a government entity or person. 35108

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 35138
provide health assistance to any individual who meets all of the 35139
following requirements: 35140

(1) Is the parent of a child under nineteen years of age who 35141
resides with the parent and is eligible for health assistance 35142
under the children's health insurance program part I or II or the 35143
medicaid program ~~established under Chapter 5111. of the Revised~~ 35144
~~Code;~~ 35145

(2) Is uninsured; 35146

(3) Has a family income that does not exceed one hundred per 35147
cent of the federal poverty guidelines. 35148

(B) A waiver request the director submits under division (A) 35149
of this section may seek federal funds allotted to the state under 35150
~~Title XXI of the "Social Security Act," 111 Stat. 558 (1997), 42~~ 35151
~~U.S.C.A. 1397dd, as amended,~~ that are not otherwise used to fund 35152
the children's health insurance program parts I and II. 35153

(C) If a waiver request the director submits under division 35154
(A) of this section is granted, the director may adopt rules in 35155
accordance with Chapter 119. of the Revised Code as necessary for 35156
the efficient administration of the program authorization by the 35157
waiver. 35158

Sec. ~~5115.10~~ 5168.01. (A) The director of ~~job and family~~ 35159
~~services~~ health care administration shall establish a disability 35160
medical assistance program. 35161

(B) Subject to all other eligibility requirements established 35162
by this chapter and the rules adopted under it for the disability 35163
medical assistance program, a person may be eligible for 35164
disability medical assistance only if the person is medication 35165
dependent, as determined by the department of ~~job and family~~ 35166
~~services~~ health care administration. 35167

(C) The director shall adopt rules under section 111.15 of 35168
the Revised Code for purposes of implementing division (B) of this 35169
section. The rules may specify or establish any or all of the 35170
following: 35171

(1) Standards for determining whether a person is medication 35172
dependent, including standards under which a person may qualify as 35173
being medication dependent only if it is determined that both of 35174
the following are the case: 35175

(a) The person is receiving ongoing treatment for a chronic 35176
medical condition that requires continuous prescription medication 35177
for an indefinite, long-term period of time; 35178

(b) Loss of the medication would result in a significant risk 35179
of medical emergency and loss of employability lasting at least 35180
nine months. 35181

(2) A requirement that a person's medical condition be 35182
certified by an individual authorized under Chapter 4731. of the 35183
Revised Code to practice medicine and surgery or osteopathic 35184
medicine and surgery; 35185

(3) Limitations on the chronic medical conditions and 35186
prescription medications that may qualify a person as being 35187
medication dependent. 35188

Sec. ~~5115.11~~ 5168.02. An individual who qualifies for the 35189
~~medical assistance~~ medicaid program ~~established under Chapter~~ 35190
~~5111. of the Revised Code~~ shall receive medical assistance through 35191
that program rather than through the disability medical assistance 35192
program. 35193

An individual is ineligible for disability medical assistance 35194
if, for the purpose of avoiding consideration of property in 35195
determinations of the individual's eligibility for disability 35196
medical assistance or a greater amount of assistance, the person 35197

has transferred property during the two years preceding 35198
application for or most recent redetermination of eligibility for 35199
disability medical assistance. 35200

Sec. 5168.03. Each applicant for or recipient of disability 35201
medical assistance who, in the judgment of the department of 35202
health care administration or a county department of job and 35203
family services might be eligible for benefits under the 35204
supplemental security program, shall, as a condition of 35205
eligibility for assistance, apply for such benefits if directed to 35206
do so by the department or county department. 35207

Sec. 5168.04. As a condition of eligibility for disability 35208
medical assistance, and as a means of preventing or reducing the 35209
provision of assistance at public expense, each applicant for or 35210
recipient of the assistance shall make reasonable efforts to 35211
secure support from persons responsible for the applicant's or 35212
recipient's support, and from other sources, including any federal 35213
program designed to provide assistance to individuals with 35214
disabilities. The department of health care administration or 35215
county department of job and family services may provide 35216
assistance to the applicant or recipient in securing other forms 35217
of assistance. 35218

~~Sec. 5115.12~~ 5168.05. (A) The director of ~~job and family~~ 35219
~~services~~ health care administration shall adopt rules in 35220
accordance with section 111.15 of the Revised Code governing the 35221
disability medical assistance program. The rules may establish or 35222
specify any or all of the following: 35223

(1) Income, resource, citizenship, age, residence, living 35224
arrangement, and other eligibility requirements; 35225

(2) Health services to be included in the program; 35226

(3) The maximum authorized amount, scope, duration, or limit of payment for services;	35227 35228
(4) Limits on the length of time an individual may receive disability medical assistance;	35229 35230
(5) Limits on the total number of individuals in the state who may receive disability medical assistance.	35231 35232
(B) For purposes of limiting the cost of the disability medical assistance program, the director may do either of the following:	35233 35234 35235
(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 <u>5168.01</u> of the Revised Code;	35236 35237 35238 35239 35240 35241 35242
(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.	35243 35244 35245 35246 35247 35248 35249 35250 35251 35252 35253
Sec. 5115.14 <u>5168.06</u>. (A) The director of job and family services <u>health care administration</u> shall adopt rules in accordance with section 111.15 of the Revised Code establishing	35254 35255 35256

application and verification procedures, reapplication procedures, 35257
and other requirements the director considers necessary in the 35258
administration of the application process for disability medical 35259
assistance. 35260

(B) Any person who applies for disability medical assistance 35261
shall receive a voter registration application under section 35262
3503.10 of the Revised Code. 35263

Sec. ~~5115.13~~ 5168.07. (A) The department of ~~job and family~~ 35264
~~services~~ health care administration shall supervise and administer 35265
the disability medical program, except as follows: 35266

(1) The department may require county departments of job and 35267
family services to perform any administrative function specified 35268
in rules adopted by the director of ~~job and family services~~ health 35269
care administration. 35270

(2) The director may contract with any private or public 35271
entity in this state to perform any administrative function or to 35272
administer any or all of the program. 35273

(B) If the department requires county departments to perform 35274
administrative functions, the director of ~~job and family services~~ 35275
health care administration shall adopt rules in accordance with 35276
section 111.15 of the Revised Code governing the performance of 35277
the functions to be performed by county departments. County 35278
departments shall perform the functions in accordance with the 35279
rules. 35280

If the director contracts with a private or public entity to 35281
perform administrative functions or to administer any or all of 35282
the program, the director may either adopt rules in accordance 35283
with section 111.15 of the Revised Code or include provisions in 35284
the contract governing the performance of the functions by the 35285
private or public entity. Entities under contract shall perform 35286

the functions in accordance with the requirements established by 35287
the director. 35288

(C) Whenever division (A)(1) or (2) of this section is 35289
implemented, the director shall conduct investigations to 35290
determine whether disability medical assistance is being 35291
administered in compliance with the Revised Code and rules adopted 35292
by the director or in accordance with the terms of the contract. 35293

Sec. 5168.08. If a recipient of disability medical 35294
assistance, or an individual whose income and resources are 35295
included in determining the recipient's eligibility for the 35296
assistance, becomes possessed of resources or income in excess of 35297
the amount allowed to retain eligibility, or if other changes 35298
occur that affect the recipient's eligibility or need for 35299
assistance, the recipient shall notify the department of health 35300
care administration or county department of job and family 35301
services within the time limits specified in rules adopted by the 35302
director of health care administration in accordance with section 35303
111.15 of the Revised Code. Failure of a recipient to report 35304
possession of excess resources or income or a change affecting 35305
eligibility or need within those time limits shall be considered 35306
prima-facie evidence of intent to defraud under section 5168.09 of 35307
the Revised Code. 35308

Sec. 5168.09. As used in this section, "erroneous payments" 35309
means disability medical assistance payments made to persons who 35310
are not entitled to receive them, including payments made as a 35311
result of misrepresentation or fraud, and payments made due to an 35312
error by the recipient or by the county department of job and 35313
family services that made the payment. 35314

The department of health care administration shall adopt 35315
rules in accordance with section 111.15 of the Revised Code 35316

specifying the circumstances under which action is to be taken 35317
under this section to recover erroneous payments. The department, 35318
or a county department of job and family services at the request 35319
of the department, shall take action to recover erroneous payments 35320
in the circumstances specified in the rules. The department or 35321
county department may institute a civil action to recover 35322
erroneous payments. 35323

Each county department of job and family services shall 35324
retain fifty per cent of the erroneous payments it recovers under 35325
this section. The department of health care administration shall 35326
receive the remaining fifty per cent. 35327

Sec. 5168.10. Whenever disability medical assistance has been 35328
furnished to a recipient for whose support another person is 35329
responsible, the other person shall, in addition to the liability 35330
otherwise imposed, as a consequence of failure to support the 35331
recipient, be liable for all assistance furnished the recipient. 35332
The value of the assistance so furnished may be recovered in a 35333
civil action brought by the county department of job and family 35334
services. 35335

Sec. ~~173.71~~ 5169.01. As used in sections ~~173.71 to 173.91~~ of 35336
the Revised Code this chapter: 35337

(A) "Children's health insurance program" means the 35338
children's health insurance program part I and part II established 35339
under sections ~~5101.50 to 5101.5110~~ of the Revised Code. 35340

(B) "Disability medical assistance program" means the program 35341
established under section ~~5115.10~~ of the Revised Code. 35342

(C) "Medicaid program" or "medicaid" means the medical 35343
assistance program established under Chapter ~~5111~~ of the Revised 35344
Code. 35345

(D) "National drug code number" means the number registered 35346

for a drug pursuant to the listing system established by the 35347
United States food and drug administration under the "Drug Listing 35348
Act of 1972," 86 Stat. 559, 21 U.S.C. 360, as amended. 35349

~~(E)~~(B) "Ohio's best Rx program participant" or "participant" 35350
means an individual determined eligible for the Ohio's best Rx 35351
program and included under an Ohio's best Rx program enrollment 35352
card. 35353

~~(F)~~(C) "Participating manufacturer" means a drug manufacturer 35354
participating in the Ohio's best Rx program pursuant to a 35355
manufacturer agreement entered into under section ~~173.81~~ 5169.11 35356
of the Revised Code. 35357

~~(G)~~(D) "Participating terminal distributor" means a terminal 35358
distributor of dangerous drugs participating in the Ohio's best Rx 35359
program pursuant to an agreement entered into under section ~~173.79~~ 35360
5169.09 of the Revised Code. 35361

~~(H)~~(E) "Political subdivision" has the same meaning as in 35362
section 9.23 of the Revised Code. 35363

~~(I)~~(F) "State agency" has the same meaning as in section 9.23 35364
of the Revised Code. 35365

~~(J)~~(G) "Terminal distributor of dangerous drugs" has the same 35366
meaning as in section 4729.01 of the Revised Code. 35367

~~(K)~~(H) "Third-party payer" has the same meaning as in section 35368
3901.38 of the Revised Code. 35369

~~(L)~~(I) "Trade secret" has the same meaning as in section 35370
1333.61 of the Revised Code. 35371

~~(M)~~(J) "Usual and customary charge" means the amount a 35372
participating terminal distributor or the drug mail order system 35373
included in the Ohio's best Rx program pursuant to section ~~173.78~~ 35374
5169.08 of the Revised Code charges when a drug included in the 35375
program is purchased by an individual who does not receive a 35376

discounted price for the drug pursuant to any drug discount 35377
program, including the Ohio's best Rx program or a pharmacy 35378
assistance program established by any person or government entity, 35379
and for whom no third-party payer or program funded in whole or 35380
part with state or federal funds is responsible for all or part of 35381
the cost of the drug. 35382

Sec. ~~173.72~~ 5169.02. There is hereby established the Ohio's 35383
best Rx program for the purpose of providing outpatient 35384
prescription drug discounts to individuals residing in this state 35385
who are enrolled in the program by meeting the eligibility 35386
requirements specified in section ~~173.76~~ 5169.06 of the Revised 35387
Code, including eligible individuals who are sixty years of age or 35388
older, eligible individuals who have low incomes but are not 35389
eligible for medicaid, and other eligible individuals who do not 35390
have health benefits that cover outpatient drugs. The program 35391
shall include all drugs that are included in a manufacturer 35392
agreement entered into under section ~~173.81~~ 5169.11 of the Revised 35393
Code and all other drugs that may be dispensed only pursuant to a 35394
prescription issued by a licensed health professional authorized 35395
to prescribe drugs, as defined in section 4729.01 of the Revised 35396
Code. 35397

Sec. ~~173.721~~ 5169.021. (A) Except as provided in division (B) 35398
of this section, the Ohio's best Rx program shall be administered 35399
by the department of ~~aging~~ health care administration. 35400

(B)(1) The department may enter into a contract with any 35401
person under which the person serves as the administrator of the 35402
Ohio's best Rx program. Before entering into a contract for a 35403
program administrator, the department shall issue a request for 35404
proposals from persons seeking to be considered. The department 35405
shall develop a process to be used in issuing the request for 35406
proposals, receiving responses to the request, and evaluating the 35407

responses on a competitive basis. In accordance with that process, 35408
the department shall select the person to be awarded the contract. 35409

(2) Subject to divisions (B)(5) and (6) of this section, the 35410
department may delegate to the person awarded the contract any of 35411
the department's powers or duties specified in sections ~~173.71~~ 35412
5169.01 to ~~173.91~~ 5169.21 of the Revised Code or any other 35413
provision of the Revised Code pertaining to the Ohio's best Rx 35414
program. The terms of the contract shall specify the extent to 35415
which the powers or duties are delegated to the program 35416
administrator. 35417

(3) In exercising powers or performing duties delegated under 35418
the contract, the program administrator is subject to the same 35419
provisions of sections ~~173.71~~ 5169.01 to ~~173.91~~ 5169.21 of the 35420
Revised Code or other provisions of the Revised Code that grant 35421
the powers or duties to the department, as well as any limitations 35422
or restrictions that are applicable to or associated with those 35423
powers or duties. 35424

(4) Wherever the department is referred to in sections ~~173.71~~ 35425
5169.01 to ~~173.91~~ 5169.21 of the Revised Code or another provision 35426
of the Revised Code relative to a power or duty delegated to the 35427
program administrator, both of the following apply: 35428

(a) If the department has delegated the power or duty in 35429
whole to the program administrator, the reference to the 35430
department is, instead, a reference to the administrator. 35431

(b) If the department retains any part of the power or duty 35432
that is delegated to the program administrator, the reference to 35433
the department is a reference to both the department and the 35434
administrator. 35435

(5) The terms of a contract for a program administrator shall 35436
include provisions for offering the drug mail order system 35437
included in the Ohio's best Rx program pursuant to section ~~173.78~~ 35438

5169.08 of the Revised Code. The terms of the contract may permit 35439
the administrator to offer the drug mail order system by 35440
contracting with another person. 35441

(6) The department shall not delegate to a program 35442
administrator the department's powers or duties to do any of the 35443
following: 35444

(a) Enter into contracts under this section other than a 35445
contract to offer a drug mail order system; 35446

(b) Receive verification of drug pricing information under 35447
section ~~173.742~~ 5169.042 of the Revised Code or verification of 35448
drug manufacturer payment information under section ~~173.814~~ 35449
5169.114 of the Revised Code from the pharmacy benefit manager 35450
selected under section ~~173.731~~ 5169.031 of the Revised Code to 35451
serve as the Ohio's best Rx program's consulting pharmacy benefit 35452
manager; 35453

(c) Request the program's consulting pharmacy benefit manager 35454
to provide for an audit under section ~~173.732~~ 5169.032 of the 35455
Revised Code; 35456

(d) Review or use any information contained in or pertaining 35457
to an audit provided for by the program's consulting pharmacy 35458
benefit manager other than the audit's findings of whether the 35459
consulting pharmacy benefit manager provided valid information 35460
when providing drug pricing verification services or drug 35461
manufacturer payment verification services; 35462

(e) Adopt rules under section ~~173.83~~ 5169.13 or ~~173.84~~ 35463
5169.14 of the Revised Code; 35464

(f) Employ an ombudsperson pursuant to section ~~173.723~~ 35465
5169.023 of the Revised Code. 35466

Sec. ~~173.722~~ 5169.022. The department of ~~aging~~ health care 35467
administration shall undertake outreach efforts to publicize the 35468

Ohio's best Rx program and maximize participation in the program. 35469

Sec. ~~173.723~~ 5169.023. The department of ~~aging~~ health care 35470
administration shall employ an ombudsperson to assist terminal 35471
distributors of dangerous drugs with grievances regarding the 35472
Ohio's best Rx program. 35473

Sec. ~~173.724~~ 5169.024. The department of ~~aging~~ health care 35474
administration may coordinate the Ohio's best Rx program with 35475
either of the following: 35476

(A) ~~The~~ In cooperation with the department of aging, the 35477
golden buckeye card program established under section 173.06 of 35478
the Revised Code. In coordinating the programs, the ~~department~~ 35479
departments may establish a card that serves as both a golden 35480
buckeye card provided under section 173.06 of the Revised Code and 35481
an Ohio's best Rx program enrollment card issued under section 35482
~~173.773~~ 5169.073 of the Revised Code. The ~~department~~ departments 35483
may identify the card by including the names of both programs on 35484
the card or by selecting a combined name for inclusion on the 35485
card. 35486

(B) Any health benefit plan offered to the employees of state 35487
agencies and the eligible dependents of those employees, for 35488
purposes of enhancing efficiency, reducing the cost of drugs, and 35489
maximizing the benefits of the Ohio's best Rx program and the 35490
health benefit plan. 35491

Sec. ~~173.73~~ 5169.03. (A) Any entity that provides services as 35492
a pharmacy benefit manager relative to the outpatient drug 35493
coverage included in a health benefit plan offered to the 35494
employees or retirees of a state agency or political subdivision 35495
and the eligible dependents of those employees or retirees shall 35496
provide drug pricing verification services under section ~~173.742~~ 35497
5169.042 of the Revised Code and drug manufacturer payment 35498

verification services under section ~~173.814~~ 5169.114 of the 35499
Revised Code if the entity is selected under section ~~173.731~~ 35500
5169.031 of the Revised Code by the department of ~~aging~~ health 35501
care administration to serve as the Ohio's best Rx program's 35502
consulting pharmacy benefit manager for purposes of providing the 35503
verification services. 35504

(B) Both of the following apply to the entity selected to 35505
serve as the Ohio's best Rx program's consulting pharmacy benefit 35506
manager: 35507

(1) The entity shall provide the drug pricing verification 35508
services and drug manufacturer payment verification services 35509
without charge, either to the Ohio's best Rx program or to the 35510
state agency or political subdivision for which it provides 35511
services as a pharmacy benefit manager. 35512

(2) The entity shall provide the verification services for 35513
the entire year for which it is selected to serve as the program's 35514
consulting pharmacy benefit manager, regardless of the duration or 35515
termination of its responsibility to the state agency or political 35516
subdivision for which it provides services as a pharmacy benefit 35517
manager. 35518

(C) If the entity selected to serve as the consulting 35519
pharmacy benefit manager fails to provide the program with drug 35520
pricing verification services or drug manufacturer payment 35521
verification services, or fails to provide for an audit when 35522
requested to do so under section ~~173.732~~ 5169.032 of the Revised 35523
Code, the department may ask the attorney general to bring an 35524
action for injunctive relief in any court of competent 35525
jurisdiction. On the filing of an appropriate petition in the 35526
court, the court shall conduct a hearing on the petition. If it is 35527
demonstrated in the proceedings that the pharmacy benefit manager 35528
has failed to provide the verification services or has failed to 35529
provide for the audit, the court shall grant a temporary or 35530

permanent injunction enjoining the pharmacy benefit manager from 35531
continuing to fail to provide the verification services or from 35532
continuing to fail to provide for the audit. 35533

(D) This section does not impose any duty on the state agency 35534
or political subdivision for which an entity provides services as 35535
a pharmacy benefit manager. 35536

Sec. ~~173.731~~ 5169.031. Annually, the department of ~~aging~~ 35537
health care administration shall select a pharmacy benefit 35538
manager, from among the pharmacy benefit managers subject to 35539
section ~~173.73~~ 5169.03 of the Revised Code, to serve as the Ohio's 35540
best Rx program's consulting pharmacy benefit manager for purposes 35541
of providing drug pricing verification services under section 35542
~~173.742~~ 5169.042 of the Revised Code and drug manufacturer payment 35543
verification services under section ~~173.814~~ 5169.114 of the 35544
Revised Code. The department shall select the pharmacy benefit 35545
manager that the department considers to be the most appropriate 35546
pharmacy benefit manager to provide the verification services for 35547
the Ohio's best Rx program. In making the selection, the 35548
department shall consider the pharmacy benefit manager that 35549
provides services relative to the outpatient drug coverage 35550
included in the health benefit plan offered to the greatest number 35551
of employees or retirees of a state agency or political 35552
subdivision and the eligible dependents of those employees or 35553
retirees. 35554

The department shall provide written notice to the pharmacy 35555
benefit manager that it has been selected to serve as the Ohio's 35556
best Rx program's consulting pharmacy benefit manager. The notice 35557
shall specify the date on which the pharmacy benefit manager is to 35558
begin serving as the program's consulting pharmacy benefit manager 35559
for the ensuing year. 35560

Before the end of the one-year period during which a pharmacy 35561

benefit manager is to serve as the program's consulting pharmacy 35562
benefit manager, the department shall make another selection in 35563
accordance with this section. In making the selection, the 35564
department may select the same pharmacy benefit manager to serve 35565
as the program's consulting pharmacy benefit manager or may select 35566
another pharmacy benefit manager. 35567

Sec. ~~173.732~~ 5169.032. (A) To determine whether the pharmacy 35568
benefit manager selected under section ~~173.731~~ 5169.031 of the 35569
Revised Code to serve as the Ohio's best Rx program's consulting 35570
pharmacy benefit manager has provided valid information when 35571
providing drug pricing verification services under section ~~173.742~~ 35572
5169.042 of the Revised Code or drug manufacturer payment 35573
verification services under section ~~173.814~~ 5169.114 of the 35574
Revised Code, the department of ~~aging~~ health care administration 35575
may request that the consulting pharmacy benefit manager provide 35576
for an audit of its relevant contracts with drug manufacturers and 35577
terminal distributors of dangerous drugs. 35578

In making audit requests under this section, both of the 35579
following apply: 35580

(1) The department may request an audit on a regularly 35581
occurring basis, but not more frequently than once every three 35582
years. 35583

(2) The department may request an audit at any time it has a 35584
reasonable basis to believe that the consulting pharmacy benefit 35585
manager is not acting in good faith in providing drug pricing 35586
verification services or drug manufacturer payment verification 35587
services. Notice of the request shall be made in writing and 35588
signed by the director of ~~aging~~ health care administration. The 35589
notice may specify the basis for the belief that the consulting 35590
pharmacy benefit manager is not acting in good faith. If the basis 35591
for the belief is not specified and the audit findings demonstrate 35592

that the consulting pharmacy benefit manager acted in good faith, 35593
the department shall pay the cost incurred by the consulting 35594
pharmacy benefit manager in providing for the audit. 35595

(B) An audit provided for under this section shall be 35596
performed only by an auditor that is mutually satisfactory to the 35597
department and consulting pharmacy benefit manager and independent 35598
of both the department and consulting pharmacy benefit manager. 35599

(C) If the findings of an audit provided for under this 35600
section demonstrate that the verification services provided by the 35601
consulting pharmacy benefit manager did not result in valid 35602
information, the department shall use the audit findings for 35603
purposes of confirming the validity of the one or more drug 35604
pricing formulas designated under section ~~173.741~~ 5169.041 of the 35605
Revised Code and entering into agreements with drug manufacturers 35606
under section ~~173.81~~ 5169.11 of the Revised Code. 35607

Sec. ~~173.74~~ 5169.04. Annually, the department of ~~aging~~ health 35608
care administration shall establish a base price for each drug 35609
included in the Ohio's best Rx program. In the case of drugs 35610
dispensed by a terminal distributor of dangerous drugs that has 35611
entered into an agreement under section ~~173.79~~ 5169.09 of the 35612
Revised Code, the base price shall be established by using the one 35613
or more formulas designated under section ~~173.741~~ 5169.041 of the 35614
Revised Code. In the case of the drug mail order system included 35615
in the program pursuant to section ~~173.78~~ 5169.08 of the Revised 35616
Code, the base price shall be established in accordance with the 35617
rules adopted under section ~~173.83~~ 5169.13 of the Revised Code 35618
governing the drug mail order system. 35619

Sec. ~~173.741~~ 5169.041. Annually, the department of ~~aging~~ 35620
health care administration shall designate one or more formulas 35621
for use in establishing under section ~~173.74~~ 5169.04 of the 35622

Revised Code the Ohio's best Rx program's base price for drugs 35623
dispensed by a terminal distributor of dangerous drugs that has 35624
entered into an agreement under section ~~173.79~~ 5169.09 of the 35625
Revised Code. Each formula shall include a drug pricing discount 35626
component that is expressed as a percentage discount. The formula 35627
used for generic drugs may include the maximum allowable cost 35628
limits that apply to generic drugs under the medicaid program. 35629

In designating the one or more formulas, the department shall 35630
use the best information on drug pricing that is available to the 35631
department, including information obtained through the drug 35632
pricing verification services provided under section ~~173.742~~ 35633
5169.042 of the Revised Code by the Ohio's best Rx program's 35634
consulting pharmacy benefit manager selected under section ~~173.731~~ 35635
5169.031 of the Revised Code. Based on the available information, 35636
the department shall modify the one or more formulas as it 35637
considers appropriate to maximize the benefits provided to Ohio's 35638
best Rx program participants. 35639

Sec. ~~173.742~~ 5169.042. For purposes of section ~~173.741~~ 35640
5169.041 of the Revised Code, the department of ~~aging~~ health care 35641
administration shall obtain verification of drug pricing 35642
information from the Ohio's best Rx program's consulting pharmacy 35643
benefit manager selected under section ~~173.731~~ 5169.031 of the 35644
Revised Code. The information shall be obtained in accordance with 35645
the following procedures: 35646

(A) For brand name drugs, excluding generic drugs marketed 35647
under brand names, the department shall submit to the consulting 35648
pharmacy benefit manager the formula the department proposes to 35649
use to establish the program's base price for brand name drugs 35650
during the year. 35651

The consulting pharmacy benefit manager shall review the 35652
formula submitted by the department. In conducting the review, the 35653

consulting pharmacy benefit manager shall compare the drug pricing 35654
discount percentage included in the department's formula to the 35655
drug pricing discount percentage included in the formula most 35656
commonly used by the consulting pharmacy benefit manager to 35657
establish part of its payment rate for brand name drugs dispensed 35658
by terminal distributors of dangerous drugs other than drug mail 35659
order systems. If the formulas are not expressed in equivalent 35660
terms, the consulting pharmacy benefit manager shall make all 35661
accommodations necessary to make the comparison of the discount 35662
percentages. 35663

After conducting the review, the consulting pharmacy benefit 35664
manager shall provide information to the department verifying 35665
whether the discount percentage included in the department's 35666
formula is more than two percentage points below the discount 35667
percentage included in the formula used by the consulting pharmacy 35668
benefit manager. The information provided to the department shall 35669
be certified by signature of an officer of the consulting pharmacy 35670
benefit manager. 35671

(B) For generic drugs, the department shall identify the 35672
fifty generic drugs most frequently purchased by Ohio's best Rx 35673
program participants in the immediately preceding year from 35674
terminal distributors of dangerous drugs other than the drug mail 35675
order system included in the program pursuant to section ~~173.78~~ 35676
5169.08 of the Revised Code. The department shall submit to the 35677
consulting pharmacy benefit manager the names of the fifty drugs, 35678
the number of prescriptions filled for each of the drugs, the 35679
formula used to compute the base price for the drugs during the 35680
year, and the weighted average base price for the drugs that 35681
resulted for the year. 35682

The consulting pharmacy benefit manager shall review the 35683
submitted information. In conducting the review, the consulting 35684
pharmacy benefit manager shall compare the department's weighted 35685

average base price to the equivalent part of the consulting 35686
pharmacy benefit manager's weighted average payment rate for the 35687
same drugs when dispensed by terminal distributors of dangerous 35688
drugs other than drug mail order systems. For purposes of the 35689
comparison, the department and consulting pharmacy benefit manager 35690
shall express the weighted average base price and payment rate in 35691
terms of a discount percentage that is taken from the drugs' 35692
average wholesale price, as identified by a national drug price 35693
reporting service selected by the department and the consulting 35694
pharmacy benefit manager. 35695

After conducting the review, the consulting pharmacy benefit 35696
manager shall provide information to the department verifying 35697
whether the discount percentage reflected in the department's 35698
weighted average base price for the drugs is more than two 35699
percentage points below the equivalent part of the consulting 35700
pharmacy benefit manager's weighted average payment rate for the 35701
same drugs. The information provided to the department shall be 35702
certified by signature of an officer of the consulting pharmacy 35703
benefit manager. 35704

Sec. ~~173.75~~ 5169.05. (A) Subject to division (B) of this 35705
section, the amount that an Ohio's best Rx program participant is 35706
to be charged for a quantity of a drug purchased under the program 35707
shall be established in accordance with all of the following: 35708

(1) If the drug is not included in a manufacturer agreement 35709
entered into under section ~~173.81~~ 5169.11 of the Revised Code, the 35710
participant shall be charged an amount that is computed according 35711
to the drug's base price established under section ~~173.74~~ 5169.04 35712
of the Revised Code. 35713

(2) If the drug is included in a manufacturer agreement 35714
entered into under section ~~173.81~~ 5169.11 of the Revised Code, the 35715
participant shall be charged an amount that is computed by 35716

subtracting from the drug's base price established under section 35717
~~173.74~~ 5169.04 of the Revised Code the amount of the manufacturer 35718
payment that applies to the transaction, as established under 35719
section ~~173.812~~ 5169.112 of the Revised Code. 35720

(3) If an administrative fee is specified in rules adopted 35721
under section ~~173.83~~ 5169.13 of the Revised Code, the participant 35722
shall be charged the amount of the administrative fee. 35723

(4) If the drug is dispensed by a terminal distributor of 35724
dangerous drugs under an agreement entered into under section 35725
~~173.79~~ 5169.09 of the Revised Code, and the terminal distributor 35726
charges a professional fee pursuant to the agreement, the 35727
participant shall be charged the amount of the professional fee. 35728

(5) If the drug is dispensed through the drug mail order 35729
system included in the program pursuant to section ~~173.78~~ 5169.08 35730
of the Revised Code, the participant shall not be charged a 35731
professional fee. 35732

(B) When a quantity of a drug is purchased by an Ohio's best 35733
Rx program participant, the participating terminal distributor or 35734
drug mail order system dispensing the drug shall charge the lesser 35735
of the amount that applies to the transaction, as established in 35736
accordance with division (A) of this section, or the usual and 35737
customary charge that otherwise would apply to the transaction. 35738
When a drug is purchased at the usual and customary charge 35739
pursuant to this division, the transaction is not subject to 35740
sections ~~173.71~~ 5169.01 to ~~173.91~~ 5169.21 of the Revised Code as 35741
the purchase or dispensing of a drug under the program. 35742

Sec. ~~173.751~~ 5169.051. The department of ~~aging~~ health care 35743
administration shall report the following to each participating 35744
terminal distributor and the drug mail order system included in 35745
the Ohio's best Rx program pursuant to section ~~173.78~~ 5169.08 of 35746
the Revised Code in a manner enabling the distributor and system 35747

to comply with section ~~173.75~~ 5169.05 of the Revised Code: 35748

(A) For each drug included in the program, the amount to be 35749
charged under division (A)(1) or (2) of section ~~173.75~~ 5169.05 of 35750
the Revised Code; 35751

(B) The administrative fee, if any, specified by the 35752
department in rules adopted under section ~~173.83~~ 5169.13 of the 35753
Revised Code. 35754

Sec. ~~173.752~~ 5169.052. The amount that an Ohio's best Rx 35755
program participant saves when a drug is purchased under the 35756
program shall be determined by subtracting the amount that the 35757
participant is charged in accordance with division (A) of section 35758
~~173.75~~ 5169.05 of the Revised Code from the usual and customary 35759
charge that otherwise would apply to the transaction. 35760

Sec. ~~173.753~~ 5169.053. Not later than the first day of March 35761
of each year, the department of ~~aging~~ health care administration 35762
shall do all of the following: 35763

(A) Create a list of the twenty-five drugs most often 35764
dispensed to Ohio's best Rx program participants under the 35765
program, using data from the most recent six-month period for 35766
which the data is available; 35767

(B) Determine the average amount that participants are 35768
charged under the program, on a date selected by the department, 35769
for each drug included on the list created under division (A) of 35770
this section; 35771

(C) Determine, for the date selected for division (B) of this 35772
section, the average usual and customary charge for each drug 35773
included on the list created under division (A) of this section; 35774

(D) By comparing the average charges determined under 35775
divisions (B) and (C) of this section, determine the average 35776

percentage savings Ohio's best Rx program participants receive for 35777
each drug included on the list created under division (A) of this 35778
section. 35779

Sec. ~~173.76~~ 5169.06. (A) To be eligible for the Ohio's best 35780
Rx program, an individual must meet all of the following 35781
requirements at the time of application for the program: 35782

(1) The individual must be a resident of this state. 35783

(2) One of the following must be the case: 35784

(a) The individual has family income, as determined under 35785
rules adopted pursuant to section ~~173.83~~ 5169.13 of the Revised 35786
Code, that does not exceed three hundred per cent of the federal 35787
poverty guidelines, as revised annually by the United States 35788
department of health and human services in accordance with section 35789
673(2) of the "Omnibus Budget Reconciliation Act of 1981," 95 35790
Stat. 511, 42 U.S.C. 9902, as amended; 35791

(b) The individual is sixty years of age or older; 35792

(c) The individual is a person with a disability, as defined 35793
in section 173.06 of the Revised Code. 35794

(3) Except as provided in division (B) of this section, the 35795
individual must not have coverage for outpatient drugs paid for in 35796
whole or in part by any of the following: 35797

(a) A third-party payer, including an employer; 35798

(b) The medicaid program; 35799

(c) The children's health insurance program; 35800

(d) The disability medical assistance program; 35801

(e) Another health plan or pharmacy assistance program that 35802
uses state or federal funds to pay part or all of the cost of the 35803
individual's outpatient drugs. 35804

(4) The individual must not have had coverage for outpatient 35805
drugs paid for by any of the entities or programs specified in 35806
division (A)(3) of this section during any of the four months 35807
preceding the month in which the application for the Ohio's best 35808
Rx program is made, unless any of the following applies: 35809

(a) The individual is sixty years of age or older. 35810

(b) The third-party payer, including an employer, that paid 35811
for the coverage filed for bankruptcy under federal bankruptcy 35812
laws. 35813

(c) The individual is no longer eligible for coverage 35814
provided through a retirement plan subject to protection under the 35815
"Employee Retirement Income Security Act of 1974," 88 Stat. 832, 35816
29 U.S.C. 1001, as amended. 35817

(d) The individual is no longer eligible for the medicaid 35818
program, children's health insurance program, or disability 35819
medical assistance program. 35820

(e) The individual is either temporarily or permanently 35821
discharged from employment due to a business reorganization. 35822

(B) An individual is not subject to division (A)(3) of this 35823
section if the individual has coverage for outpatient drugs paid 35824
for in whole or in part by either of the following: 35825

(1) The workers' compensation program; 35826

(2) A medicare prescription drug plan offered pursuant to the 35827
"Medicare Prescription Drug, Improvement, and Modernization Act of 35828
2003," 117 Stat. 2071, 42 U.S.C. 1395w-101, as amended, but only 35829
if all of the following are the case with respect to the 35830
particular drug being purchased through the Ohio's best Rx 35831
program: 35832

(a) The individual is responsible for the full cost of the 35833
drug. 35834

(b) The drug is not subject to a rebate from the manufacturer 35835
under the individual's medicare prescription drug plan. 35836

(c) The manufacturer of the drug has agreed to the Ohio's 35837
best Rx program's inclusion of individuals who have coverage 35838
through a medicare prescription drug plan. 35839

Sec. ~~173.77~~ 5169.07. Application for participation in the 35840
Ohio's best Rx program shall be made in accordance with rules 35841
adopted by the department of ~~aging~~ health care administration 35842
under section ~~173.83~~ 5169.13 of the Revised Code. When applying 35843
for participation, an individual may include application for 35844
participation by the individual's spouse and children. An 35845
individual's guardian or custodian may apply on behalf of the 35846
individual. 35847

When submitting an application, the applicant shall include 35848
the information and documentation specified in the department's 35849
rules as necessary to verify eligibility for the program. The 35850
application may be submitted on a paper form prescribed and 35851
supplied by the department or pursuant to any other application 35852
method the department makes available for the program, including 35853
methods that permit an individual to apply by telephone or through 35854
the internet. 35855

An applicant shall attest that the information and 35856
documentation the applicant submits with an application is 35857
accurate to the best knowledge and belief of the applicant. In the 35858
case of a paper application form, the applicant's signature shall 35859
be used to certify that the applicant has attested to the accuracy 35860
of the information and documentation. In the case of other 35861
application methods, the application certification process 35862
specified in the department's rules shall be used to certify that 35863
the applicant has attested to the accuracy of the information and 35864
documentation. 35865

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 35896
apply through the internet, the department may issue the 35897
enrollment card by sending the applicant an electronic version of 35898
the card in a printable format. 35899

(B) Each time a drug is purchased under the program, the 35900
entity dispensing the drug shall confirm whether the individual 35901
for whom the drug is dispensed is enrolled in the program. If the 35902
drug is being purchased from a participating terminal distributor 35903
rather than the drug mail order system included in the program 35904
pursuant to section ~~173.78~~ 5169.08 of the Revised Code, and the 35905
individual's enrollment card is available for presentation at the 35906
time of the purchase, the purchaser shall present the card to the 35907
participating terminal distributor as confirmation of the 35908
individual's enrollment in the program. If the drug is being 35909
purchased through the drug mail order system and the individual's 35910
program identification number is available, the purchaser shall 35911
present the identification number as confirmation of enrollment. 35912
Otherwise, the terminal distributor or mail order system shall 35913
confirm the individual's enrollment through the department. The 35914
department shall establish the methods to be used in confirming 35915
enrollment through the department, including confirmation by 35916
telephone, through the internet, or by any other electronic means. 35917

(C) Purchasing a drug under the program by using an 35918
enrollment card or any other method shall serve as an attestation 35919
by the participant for whom the drug is dispensed that the 35920
participant meets the eligibility requirements specified in 35921
division (A)(3) of section ~~173.76~~ 5169.06 of the Revised Code 35922
regarding not having coverage for outpatient drugs. 35923

Sec. ~~173.78~~ 5169.08. (A) For purposes of making drugs 35924
included in the Ohio's best Rx program available to participants 35925
by mail, the department of ~~aging~~ health care administration shall 35926

include a drug mail order system within the program. Not more than 35927
one drug mail order system shall be included in the program. 35928
Subject to division (B) of this section, the program's drug mail 35929
order system shall be provided in accordance with rules adopted 35930
under section ~~173.83~~ 5169.13 of the Revised Code. 35931

(B) Neither the department nor the drug mail order system 35932
shall promote the purchase of drugs through the system by using 35933
information collected under the program regarding the drugs 35934
purchased by participants from participating terminal 35935
distributors. This division does not preclude the use of the 35936
information for purposes of limiting the amount that a participant 35937
may be charged for a quantity of a drug purchased through the drug 35938
mail order system to an amount that is not more than the amount 35939
that would be charged if the same quantity of the drug were 35940
purchased from a participating terminal distributor. 35941

Sec. ~~173.79~~ 5169.09. (A) For purposes of making drugs 35942
included in the Ohio's best Rx program available to participants 35943
from terminal distributors of dangerous drugs other than the drug 35944
mail order system included in the program pursuant to section 35945
~~173.78~~ 5169.08 of the Revised Code, the department of ~~aging~~ health 35946
care administration shall enter into agreements under this section 35947
with terminal distributors of dangerous drugs. Any terminal 35948
distributor of dangerous drugs may enter into an agreement with 35949
the department to participate in the program pursuant to this 35950
section. 35951

Before entering into an agreement with a terminal 35952
distributor, the department shall provide the terminal distributor 35953
with one of the following: 35954

(1) A formula that allows the terminal distributor to 35955
calculate for each drug included in the program the amount to be 35956
charged under division (A)(1) or (2) of section ~~173.75~~ 5169.05 of 35957

the Revised Code by participating terminal distributors. 35958

(2) A statistically valid sampling of drug prices that 35959
includes the amount to be charged under division (A)(1) or (2) of 35960
section ~~173.75~~ 5169.05 of the Revised Code by participating 35961
terminal distributors for not fewer than two brand name drugs and 35962
two generic drugs from each category of drugs included in the 35963
program. 35964

(3) The current amount to be charged under division (A)(1) or 35965
(2) of section ~~173.75~~ 5169.05 of the Revised Code by participating 35966
terminal distributors for each drug included in the program. 35967

(B) An agreement entered into under this section shall do all 35968
of the following: 35969

(1) Except as provided in division (B)(3) of this section, be 35970
in effect for not less than one year; 35971

(2) Specify the dates that the agreement is to begin and end; 35972

(3) Permit the terminal distributor to terminate the 35973
agreement before the date the agreement would otherwise end as 35974
specified pursuant to division (B)(2) of this section by providing 35975
the department notice of early termination at least thirty days 35976
before the effective date of the early termination; 35977

(4) Require that the terminal distributor comply with section 35978
~~173.75~~ 5169.05 of the Revised Code when charging for a drug 35979
purchased under the program; 35980

(5) Permit the terminal distributor to add to the amount to 35981
be charged under division (A)(1) or (2) of section ~~173.75~~ 5169.05 35982
of the Revised Code a professional fee in an amount not to exceed, 35983
except as provided in rules adopted under section ~~173.83~~ 5169.13 35984
of the Revised Code, three dollars; 35985

(6) Require the terminal distributor to disclose to each 35986
participant the amount the participant saves under the program as 35987

determined in accordance with section ~~173.752~~ 5169.052 of the Revised Code; 35988
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(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; 35990
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(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. 35993
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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. 35998
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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. 36004
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The claim shall specify all of the following: 36013

(A) The prescription number of the participant's prescription under which the drug was dispensed to the participant; 36014
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(B) The name of, and national drug code number for, the drug dispensed to the participant; 36016
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(C) The number of units of the drug dispensed to the participant; 36018
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(D) The amount the participant was charged for the drug; 36020

(E) The date the drug was dispensed to the participant; 36021

(F) Any additional information required by rules adopted under section ~~173.83~~ 5169.13 of the Revised Code. 36022
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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. 36024
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(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: 36037
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(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; 36040
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(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 36045
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drug was dispensed, subtract from the amount computed under 36048
division (B)(1) of this section the administrative fee amount 36049
specified in those rules. 36050

(C) The department may combine the claims submitted by a 36051
participating terminal distributor or the program's drug mail 36052
order system to make aggregate payments under this section to the 36053
distributor or system. 36054

(D) If the total of the amounts computed under division (B) 36055
of this section for any period for which payments are due is a 36056
negative number, the participating terminal distributor or the 36057
program's drug mail order system that submitted the claims has 36058
been overpaid for the claims. When there is an overpayment, the 36059
department shall reduce future payments made under this section to 36060
the distributor or system or collect an amount from the 36061
distributor or system sufficient to reimburse the department for 36062
the overpayment. 36063

Sec. ~~173.802~~ 5169.102. Neither a participating terminal 36064
distributor nor the drug mail order system included in the Ohio's 36065
best Rx program pursuant to section ~~173.78~~ 5169.08 of the Revised 36066
Code may be charged by the department of ~~aging health care~~ 36067
administration for the submission of a claim under section ~~173.80~~ 36068
5169.10 of the Revised Code or the processing of a claim under 36069
section ~~173.801~~ 5169.101 of the Revised Code. 36070

Sec. ~~173.803~~ 5169.103. The department of ~~aging health care~~ 36071
administration may not make a payment under section ~~173.801~~ 36072
5169.101 of the Revised Code for a claim submitted under section 36073
~~173.80~~ 5169.10 of the Revised Code if any of the following are the 36074
case: 36075

(A) The claim is submitted by either a terminal distributor 36076
of dangerous drugs that is not a participating terminal 36077

distributor or a drug mail order system that is not the system 36078
included in the Ohio's best Rx program pursuant to section ~~173.78~~ 36079
5169.08 of the Revised Code. 36080

(B) The claim is for a drug that is not included in the 36081
program. 36082

(C) The claim is for a drug included in the program but the 36083
drug is dispensed to an individual who is not covered by an Ohio's 36084
best Rx program enrollment card. 36085

(D) A person or government entity has paid the participating 36086
terminal distributor or the program's drug mail order system 36087
through any other prescription drug coverage program or 36088
prescription drug discount program for dispensing the drug, unless 36089
the payment is reimbursement for redeeming a coupon or is an 36090
amount directly paid by a drug manufacturer to the distributor or 36091
system for dispensing drugs to residents of a long-term care 36092
facility. 36093

Sec. ~~173.81~~ 5169.11. For purposes of participating in the 36094
Ohio's best Rx program, any drug manufacturer may enter into an 36095
agreement with the department of ~~aging~~ health care administration 36096
under which the manufacturer agrees to make payments to the 36097
department with respect to one or more of the manufacturer's drugs 36098
when the one or more drugs are dispensed under the program. The 36099
terms of the agreement shall comply with section ~~173.811~~ 5169.111 36100
of the Revised Code. 36101

Sec. ~~173.811~~ 5169.111. (A) A manufacturer agreement entered 36102
into under section ~~173.81~~ 5169.11 of the Revised Code by a drug 36103
manufacturer and the department of ~~aging~~ health care 36104
administration shall include terms that do all of the following: 36105

(1) Specify the time the agreement is to be in effect, which 36106
shall be not less than one year from the date the agreement is 36107

entered into; 36108

(2) Specify which of the manufacturer's drugs are included in 36109
the agreement; 36110

(3) Permit the department to remove a drug from the agreement 36111
in the event of a dispute over the drug's utilization; 36112

(4) Require that the manufacturer specify a per unit amount 36113
that will be paid to the department for each drug included in the 36114
agreement that is dispensed to an Ohio's best Rx program 36115
participant; 36116

(5) Require that the per unit amount specified by the 36117
manufacturer be an amount that the manufacturer believes is 36118
greater than or comparable to the per unit amount generally 36119
payable by the manufacturer for the same drug when the drug is 36120
dispensed to an individual using the outpatient drug coverage 36121
included in a health benefit plan offered in this state or another 36122
state to public employees or retirees and the eligible dependents 36123
of those employees or retirees; 36124

(6) Require the manufacturer to make payments in accordance 36125
with the amounts computed under division (A) of section ~~173.812~~ 36126
5169.112 of the Revised Code; 36127

(7) Require that the manufacturer make the payments on a 36128
quarterly basis or in accordance with a schedule established by 36129
rules adopted under section ~~173.83~~ 5169.13 of the Revised Code. 36130

(B) For any drug included in a manufacturer agreement, the 36131
terms of the agreement may provide for the establishment of a 36132
process for referring Ohio's best Rx program applicants and 36133
participants to a patient assistance program operated or sponsored 36134
by the manufacturer. The referral process may be included only if 36135
the manufacturer agrees to refer to the Ohio's best Rx program 36136
residents of this state who apply but are found to be ineligible 36137
for the patient assistance program. 36138

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 36168
manufacturer proposing to enter into an agreement under section 36169
~~173.81~~ 5169.11 of the Revised Code, the department of ~~aging~~ health 36170
care administration shall use the best information on manufacturer 36171
payments that is available to the department, including 36172
information obtained from the verifications made under section 36173
~~173.814~~ 5169.114 of the Revised Code by the Ohio's best Rx 36174
program's consulting pharmacy benefit manager selected under 36175
section ~~173.731~~ 5169.031 of the Revised Code. The department shall 36176
use the information in an attempt to obtain manufacturer payments 36177
that maximize the benefits provided to Ohio's best Rx program 36178
participants. 36179

Sec. ~~173.814~~ 5169.114. Annually, the department of ~~aging~~ 36180
health care administration shall select a sample of not more than 36181
ten of the drugs that were included in the manufacturer agreements 36182
entered into under section ~~173.81~~ 5169.11 of the Revised Code in 36183
the immediately preceding year. The department shall submit to the 36184
program's consulting pharmacy benefit manager selected under 36185
section ~~173.731~~ 5169.031 of the Revised Code information that 36186
identifies the per unit amount of the manufacturer payments that 36187
applied to each of the drugs in the sample. 36188

The consulting pharmacy benefit manager shall review the 36189
submitted information. After the review, the consulting pharmacy 36190
benefit manager shall provide information to the department 36191
verifying whether any of the per unit payment amounts that applied 36192
to the selected drugs were more than two per cent lower than the 36193
per unit payment amounts negotiated by the consulting pharmacy 36194
benefit manager for the same drugs in connection with health 36195
benefit plans that generally do not use formularies to restrict 36196
the outpatient drug coverage included in the plans. The consulting 36197
pharmacy benefit manager shall specify which, if any, of the drugs 36198

in the sample were subject to the lower per unit payment amounts. 36199
The information provided to the department shall be certified by 36200
signature of an officer of the consulting pharmacy benefit 36201
manager. 36202

Sec. ~~173.815~~ 5169.115. (A) The department of ~~aging~~ health 36203
care administration shall seek from the centers for medicare and 36204
medicaid services of the United States department of health and 36205
human services written confirmation that manufacturer payments 36206
made pursuant to an agreement entered into under section ~~173.81~~ 36207
5169.11 of the Revised Code are exempt from the medicaid best 36208
price computation applicable under Title XIX of the "Social 36209
Security Act," 79 Stat. 286 (1965), 42 U.S.C. 1396r-8, as amended. 36210
36211

(B) Entering into a manufacturer agreement under section 36212
~~173.81~~ 5169.11 of the Revised Code does not require a drug 36213
manufacturer to make a manufacturer payment that would establish 36214
the manufacturer's medicaid best price for a drug. 36215

Sec. ~~173.82~~ 5169.12. A drug manufacturer that enters into an 36216
agreement under section ~~173.81~~ 5169.11 of the Revised Code may 36217
submit a request to the department of ~~aging~~ health care 36218
administration to audit claims submitted under section ~~173.80~~ 36219
5169.10 of the Revised Code. On submission of a request that the 36220
department considers reasonable, the department shall permit the 36221
manufacturer to audit the claims. 36222

Sec. ~~173.83~~ 5169.13. The department of ~~aging~~ health care 36223
administration shall adopt rules in accordance with Chapter 119. 36224
of the Revised Code to implement the Ohio's best Rx program. The 36225
rules shall provide for all of the following: 36226

(A) Standards and procedures for establishing, pursuant to 36227
section ~~173.74~~ 5169.04 of the Revised Code, the base price for 36228

each drug included in the program;	36229
(B) Determination of family income for the purpose of	36230
division (A)(2)(a) of section 173.76 <u>5169.06</u> of the Revised Code;	36231
(C) For the purpose of section 173.77 <u>5169.07</u> of the Revised	36232
Code, the application process for the program, including the	36233
information and documentation to be submitted with applications to	36234
verify eligibility and a process to be used in certifying that an	36235
applicant has attested to the accuracy of the submitted	36236
information and documentation;	36237
(D) The method of providing information about the medicaid	36238
program to applicants under section 173.771 <u>5169.071</u> of the	36239
Revised Code;	36240
(E) For the purpose of section 173.772 <u>5169.072</u> of the	36241
Revised Code, eligibility determination procedures;	36242
(F) Standards and procedures governing the drug mail order	36243
system included in the program pursuant to section 173.78 <u>5169.08</u>	36244
of the Revised Code;	36245
(G) Subject to section 173.831 <u>5169.131</u> of the Revised Code,	36246
periodically increasing the maximum professional fee that	36247
participating terminal distributors may charge Ohio's best Rx	36248
program participants pursuant to an agreement entered into under	36249
section 173.79 <u>5169.09</u> of the Revised Code;	36250
(H) Subject to section 173.832 <u>5169.132</u> of the Revised Code,	36251
the amount of the administrative fee, if any, that Ohio's best Rx	36252
program participants are to be charged under the program;	36253
(I) The electronic method for submission of claims to the	36254
department under section 173.80 <u>5169.10</u> of the Revised Code;	36255
(J) Additional information to be included on claims submitted	36256
under section 173.80 <u>5169.10</u> of the Revised Code that the	36257
department determines is necessary for the department to be able	36258

to make payments under section ~~173.801~~ 5169.101 of the Revised Code; 36259
36260

(K) The method for making payments under section ~~173.801~~ 5169.101 of the Revised Code; 36261
36262

(L) Subject to section ~~173.833~~ 5169.133 of the Revised Code, the percentage, if any, that is the program administration percentage; 36263
36264
36265

(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; 36266
36267
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36270

(N) Procedures for making computations under sections ~~173.75~~ 5169.05 and ~~173.812~~ 5169.112 of the Revised Code; 36271
36272

(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; 36273
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(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. 36276
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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. 36279
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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 36282
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discretion, at more frequent intervals. The department shall not 36289
increase the professional fee to an amount exceeding the medicaid 36290
dispensing fee. 36291

A participating terminal distributor may charge a maximum 36292
three dollar professional fee regardless of whether the medicaid 36293
dispensing fee for that drug is less than that amount. The 36294
department, however, may not adopt a rule increasing the maximum 36295
professional fee for that drug until the medicaid dispensing fee 36296
for that drug exceeds that amount. 36297

Sec. ~~173.832~~ 5169.132. (A) Once a year or, at the discretion 36298
of the department of ~~aging~~ health care administration, at more 36299
frequent intervals, the department shall determine the amount, if 36300
any, that each Ohio's best Rx program participant will be charged 36301
as an administrative fee to be used in paying the administrative 36302
costs of the program. The fee, which shall not exceed one dollar 36303
per transaction, shall be specified in rules adopted under section 36304
~~173.83~~ 5169.13 of the Revised Code. In adopting the rules, the 36305
department shall specify a fee that results in an amount that 36306
equals or is less than the amount needed to cover the 36307
administrative costs of the Ohio's best Rx program when added to 36308
the sum of the following: 36309

(1) The amount resulting from the program administration 36310
percentage, if the department determines a program administration 36311
percentage in rules adopted under section ~~173.83~~ 5169.13 of the 36312
Revised Code; 36313

(2) The investment earnings of the Ohio's best Rx program 36314
fund created by section ~~173.85~~ 5169.15 of the Revised Code; 36315

(3) Any amounts accepted by the department as donations to 36316
the Ohio's best Rx program fund. 36317

(B) Once a year or, at the discretion of the department, at 36318

more frequent intervals, the department shall report the 36319
methodology underlying the determination of the administrative fee 36320
to the Ohio's best Rx program council. 36321

Sec. ~~173.833~~ 5169.133. (A) At least once a year or, at the 36322
discretion of the department of ~~aging~~ health care administration, 36323
at more frequent intervals, the department shall determine the 36324
percentage, if any, of each manufacturer payment made under an 36325
agreement entered into under section ~~173.81~~ 5169.11 of the Revised 36326
Code that will be retained by the department for use in paying the 36327
administrative costs of the Ohio's best Rx program. The 36328
percentage, which shall not exceed five per cent, shall be 36329
specified in rules adopted under section ~~173.83~~ 5169.13 of the 36330
Revised Code. In adopting the rules, the department shall specify 36331
a percentage that results in an amount that equals or is less than 36332
the amount needed to cover the administrative costs of the Ohio's 36333
best Rx program when added to the sum of the following: 36334

(1) The amount resulting from administrative fees, if the 36335
department determines an administrative fee in rules adopted under 36336
section ~~173.83~~ 5169.13 of the Revised Code; 36337

(2) The investment earnings of the Ohio's best Rx program 36338
fund created by section ~~173.85~~ 5169.15 of the Revised Code; 36339

(3) Any amounts accepted by the department as donations to 36340
the Ohio's best Rx program fund. 36341

(B) Once a year or, at the discretion of the department, at 36342
more frequent intervals, the department shall report the 36343
methodology underlying the determination of the program 36344
administration percentage to the Ohio's best Rx program council. 36345

Sec. ~~173.84~~ 5169.14. Notwithstanding any conflicting 36346
provision of sections ~~173.71~~ 5169.01 to ~~173.91~~ 5169.21 of the 36347
Revised Code, the department of ~~aging~~ health care administration 36348

may adopt rules in accordance with Chapter 119. of the Revised 36349
Code to make adjustments to the Ohio's best Rx program that the 36350
department considers appropriate to conform the program to, or 36351
coordinate it with, any federally funded prescription drug program 36352
created after October 1, 2003. 36353

Sec. ~~173.85~~ 5169.15. (A) The Ohio's best Rx program fund is 36354
hereby created. The fund shall be in the custody of the treasurer 36355
of state, but shall not be part of the state treasury. The fund 36356
shall consist of the following: 36357

(1) Manufacturer payments made by participating manufacturers 36358
pursuant to agreements entered into under section ~~173.81~~ 5169.11 36359
of the Revised Code; 36360

(2) Administrative fees, if an administrative fee is 36361
determined by the department of ~~aging~~ health care administration 36362
in rules adopted under section ~~173.83~~ 5169.13 of the Revised Code; 36363

(3) Any amounts donated to the fund and accepted by the 36364
department; 36365

(4) The fund's investment earnings. 36366

(B) Money in the Ohio's best Rx program fund shall be used to 36367
make payments under section ~~173.801~~ 5169.101 of the Revised Code 36368
and to make transfers to the Ohio's best Rx administration fund in 36369
accordance with section ~~173.86~~ 5169.16 of the Revised Code. 36370

Sec. ~~173.86~~ 5169.16. (A) The Ohio's best Rx administration 36371
fund is hereby created in the state treasury. The treasurer of 36372
state shall transfer from the Ohio's best Rx program fund to the 36373
Ohio's best Rx administration fund amounts equal to the following: 36374

(1) Amounts resulting from application of the program 36375
administration percentage, if a program administration percentage 36376
is determined by the department of ~~aging~~ health care 36377

administration in rules adopted under section ~~173.83~~ 5169.13 of 36378
the Revised Code; 36379

(2) The amount of the administrative fees charged Ohio's best 36380
Rx participants, if an administrative fee is determined by the 36381
department of ~~aging~~ health care administration in rules adopted 36382
under section ~~173.83~~ 5169.13 of the Revised Code; 36383

(3) The amount of any donations credited to the Ohio's best 36384
Rx program fund; 36385

(4) The amount of investment earnings credited to the Ohio's 36386
best Rx program fund. 36387

The treasurer of state shall make the transfers in accordance 36388
with a schedule developed by the treasurer of state and the 36389
department of ~~aging~~ health care administration. 36390

(B) The department of ~~aging~~ health care administration shall 36391
use money in the Ohio's best Rx administration fund to pay the 36392
administrative costs of the Ohio's best Rx program, including, but 36393
not limited to, costs associated with contracted services, staff, 36394
outreach activities, computers and network services, and the 36395
Ohio's best Rx program council. If the fund includes an amount 36396
that exceeds the amount necessary to pay the administrative costs 36397
of the program, the department may use the excess amount to pay 36398
the cost of subsidies provided to Ohio's best Rx program 36399
participants under any subsidy program established pursuant to 36400
section ~~173.861~~ 5169.161 of the Revised Code. 36401

Sec. ~~173.861~~ 5169.161. The department of ~~aging~~ health care 36402
administration may establish a component of the Ohio's best Rx 36403
program under which subsidies are provided to participants to 36404
assist them with the cost of purchasing drugs under the program, 36405
including the cost of any professional fees charged for dispensing 36406
the drugs. The subsidies shall be provided only when the Ohio's 36407

best Rx administration fund created under section ~~173.86~~ 5169.16 36408
of the Revised Code includes an amount that exceeds the amount 36409
necessary to pay the administrative costs of the program. 36410

Sec. ~~173.87~~ 5169.17. There is hereby created the Ohio's best 36411
Rx program council. The council shall advise the department of 36412
~~aging~~ health care administration on the Ohio's best Rx program. 36413
With the approval of a majority of the council's appointed 36414
members, the council may initiate studies to determine whether 36415
there are more effective ways to administer the program and 36416
provide the department with suggestions for improvements. 36417

Sec. ~~173.871~~ 5169.171. The Ohio's best Rx program council 36418
shall consist of the following members: 36419

(A) The president of the senate; 36420

(B) The speaker of the house of representatives; 36421

(C) The minority leader of the senate; 36422

(D) The minority leader of the house of representatives; 36423

(E) A representative of the Ohio chapter of the American 36424
federation of labor-congress of industrial organizations, 36425
appointed by the governor from a list of names submitted to the 36426
governor by that organization; 36427

(F) A representative of the Ohio chapter of the American 36428
association of retired persons, appointed by the governor from a 36429
list of names submitted to the governor by that organization; 36430

(G) A representative of a disability advocacy organization 36431
located in the state of Ohio, appointed by the governor from a 36432
list of names submitted to the governor by disability advocacy 36433
organizations located in the state of Ohio; 36434

(H) A representative of the Ohio chapter of the united way, 36435
appointed by the governor from a list of names submitted to the 36436

governor by that organization; 36437

(I) A representative of the Ohio alliance of retired 36438
Americans, appointed by the governor from a list of names 36439
submitted to the governor by that organization; 36440

(J) Three representatives of research-based drug 36441
manufacturers, appointed by the governor from a list of names 36442
submitted to the governor by the pharmaceutical research and 36443
manufacturers of America; 36444

(K) A pharmacist licensed under Chapter 4729. of the Revised 36445
Code, appointed by the governor from a list of names submitted to 36446
the governor by the Ohio pharmacists association. 36447

Sec. ~~173.872~~ 5169.172. The governor shall make initial 36448
appointments to the Ohio's best Rx program council not later than 36449
thirty days after December 18, 2003. The members appointed by the 36450
governor shall serve at the pleasure of the governor. If an 36451
appointed member's seat becomes vacant, the governor shall fill 36452
the vacancy not later than thirty days after the vacancy occurs 36453
and in the manner provided for the initial appointment. 36454

Sec. ~~173.873~~ 5169.173. The president of the senate and 36455
speaker of the house of representatives shall serve as co-chairs 36456
of the Ohio's best Rx program council. 36457

The president of the senate, the minority leader of the 36458
senate, the speaker of the house of representatives, and the 36459
minority leader of the house of representatives may each appoint a 36460
member of the general assembly to attend any meeting of the Ohio's 36461
best Rx program council on behalf of the president of the senate, 36462
the minority leader of the senate, the speaker of the house of 36463
representatives, or the minority leader of the house of 36464
representatives, respectively. 36465

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 36495
expressed only as a percentage of the sample of drugs selected 36496
under section ~~173.814~~ 5169.114 of the Revised Code. 36497

(C) The lists compiled under this section are public records 36498
for the purpose of section 149.43 of the Revised Code. The 36499
department shall specifically make the lists available to 36500
physicians, participating terminal distributors, and other health 36501
professionals. 36502

Sec. ~~173.89~~ 5169.19. Information transmitted by or to any of 36503
the following for any purpose related to the Ohio's best Rx 36504
program is confidential to the extent required by federal and 36505
state law: 36506

(A) Drug manufacturers; 36507

(B) Terminal distributors of dangerous drugs; 36508

(C) The department of ~~aging~~ health care administration; 36509

(D) The program's consulting pharmacy benefit manager 36510
selected under section ~~173.731~~ 5169.031 of the Revised Code; 36511

(E) Ohio's best Rx program participants; 36512

(F) Any other government entity or person. 36513

Sec. ~~173.891~~ 5169.191. (A) Except as provided by section 36514
~~173.892~~ 5169.192 of the Revised Code, all of the following are 36515
trade secrets, are not public records for the purposes of section 36516
149.43 of the Revised Code, and shall not be used, released, 36517
published, or disclosed in a form that reveals a specific drug or 36518
the identity of a drug manufacturer: 36519

(1) The amounts determined under section ~~173.801~~ 5169.101 of 36520
the Revised Code for payment of claims submitted by participating 36521
terminal distributors and the drug mail order system included in 36522
the Ohio's best Rx program pursuant to section ~~173.78~~ 5169.08 of 36523

the Revised Code; 36524

(2) Information disclosed in a manufacturer agreement entered 36525
into under section ~~173.81~~ 5169.11 of the Revised Code or in 36526
communications related to an agreement; 36527

(3) Drug pricing and drug manufacturer payment information 36528
verified under sections ~~173.742~~ 5169.042 and ~~173.814~~ 5169.114 of 36529
the Revised Code by the program's consulting pharmacy benefit 36530
manager selected under section ~~173.731~~ 5169.031 of the Revised 36531
Code; 36532

(4) Information contained in or pertaining to an audit 36533
provided for by the program's consulting pharmacy benefit manager 36534
under section ~~173.732~~ 5169.032 of the Revised Code; 36535

(5) The elements of the computations made pursuant to 36536
sections ~~173.75~~ 5169.05, ~~173.801~~ 5169.101, and ~~173.812~~ 5169.112 of 36537
the Revised Code and any results of those computations that reveal 36538
or could be used to reveal the manufacturer payment amounts used 36539
to make the computations. 36540

(B) No person or government entity shall use or reveal any 36541
information specified in division (A) of this section except as 36542
required for the implementation of sections ~~173.71~~ 5169.01 to 36543
~~173.91~~ 5169.21 of the Revised Code. 36544

Sec. ~~173.892~~ 5169.192. Sections ~~173.89~~ 5169.19 and ~~173.891~~ 36545
5169.191 of the Revised Code shall not preclude the department of 36546
~~aging~~ health care administration from disclosing information 36547
necessary for the implementation of sections ~~173.71~~ 5169.01 to 36548
~~173.91~~ 5169.21 of the Revised Code, including the amount an Ohio's 36549
best Rx program participant is to be charged when the amount is 36550
disclosed under section ~~173.751~~ 5169.051 of the Revised Code to 36551
participating terminal distributors or the drug mail order system 36552
included in the program pursuant to section ~~173.78~~ 5169.08 of the 36553

Revised Code. 36554

Sec. ~~173.90~~ 5169.20. (A) As used in this section, 36555
"identifying information" means information that identifies or 36556
could be used to identify an Ohio's best Rx program applicant or 36557
participant. "Identifying information" does not include aggregate 36558
information about applicants and participants that does not 36559
identify and could not be used to identify an individual applicant 36560
or participant. 36561

(B) Except as provided in divisions (C), (D), and (E) of this 36562
section, no person or government entity shall sell, solicit, 36563
disclose, receive, or use identifying information or knowingly 36564
permit the use of identifying information. 36565

(C)(1) The department of ~~aging~~ health care administration may 36566
solicit, disclose, receive, or use identifying information or 36567
knowingly permit the use of identifying information for a purpose 36568
directly connected to the administration of the Ohio's best Rx 36569
program, including disclosing and knowingly permitting the use of 36570
identifying information included in a claim that a participating 36571
manufacturer audits pursuant to section ~~173.82~~ 5169.12 of the 36572
Revised Code, contacting Ohio's best Rx program applicants or 36573
participants regarding participation in the program, and notifying 36574
applicants and participants regarding participating terminal 36575
distributors and the drug mail order system included in the 36576
program pursuant to section ~~173.78~~ 5169.08 of the Revised Code. 36577

(2) The department may solicit, disclose, receive, or use 36578
identifying information or knowingly permit the use of identifying 36579
information to the extent required by federal law. 36580

(3) The department may disclose identifying information to 36581
the Ohio's best Rx program applicant or participant who is the 36582
subject of that information or to the parent, spouse, guardian, or 36583
custodian of that applicant or participant. 36584

(D)(1) A participating terminal distributor may solicit, 36585
disclose, receive, or use identifying information or knowingly 36586
permit the use of identifying information to the extent required 36587
or permitted by an agreement the distributor enters into under 36588
section ~~173.79~~ 5169.09 of the Revised Code. 36589

(2) Subject to division (B) of section ~~173.78~~ 5169.08 of the 36590
Revised Code, the drug mail order system included in the program 36591
pursuant to section ~~173.78~~ 5169.08 of the Revised Code may 36592
solicit, disclose, receive, or use identifying information or 36593
knowingly permit the use of identifying information to the extent 36594
required or permitted by the department. 36595

(E) A participating manufacturer may, for the purpose of 36596
auditing a claim pursuant to section ~~173.82~~ 5169.12 of the Revised 36597
Code, solicit, receive, and use identifying information included 36598
in the claim. 36599

Sec. ~~173.91~~ 5169.21. (A) Except as provided in division (B) 36600
of this section, the department of ~~aging~~ health care 36601
administration shall use and preserve records regarding the Ohio's 36602
best Rx program in accordance with rules adopted under section 36603
~~173.83~~ 5169.13 of the Revised Code. The department shall use and 36604
preserve the records in accordance with those rules, regardless of 36605
whether the department generated the records or received them from 36606
another government entity or any person. 36607

(B) All records received by the department under sections 36608
~~173.742~~ 5169.042 and ~~173.814~~ 5169.114 of the Revised Code from the 36609
program's consulting pharmacy benefit manager selected under 36610
section ~~173.731~~ 5169.031 of the Revised Code shall be destroyed 36611
promptly after the department has completed the purpose for which 36612
the information contained in the records was obtained. 36613

Sec. 5169.99. Whoever violates division (B) of section 36614

5169.20 of the Revised Code is guilty of a misdemeanor of the 36615
first degree. 36616

Sec. 5505.04. (A)(1) The general administration and 36617
management of the state highway patrol retirement system and the 36618
making effective of this chapter are hereby vested in the state 36619
highway patrol retirement board. The board may sue and be sued, 36620
plead and be impleaded, contract and be contracted with, and do 36621
all things necessary to carry out this chapter. 36622

The board shall consist of the following members: 36623

(a) The superintendent of the state highway patrol; 36624

(b) Two retirant members who reside in this state; 36625

(c) Five employee-members; 36626

(d) One member, known as the treasurer of state's investment 36627
designee, who shall be appointed by the treasurer of state for a 36628
term of four years and who shall have the following 36629
qualifications: 36630

(i) The member is a resident of this state. 36631

(ii) Within the three years immediately preceding the 36632
appointment, the member has not been employed by the public 36633
employees retirement system, police and fire pension fund, state 36634
teachers retirement system, school employees retirement system, or 36635
state highway patrol retirement system or by any person, 36636
partnership, or corporation that has provided to one of those 36637
retirement systems services of a financial or investment nature, 36638
including the management, analysis, supervision, or investment of 36639
assets. 36640

(iii) The member has direct experience in the management, 36641
analysis, supervision, or investment of assets. 36642

(iv) The member is not currently employed by the state or a 36643

political subdivision of the state. 36644

(e) Two investment expert members, who shall be appointed to 36645
four-year terms. One investment expert member shall be appointed 36646
by the governor, and one investment expert member shall be jointly 36647
appointed by the speaker of the house of representatives and the 36648
president of the senate. Each investment expert member shall have 36649
the following qualifications: 36650

(i) Each investment expert member shall be a resident of this 36651
state. 36652

(ii) Within the three years immediately preceding the 36653
appointment, each investment expert member shall not have been 36654
employed by the public employees retirement system, police and 36655
fire pension fund, state teachers retirement system, school 36656
employees retirement system, or state highway patrol retirement 36657
system or by any person, partnership, or corporation that has 36658
provided to one of those retirement systems services of a 36659
financial or investment nature, including the management, 36660
analysis, supervision, or investment of assets. 36661

(iii) Each investment expert member shall have direct 36662
experience in the management, analysis, supervision, or investment 36663
of assets. 36664

(2) The board shall annually elect a chairperson and 36665
vice-chairperson from among its members. The vice-chairperson 36666
shall act as chairperson in the absence of the chairperson. A 36667
majority of the members of the board shall constitute a quorum and 36668
any action taken shall be approved by a majority of the members of 36669
the board. The board shall meet not less than once each year, upon 36670
sufficient notice to the members. All meetings of the board shall 36671
be open to the public except executive sessions as set forth in 36672
division (G) of section 121.22 of the Revised Code, and any 36673
portions of any sessions discussing medical records or the degree 36674

of disability of a member excluded from public inspection by this section. 36675
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(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. 36677
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(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. 36684
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(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. 36696
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(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 36702
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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~~ 36738
~~job and family services~~ a list of the names and social security 36739
numbers of recipients of public assistance pursuant to section 36740
5101.181 of the Revised Code or a list of the names and social 36741
security numbers of public medical assistance recipients pursuant 36742
to section 5160.43 of the Revised Code, the board shall inform the 36743
auditor of state of the name, current or most recent employer 36744
address, and social security number of each member whose name and 36745
social security number are the same as those of a person whose 36746
name or social security number ~~was submitted by the director~~ is 36747
included on the list. The board and its employees, except for 36748
purposes of furnishing the auditor of state with information 36749
required by this section, shall preserve the confidentiality of 36750
recipients of public assistance in compliance with ~~division (A) of~~ 36751
section 5101.181 of the Revised Code and preserve the 36752
confidentiality of public medical assistance program recipients in 36753
compliance with section 5160.43 of the Revised Code. 36754

(5) The system shall comply with orders issued under section 36755
3105.87 of the Revised Code. 36756

On the written request of an alternate payee, as defined in 36757
section 3105.80 of the Revised Code, the system shall furnish to 36758
the alternate payee information on the amount and status of any 36759
amounts payable to the alternate payee under an order issued under 36760
section 3105.171 or 3105.65 of the Revised Code. 36761

(6) At the request of any person, the board shall make 36762
available to the person copies of all documents, including 36763
resumes, in the board's possession regarding filling a vacancy of 36764
an employee member or retirant member of the board. The person who 36765
made the request shall pay the cost of compiling, copying, and 36766
mailing the documents. The information described in this division 36767
is a public record. 36768

(E) A statement that contains information obtained from the 36769

system's records that is certified and signed by an officer of the 36770
retirement system and to which the system's official seal is 36771
affixed, or copies of the system's records to which the signature 36772
and seal are attached, shall be received as true copies of the 36773
system's records in any court or before any officer of this state. 36774

Sec. 5725.18. (A) An annual franchise tax on the privilege of 36775
being an insurance company is hereby levied on each domestic 36776
insurance company. In the month of May, annually, the treasurer of 36777
state shall charge for collection from each domestic insurance 36778
company a franchise tax in the amount computed in accordance with 36779
the following, as applicable: 36780

(1) With respect to a domestic insurance company that is a 36781
health insuring corporation, one per cent of all premium rate 36782
payments received, exclusive of payments received under the 36783
medicare program ~~established under Title XVIII of the "Social~~ 36784
~~Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended,~~ 36785
or pursuant to the ~~medical assistance~~ medicaid program ~~established~~ 36786
~~under Chapter 5111. of the Revised Code,~~ as reflected in its 36787
annual report for the preceding calendar year; 36788

(2) With respect to a domestic insurance company that is not 36789
a health insuring corporation, one and four-tenths per cent of the 36790
gross amount of premiums received from policies covering risks 36791
within this state, exclusive of premiums received under the 36792
medicare program ~~established under Title XVIII of the "Social~~ 36793
~~Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended,~~ 36794
or pursuant to the ~~medical assistance~~ medicaid program ~~established~~ 36795
~~under Chapter 5111. of the Revised Code,~~ as reflected in its 36796
annual statement for the preceding calendar year, and, if the 36797
company operates a health insuring corporation as a line of 36798
business, one per cent of all premium rate payments received from 36799
that line of business, exclusive of payments received under the 36800

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, 36863
control, or custody a deposit standing in the name of a decedent, 36864
or in trust for a decedent, or in the name of a decedent and 36865
another person or persons, shall deliver or transfer an amount in 36866
excess of three-fourths of the total value of such deposit, 36867
including accrued interest and dividends, as of the date of 36868
decedent's death, without the written consent of the tax 36869
commissioner. The written consent of the tax commissioner need not 36870
be obtained prior to the delivery or transfer of amounts having a 36871
value of three-fourths or less of said total value. 36872

(C) No life insurance company shall pay the proceeds of an 36873
annuity or matured endowment contract, or of a life insurance 36874
contract payable to the estate of a decedent, or of any other 36875
insurance contract taxable under Chapter 5731. of the Revised 36876
Code, without the written consent of the tax commissioner. Any 36877
life insurance company may pay the proceeds of any insurance 36878
contract not specified in this division (C) without the written 36879
consent of the tax commissioner. 36880

(D) No trust company or other corporation or person shall pay 36881
the proceeds of any death benefit, retirement, pension or profit 36882
sharing plan in excess of two thousand dollars, without the 36883
written consent of the tax commissioner. Such trust company or 36884
other corporation or person, however, may pay the proceeds of any 36885
death benefit, retirement, pension, or profit-sharing plan which 36886
consists of insurance on the life of the decedent payable to a 36887
beneficiary other than the estate of the insured without the 36888
written consent of the tax commissioner. 36889

(E) No safe deposit company, trust company, financial 36890
institution as defined in division (A) of section 5725.01 of the 36891
Revised Code, or other corporation or person, having in 36892
possession, control, or custody securities, assets, or other 36893
property (including the shares of the capital stock of, or other 36894

interest in, such safe deposit company, trust company, financial 36895
institution as defined in division (A) of section 5725.01 of the 36896
Revised Code, or other corporation), standing in the name of a 36897
decedent, or in trust for a decedent, or in the name of a decedent 36898
and another person or persons, and the transfer of which is 36899
taxable under Chapter 5731. of the Revised Code, shall deliver or 36900
transfer any such securities, assets, or other property which have 36901
a value as of the date of decedent's death in excess of 36902
three-fourths of the total value thereof, without the written 36903
consent of the tax commissioner. The written consent of the tax 36904
commissioner need not be obtained prior to the delivery or 36905
transfer of any such securities, assets, or other property having 36906
a value of three-fourths or less of said total value. 36907

(F) No safe deposit company, financial institution as defined 36908
in division (A) of section 5725.01 of the Revised Code, or other 36909
corporation or person having possession or control of a safe 36910
deposit box or similar receptacle standing in the name of a 36911
decedent or in the name of the decedent and another person or 36912
persons, or to which the decedent had a right of access, except 36913
when such safe deposit box or other receptacle stands in the name 36914
of a corporation or partnership, or in the name of the decedent as 36915
guardian or executor, shall deliver any of the contents thereof 36916
unless the safe deposit box or similar receptacle has been opened 36917
and inventoried in the presence of the tax commissioner or the 36918
commissioner's agent, and a written consent to transfer issued; 36919
provided, however, that a safe deposit company, financial 36920
institution, or other corporation or person having possession or 36921
control of a safe deposit box may deliver wills, deeds to burial 36922
lots, and insurance policies to a representative of the decedent, 36923
but that a representative of the safe deposit company, financial 36924
institution, or other corporation or person must supervise the 36925
opening of the box and make a written record of the wills, deeds, 36926
and policies removed. Such written record shall be included in the 36927

tax commissioner's inventory records. 36928

(G) Notwithstanding any provision of this section: 36929

(1) The tax commissioner may authorize any delivery or 36930
transfer or waive any of the foregoing requirements under such 36931
terms and conditions as the commissioner may prescribe; 36932

(2) An adult care facility, as defined in section 3722.01 of 36933
the Revised Code, or a home, as defined in section 3721.10 of the 36934
Revised Code, may transfer or use the money in a personal needs 36935
allowance account in accordance with section ~~5111.113~~ 5162.37 of 36936
the Revised Code without the written consent of the tax 36937
commissioner, and without the account having been opened and 36938
inventoried in the presence of the commissioner or the 36939
commissioner's agent. 36940

Failure to comply with this section shall render such safe 36941
deposit company, trust company, life insurance company, financial 36942
institution as defined in division (A) of section 5725.01 of the 36943
Revised Code, or other corporation or person liable for the amount 36944
of the taxes and interest due under the provisions of Chapter 36945
5731. of the Revised Code on the transfer of such stock, deposit, 36946
proceeds of an annuity or matured endowment contract or of a life 36947
insurance contract payable to the estate of a decedent, or other 36948
insurance contract taxable under Chapter 5731. of the Revised 36949
Code, proceeds of any death benefit, retirement, pension, or 36950
profit sharing plan in excess of two thousand dollars, or 36951
securities, assets, or other property of any resident decedent, 36952
and in addition thereto, to a penalty of not less than five 36953
hundred or more than five thousand dollars. 36954

Sec. 5747.01. Except as otherwise expressly provided or 36955
clearly appearing from the context, any term used in this chapter 36956
that is not otherwise defined in this section has the same meaning 36957
as when used in a comparable context in the laws of the United 36958

States relating to federal income taxes or if not used in a 36959
comparable context in those laws, has the same meaning as in 36960
section 5733.40 of the Revised Code. Any reference in this chapter 36961
to the Internal Revenue Code includes other laws of the United 36962
States relating to federal income taxes. 36963

As used in this chapter: 36964

(A) "Adjusted gross income" or "Ohio adjusted gross income" 36965
means federal adjusted gross income, as defined and used in the 36966
Internal Revenue Code, adjusted as provided in this section: 36967

(1) Add interest or dividends on obligations or securities of 36968
any state or of any political subdivision or authority of any 36969
state, other than this state and its subdivisions and authorities. 36970

(2) Add interest or dividends on obligations of any 36971
authority, commission, instrumentality, territory, or possession 36972
of the United States to the extent that the interest or dividends 36973
are exempt from federal income taxes but not from state income 36974
taxes. 36975

(3) Deduct interest or dividends on obligations of the United 36976
States and its territories and possessions or of any authority, 36977
commission, or instrumentality of the United States to the extent 36978
that the interest or dividends are included in federal adjusted 36979
gross income but exempt from state income taxes under the laws of 36980
the United States. 36981

(4) Deduct disability and survivor's benefits to the extent 36982
included in federal adjusted gross income. 36983

(5) Deduct benefits under Title II of the Social Security Act 36984
and tier 1 railroad retirement benefits to the extent included in 36985
federal adjusted gross income under section 86 of the Internal 36986
Revenue Code. 36987

(6) In the case of a taxpayer who is a beneficiary of a trust 36988

that makes an accumulation distribution as defined in section 665 36989
of the Internal Revenue Code, add, for the beneficiary's taxable 36990
years beginning before 2002, the portion, if any, of such 36991
distribution that does not exceed the undistributed net income of 36992
the trust for the three taxable years preceding the taxable year 36993
in which the distribution is made to the extent that the portion 36994
was not included in the trust's taxable income for any of the 36995
trust's taxable years beginning in 2002 or thereafter. 36996

"Undistributed net income of a trust" means the taxable income of 36997
the trust increased by (a)(i) the additions to adjusted gross 36998
income required under division (A) of this section and (ii) the 36999
personal exemptions allowed to the trust pursuant to section 37000
642(b) of the Internal Revenue Code, and decreased by (b)(i) the 37001
deductions to adjusted gross income required under division (A) of 37002
this section, (ii) the amount of federal income taxes attributable 37003
to such income, and (iii) the amount of taxable income that has 37004
been included in the adjusted gross income of a beneficiary by 37005
reason of a prior accumulation distribution. Any undistributed net 37006
income included in the adjusted gross income of a beneficiary 37007
shall reduce the undistributed net income of the trust commencing 37008
with the earliest years of the accumulation period. 37009

(7) Deduct the amount of wages and salaries, if any, not 37010
otherwise allowable as a deduction but that would have been 37011
allowable as a deduction in computing federal adjusted gross 37012
income for the taxable year, had the targeted jobs credit allowed 37013
and determined under sections 38, 51, and 52 of the Internal 37014
Revenue Code not been in effect. 37015

(8) Deduct any interest or interest equivalent on public 37016
obligations and purchase obligations to the extent that the 37017
interest or interest equivalent is included in federal adjusted 37018
gross income. 37019

(9) Add any loss or deduct any gain resulting from the sale, 37020

exchange, or other disposition of public obligations to the extent 37021
that the loss has been deducted or the gain has been included in 37022
computing federal adjusted gross income. 37023

(10) Deduct or add amounts, as provided under section 5747.70 37024
of the Revised Code, related to contributions to variable college 37025
savings program accounts made or tuition units purchased pursuant 37026
to Chapter 3334. of the Revised Code. 37027

(11)(a) Deduct, to the extent not otherwise allowable as a 37028
deduction or exclusion in computing federal or Ohio adjusted gross 37029
income for the taxable year, the amount the taxpayer paid during 37030
the taxable year for medical care insurance and qualified 37031
long-term care insurance for the taxpayer, the taxpayer's spouse, 37032
and dependents. No deduction for medical care insurance under 37033
division (A)(11) of this section shall be allowed either to any 37034
taxpayer who is eligible to participate in any subsidized health 37035
plan maintained by any employer of the taxpayer or of the 37036
taxpayer's spouse, or to any taxpayer who is entitled to, or on 37037
application would be entitled to, benefits under part A of ~~Title~~ 37038
~~XVIII of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.~~ 37039
~~301, as amended~~ medicare program. For the purposes of division 37040
(A)(11)(a) of this section, "subsidized health plan" means a 37041
health plan for which the employer pays any portion of the plan's 37042
cost. The deduction allowed under division (A)(11)(a) of this 37043
section shall be the net of any related premium refunds, related 37044
premium reimbursements, or related insurance premium dividends 37045
received during the taxable year. 37046

(b) Deduct, to the extent not otherwise deducted or excluded 37047
in computing federal or Ohio adjusted gross income during the 37048
taxable year, the amount the taxpayer paid during the taxable 37049
year, not compensated for by any insurance or otherwise, for 37050
medical care of the taxpayer, the taxpayer's spouse, and 37051
dependents, to the extent the expenses exceed seven and one-half 37052

per cent of the taxpayer's federal adjusted gross income. 37053

(c) For purposes of division (A)(11) of this section, 37054
"medical care" has the meaning given in section 213 of the 37055
Internal Revenue Code, subject to the special rules, limitations, 37056
and exclusions set forth therein, and "qualified long-term care" 37057
has the same meaning given in section 7702B(c) of the Internal 37058
Revenue Code. 37059

(12)(a) Deduct any amount included in federal adjusted gross 37060
income solely because the amount represents a reimbursement or 37061
refund of expenses that in any year the taxpayer had deducted as 37062
an itemized deduction pursuant to section 63 of the Internal 37063
Revenue Code and applicable United States department of the 37064
treasury regulations. The deduction otherwise allowed under 37065
division (A)(12)(a) of this section shall be reduced to the extent 37066
the reimbursement is attributable to an amount the taxpayer 37067
deducted under this section in any taxable year. 37068

(b) Add any amount not otherwise included in Ohio adjusted 37069
gross income for any taxable year to the extent that the amount is 37070
attributable to the recovery during the taxable year of any amount 37071
deducted or excluded in computing federal or Ohio adjusted gross 37072
income in any taxable year. 37073

(13) Deduct any portion of the deduction described in section 37074
1341(a)(2) of the Internal Revenue Code, for repaying previously 37075
reported income received under a claim of right, that meets both 37076
of the following requirements: 37077

(a) It is allowable for repayment of an item that was 37078
included in the taxpayer's adjusted gross income for a prior 37079
taxable year and did not qualify for a credit under division (A) 37080
or (B) of section 5747.05 of the Revised Code for that year; 37081

(b) It does not otherwise reduce the taxpayer's adjusted 37082
gross income for the current or any other taxable year. 37083

(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 37115
the tax commissioner's opinion, is necessary to establish the 37116
amount deducted under division (A)(17) of this section. 37117

(18) Beginning in taxable year 2001 but not for any taxable 37118
year beginning after December 31, 2005, if the taxpayer is married 37119
and files a joint return and the combined federal adjusted gross 37120
income of the taxpayer and the taxpayer's spouse for the taxable 37121
year does not exceed one hundred thousand dollars, or if the 37122
taxpayer is single and has a federal adjusted gross income for the 37123
taxable year not exceeding fifty thousand dollars, deduct amounts 37124
paid during the taxable year for qualified tuition and fees paid 37125
to an eligible institution for the taxpayer, the taxpayer's 37126
spouse, or any dependent of the taxpayer, who is a resident of 37127
this state and is enrolled in or attending a program that 37128
culminates in a degree or diploma at an eligible institution. The 37129
deduction may be claimed only to the extent that qualified tuition 37130
and fees are not otherwise deducted or excluded for any taxable 37131
year from federal or Ohio adjusted gross income. The deduction may 37132
not be claimed for educational expenses for which the taxpayer 37133
claims a credit under section 5747.27 of the Revised Code. 37134

(19) Add any reimbursement received during the taxable year 37135
of any amount the taxpayer deducted under division (A)(18) of this 37136
section in any previous taxable year to the extent the amount is 37137
not otherwise included in Ohio adjusted gross income. 37138

(20)(a)(i) Add five-sixths of the amount of depreciation 37139
expense allowed by subsection (k) of section 168 of the Internal 37140
Revenue Code, including the taxpayer's proportionate or 37141
distributive share of the amount of depreciation expense allowed 37142
by that subsection to a pass-through entity in which the taxpayer 37143
has a direct or indirect ownership interest. 37144

(ii) Add five-sixths of the amount of qualifying section 179 37145
depreciation expense, including a person's proportionate or 37146

distributive share of the amount of qualifying section 179 37147
depreciation expense allowed to any pass-through entity in which 37148
the person has a direct or indirect ownership. For the purposes of 37149
this division, "qualifying section 179 depreciation expense" means 37150
the difference between (I) the amount of depreciation expense 37151
directly or indirectly allowed to the taxpayer under section 179 37152
of the Internal Revenue Code, and (II) the amount of depreciation 37153
expense directly or indirectly allowed to the taxpayer under 37154
section 179 of the Internal Revenue Code as that section existed 37155
on December 31, 2002. 37156

The tax commissioner, under procedures established by the 37157
commissioner, may waive the add-backs related to a pass-through 37158
entity if the taxpayer owns, directly or indirectly, less than 37159
five per cent of the pass-through entity. 37160

(b) Nothing in division (A)(20) of this section shall be 37161
construed to adjust or modify the adjusted basis of any asset. 37162

(c) To the extent the add-back required under division 37163
(A)(20)(a) of this section is attributable to property generating 37164
nonbusiness income or loss allocated under section 5747.20 of the 37165
Revised Code, the add-back shall be situated to the same location 37166
as the nonbusiness income or loss generated by the property for 37167
the purpose of determining the credit under division (A) of 37168
section 5747.05 of the Revised Code. Otherwise, the add-back shall 37169
be apportioned, subject to one or more of the four alternative 37170
methods of apportionment enumerated in section 5747.21 of the 37171
Revised Code. 37172

(d) For the purposes of division (A) of this section, net 37173
operating loss carryback and carryforward shall not include 37174
five-sixths of the allowance of any net operating loss deduction 37175
carryback or carryforward to the taxable year to the extent such 37176
loss resulted from depreciation allowed by section 168(k) of the 37177
Internal Revenue Code and by the qualifying section 179 37178

depreciation expense amount.	37179
(21)(a) If the taxpayer was required to add an amount under	37180
division (A)(20)(a) of this section for a taxable year, deduct	37181
one-fifth of the amount so added for each of the five succeeding	37182
taxable years.	37183
(b) If the amount deducted under division (A)(21)(a) of this	37184
section is attributable to an add-back allocated under division	37185
(A)(20)(c) of this section, the amount deducted shall be sitused	37186
to the same location. Otherwise, the add-back shall be apportioned	37187
using the apportionment factors for the taxable year in which the	37188
deduction is taken, subject to one or more of the four alternative	37189
methods of apportionment enumerated in section 5747.21 of the	37190
Revised Code.	37191
(c) No deduction is available under division (A)(21)(a) of	37192
this section with regard to any depreciation allowed by section	37193
168(k) of the Internal Revenue Code and by the qualifying section	37194
179 depreciation expense amount to the extent that such	37195
depreciation resulted in or increased a federal net operating loss	37196
carryback or carryforward to a taxable year to which division	37197
(A)(20)(d) of this section does not apply.	37198
(22) Deduct, to the extent not otherwise deducted or excluded	37199
in computing federal or Ohio adjusted gross income for the taxable	37200
year, the amount the taxpayer received during the taxable year as	37201
reimbursement for life insurance premiums under section 5919.31 of	37202
the Revised Code.	37203
(23) Deduct, to the extent not otherwise deducted or excluded	37204
in computing federal or Ohio adjusted gross income for the taxable	37205
year, the amount the taxpayer received during the taxable year as	37206
a death benefit paid by the adjutant general under section 5919.33	37207
of the Revised Code.	37208
(24) Deduct, to the extent included in federal adjusted gross	37209

income and not otherwise allowable as a deduction or exclusion in 37210
computing federal or Ohio adjusted gross income for the taxable 37211
year, military pay and allowances received by the taxpayer during 37212
the taxable year for active duty service in the United States 37213
army, air force, navy, marine corps, or coast guard or reserve 37214
components thereof or the national guard. The deduction may not be 37215
claimed for military pay and allowances received by the taxpayer 37216
while the taxpayer is stationed in this state. 37217

(B) "Business income" means income, including gain or loss, 37218
arising from transactions, activities, and sources in the regular 37219
course of a trade or business and includes income, gain, or loss 37220
from real property, tangible property, and intangible property if 37221
the acquisition, rental, management, and disposition of the 37222
property constitute integral parts of the regular course of a 37223
trade or business operation. "Business income" includes income, 37224
including gain or loss, from a partial or complete liquidation of 37225
a business, including, but not limited to, gain or loss from the 37226
sale or other disposition of goodwill. 37227

(C) "Nonbusiness income" means all income other than business 37228
income and may include, but is not limited to, compensation, rents 37229
and royalties from real or tangible personal property, capital 37230
gains, interest, dividends and distributions, patent or copyright 37231
royalties, or lottery winnings, prizes, and awards. 37232

(D) "Compensation" means any form of remuneration paid to an 37233
employee for personal services. 37234

(E) "Fiduciary" means a guardian, trustee, executor, 37235
administrator, receiver, conservator, or any other person acting 37236
in any fiduciary capacity for any individual, trust, or estate. 37237

(F) "Fiscal year" means an accounting period of twelve months 37238
ending on the last day of any month other than December. 37239

(G) "Individual" means any natural person. 37240

(H) "Internal Revenue Code" means the "Internal Revenue Code of 1986," 100 Stat. 2085, 26 U.S.C.A. 1, as amended. 37241
37242

(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: 37243
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37245

(1) An individual who is domiciled in this state, subject to section 5747.24 of the Revised Code; 37246
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(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. 37248
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(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. 37252
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37254

For the purposes of division (I)(3) of this section: 37255

(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: 37256
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(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; 37262
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37265

(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 37266
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of the trust's current taxable year; 37271

(iii) A person who was domiciled in this state for the 37272
purposes of this chapter when the trust document or instrument or 37273
part of the trust document or instrument became irrevocable, but 37274
only if at least one of the trust's qualifying beneficiaries is a 37275
resident domiciled in this state for the purposes of this chapter 37276
during all or some portion of the trust's current taxable year. If 37277
a trust document or instrument became irrevocable upon the death 37278
of a person who at the time of death was domiciled in this state 37279
for purposes of this chapter, that person is a person described in 37280
division (I)(3)(a)(iii) of this section. 37281

(b) A trust is irrevocable to the extent that the transferor 37282
is not considered to be the owner of the net assets of the trust 37283
under sections 671 to 678 of the Internal Revenue Code. 37284

(c) With respect to a trust other than a charitable lead 37285
trust, "qualifying beneficiary" has the same meaning as "potential 37286
current beneficiary" as defined in section 1361(e)(2) of the 37287
Internal Revenue Code, and with respect to a charitable lead trust 37288
"qualifying beneficiary" is any current, future, or contingent 37289
beneficiary, but with respect to any trust "qualifying 37290
beneficiary" excludes a person or a governmental entity or 37291
instrumentality to any of which a contribution would qualify for 37292
the charitable deduction under section 170 of the Internal Revenue 37293
Code. 37294

(d) For the purposes of division (I)(3)(a) of this section, 37295
the extent to which a trust consists directly or indirectly, in 37296
whole or in part, of assets, net of any related liabilities, that 37297
were transferred directly or indirectly, in whole or part, to the 37298
trust by any of the sources enumerated in that division shall be 37299
ascertained by multiplying the fair market value of the trust's 37300
assets, net of related liabilities, by the qualifying ratio, which 37301
shall be computed as follows: 37302

(i) The first time the trust receives assets, the numerator 37303
of the qualifying ratio is the fair market value of those assets 37304
at that time, net of any related liabilities, from sources 37305
enumerated in division (I)(3)(a) of this section. The denominator 37306
of the qualifying ratio is the fair market value of all the 37307
trust's assets at that time, net of any related liabilities. 37308

(ii) Each subsequent time the trust receives assets, a 37309
revised qualifying ratio shall be computed. The numerator of the 37310
revised qualifying ratio is the sum of (1) the fair market value 37311
of the trust's assets immediately prior to the subsequent 37312
transfer, net of any related liabilities, multiplied by the 37313
qualifying ratio last computed without regard to the subsequent 37314
transfer, and (2) the fair market value of the subsequently 37315
transferred assets at the time transferred, net of any related 37316
liabilities, from sources enumerated in division (I)(3)(a) of this 37317
section. The denominator of the revised qualifying ratio is the 37318
fair market value of all the trust's assets immediately after the 37319
subsequent transfer, net of any related liabilities. 37320

(iii) Whether a transfer to the trust is by or from any of 37321
the sources enumerated in division (I)(3)(a) of this section shall 37322
be ascertained without regard to the domicile of the trust's 37323
beneficiaries. 37324

(e) For the purposes of division (I)(3)(a)(i) of this 37325
section: 37326

(i) A trust is described in division (I)(3)(e)(i) of this 37327
section if the trust is a testamentary trust and the testator of 37328
that testamentary trust was domiciled in this state at the time of 37329
the testator's death for purposes of the taxes levied under 37330
Chapter 5731. of the Revised Code. 37331

(ii) A trust is described in division (I)(3)(e)(ii) of this 37332
section if the transfer is a qualifying transfer described in any 37333

of divisions (I)(3)(f)(i) to (vi) of this section, the trust is an 37334
irrevocable inter vivos trust, and at least one of the trust's 37335
qualifying beneficiaries is domiciled in this state for purposes 37336
of this chapter during all or some portion of the trust's current 37337
taxable year. 37338

(f) For the purposes of division (I)(3)(e)(ii) of this 37339
section, a "qualifying transfer" is a transfer of assets, net of 37340
any related liabilities, directly or indirectly to a trust, if the 37341
transfer is described in any of the following: 37342

(i) The transfer is made to a trust, created by the decedent 37343
before the decedent's death and while the decedent was domiciled 37344
in this state for the purposes of this chapter, and, prior to the 37345
death of the decedent, the trust became irrevocable while the 37346
decedent was domiciled in this state for the purposes of this 37347
chapter. 37348

(ii) The transfer is made to a trust to which the decedent, 37349
prior to the decedent's death, had directly or indirectly 37350
transferred assets, net of any related liabilities, while the 37351
decedent was domiciled in this state for the purposes of this 37352
chapter, and prior to the death of the decedent the trust became 37353
irrevocable while the decedent was domiciled in this state for the 37354
purposes of this chapter. 37355

(iii) The transfer is made on account of a contractual 37356
relationship existing directly or indirectly between the 37357
transferor and either the decedent or the estate of the decedent 37358
at any time prior to the date of the decedent's death, and the 37359
decedent was domiciled in this state at the time of death for 37360
purposes of the taxes levied under Chapter 5731. of the Revised 37361
Code. 37362

(iv) The transfer is made to a trust on account of a 37363
contractual relationship existing directly or indirectly between 37364

the transferor and another person who at the time of the 37365
decedent's death was domiciled in this state for purposes of this 37366
chapter. 37367

(v) The transfer is made to a trust on account of the will of 37368
a testator. 37369

(vi) The transfer is made to a trust created by or caused to 37370
be created by a court, and the trust was directly or indirectly 37371
created in connection with or as a result of the death of an 37372
individual who, for purposes of the taxes levied under Chapter 37373
5731. of the Revised Code, was domiciled in this state at the time 37374
of the individual's death. 37375

(g) The tax commissioner may adopt rules to ascertain the 37376
part of a trust residing in this state. 37377

(J) "Nonresident" means an individual or estate that is not a 37378
resident. An individual who is a resident for only part of a 37379
taxable year is a nonresident for the remainder of that taxable 37380
year. 37381

(K) "Pass-through entity" has the same meaning as in section 37382
5733.04 of the Revised Code. 37383

(L) "Return" means the notifications and reports required to 37384
be filed pursuant to this chapter for the purpose of reporting the 37385
tax due and includes declarations of estimated tax when so 37386
required. 37387

(M) "Taxable year" means the calendar year or the taxpayer's 37388
fiscal year ending during the calendar year, or fractional part 37389
thereof, upon which the adjusted gross income is calculated 37390
pursuant to this chapter. 37391

(N) "Taxpayer" means any person subject to the tax imposed by 37392
section 5747.02 of the Revised Code or any pass-through entity 37393
that makes the election under division (D) of section 5747.08 of 37394

the Revised Code. 37395

(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. 37396
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(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. 37401
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(Q) As used in sections 5747.50 to 5747.55 of the Revised Code: 37406
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(1) "Subdivision" means any county, municipal corporation, park district, or township. 37408
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(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. 37410
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(R) "Overpayment" means any amount already paid that exceeds the figure determined to be the correct amount of the tax. 37414
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(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: 37416
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(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 37419
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income and is described in either division (S)(1)(a) or (b) of 37425
this section: 37426

(a) The net amount is not attributable to the S portion of an 37427
electing small business trust and has not been distributed to 37428
beneficiaries for the taxable year; 37429

(b) The net amount is attributable to the S portion of an 37430
electing small business trust for the taxable year. 37431

(2) Add interest or dividends, net of ordinary, necessary, 37432
and reasonable expenses not deducted in computing federal taxable 37433
income, on obligations of any authority, commission, 37434
instrumentality, territory, or possession of the United States to 37435
the extent that the interest or dividends are exempt from federal 37436
income taxes but not from state income taxes, but only to the 37437
extent that such net amount is not otherwise includible in Ohio 37438
taxable income and is described in either division (S)(1)(a) or 37439
(b) of this section; 37440

(3) Add the amount of personal exemption allowed to the 37441
estate pursuant to section 642(b) of the Internal Revenue Code; 37442

(4) Deduct interest or dividends, net of related expenses 37443
deducted in computing federal taxable income, on obligations of 37444
the United States and its territories and possessions or of any 37445
authority, commission, or instrumentality of the United States to 37446
the extent that the interest or dividends are exempt from state 37447
taxes under the laws of the United States, but only to the extent 37448
that such amount is included in federal taxable income and is 37449
described in either division (S)(1)(a) or (b) of this section; 37450

(5) Deduct the amount of wages and salaries, if any, not 37451
otherwise allowable as a deduction but that would have been 37452
allowable as a deduction in computing federal taxable income for 37453
the taxable year, had the targeted jobs credit allowed under 37454
sections 38, 51, and 52 of the Internal Revenue Code not been in 37455

effect, but only to the extent such amount relates either to 37456
income included in federal taxable income for the taxable year or 37457
to income of the S portion of an electing small business trust for 37458
the taxable year; 37459

(6) Deduct any interest or interest equivalent, net of 37460
related expenses deducted in computing federal taxable income, on 37461
public obligations and purchase obligations, but only to the 37462
extent that such net amount relates either to income included in 37463
federal taxable income for the taxable year or to income of the S 37464
portion of an electing small business trust for the taxable year; 37465

(7) Add any loss or deduct any gain resulting from sale, 37466
exchange, or other disposition of public obligations to the extent 37467
that such loss has been deducted or such gain has been included in 37468
computing either federal taxable income or income of the S portion 37469
of an electing small business trust for the taxable year; 37470

(8) Except in the case of the final return of an estate, add 37471
any amount deducted by the taxpayer on both its Ohio estate tax 37472
return pursuant to section 5731.14 of the Revised Code, and on its 37473
federal income tax return in determining federal taxable income; 37474

(9)(a) Deduct any amount included in federal taxable income 37475
solely because the amount represents a reimbursement or refund of 37476
expenses that in a previous year the decedent had deducted as an 37477
itemized deduction pursuant to section 63 of the Internal Revenue 37478
Code and applicable treasury regulations. The deduction otherwise 37479
allowed under division (S)(9)(a) of this section shall be reduced 37480
to the extent the reimbursement is attributable to an amount the 37481
taxpayer or decedent deducted under this section in any taxable 37482
year. 37483

(b) Add any amount not otherwise included in Ohio taxable 37484
income for any taxable year to the extent that the amount is 37485
attributable to the recovery during the taxable year of any amount 37486

deducted or excluded in computing federal or Ohio taxable income 37487
in any taxable year, but only to the extent such amount has not 37488
been distributed to beneficiaries for the taxable year. 37489

(10) Deduct any portion of the deduction described in section 37490
1341(a)(2) of the Internal Revenue Code, for repaying previously 37491
reported income received under a claim of right, that meets both 37492
of the following requirements: 37493

(a) It is allowable for repayment of an item that was 37494
included in the taxpayer's taxable income or the decedent's 37495
adjusted gross income for a prior taxable year and did not qualify 37496
for a credit under division (A) or (B) of section 5747.05 of the 37497
Revised Code for that year. 37498

(b) It does not otherwise reduce the taxpayer's taxable 37499
income or the decedent's adjusted gross income for the current or 37500
any other taxable year. 37501

(11) Add any amount claimed as a credit under section 37502
5747.059 of the Revised Code to the extent that the amount 37503
satisfies either of the following: 37504

(a) The amount was deducted or excluded from the computation 37505
of the taxpayer's federal taxable income as required to be 37506
reported for the taxpayer's taxable year under the Internal 37507
Revenue Code; 37508

(b) The amount resulted in a reduction in the taxpayer's 37509
federal taxable income as required to be reported for any of the 37510
taxpayer's taxable years under the Internal Revenue Code. 37511

(12) Deduct any amount, net of related expenses deducted in 37512
computing federal taxable income, that a trust is required to 37513
report as farm income on its federal income tax return, but only 37514
if the assets of the trust include at least ten acres of land 37515
satisfying the definition of "land devoted exclusively to 37516
agricultural use" under section 5713.30 of the Revised Code, 37517

regardless of whether the land is valued for tax purposes as such 37518
land under sections 5713.30 to 5713.38 of the Revised Code. If the 37519
trust is a pass-through entity investor, section 5747.231 of the 37520
Revised Code applies in ascertaining if the trust is eligible to 37521
claim the deduction provided by division (S)(12) of this section 37522
in connection with the pass-through entity's farm income. 37523

Except for farm income attributable to the S portion of an 37524
electing small business trust, the deduction provided by division 37525
(S)(12) of this section is allowed only to the extent that the 37526
trust has not distributed such farm income. Division (S)(12) of 37527
this section applies only to taxable years of a trust beginning in 37528
2002 or thereafter. 37529

(13) Add the net amount of income described in section 641(c) 37530
of the Internal Revenue Code to the extent that amount is not 37531
included in federal taxable income. 37532

(14) Add or deduct the amount the taxpayer would be required 37533
to add or deduct under division (A)(20) or (21) of this section if 37534
the taxpayer's Ohio taxable income were computed in the same 37535
manner as an individual's Ohio adjusted gross income is computed 37536
under this section. In the case of a trust, division (S)(14) of 37537
this section applies only to any of the trust's taxable years 37538
beginning in 2002 or thereafter. 37539

(T) "School district income" and "school district income tax" 37540
have the same meanings as in section 5748.01 of the Revised Code. 37541

(U) As used in divisions (A)(8), (A)(9), (S)(6), and (S)(7) 37542
of this section, "public obligations," "purchase obligations," and 37543
"interest or interest equivalent" have the same meanings as in 37544
section 5709.76 of the Revised Code. 37545

(V) "Limited liability company" means any limited liability 37546
company formed under Chapter 1705. of the Revised Code or under 37547
the laws of any other state. 37548

(W) "Pass-through entity investor" means any person who, 37549
during any portion of a taxable year of a pass-through entity, is 37550
a partner, member, shareholder, or equity investor in that 37551
pass-through entity. 37552

(X) "Banking day" has the same meaning as in section 1304.01 37553
of the Revised Code. 37554

(Y) "Month" means a calendar month. 37555

(Z) "Quarter" means the first three months, the second three 37556
months, the third three months, or the last three months of the 37557
taxpayer's taxable year. 37558

(AA)(1) "Eligible institution" means a state university or 37559
state institution of higher education as defined in section 37560
3345.011 of the Revised Code, or a private, nonprofit college, 37561
university, or other post-secondary institution located in this 37562
state that possesses a certificate of authorization issued by the 37563
Ohio board of regents pursuant to Chapter 1713. of the Revised 37564
Code or a certificate of registration issued by the state board of 37565
career colleges and schools under Chapter 3332. of the Revised 37566
Code. 37567

(2) "Qualified tuition and fees" means tuition and fees 37568
imposed by an eligible institution as a condition of enrollment or 37569
attendance, not exceeding two thousand five hundred dollars in 37570
each of the individual's first two years of post-secondary 37571
education. If the individual is a part-time student, "qualified 37572
tuition and fees" includes tuition and fees paid for the academic 37573
equivalent of the first two years of post-secondary education 37574
during a maximum of five taxable years, not exceeding a total of 37575
five thousand dollars. "Qualified tuition and fees" does not 37576
include: 37577

(a) Expenses for any course or activity involving sports, 37578
games, or hobbies unless the course or activity is part of the 37579

individual's degree or diploma program;	37580
(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;	37581 37582 37583
(c) Tuition, fees, or other expenses paid or reimbursed through an employer, scholarship, grant in aid, or other educational benefit program.	37584 37585 37586
(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.	37587 37588 37589
(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:	37590 37591 37592 37593 37594
(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.	37595 37596 37597 37598 37599
(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.	37600 37601 37602
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.	37603 37604 37605
(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	37606 37607 37608 37609

extent such qualifying investment income is not otherwise part of 37610
modified business income. 37611

(4) "Modified Ohio taxable income" applies only to trusts, 37612
and means the sum of the amounts described in divisions (BB)(4)(a) 37613
to (c) of this section: 37614

(a) The fraction, calculated under section 5747.013, and 37615
applying section 5747.231 of the Revised Code, multiplied by the 37616
sum of the following amounts: 37617

(i) The trust's modified business income; 37618

(ii) The trust's qualifying investment income, as defined in 37619
section 5747.012 of the Revised Code, but only to the extent the 37620
qualifying investment income does not otherwise constitute 37621
modified business income and does not otherwise constitute a 37622
qualifying trust amount. 37623

(b) The qualifying trust amount multiplied by a fraction, the 37624
numerator of which is the sum of the book value of the qualifying 37625
investee's physical assets in this state on the last day of the 37626
qualifying investee's fiscal or calendar year ending immediately 37627
prior to the day on which the trust recognizes the qualifying 37628
trust amount, and the denominator of which is the sum of the book 37629
value of the qualifying investee's total physical assets 37630
everywhere on the last day of the qualifying investee's fiscal or 37631
calendar year ending immediately prior to the day on which the 37632
trust recognizes the qualifying trust amount. If, for a taxable 37633
year, the trust recognizes a qualifying trust amount with respect 37634
to more than one qualifying investee, the amount described in 37635
division (BB)(4)(b) of this section shall equal the sum of the 37636
products so computed for each such qualifying investee. 37637

(c)(i) With respect to a trust or portion of a trust that is 37638
a resident as ascertained in accordance with division (I)(3)(d) of 37639
this section, its modified nonbusiness income. 37640

(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 37673
which the trust recognizes the gain or loss, then "qualifying 37674
investee" includes all persons in the qualifying controlled group 37675
on such last day. 37676

(ii) If the qualifying investee, or if the qualifying 37677
investee and any members of the qualifying controlled group of 37678
which the qualifying investee is a member on the last day of the 37679
qualifying investee's fiscal or calendar year ending immediately 37680
prior to the date on which the trust recognizes the gain or loss, 37681
separately or cumulatively own, directly or indirectly, on the 37682
last day of the qualifying investee's fiscal or calendar year 37683
ending immediately prior to the date on which the trust recognizes 37684
the qualifying trust amount, more than fifty per cent of the 37685
equity of a pass-through entity, then the qualifying investee and 37686
the other members are deemed to own the proportionate share of the 37687
pass-through entity's physical assets which the pass-through 37688
entity directly or indirectly owns on the last day of the 37689
pass-through entity's calendar or fiscal year ending within or 37690
with the last day of the qualifying investee's fiscal or calendar 37691
year ending immediately prior to the date on which the trust 37692
recognizes the qualifying trust amount. 37693

(iii) For the purposes of division (BB)(5)(a)(iii) of this 37694
section, "upper level pass-through entity" means a pass-through 37695
entity directly or indirectly owning any equity of another 37696
pass-through entity, and "lower level pass-through entity" means 37697
that other pass-through entity. 37698

An upper level pass-through entity, whether or not it is also 37699
a qualifying investee, is deemed to own, on the last day of the 37700
upper level pass-through entity's calendar or fiscal year, the 37701
proportionate share of the lower level pass-through entity's 37702
physical assets that the lower level pass-through entity directly 37703
or indirectly owns on the last day of the lower level pass-through 37704

entity's calendar or fiscal year ending within or with the last 37705
day of the upper level pass-through entity's fiscal or calendar 37706
year. If the upper level pass-through entity directly and 37707
indirectly owns less than fifty per cent of the equity of the 37708
lower level pass-through entity on each day of the upper level 37709
pass-through entity's calendar or fiscal year in which or with 37710
which ends the calendar or fiscal year of the lower level 37711
pass-through entity and if, based upon clear and convincing 37712
evidence, complete information about the location and cost of the 37713
physical assets of the lower pass-through entity is not available 37714
to the upper level pass-through entity, then solely for purposes 37715
of ascertaining if a gain or loss constitutes a qualifying trust 37716
amount, the upper level pass-through entity shall be deemed as 37717
owning no equity of the lower level pass-through entity for each 37718
day during the upper level pass-through entity's calendar or 37719
fiscal year in which or with which ends the lower level 37720
pass-through entity's calendar or fiscal year. Nothing in division 37721
(BB)(5)(a)(iii) of this section shall be construed to provide for 37722
any deduction or exclusion in computing any trust's Ohio taxable 37723
income. 37724

(b) With respect to a trust that is not a resident for the 37725
taxable year and with respect to a part of a trust that is not a 37726
resident for the taxable year, "qualifying investee" for that 37727
taxable year does not include a C corporation if both of the 37728
following apply: 37729

(i) During the taxable year the trust or part of the trust 37730
recognizes a gain or loss from the sale, exchange, or other 37731
disposition of equity or ownership interests in, or debt 37732
obligations of, the C corporation. 37733

(ii) Such gain or loss constitutes nonbusiness income. 37734

(6) "Available" means information is such that a person is 37735
able to learn of the information by the due date plus extensions, 37736

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 37767
election by a pre-income tax trust to subject to the tax imposed 37768
by section 5751.02 of the Revised Code the pre-income tax trust 37769
and all pass-through entities of which the trust owns or controls, 37770
directly, indirectly, or constructively through related interests, 37771
five per cent or more of the ownership or equity interests. The 37772
trustee shall notify the tax commissioner in writing of the 37773
election on or before April 15, 2006. The election, if timely 37774
made, shall be effective on and after January 1, 2006, and shall 37775
apply for all tax periods and tax years until revoked by the 37776
trustee of the trust. 37777

(4) A "pre-income tax trust" is a trust that satisfies all of 37778
the following requirements: 37779

(a) The document or instrument creating the trust was 37780
executed by the grantor before January 1, 1972; 37781

(b) The trust became irrevocable upon the creation of the 37782
trust; and 37783

(c) The grantor was domiciled in this state at the time the 37784
trust was created. 37785

Sec. 5747.122. (A) The tax commissioner, in accordance with 37786
section 5101.184 of the Revised Code, shall cooperate with the 37787
director of job and family services to collect overpayments of 37788
assistance under Chapter 5107., ~~5111.~~, or 5115., former Chapter 37789
5113., or section 5101.54 of the Revised Code from refunds of 37790
state income taxes for taxable year 1992 and thereafter that are 37791
payable to the recipients of such overpayments. The tax 37792
commissioner, in accordance with section 5160.45 of the Revised 37793
Code, shall cooperate with the director of health care 37794
administration to collect overpayments of assistance under the 37795
disability medical assistance program or medicaid program from 37796
refunds of state income taxes for taxable year 1992 and thereafter 37797

that are payable to disability medical assistance recipients or 37798
medicaid recipients. 37799

(B) At the request of the department of job and family 37800
services or department of health care administration in connection 37801
with the collection of an overpayment of assistance from a refund 37802
of state income taxes pursuant to this section and section 37803
5101.184 or 5160.45 of the Revised Code, the tax commissioner 37804
shall release to the department the home address and social 37805
security number of any recipient of assistance whose overpayment 37806
may be collected from a refund of state income taxes under those 37807
sections. 37808

(C) In the case of a joint income tax return for two people 37809
who were not married to each other at the time one of them 37810
received an overpayment of assistance, only the portion of a 37811
refund that is due to the recipient of the overpayment shall be 37812
available for collection of the overpayment under this section and 37813
section 5101.184 or 5160.45 of the Revised Code. The tax 37814
commissioner shall determine such portion. A recipient's spouse 37815
who objects to the portion as determined by the commissioner may 37816
file a complaint with the commissioner within twenty-one days 37817
after receiving notice of the collection, and the commissioner 37818
shall afford the spouse an opportunity to be heard on the 37819
complaint. The commissioner shall waive or extend the 37820
twenty-one-day period if the recipient's spouse establishes that 37821
such action is necessary to avoid unjust, unfair, or unreasonable 37822
results. After the hearing, the commissioner shall make a final 37823
determination of the portion of the refund available for 37824
collection of the overpayment. 37825

(D) The welfare overpayment intercept fund is hereby created 37826
in the state treasury. The tax commissioner shall deposit amounts 37827
collected from income tax refunds under this section to the credit 37828
of the welfare overpayment intercept fund. The director of job and 37829

family services and director of health care administration shall 37830
distribute money in the fund in accordance with appropriate 37831
federal or state laws and procedures regarding collection of 37832
welfare overpayments and disability medical assistance program and 37833
medicaid payments. 37834

Sec. 5747.18. The tax commissioner shall enforce and 37835
administer this chapter. In addition to any other powers conferred 37836
upon the commissioner by law, the commissioner may: 37837

(A) Prescribe all forms required to be filed pursuant to this 37838
chapter; 37839

(B) Adopt such rules as the commissioner finds necessary to 37840
carry out this chapter; 37841

(C) Appoint and employ such personnel as are necessary to 37842
carry out the duties imposed upon the commissioner by this 37843
chapter. 37844

Any information gained as the result of returns, 37845
investigations, hearings, or verifications required or authorized 37846
by this chapter is confidential, and no person shall disclose such 37847
information, except for official purposes, or as provided by 37848
section 3125.43, 4123.271, 4123.591, 4507.023, ~~or~~ 5101.182, or 37849
5160.44, division (B) of section 5703.21 of the Revised Code, or 37850
in accordance with a proper judicial order. The tax commissioner 37851
may furnish the internal revenue service with copies of returns or 37852
reports filed and may furnish the officer of a municipal 37853
corporation charged with the duty of enforcing a tax subject to 37854
Chapter 718. of the Revised Code with the names, addresses, and 37855
identification numbers of taxpayers who may be subject to such 37856
tax. A municipal corporation shall use this information for tax 37857
collection purposes only. This section does not prohibit the 37858
publication of statistics in a form which does not disclose 37859
information with respect to individual taxpayers. 37860

Sec. 5751.081. As used in this section, "debt to this state" 37861
means unpaid taxes due the state, unpaid workers' compensation 37862
premiums due under section 4123.35 of the Revised Code, unpaid 37863
unemployment compensation contributions due under section 4141.25 37864
of the Revised Code, unpaid unemployment compensation payment in 37865
lieu of contribution under section 4141.241 of the Revised Code, 37866
unpaid fee payable to the state or to the clerk of courts pursuant 37867
to section 4505.06 of the Revised Code, incorrect ~~medical~~ 37868
~~assistance~~ medicaid payments ~~under section 5111.02 of the Revised~~ 37869
~~Code~~, or any unpaid charge, penalty, or interest arising from any 37870
of the foregoing. 37871

If a taxpayer entitled to a refund under section 5751.08 of 37872
the Revised Code owes any debt to this state, the amount 37873
refundable may be applied in satisfaction of the debt. If the 37874
amount refundable is less than the amount of the debt, it may be 37875
applied in partial satisfaction of the debt. If the amount 37876
refundable is greater than the amount of the debt, the amount 37877
remaining after satisfaction of the debt shall be refunded. This 37878
section applies only to debts that have become final. For the 37879
purposes of this section, a debt becomes final when, under the 37880
applicable law, any time provided for petition for reassessment, 37881
request for reconsideration, or other appeal of the legality or 37882
validity of the amount giving rise to the debt expires without an 37883
appeal having been filed in the manner provided by law. 37884

Sec. 5815.28. (A) As used in this section: 37885

(1) "Ascertainable standard" includes a standard in a trust 37886
instrument requiring the trustee to provide for the care, comfort, 37887
maintenance, welfare, education, or general well-being of the 37888
beneficiary. 37889

(2) "Disability" means any substantial, medically 37890

determinable impairment that can be expected to result in death or 37891
that has lasted or can be expected to last for a continuous period 37892
of at least twelve months, except that "disability" does not 37893
include an impairment that is the result of abuse of alcohol or 37894
drugs. 37895

(3) "Political subdivision" and "state" have the same 37896
meanings as in section 2744.01 of the Revised Code. 37897

(4) "Supplemental services" means services specified by rule 37898
of the department of mental health under section 5119.01 of the 37899
Revised Code or the department of mental retardation and 37900
developmental disabilities under section 5123.04 of the Revised 37901
Code that are provided to an individual with a disability in 37902
addition to services the individual is eligible to receive under 37903
programs authorized by federal or state law. 37904

(B) Any person may create a trust under this section to 37905
provide funding for supplemental services for the benefit of 37906
another individual who meets either of the following conditions: 37907

(1) The individual has a physical or mental disability and is 37908
eligible to receive services through the department of mental 37909
retardation and developmental disabilities or a county board of 37910
mental retardation and developmental disabilities; 37911

(2) The individual has a mental disability and is eligible to 37912
receive services through the department of mental health or a 37913
board of alcohol, drug addiction, and mental health services. 37914

The trust may confer discretion upon the trustee and may 37915
contain specific instructions or conditions governing the exercise 37916
of the discretion. 37917

(C) The general division of the court of common pleas and the 37918
probate court of the county in which the beneficiary of a trust 37919
authorized by division (B) of this section resides or is confined 37920
have concurrent original jurisdiction to hear and determine 37921

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 ~~5111.7~~, 5121.7 or 5123. of the Revised Code 37954
or the medicaid program and claims sought to be satisfied by way 37955
of a civil action, subrogation, execution, garnishment, 37956
attachment, judicial sale, or other legal process, if all of the 37957
following apply: 37958

(1) At the time the trust is created, the trust principal 37959
does not exceed the maximum amount determined under division (E) 37960
of this section; 37961

(2) The trust instrument contains a statement of the 37962
settlor's intent, or otherwise clearly evidences the settlor's 37963
intent, that the beneficiary does not have authority to compel the 37964
trustee under any circumstances to furnish the beneficiary with 37965
minimal or other maintenance or support, to make payments from the 37966
principal of the trust or from the income derived from the 37967
principal, or to convert any portion of the principal into cash, 37968
whether pursuant to an ascertainable standard specified in the 37969
instrument or otherwise; 37970

(3) The trust instrument provides that trust assets can be 37971
used only to provide supplemental services, as defined by rule of 37972
the director of mental health under section 5119.01 of the Revised 37973
Code or the director of mental retardation and developmental 37974
disabilities under section 5123.04 of the Revised Code, to the 37975
beneficiary; 37976

(4) The trust is maintained and assets are distributed in 37977
accordance with rules adopted by the director of mental health 37978
under section 5119.01 of the Revised Code or the director of 37979
mental retardation and developmental disabilities under section 37980
5123.04 of the Revised Code; 37981

(5) The trust instrument provides that on the death of the 37982
beneficiary, a portion of the remaining assets of the trust, which 37983
shall be not less than fifty per cent of such assets, will be 37984

deposited to the credit of the services fund for individuals with 37985
mental illness created by section 5119.17 of the Revised Code or 37986
the services fund for individuals with mental retardation and 37987
developmental disabilities created by section 5123.40 of the 37988
Revised Code. 37989

(E) In 1994, the trust principal maximum amount for a trust 37990
created under this section shall be two hundred thousand dollars. 37991
The maximum amount for a trust created under this section prior to 37992
November 11, 1994, may be increased to two hundred thousand 37993
dollars. 37994

In 1995, the maximum amount for a trust created under this 37995
section shall be two hundred two thousand dollars. Each year 37996
thereafter, the maximum amount shall be the prior year's amount 37997
plus two thousand dollars. 37998

(F) This section does not limit or otherwise affect the 37999
creation, validity, interpretation, or effect of any trust that is 38000
not created under this section. 38001

(G) Once a trustee takes action on a trust created by a 38002
settlor under this section and disburses trust funds on behalf of 38003
the beneficiary of the trust, then the trust may not be terminated 38004
or otherwise revoked by a particular event or otherwise without 38005
payment into the services fund created pursuant to section 5119.17 38006
or 5123.40 of the Revised Code of an amount that is equal to the 38007
disbursements made on behalf of the beneficiary for medical care 38008
by the state from the date the trust vests but that is not more 38009
than fifty per cent of the trust corpus. 38010

Sec. 5907.04. All members of the armed forces, who served in 38011
the regular or volunteer forces of the United States or the Ohio 38012
national guard or members of the naval militia during the war with 38013
Spain, the Philippine insurrection, the China relief expedition, 38014
the Indian war, the Mexican expedition, World War I, World War II, 38015

or during the period beginning June 25, 1950 and ending July 19, 38016
1953, known as the Korean conflict, or during the period beginning 38017
August 5, 1964, and ending July 1, 1973, known as the Vietnam 38018
conflict, or any person who is awarded either the armed forces 38019
expeditionary medal established by presidential executive order 38020
10977 dated December 4, 1961, or the Vietnam service medal 38021
established by presidential executive order 11231 dated July 8, 38022
1965, who have been honorably discharged or separated under 38023
honorable conditions therefrom, or any discharged members of the 38024
Polish and Czechoslovakian armed forces who served in armed 38025
conflict with an enemy of the United States in World War I or 38026
World War II who have been citizens of the United States for at 38027
least ten years, provided that the above-mentioned persons have 38028
been citizens of this state for five consecutive years or more at 38029
the date of making application for admission, are disabled by 38030
disease, wounds, or otherwise, and are by reason of such 38031
disability incapable of earning their living, and all members of 38032
the Ohio national guard or naval militia who have lost an arm or 38033
leg, or their sight, or become permanently disabled from any 38034
cause, while in the line and discharge of duty, and are not able 38035
to support themselves, may be admitted to a veterans' home under 38036
such rules as the board of trustees of the Ohio veterans' home 38037
agency adopts. 38038

The superintendent of the Ohio veterans' home agency shall 38039
promptly and diligently pursue the establishment of the 38040
eligibility for ~~medical assistance under Chapter 5111. of the~~ 38041
~~Revised Code~~ the medicaid program of all persons admitted to a 38042
veterans' home and all residents of a home who appear to qualify 38043
and shall promptly and diligently pursue and maintain the 38044
certification of each home's compliance with federal laws and 38045
regulations governing participation in the ~~medical assistance~~ 38046
medicaid program to include as large as possible a part of the 38047
home's bed capacity. 38048

Veterans' homes may reserve a bed during the temporary 38049
absence of a resident or patient from the home, including a 38050
nursing home within it, under conditions prescribed by the board 38051
of trustees, to include hospitalization for an acute condition, 38052
visits with relatives and friends, and participation in 38053
therapeutic programs outside the home. A home shall not reserve a 38054
bed for more than thirty days, except that absences for more than 38055
thirty days due to hospitalization may be authorized. 38056

Section 2. That existing sections 9.231, 9.239, 9.24, 101.39, 38057
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5111.887, 5111.888, 5111.889, 5111.8810, 5111.8811, 5111.8812, 38129
5111.8813, 5111.8814, 5111.8815, 5111.8816, 5111.8817, 5111.89, 38130
5111.891, 5111.892, 5111.893, 5111.90, 5111.91, 5111.911, 38131
5111.912, 5111.913, 5111.914, 5111.915, 5111.92, 5111.93, 5111.94, 38132
5111.941, 5111.942, 5111.943, 5111.95, 5111.96, 5111.97, 5111.971, 38133
5111.98, 5111.99, 5112.01, 5112.03, 5112.04, 5112.05, 5112.06, 38134
5112.07, 5112.08, 5112.09, 5112.10, 5112.11, 5112.17, 5112.18, 38135
5112.19, 5112.21, 5112.30, 5112.31, 5112.311, 5112.32, 5112.33, 38136
5112.34, 5112.341, 5112.35, 5112.37, 5112.38, 5112.39, 5112.99, 38137
5115.02, 5115.10, 5115.11, 5115.12, 5115.13, 5115.14, 5115.20, 38138
5115.22, 5115.23, 5117.10, 5119.04, 5119.061, 5119.16, 5119.351, 38139
5119.61, 5120.65, 5120.652, 5121.04, 5123.01, 5123.021, 5123.0412, 38140
5123.171, 5123.181, 5123.19, 5123.192, 5123.196, 5123.198, 38141
5123.199, 5123.211, 5123.41, 5123.71, 5123.76, 5126.01, 5126.035, 38142
5126.036, 5126.042, 5126.046, 5126.054, 5126.055, 5126.082, 38143
5126.12, 5505.04, 5725.18, 5729.03, 5731.39, 5747.01, 5747.122, 38144
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 38178
liability shall be administered by the Department of Health Care 38179
Administration pursuant to Chapters 5160., 5161., 5162., 5163., 38180
5164., 5165., 5166., 5167., and 5168. of the Revised Code. 38181

All rules, orders, and determinations pertaining to the 38182
programs as they were operated under Chapters 5101., 5111., 5112., 38183
and 5115. of the Revised Code immediately prior to July 1, 2007, 38184
continue in effect as rules, orders, and determinations of the 38185
programs under Chapters 5160., 5161., 5162., 5163., 5164., 5165., 38186
5166., 5167., and 5168. of the Revised Code, until modified or 38187
rescinded by the Department of Health Care Administration. If 38188
necessary to ensure the integrity of the numbering of the 38189
Administrative Code, the Director of the Legislative Service 38190
Commission shall renumber the rules to reflect the transfer of the 38191
programs from the Department of Job and Family Services to the 38192
Department of Health Care Administration. 38193

Subject to the lay-off provisions of sections 124.321 to 38194
124.328 of the Revised Code, all of the programs' employees in the 38195
Department of Job and Family Services shall be transferred to the 38196
Department of Health Care Administration. The transferred 38197
employees shall retain their positions and all of the benefits 38198
accruing to those positions. 38199

The Director of Budget and Management shall determine the 38200
amount of the unexpended balances in the appropriation accounts 38201
that pertain to the programs as they were operated under Chapters 38202
5101., 5111., 5112., and 5115. of the Revised Code immediately 38203
prior to July 1, 2007, and shall recommend to the Controlling 38204
Board their transfer to the appropriation accounts that pertain to 38205
the Department of Health Care Administration. The Department of 38206
Job and Family Services shall provide full and timely information 38207
to the Controlling Board to facilitate this transfer. Any funds 38208
transferred under this section are hereby appropriated. 38209

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. 38241

Subject to the lay-off provisions of sections 124.321 to 38242
124.328 of the Revised Code, all of the program's employees in the 38243
Department of Aging shall be transferred to the Department of 38244
Health Care Administration. The transferred employees shall retain 38245
their positions and all of the benefits accruing to those 38246
positions. 38247

The Director of Budget and Management shall determine the 38248
amount of the unexpended balances in the appropriation accounts 38249
that pertain to the program as it was operated under section 38250
173.35 of the Revised Code immediately prior to July 1, 2007, and 38251
shall recommend to the Controlling Board their transfer to the 38252
appropriation accounts that pertain to the Department of Health 38253
Care Administration. The Department of Aging shall provide full 38254
and timely information to the Controlling Board to facilitate this 38255
transfer. Any funds transferred under this section are hereby 38256
appropriated. 38257

Section 6. That Section 7 of Am. Sub. H.B. 468 of the 126th 38258
General Assembly be amended to read as follows: 38259

Sec. 7. On July 1, 2007, the Ohio's Best Rx Program and all 38260
of its functions, assets, and liabilities are transferred from the 38261
Department of Job and Family Services to the Department of ~~Aging~~ 38262
Health Care Administration. The transferred Program is thereupon 38263
and thereafter successor to, assumes the obligations of, and 38264
otherwise constitutes the continuation of the Program as it was 38265
operated under Chapter 5110. of the Revised Code immediately prior 38266
to July 1, 2007. 38267

Any Program business commenced but not completed before July 38268
1, 2007, shall be completed by the Department of ~~Aging~~ Health Care 38269
Administration under ~~sections 173.71 to 173.91~~ Chapter 5169. of 38270

the Revised Code. The business shall be completed in the same 38271
manner, and with the same effect, as if completed by the 38272
Department of Job and Family Services under Chapter 5110. of the 38273
Revised Code immediately prior to July 1, 2007. 38274

No validation, cure, right, privilege, remedy, obligation, or 38275
liability pertaining to the Program is lost or impaired by reason 38276
of the Program's transfer from the Department of Job and Family 38277
Services to the Department of ~~Aging~~ Health Care Administration. 38278
Each such validation, cure, right, privilege, remedy, obligation, 38279
or liability shall be administered by the Department of ~~Aging~~ 38280
Health Care Administration pursuant to ~~sections 173.71 to 173.91~~ 38281
Chapter 5169. of the Revised Code. 38282

All rules, orders, and determinations pertaining to the 38283
Program as it was operated under Chapter 5110. of the Revised Code 38284
immediately prior to July 1, 2007, continue in effect as rules, 38285
orders, and determinations of the Program under ~~sections 173.71 to~~ 38286
~~173.91~~ Chapter 5169. of the Revised Code, until modified or 38287
rescinded by the Department of ~~Aging~~ Health Care Administration. 38288
If necessary to ensure the integrity of the numbering of the 38289
Administrative Code, the Director of the Legislative Service 38290
Commission shall renumber the rules to reflect the transfer of the 38291
Program from the Department of Job and Family Services to the 38292
Department of ~~Aging~~ Health Care Administration. 38293

Subject to the lay-off provisions of sections 124.321 to 38294
124.328 of the Revised Code, all of the Program's employees in the 38295
Department of Job and Family Services shall be transferred to the 38296
Department of ~~Aging~~ Health Care Administration. The transferred 38297
employees shall retain their positions and all of the benefits 38298
accruing to those positions. 38299

The Director of Budget and Management shall determine the 38300
amount of the unexpended balances in the appropriation accounts 38301
that pertain to the Program as it was operated under Chapter 5110. 38302

of the Revised Code immediately prior to July 1, 2007, and shall 38303
recommend to the Controlling Board their transfer to the 38304
appropriation accounts that pertain to the Department of ~~Aging~~ 38305
Health Care Administration. The Department of Job and Family 38306
Services shall provide full and timely information to the 38307
Controlling Board to facilitate this transfer. Any funds 38308
transferred under this section are hereby appropriated. 38309

In anticipation of the Program's transfer to the Department 38310
of ~~Aging~~ Health Care Administration, the Department may negotiate 38311
or enter into a contract with a person to serve as the Program 38312
administrator beginning on or after July 1, 2007. When negotiating 38313
or entering into the contract, the Department shall comply with 38314
the same provisions that apply to the Department of Job and Family 38315
Services under section 5110.021 of the Revised Code. 38316

Section 7. That existing Section 7 of Am. Sub. H.B. 468 of 38317
the 126th General Assembly is hereby repealed. 38318

Section 8. The amendments of sections 4723.063, 5112.01, 38319
5112.03, 5112.04, 5112.05, 5112.06, 5112.07, 5112.08, 5112.09, 38320
5112.10, 5112.11, 5112.18, 5112.19, 5112.21, and 5112.99 of the 38321
Revised Code are not intended to supersede the earlier repeals, 38322
with delayed effective dates, of those sections. 38323

Section 9. The sections of law amended, enacted, or repealed 38324
by this act, and the items of law of which such sections are 38325
composed, are not subject to the referendum. Therefore, under Ohio 38326
Constitution, Article II, Section 1d and section 1.471 of the 38327
Revised Code, the sections go into effect July 1, 2007. 38328

Section 10. The General Assembly, applying the principle 38329
stated in division (B) of section 1.52 of the Revised Code that 38330
amendments are to be harmonized if reasonably capable of 38331

simultaneous operation, finds that the following sections, 38332
presented in this act as composites of the sections as amended by 38333
the acts indicated, are the resulting versions of the sections in 38334
effect prior to the effective date of the sections as presented in 38335
this act: 38336

Section 109.572 of the Revised Code as amended by both Am. 38337
Sub. S.B. 185 and Am. Sub. S.B. 238 of the 126th General Assembly. 38338

Section 2505.02 of the Revised Code as amended by both Am. 38339
Sub. H.B. 516 and Am. Sub. S.B. 80 of the 125th General Assembly. 38340

Section 11. Section 1337.11 of the Revised Code was amended 38341
by both Am. H.B. 72 and Am. Sub. H.B. 95 of the 125th General 38342
Assembly. Comparison of these amendments in pursuance of section 38343
1.52 of the Revised Code discloses that while certain of the 38344
amendments of these acts are reconcilable, certain other of the 38345
amendments are substantively irreconcilable. Am. H.B. 72 was 38346
passed on June 10, 2003; Am. Sub. H.B. 95 was passed on June 19, 38347
2003. Section 1337.11 of the Revised Code is therefore presented 38348
in this act as it results from Am. Sub. H.B. 95 and such of the 38349
amendments of Am. H.B. 72 as are not in conflict with the 38350
amendments of Am. Sub. H.B. 95. The General Assembly, applying the 38351
principle stated in division (B) of section 1.52 of the Revised 38352
Code that amendments are to be harmonized if reasonably capable of 38353
simultaneous operation, finds that the composite is the resulting 38354
version of the section in effect prior to the effective date of 38355
the section as presented in this act. 38356