

As Introduced

**128th General Assembly
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H. B. No. 398

Representatives Newcomb, Lehner

**Cosponsors: Representatives Harwood, Derickson, Domenick, Grossman,
Garland, Hagan, Evans, Snitchler, Phillips, Williams, B., Dyer, Fende,
Wachtmann, Ruhl, Hackett, Letson, Stebelton, Harris, Bubp, Hottinger,
Stautberg, Pillich, Murray, Driehaus, Brown, McClain, Weddington, Mallory,
Goyal, Baker, Blessing, Dolan, Yuko, Okey, Foley**

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A B I L L

To amend sections 173.401, 3702.51, 3702.59, 5111.65, 1
5111.651, 5111.68, 5111.681, 5111.685, 5111.686, 2
5111.688, and 5111.894; to amend, for the purpose 3
of adopting a new section number as indicated in 4
parentheses, section 5111.688 (5111.689); and to 5
enact new section 5111.688 of the Revised Code; 6
and to amend Section 209.20 of Am. Sub. H.B. 1 of 7
the 128th General Assembly to revise the waiting 8
list provisions of the PASSPORT and Assisted 9
Living programs, to revise the law governing the 10
collection of long-term care facilities' Medicaid 11
debts, and to revise the law governing the reasons 12
for denying a Certificate of Need application. 13

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

Section 1. That sections 173.401, 3702.51, 3702.59, 5111.65, 14
5111.651, 5111.68, 5111.681, 5111.685, 5111.686, 5111.688, and 15
5111.894 be amended; section 5111.688 (5111.689) be amended for 16

the purpose of adopting a new section number as indicated in 17
parentheses; and new section 5111.688 of the Revised Code be 18
enacted to read as follows: 19

Sec. 173.401. (A) As used in this section: 20

"Area agency on aging" has the same meaning as in section 21
173.14 of the Revised Code. 22

"Long-term care consultation program" means the program the 23
department of aging is required to develop under section 173.42 of 24
the Revised Code. 25

"Long-term care consultation program administrator" or 26
"administrator" means the department of aging or, if the 27
department contracts with an area agency on aging or other entity 28
to administer the long-term care consultation program for a 29
particular area, that agency or entity. 30

"Nursing facility" has the same meaning as in section 5111.20 31
of the Revised Code. 32

"PASSPORT waiver" means the federal medicaid waiver granted 33
by the United States secretary of health and human services that 34
authorizes the PASSPORT program. 35

~~(B) The director of job and family services shall submit to 36
the United States secretary of health and human services an 37
amendment to the PASSPORT waiver that authorizes additional 38
enrollments in the PASSPORT program pursuant to this section. 39
Beginning with the month following the month in which the United 40
States secretary approves the amendment and each The department of 41
aging may establish one or more waiting lists for the PASSPORT 42
program. Only individuals eligible for the PASSPORT program may be 43
placed on a waiting list. 44~~

(C) The department shall establish a home first component of 45

the PASSPORT program under which eligible individuals may be 46
enrolled in the PASSPORT program in accordance with this section. 47
An individual is eligible for the PASSPORT program's home first 48
component if the individual is on a PASSPORT program waiting list 49
and at least one of the following applies: 50

(1) The individual has been admitted to a nursing facility; 51

(2) A physician has determined and documented in writing that 52
the individual has a medical condition that, unless enrolled in 53
home and community-based services such as the PASSPORT program, 54
will require the individual to be admitted to a nursing facility 55
within thirty days of the physician's determination; 56

(3) The individual has been hospitalized and a physician has 57
determined and documented in writing that, unless the individual 58
is enrolled in home and community-based services such as the 59
PASSPORT program, the individual is to be transported directly 60
from the hospital to a nursing facility and admitted; 61

(4) Both of the following apply: 62

(a) The individual is the subject of a report made under 63
section 5101.61 of the Revised Code regarding abuse, neglect, or 64
exploitation or such a report referred to a county department of 65
job and family services under section 5126.31 of the Revised Code 66
or has made a request to a county department for protective 67
services as defined in section 5101.60 of the Revised Code; 68

(b) A county department of job and family services and an 69
area agency on aging have jointly documented in writing that, 70
unless the individual is enrolled in home and community-based 71
services such as the PASSPORT program, the individual should be 72
admitted to a nursing facility. 73

(D) ~~Each~~ month thereafter, each area agency on aging shall 74
determine whether identify individuals who reside residing in the 75
area that the area agency on aging serves and who are on a waiting 76

~~list eligible for the home first component of the PASSPORT program~~ 77
~~have been admitted to a nursing facility. If~~ When an area agency 78
~~on aging determines that~~ identifies such an individual ~~has been~~ 79
~~admitted to a nursing facility,~~ the agency shall notify the 80
long-term care consultation program administrator serving the area 81
in which the individual resides ~~about the determination.~~ The 82
administrator shall determine whether the PASSPORT program is 83
appropriate for the individual and whether the individual would 84
rather participate in the PASSPORT program than continue ~~residing~~ 85
or begin to reside in ~~the~~ a nursing facility. If the administrator 86
determines that the PASSPORT program is appropriate for the 87
individual and the individual would rather participate in the 88
PASSPORT program than continue ~~residing~~ or begin to reside in ~~the~~ 89
a nursing facility, the administrator shall so notify the 90
department of aging. On receipt of the notice from the 91
administrator, the department ~~of aging~~ shall approve the 92
individual's enrollment in the PASSPORT program regardless of the 93
PASSPORT program's waiting list ~~and even though the enrollment~~ 94
~~causes enrollment in the program to exceed the limit that would~~ 95
~~otherwise apply, unless the enrollment would cause the PASSPORT~~ 96
program to exceed any limit on the number of individuals who may 97
be enrolled in the program as set by the United States secretary 98
of health and human services in the PASSPORT waiver. 99

(E) Each quarter, the department of aging shall certify to 100
the director of budget and management the estimated increase in 101
costs of the PASSPORT program resulting from enrollment of 102
individuals in the PASSPORT program pursuant to this section. 103

Sec. 3702.51. As used in sections 3702.51 to 3702.62 of the 104
Revised Code: 105

(A) "Applicant" means any person that submits an application 106
for a certificate of need and who is designated in the application 107

as the applicant.	108
(B) "Person" means any individual, corporation, business trust, estate, firm, partnership, association, joint stock company, insurance company, government unit, or other entity.	109 110 111
(C) "Certificate of need" means a written approval granted by the director of health to an applicant to authorize conducting a reviewable activity.	112 113 114
(D) "Health service area" means a geographic region designated by the director of health under section 3702.58 of the Revised Code.	115 116 117
(E) "Health service" means a clinically related service, such as a diagnostic, treatment, rehabilitative, or preventive service.	118 119
(F) "Health service agency" means an agency designated to serve a health service area in accordance with section 3702.58 of the Revised Code.	120 121 122
(G) "Health care facility" means:	123
(1) A hospital registered under section 3701.07 of the Revised Code;	124 125
(2) A nursing home licensed under section 3721.02 of the Revised Code, or by a political subdivision certified under section 3721.09 of the Revised Code;	126 127 128
(3) A county home or a county nursing home as defined in section 5155.31 of the Revised Code that is certified under Title XVIII or XIX of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended;	129 130 131 132
(4) A freestanding dialysis center;	133
(5) A freestanding inpatient rehabilitation facility;	134
(6) An ambulatory surgical facility;	135
(7) A freestanding cardiac catheterization facility;	136

(8) A freestanding birthing center; 137

(9) A freestanding or mobile diagnostic imaging center; 138

(10) A freestanding radiation therapy center. 139

A health care facility does not include the offices of 140
private physicians and dentists whether for individual or group 141
practice, residential facilities licensed under section 5123.19 of 142
the Revised Code, or an institution for the sick that is operated 143
exclusively for patients who use spiritual means for healing and 144
for whom the acceptance of medical care is inconsistent with their 145
religious beliefs, accredited by a national accrediting 146
organization, exempt from federal income taxation under section 147
501 of the Internal Revenue Code of 1986, 100 Stat. 2085, 26 148
U.S.C.A. 1, as amended, and providing twenty-four hour nursing 149
care pursuant to the exemption in division (E) of section 4723.32 150
of the Revised Code from the licensing requirements of Chapter 151
4723. of the Revised Code. 152

(H) "Medical equipment" means a single unit of medical 153
equipment or a single system of components with related functions 154
that is used to provide health services. 155

(I) "Third-party payer" means a health insuring corporation 156
licensed under Chapter 1751. of the Revised Code, a health 157
maintenance organization as defined in division (K) of this 158
section, an insurance company that issues sickness and accident 159
insurance in conformity with Chapter 3923. of the Revised Code, a 160
state-financed health insurance program under Chapter 3701., 161
4123., or 5111. of the Revised Code, or any self-insurance plan. 162

(J) "Government unit" means the state and any county, 163
municipal corporation, township, or other political subdivision of 164
the state, or any department, division, board, or other agency of 165
the state or a political subdivision. 166

(K) "Health maintenance organization" means a public or 167

private organization organized under the law of any state that is 168
qualified under section 1310(d) of Title XIII of the "Public 169
Health Service Act," 87 Stat. 931 (1973), 42 U.S.C. 300e-9. 170

(L) "Existing health care facility" means either of the 171
following: 172

(1) A health care facility that is licensed or otherwise 173
authorized to operate in this state in accordance with applicable 174
law, including a county home or a county nursing home that is 175
certified as of February 1, 2008, under Title XVIII or Title XIX 176
of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C. 301, 177
as amended, is staffed and equipped to provide health care 178
services, and is actively providing health services; 179

(2) A health care facility that is licensed or otherwise 180
authorized to operate in this state in accordance with applicable 181
law, including a county home or a county nursing home that is 182
certified as of February 1, 2008, under Title XVIII or Title XIX 183
of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C. 301, 184
as amended, or that has beds registered under section 3701.07 of 185
the Revised Code as skilled nursing beds or long-term care beds 186
and has provided services for at least three hundred sixty-five 187
consecutive days within the twenty-four months immediately 188
preceding the date a certificate of need application is filed with 189
the director of health. 190

(M) "State" means the state of Ohio, including, but not 191
limited to, the general assembly, the supreme court, the offices 192
of all elected state officers, and all departments, boards, 193
offices, commissions, agencies, institutions, and other 194
instrumentalities of the state of Ohio. "State" does not include 195
political subdivisions. 196

(N) "Political subdivision" means a municipal corporation, 197
township, county, school district, and all other bodies corporate 198

and politic responsible for governmental activities only in	199
geographic areas smaller than that of the state to which the	200
sovereign immunity of the state attaches.	201
(O) "Affected person" means:	202
(1) An applicant for a certificate of need, including an	203
applicant whose application was reviewed comparatively with the	204
application in question;	205
(2) The person that requested the reviewability ruling in	206
question;	207
(3) Any person that resides or regularly uses health care	208
facilities within the geographic area served or to be served by	209
the health care services that would be provided under the	210
certificate of need or reviewability ruling in question;	211
(4) Any health care facility that is located in the health	212
service area where the health care services would be provided	213
under the certificate of need or reviewability ruling in question;	214
(5) Third-party payers that reimburse health care facilities	215
for services in the health service area where the health care	216
services would be provided under the certificate of need or	217
reviewability ruling in question;	218
(6) Any other person who testified at a public hearing held	219
under division (B) of section 3702.52 of the Revised Code or	220
submitted written comments in the course of review of the	221
certificate of need application in question.	222
(P) "Osteopathic hospital" means a hospital registered under	223
section 3701.07 of the Revised Code that advocates osteopathic	224
principles and the practice and perpetuation of osteopathic	225
medicine by doing any of the following:	226
(1) Maintaining a department or service of osteopathic	227
medicine or a committee on the utilization of osteopathic	228

principles and methods, under the supervision of an osteopathic physician;	229 230
(2) Maintaining an active medical staff, the majority of which is comprised of osteopathic physicians;	231 232
(3) Maintaining a medical staff executive committee that has osteopathic physicians as a majority of its members.	233 234
(Q) "Ambulatory surgical facility" has the same meaning as in section 3702.30 of the Revised Code.	235 236
(R) Except as provided in division (S) of this section, "reviewable activity" means any of the following activities:	237 238
(1) The establishment, development, or construction of a new long-term care facility;	239 240
(2) The replacement of an existing long-term care facility;	241
(3) The renovation of a long-term care facility that involves a capital expenditure of two million dollars or more, not including expenditures for equipment, staffing, or operational costs;	242 243 244 245
(4) Either of the following changes in long-term care bed capacity:	246 247
(a) An increase in bed capacity;	248
(b) A relocation of beds from one physical facility or site to another, excluding the relocation of beds within a long-term care facility or among buildings of a long-term care facility at the same site.	249 250 251 252
(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;	253 254 255 256 257 258

(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.	259 260 261
(S) "Reviewable activity" does not include any of the following activities:	262 263
(1) Acquisition of computer hardware or software;	264
(2) Acquisition of a telephone system;	265
(3) Construction or acquisition of parking facilities;	266
(4) Correction of cited deficiencies that are in violation of federal, state, or local fire, building, or safety laws and rules and that constitute an imminent threat to public health or safety;	267 268 269
(5) Acquisition of an existing health care facility that does not involve a change in the number of the beds, by service, or in the number or type of health services;	270 271 272
(6) Correction of cited deficiencies identified by accreditation surveys of the joint commission on accreditation of healthcare organizations or of the American osteopathic association;	273 274 275 276
(7) Acquisition of medical equipment to replace the same or similar equipment for which a certificate of need has been issued if the replaced equipment is removed from service;	277 278 279
(8) Mergers, consolidations, or other corporate reorganizations of health care facilities that do not involve a change in the number of beds, by service, or in the number or type of health services;	280 281 282 283
(9) Construction, repair, or renovation of bathroom facilities;	284 285
(10) Construction of laundry facilities, waste disposal facilities, dietary department projects, heating and air conditioning projects, administrative offices, and portions of	286 287 288

medical office buildings used exclusively for physician services; 289

(11) Acquisition of medical equipment to conduct research 290
required by the United States food and drug administration or 291
clinical trials sponsored by the national institute of health. Use 292
of medical equipment that was acquired without a certificate of 293
need under division (S)(11) of this section and for which 294
premarket approval has been granted by the United States food and 295
drug administration to provide services for which patients or 296
reimbursement entities will be charged shall be a reviewable 297
activity. 298

(12) Removal of asbestos from a health care facility. 299

Only that portion of a project that meets the requirements of 300
this division is not a reviewable activity. 301

(T) "Small rural hospital" means a hospital that is located 302
within a rural area, has fewer than one hundred beds, and to which 303
fewer than four thousand persons were admitted during the most 304
recent calendar year. 305

(U) "Children's hospital" means any of the following: 306

(1) A hospital registered under section 3701.07 of the 307
Revised Code that provides general pediatric medical and surgical 308
care, and in which at least seventy-five per cent of annual 309
inpatient discharges for the preceding two calendar years were 310
individuals less than eighteen years of age; 311

(2) A distinct portion of a hospital registered under section 312
3701.07 of the Revised Code that provides general pediatric 313
medical and surgical care, has a total of at least one hundred 314
fifty registered pediatric special care and pediatric acute care 315
beds, and in which at least seventy-five per cent of annual 316
inpatient discharges for the preceding two calendar years were 317
individuals less than eighteen years of age; 318

(3) A distinct portion of a hospital, if the hospital is registered under section 3701.07 of the Revised Code as a children's hospital and the children's hospital meets all the requirements of division (U)(1) of this section.

(V) "Long-term care facility" means any of the following:

(1) A nursing home licensed under section 3721.02 of the Revised Code or by a political subdivision certified under section 3721.09 of the Revised Code;

(2) The portion of any facility, including a county home or county nursing home, that is certified as a skilled nursing facility or a nursing facility under Title XVIII or XIX of the "Social Security Act";

(3) The portion of any hospital that contains beds registered under section 3701.07 of the Revised Code as skilled nursing beds or long-term care beds.

(W) "Long-term care bed" means a bed in a long-term care facility.

(X) "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.

(Y)(1) "Reviewability ruling" means a ruling issued by the director of health under division (A) of section 3702.52 of the Revised Code as to whether a particular proposed project is or is not a reviewable activity.

(2) "Nonreviewability ruling" means a ruling issued under that division that a particular proposed project is not a reviewable activity.

(Z)(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. 93-17, June 30, 1993, and its attachments.

(2) "Rural area" means any area of this state not located within a metropolitan statistical area.

(AA) "County nursing home" has the same meaning as in section 5155.31 of the Revised Code.

(BB) "Principal participant" means both of the following:

(1) A person who has an ownership or controlling interest of at least five per cent in an applicant, in a health care facility that is the subject of an application for a certificate of need, or in the owner or operator of the applicant or such a facility;

(2) An officer, director, trustee, or general partner of an applicant, of a health care facility that is the subject of an application for a certificate of need, or of the owner or operator of the applicant or such a facility.

(CC) "Actual harm but not immediate jeopardy deficiency" means a deficiency that, under 42 C.F.R. 488.404, either constitutes a pattern of deficiencies resulting in actual harm that is not immediate jeopardy or represents widespread deficiencies resulting in actual harm that is not immediate jeopardy.

(DD) "Immediate jeopardy deficiency" means a deficiency that, under 42 C.F.R. 488.404, either constitutes a pattern of deficiencies resulting in immediate jeopardy to resident health or safety or represents widespread deficiencies resulting in immediate jeopardy to resident health or safety.

Sec. 3702.59. (A) The director of health shall accept for

review certificate of need applications as provided in sections 379
3702.592, 3702.593, and 3702.594 of the Revised Code. 380

(B)(1) The director shall not approve an application for a 381
certificate of need for the addition of long-term care beds to an 382
existing health care facility or for the development of a new 383
health care facility if any of the following apply: 384

~~(1)(a)~~ The existing health care facility in which the beds 385
are being placed has one or more waivers for life safety code 386
deficiencies, one or more state fire code violations, or one or 387
more state building code violations, and the project identified in 388
the application does not propose to correct all life safety code 389
deficiencies for which a waiver has been granted, all state fire 390
code violations, and all state building code violations at the 391
existing health care facility in which the beds are being placed; 392

~~(2)(b)~~ During the sixty-month period preceding the filing of 393
the application, a notice of proposed license revocation was 394
issued under section 3721.03 of the Revised Code for the existing 395
health care facility in which the beds are being placed or a 396
nursing home owned or operated by the applicant or ~~the corporation~~ 397
~~or other business that operates or seeks to operate the health~~ 398
~~care facility in which the beds are being placed~~ a principal 399
participant. 400

~~(3)(c)~~ During the period that precedes the filing of the 401
application and is encompassed by the three most recent standard 402
surveys of the existing health care facility in which the beds are 403
being placed, ~~the~~ any of the following occurred: 404

(i) The facility was cited on three or more separate 405
occasions for final, nonappealable actual harm but not immediate 406
jeopardy deficiencies that, under 42 C.F.R. 488.404, either 407
constitute a pattern of deficiencies resulting in actual harm that 408
is not immediate jeopardy or are widespread deficiencies resulting 409

~~in actual harm that is not immediate jeopardy.~~ 410

~~(4) During the period that precedes the filing of the application and is encompassed by the three most recent standard surveys of the existing health care facility in which the beds are being placed, the (ii) The facility was cited on two or more separate occasions for final, nonappealable immediate jeopardy deficiencies that, under 42 C.F.R. 488.404, either constitute a pattern of deficiencies resulting in immediate jeopardy to resident health or safety or are widespread deficiencies resulting in immediate jeopardy to resident health or safety.~~ 411-419

~~(5) During the period that precedes the filing of the application and is encompassed by the three most recent standard surveys of the existing health care facility in which the beds are being placed, more (iii) The facility was cited on two separate occasions for final, nonappealable actual harm but not immediate jeopardy deficiencies and on one occasion for a final, nonappealable immediate jeopardy deficiency.~~ 420-426

~~(d) More than two nursing homes owned or operated in this state by the applicant or the person who operates the facility in which the beds are being placed a principal participant or, if the applicant or person a principal participant owns or operates more than twenty nursing homes in this state, more than ten per cent of those nursing homes, were each cited on during the period that precedes the filing of the application for the certificate of need and is encompassed by the three most recent standard surveys of the nursing homes that were so cited in any of the following manners:~~ 427-436

~~(i) On three or more separate occasions for final, nonappealable actual harm but not immediate jeopardy deficiencies that, under 42 C.F.R. 488.404, either constitute a pattern of deficiencies resulting in actual harm that is not immediate jeopardy or are widespread deficiencies resulting in actual harm~~ 437-441

~~that is not immediate jeopardy.~~ 442

~~(6) During the period that precedes the filing of the 443
application and is encompassed by the three most recent standard 444
surveys of the existing health care facility in which the beds are 445
being placed, more than two nursing homes operated in this state 446
by the applicant or the person who operates the facility in which 447
the beds are being placed or, if the applicant or person operates 448
more than twenty nursing homes in this state, more than ten per 449
cent of those nursing homes, were each cited on;~~ 450

~~(ii) On two or more separate occasions for final, 451
nonappealable immediate jeopardy deficiencies that, under 42 452
C.F.R. 488.404, either constitute a pattern of deficiencies 453
resulting in immediate jeopardy to resident health or safety or 454
are widespread deficiencies resulting in immediate jeopardy to 455
resident health or safety;~~ 456

~~(iii) On two separate occasions for final, nonappealable 457
actual harm but not immediate jeopardy deficiencies and on one 458
occasion for a final, nonappealable immediate jeopardy deficiency. 459~~

~~(7) During the sixty month period preceding the filing of the 460
application, the applicant has violated this chapter on two or 461
more separate occasions.~~ 462

~~(2) In applying divisions (B)(1)(a) to (6)(d) of this 463
section, the director shall not consider deficiencies or 464
violations cited before the ~~current operator~~ applicant or a 465
principal participant acquired or began to own or operate the 466
health care facility at which the deficiencies or violations were 467
cited. The director may disregard deficiencies and violations 468
cited after the health care facility was acquired or began to be 469
operated by the ~~current operator~~ applicant or a principal 470
participant if the deficiencies or violations were attributable to 471
circumstances that arose under the previous owner or operator and 472~~

the ~~current operator~~ applicant or principal participant has 473
implemented measures to alleviate the circumstances. In the case 474
of an application proposing development of a new health care 475
facility by relocation of beds, the director shall not consider 476
deficiencies or violations that were solely attributable to the 477
physical plant of the existing health care facility from which the 478
beds are being relocated. 479

(C) The director also shall accept for review any application 480
for the conversion of infirmary beds to long-term care beds if the 481
infirmary meets all of the following conditions: 482

(1) Is operated exclusively by a religious order; 483

(2) Provides care exclusively to members of religious orders 484
who take vows of celibacy and live by virtue of their vows within 485
the orders as if related; 486

(3) Was providing care exclusively to members of such a 487
religious order on January 1, 1994. 488

At no time shall individuals other than those described in 489
division (C)(2) of this section be admitted to a facility to use 490
beds for which a certificate of need is approved under this 491
division. 492

Sec. 5111.65. As used in sections 5111.65 to ~~5111.688~~ 493
5111.689 of the Revised Code: 494

(A) "Affiliated operator" means an operator affiliated with 495
either of the following: 496

(1) The exiting operator for whom the affiliated operator is 497
to assume liability for the entire amount of the exiting 498
operator's debt under the medicaid program or the portion of the 499
debt that represents the franchise permit fee the exiting operator 500
owes; 501

(2) The entering operator involved in the change of operator 502

with the exiting operator specified in division (A)(1) of this 503
section. 504

(B) "Change of operator" means an entering operator becoming 505
the operator of a nursing facility or intermediate care facility 506
for the mentally retarded in the place of the exiting operator. 507

(1) Actions that constitute a change of operator include the 508
following: 509

(a) A change in an exiting operator's form of legal 510
organization, including the formation of a partnership or 511
corporation from a sole proprietorship; 512

(b) A transfer of all the exiting operator's ownership 513
interest in the operation of the facility to the entering 514
operator, regardless of whether ownership of any or all of the 515
real property or personal property associated with the facility is 516
also transferred; 517

(c) A lease of the facility to the entering operator or the 518
exiting operator's termination of the exiting operator's lease; 519

(d) If the exiting operator is a partnership, dissolution of 520
the partnership; 521

(e) If the exiting operator is a partnership, a change in 522
composition of the partnership unless both of the following apply: 523

(i) The change in composition does not cause the 524
partnership's dissolution under state law. 525

(ii) The partners agree that the change in composition does 526
not constitute a change in operator. 527

(f) If the operator is a corporation, dissolution of the 528
corporation, a merger of the corporation into another corporation 529
that is the survivor of the merger, or a consolidation of one or 530
more other corporations to form a new corporation. 531

(2) The following, alone, do not constitute a change of 532

operator: 533

(a) A contract for an entity to manage a nursing facility or 534
intermediate care facility for the mentally retarded as the 535
operator's agent, subject to the operator's approval of daily 536
operating and management decisions; 537

(b) A change of ownership, lease, or termination of a lease 538
of real property or personal property associated with a nursing 539
facility or intermediate care facility for the mentally retarded 540
if an entering operator does not become the operator in place of 541
an exiting operator; 542

(c) If the operator is a corporation, a change of one or more 543
members of the corporation's governing body or transfer of 544
ownership of one or more shares of the corporation's stock, if the 545
same corporation continues to be the operator. 546

~~(B)~~(C) "Effective date of a change of operator" means the day 547
the entering operator becomes the operator of the nursing facility 548
or intermediate care facility for the mentally retarded. 549

~~(C)~~(D) "Effective date of a facility closure" means the last 550
day that the last of the residents of the nursing facility or 551
intermediate care facility for the mentally retarded resides in 552
the facility. 553

~~(D)~~(E) "Effective date of a voluntary termination" means the 554
day the intermediate care facility for the mentally retarded 555
ceases to accept medicaid patients. 556

~~(E)~~(F) "Effective date of a voluntary withdrawal of 557
participation" means the day the nursing facility ceases to accept 558
new medicaid patients other than the individuals who reside in the 559
nursing facility on the day before the effective date of the 560
voluntary withdrawal of participation. 561

~~(F)~~(G) "Entering operator" means the person or government 562

entity that will become the operator of a nursing facility or 563
intermediate care facility for the mentally retarded when a change 564
of operator occurs. 565

~~(G)~~(H) "Exiting operator" means any of the following: 566

(1) An operator that will cease to be the operator of a 567
nursing facility or intermediate care facility for the mentally 568
retarded on the effective date of a change of operator; 569

(2) An operator that will cease to be the operator of a 570
nursing facility or intermediate care facility for the mentally 571
retarded on the effective date of a facility closure; 572

(3) An operator of an intermediate care facility for the 573
mentally retarded that is undergoing or has undergone a voluntary 574
termination; 575

(4) An operator of a nursing facility that is undergoing or 576
has undergone a voluntary withdrawal of participation. 577

~~(H)~~(I)(1) "Facility closure" means discontinuance of the use 578
of the building, or part of the building, that houses the facility 579
as a nursing facility or intermediate care facility for the 580
mentally retarded that results in the relocation of all of the 581
facility's residents. A facility closure occurs regardless of any 582
of the following: 583

(a) The operator completely or partially replacing the 584
facility by constructing a new facility or transferring the 585
facility's license to another facility; 586

(b) The facility's residents relocating to another of the 587
operator's facilities; 588

(c) Any action the department of health takes regarding the 589
facility's certification under Title XIX of the "Social Security 590
Act," 79 Stat. 286 (1965), 42 U.S.C. 1396, as amended, that may 591
result in the transfer of part of the facility's survey findings 592

to another of the operator's facilities; 593

(d) Any action the department of health takes regarding the 594
facility's license under Chapter 3721. of the Revised Code; 595

(e) Any action the department of mental retardation and 596
developmental disabilities takes regarding the facility's license 597
under section 5123.19 of the Revised Code. 598

(2) A facility closure does not occur if all of the 599
facility's residents are relocated due to an emergency evacuation 600
and one or more of the residents return to a medicaid-certified 601
bed in the facility not later than thirty days after the 602
evacuation occurs. 603

~~(I)~~(J) "Fiscal year," "franchise permit fee," "intermediate 604
care facility for the mentally retarded," "nursing facility," 605
"operator," "owner," and "provider agreement" have the same 606
meanings as in section 5111.20 of the Revised Code. 607

~~(J)~~(K) "Voluntary termination" means an operator's voluntary 608
election to terminate the participation of an intermediate care 609
facility for the mentally retarded in the medicaid program but to 610
continue to provide service of the type provided by a residential 611
facility as defined in section 5123.19 of the Revised Code. 612

~~(K)~~(L) "Voluntary withdrawal of participation" means an 613
operator's voluntary election to terminate the participation of a 614
nursing facility in the medicaid program but to continue to 615
provide service of the type provided by a nursing facility. 616

Sec. 5111.651. Sections 5111.65 to ~~5111.688~~ 5111.689 of the 617
Revised Code do not apply to a nursing facility or intermediate 618
care facility for the mentally retarded that undergoes a facility 619
closure, voluntary termination, voluntary withdrawal of 620
participation, or change of operator on or before September 30, 621
2005, if the exiting operator provided written notice of the 622

facility closure, voluntary termination, voluntary withdrawal of 623
participation, or change of operator to the department of job and 624
family services on or before June 30, 2005. 625

Sec. 5111.68. (A) On receipt of a written notice under 626
section 5111.66 of the Revised Code of a facility closure, 627
voluntary termination, or voluntary withdrawal of participation or 628
a written notice under section 5111.67 of the Revised Code of a 629
change of operator, the department of job and family services 630
shall ~~determine~~ estimate the amount of any overpayments made under 631
the medicaid program to the exiting operator, including 632
overpayments the exiting operator disputes, and other actual and 633
potential debts the exiting operator owes or may owe to the 634
department and United States centers for medicare and medicaid 635
services under the medicaid program, including a franchise permit 636
fee. ~~In determining~~ 637

(B) In estimating the exiting operator's other actual and 638
potential debts to the department and the United States centers 639
for medicare and medicaid services under the medicaid program, the 640
department shall ~~include~~ use a debt estimation methodology the 641
director of job and family services shall establish in rules 642
adopted under section 5111.689 of the Revised Code. The 643
methodology shall provide for estimating all of the following that 644
the department determines ~~is~~ are applicable: 645

(1) Refunds due the department under section 5111.27 of the 646
Revised Code; 647

(2) Interest owed to the department and United States centers 648
for medicare and medicaid services; 649

(3) Final civil monetary and other penalties for which all 650
right of appeal has been exhausted; 651

(4) Money owed the department and United States centers for 652

medicare and medicaid services from any outstanding final fiscal 653
audit, including a final fiscal audit for the last fiscal year or 654
portion thereof in which the exiting operator participated in the 655
medicaid program; 656

(5) Other amounts the department determines are applicable. 657

~~(B) If the department is unable to determine the amount of 658
the overpayments and other debts for any period before the 659
effective date of the entering operator's provider agreement or 660
the effective date of the facility closure, voluntary termination, 661
or voluntary withdrawal of participation, the department shall 662
make a reasonable estimate of the overpayments and other debts for 663
the period. The department shall make the estimate using 664
information available to the department, including prior 665
determinations of overpayments and other debts. 666~~

(C) The department shall provide the exiting operator written 667
notice of the department's estimate under division (A) of this 668
section not later than thirty days after the department receives 669
the notice under section 5111.66 of the Revised Code of the 670
facility closure, voluntary termination, or voluntary withdrawal 671
of participation or the notice under section 5111.67 of the 672
Revised Code of the change of operator. The department's written 673
notice shall include the basis for the estimate. 674

Sec. 5111.681. (A) Except as provided in ~~division~~ divisions 675
(B) and (C) of this section, the department of job and family 676
services ~~shall~~ may withhold ~~the greater of the following~~ from 677
payment due an exiting operator under the medicaid program; 678

~~(1) The the total amount of any overpayments made under the 679
medicaid program to the exiting operator, including overpayments 680
the exiting operator disputes, and other actual and potential 681
debts, including any unpaid penalties, specified in the notice 682
provided under division (C) of section 5111.68 of the Revised Code 683~~

that the exiting operator owes or may owe to the department and 684
United States centers for medicare and medicaid services under the 685
medicaid program; 686

~~(2) An amount equal to the average amount of monthly payments~~ 687
~~to the exiting operator under the medicaid program for the~~ 688
~~twelve month period immediately preceding the month that includes~~ 689
~~the last day the exiting operator's provider agreement is in~~ 690
~~effect or, in the case of a voluntary withdrawal of participation,~~ 691
~~the effective date of the voluntary withdrawal of participation.~~ 692

(B) The In the case of a change of operator and subject to 693
division (D) of this section, the following shall apply regarding 694
a withholding under division (A) of this section if the exiting 695
operator or entering operator or an affiliated operator executes a 696
successor liability agreement meeting the requirements of division 697
(E) of this section: 698

(1) If the exiting operator, entering operator, or affiliated 699
operator assumes liability for the total, actual amount of debt 700
the exiting operator owes the department and the United States 701
centers for medicare and medicaid services under the medicaid 702
program as determined under section 5111.685 of the Revised Code, 703
the department may choose shall not to make the withholding under 704
division (A) of this section if an entering operator does both of 705
the following; 706

~~(1) Enters into a nontransferable, unconditional, written~~ 707
~~agreement with the department to pay the department any debt the~~ 708
~~exiting operator owes the department under the medicaid program;~~ 709

~~(2) Provides the department a copy of the entering operator's~~ 710
~~balance sheet that assists the department in determining whether~~ 711
~~to make the withholding under division (A) of this section.~~ 712

(2) If the exiting operator, entering operator, or affiliated 713
operator assumes liability for only the portion of the amount 714

specified in division (B)(1) of this section that represents the 715
franchise permit fee the exiting operator owes, the department 716
shall withhold not more than the difference between the total 717
amount specified in the notice provided under division (C) of 718
section 5111.68 of the Revised Code and the amount for which the 719
entering operator or affiliated operator assumes liability. 720

(C) In the case of a voluntary termination, voluntary 721
withdrawal of participation, or facility closure and subject to 722
division (D) of this section, the following shall apply regarding 723
a withholding under division (A) of this section if the exiting 724
operator or an affiliated operator executes a successor liability 725
agreement meeting the requirements of division (E) of this 726
section: 727

(1) If the exiting operator or affiliated operator assumes 728
liability for the total, actual amount of debt the exiting 729
operator owes the department and the United States centers for 730
medicare and medicaid services under the medicaid program as 731
determined under section 5111.685 of the Revised Code, the 732
department shall not make the withholding. 733

(2) If the exiting operator or affiliated operator assumes 734
liability for only the portion of the amount specified in division 735
(C)(1) of this section that represents the franchise permit fee 736
the exiting operator owes, the department shall withhold not more 737
than the difference between the total amount specified in the 738
notice provided under division (C) of section 5111.68 of the 739
Revised Code and the amount for which the exiting operator or 740
affiliated operator assumes liability. 741

(D) For an exiting operator or affiliated operator to be 742
eligible to enter into a successor liability agreement under 743
division (B) or (C) of this section, both of the following must 744
apply: 745

(1) The exiting operator or affiliated operator must have one 746
or more valid provider agreements, other than the provider 747
agreement for the nursing facility or intermediate care facility 748
for the mentally retarded that is the subject of the voluntary 749
termination, voluntary withdrawal of participation, facility 750
closure, or change of operator; 751

(2) During the twelve-month period preceding the month in 752
which the department receives the notice of the voluntary 753
termination, voluntary withdrawal of participation, or facility 754
closure under section 5111.66 of the Revised Code or the notice of 755
the change of operator under section 5111.67 of the Revised Code, 756
the average monthly medicaid payment made to the exiting operator 757
or affiliated operator pursuant to the exiting operator's or 758
affiliated operator's one or more provider agreements, other than 759
the provider agreement for the nursing facility or intermediate 760
care facility for the mentally retarded that is the subject of the 761
voluntary termination, voluntary withdrawal of participation, 762
facility closure, or change of operator, must equal at least 763
ninety per cent of the sum of the following: 764

(a) The average monthly medicaid payment made to the exiting 765
operator pursuant to the exiting operator's provider agreement for 766
the nursing facility or intermediate care facility for the 767
mentally retarded that is the subject of the voluntary 768
termination, voluntary withdrawal of participation, facility 769
closure, or change of operator; 770

(b) Whichever of the following apply: 771

(i) If the exiting operator or affiliated operator has 772
assumed liability under one or more other successor liability 773
agreements, the total amount for which the exiting operator or 774
affiliated operator has assumed liability under the other 775
successor liability agreements; 776

(ii) If the exiting operator or affiliated operator has not assumed liability under any other successor liability agreements, zero. 777
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(E) A successor liability agreement executed under this section must comply with all of the following: 780
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(1) It must provide for the operator who executes the successor liability agreement to assume liability for either of the following as specified in the agreement: 782
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(a) The total, actual amount of debt the exiting operator owes the department and the United States centers for medicare and medicaid services under the medicaid program as determined under section 5111.685 of the Revised Code; 785
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(b) The portion of the amount specified in division (E)(1)(a) of this section that represents the franchise permit fee the exiting operator owes. 789
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(2) It may not require the operator who executes the successor liability agreement to furnish a surety bond. 792
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(3) It must provide that the department, after determining under section 5111.685 of the Revised Code the actual amount of debt the exiting operator owes the department and United States centers for medicare and medicaid services under the medicaid program, may deduct the lesser of the following from medicaid payments made to the operator who executes the successor liability agreement: 794
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(a) The total, actual amount of debt the exiting operator owes the department and the United States centers for medicare and medicaid services under the medicaid program as determined under section 5111.685 of the Revised Code; 801
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(b) The amount for which the operator who executes the successor liability agreement assumes liability under the 805
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agreement. 807

(4) It must provide that the deductions authorized by 808
division (E)(3) of this section are to be made for a number of 809
months, not to exceed six, agreed to by the operator who executes 810
the successor liability agreement and the department or, if the 811
operator who executes the successor liability agreement and 812
department cannot agree on a number of months that is less than 813
six, a greater number of months determined by the attorney general 814
pursuant to a claims collection process authorized by statute of 815
this state. 816

(5) It must provide that, if the attorney general determines 817
the number of months for which the deductions authorized by 818
division (E)(3) of this section are to be made, the operator who 819
executes the successor liability agreement shall pay, in addition 820
to the amount collected pursuant to the attorney general's claims 821
collection process, the part of the amount so collected that, if 822
not for division (G) of this section, would be required by section 823
109.081 of the Revised Code to be paid into the attorney general 824
claims fund. 825

(F) Execution of a successor liability agreement does not 826
waive an exiting operator's right to contest the amount specified 827
in the notice the department provides the exiting operator under 828
division (C) of section 5111.68 of the Revised Code. 829

(G) Notwithstanding section 109.081 of the Revised Code, the 830
entire amount that the attorney general, whether by employees or 831
agents of the attorney general or by special counsel appointed 832
pursuant to section 109.08 of the Revised Code, collects under a 833
successor liability agreement, other than the additional amount 834
the operator who executes the agreement is required by division 835
(E)(5) of this section to pay, shall be paid to the department of 836
job and family services for deposit into the appropriate fund. The 837
additional amount that the operator is required to pay shall be 838

paid into the state treasury to the credit of the attorney general 839
claims fund created under section 109.081 of the Revised Code. 840

Sec. 5111.685. The department of job and family services 841
shall determine the actual amount of debt an exiting operator owes 842
the department and the United States centers for medicare and 843
medicaid services under the medicaid program by completing all 844
final fiscal audits not already completed and performing all other 845
appropriate actions the department determines to be necessary. The 846
department shall issue ~~a~~ an initial debt summary report on this 847
matter not later than ~~ninety~~ sixty days after the date the exiting 848
operator files the properly completed cost report required by 849
section 5111.682 of the Revised Code with the department or, if 850
the department waives the cost report requirement for the exiting 851
operator, ~~ninety~~ sixty days after the date the department waives 852
the cost report requirement. ~~The report shall include the~~ 853
~~department's findings and the amount of debt the department~~ 854
~~determines the exiting operator owes the department and United~~ 855
~~States centers for medicare and medicaid services under the~~ 856
~~medicaid program. Only the parts of the report that are subject to~~ 857
~~an adjudication as specified in section 5111.30 of the Revised~~ 858
~~Code are subject to an adjudication conducted~~ The initial debt 859
summary report becomes the final debt summary report thirty-one 860
days after the department issues the initial debt summary report 861
unless the exiting operator, or an affiliated operator who 862
executes a successor liability agreement under section 5111.681 of 863
the Revised Code, requests a review before that date. 864

The exiting operator, and an affiliated operator who executes 865
a successor liability agreement under section 5111.681 of the 866
Revised Code, may request a review to contest any of the 867
department's findings included in the initial debt summary report. 868
The request for the review must be submitted to the department not 869
later than thirty days after the date the department issues the 870

initial debt summary report. The department shall conduct the 871
review on receipt of a timely request and issue a revised debt 872
summary report. If the department has withheld money from payment 873
due the exiting operator under division (A) of section 5111.681 of 874
the Revised Code, the department shall issue the revised debt 875
summary report not later than ninety days after the date the 876
department receives the timely request for the review unless the 877
department and exiting operator or affiliated operator agree to a 878
later date. The exiting operator or affiliated operator may submit 879
information to the department explaining what the operator 880
contests before and during the review, including documentation of 881
the amount of any debt the department owes the operator. The 882
exiting operator or affiliated operator may submit additional 883
information to the department not later than thirty days after the 884
department issues the revised debt summary report. The revised 885
debt summary report becomes the final debt summary report 886
thirty-one days after the department issues the revised debt 887
summary report unless the exiting operator or affiliated operator 888
timely submits additional information to the department. If the 889
exiting operator or affiliated operator timely submits additional 890
information to the department, the department shall consider the 891
additional information and issue a final debt summary report not 892
later than sixty days after the department issues the revised debt 893
summary report unless the department and exiting operator or 894
affiliated operator agree to a later date. 895

Each debt summary report the department issues under this 896
section shall include the department's findings and the amount of 897
debt the department determines the exiting operator owes the 898
department and United States centers for medicare and medicaid 899
services under the medicaid program. The department shall explain 900
its findings and determination in each debt summary report. 901

The exiting operator, and an affiliated operator who executes 902

a successor liability agreement under section 5111.681 of the Revised Code, may request, in accordance with Chapter 119. of the Revised Code, an adjudication regarding a finding in a final debt summary report that pertains to an audit or alleged overpayment made under the medicaid program to the exiting operator. The adjudication shall be consolidated with any other uncompleted adjudication that concerns a matter addressed in the final debt summary report. 903
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Sec. 5111.686. The department of job and family services shall release the actual amount withheld under division (A) of section 5111.681 of the Revised Code, less any amount the exiting operator owes the department and United States centers for medicare and medicaid services under the medicaid program, as follows: 911
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(A) ~~Ninety one days after the date the exiting operator files a properly completed cost report required by section 5111.682 of the Revised Code unless~~ Unless the department issues the initial debt summary report required by section 5111.685 of the Revised Code not later than ~~ninety sixty~~ sixty days after the date the exiting operator files the properly completed cost report required by section 5111.682 of the Revised Code, sixty-one days after the date the exiting operator files the properly completed cost report; 917
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(B) ~~Not later than thirty days after the exiting operator agrees to a final fiscal audit resulting from the report required by section 5111.685 of the Revised Code if~~ If the department issues the initial debt summary report required by section 5111.685 of the Revised Code not later than ~~ninety sixty~~ sixty days after the date the exiting operator files a properly completed cost report required by section 5111.682 of the Revised Code, not later than the following: 926
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(1) Thirty days after the deadline for requesting an adjudication under section 5111.685 of the Revised Code regarding the final debt summary report if the exiting operator, and an affiliated operator who executes a successor liability agreement under section 5111.681 of the Revised Code, fail to request the adjudication on or before the deadline; 934
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(2) Thirty days after the completion of an adjudication of the final debt summary report if the exiting operator, or an affiliated operator who executes a successor liability agreement under section 5111.681 of the Revised Code, requests the adjudication on or before the deadline for requesting the adjudication. 940
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~~(C) Ninety one days after the date the department waives the cost report requirement of section 5111.682 of the Revised Code unless~~ Unless the department issues the initial debt summary report required by section 5111.685 of the Revised Code not later than ninety sixty days after the date the department waives the cost report requirement of section 5111.682 of the Revised Code, sixty-one days after the date the department waives the cost report requirement; 946
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~~(D) Not later than thirty days after the exiting operator agrees to a final fiscal audit resulting from the report required by section 5111.685 of the Revised Code if~~ If the department issues the initial debt summary report required by section 5111.685 of the Revised Code not later than ninety sixty days after the date the department waives the cost report requirement of section 5111.682 of the Revised Code, not later than the following: 954
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(1) Thirty days after the deadline for requesting an adjudication under section 5111.685 of the Revised Code regarding the final debt summary report if the exiting operator, and an affiliated operator who executes a successor liability agreement 962
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under section 5111.681 of the Revised Code, fail to request the 966
adjudication on or before the deadline; 967

(2) Thirty days after the completion of an adjudication of 968
the final debt summary report if the exiting operator, or an 969
affiliated operator who executes a successor liability agreement 970
under section 5111.681 of the Revised Code, requests the 971
adjudication on or before the deadline for requesting the 972
adjudication. 973

Sec. 5111.688. (A) All amounts withheld under section 974
5111.681 of the Revised Code from payment due an exiting operator 975
under the medicaid program shall be deposited into the medicaid 976
payment withholding fund created by the controlling board pursuant 977
to section 131.35 of the Revised Code. Money in the fund shall be 978
used as follows: 979

(1) To pay an exiting operator when a withholding is released 980
to the exiting operator under section 5111.686 or 5111.687 of the 981
Revised Code; 982

(2) To pay the department of job and family services and 983
United States centers for medicare and medicaid services the 984
amount an exiting operator owes the department and United States 985
centers under the medicaid program. 986

(B) Amounts paid from the medicaid payment withholding fund 987
pursuant to division (A)(2) of this section shall be deposited 988
into the appropriate department fund. 989

Sec. ~~5111.688~~ 5111.689. The director of job and family 990
services shall adopt rules under section 5111.02 of the Revised 991
Code to implement sections 5111.65 to ~~5111.688~~ 5111.689 of the 992
Revised Code, including rules applicable to an exiting operator 993
that provides written notification under section 5111.66 of the 994
Revised Code of a voluntary withdrawal of participation. Rules 995

adopted under this section shall comply with section 1919(c)(2)(F) 996
of the "Social Security Act," 79 Stat. 286 (1965), 42 U.S.C. 997
1396r(c)(2)(F), regarding restrictions on transfers or discharges 998
of nursing facility residents in the case of a voluntary 999
withdrawal of participation. The rules may prescribe a medicaid 1000
reimbursement methodology and other procedures that are applicable 1001
after the effective date of a voluntary withdrawal of 1002
participation that differ from the reimbursement methodology and 1003
other procedures that would otherwise apply. 1004

Sec. 5111.894. (A) The state administrative agency may 1005
establish one or more waiting lists for the assisted living 1006
program. Only individuals eligible for the ~~medicaid~~ assisted 1007
living program may be placed on a waiting list. 1008

(B) The state administrative agency shall establish a home 1009
first component of the assisted living program under which 1010
eligible individuals may be enrolled in the assisted living 1011
program in accordance with this section. An individual is eligible 1012
for the assisted living program's home first component if the 1013
individual is on an assisted living program waiting list and at 1014
least one of the following applies: 1015

(1) The individual has been admitted to a nursing facility; 1016

(2) A physician has determined and documented in writing that 1017
the individual has a medical condition that, unless enrolled in 1018
home and community-based services such as the assisted living 1019
program, will require the individual to be admitted to a nursing 1020
facility within thirty days of the physician's determination; 1021

(3) The individual has been hospitalized and a physician has 1022
determined and documented in writing that, unless the individual 1023
is enrolled in home and community-based services such as the 1024
assisted living program, the individual is to be transported 1025

directly from the hospital to a nursing facility admitted; 1026

(4) Both of the following apply: 1027

(a) The individual is the subject of a report made under 1028
section 5101.61 of the Revised Code regarding abuse, neglect, or 1029
exploitation or such a report referred to a county department of 1030
job and family services under section 5126.31 of the Revised Code 1031
or has made a request to a county department for protective 1032
services as defined in section 5101.60 of the Revised Code; 1033

(b) A county department of job and family services and an 1034
area agency on aging have jointly documented in writing that, 1035
unless the individual is enrolled in home and community-based 1036
services such as the assisted living program, the individual 1037
should be admitted to a nursing facility; 1038

(5) The individual resided in a residential care facility for 1039
at least six months immediately before applying for the assisted 1040
living program and is at risk of imminent admission to a nursing 1041
facility because the costs of residing in the residential care 1042
facility have depleted the individual's resources such that the 1043
individual is unable to continue to afford the cost of residing in 1044
the residential care facility. 1045

(C) Each month, each area agency on aging shall ~~determine~~ 1046
~~whether any individual who resides~~ identify individuals residing 1047
in the area that the area agency on aging serves ~~and is on a~~ 1048
~~waiting list~~ who are eligible for the home first component of the 1049
assisted living program ~~has been admitted to a nursing facility.~~ 1050

~~¶~~ When an area agency on aging ~~determines that~~ identifies such an 1051
individual ~~has been admitted to a nursing facility~~ and determines 1052
that there is a vacancy in a residential care facility 1053
participating in the assisted living program that is acceptable to 1054
the individual, the agency shall notify the long-term care 1055
consultation program administrator serving the area in which the 1056

individual resides ~~about the determination~~. The administrator 1057
shall determine whether the assisted living program is appropriate 1058
for the individual and whether the individual would rather 1059
participate in the assisted living program than continue ~~residing~~ 1060
or begin to reside in ~~the~~ a nursing facility. If the administrator 1061
determines that the assisted living program is appropriate for the 1062
individual and the individual would rather participate in the 1063
assisted living program than continue ~~residing~~ or begin to reside 1064
in ~~the~~ a nursing facility, the administrator shall so notify the 1065
state administrative ~~agency~~. 1066

~~On~~ agency. ~~On~~ receipt of the notice from the administrator, 1067
the state administrative agency shall approve the individual's 1068
enrollment in the assisted living program regardless of any 1069
waiting list for the assisted living program, unless the 1070
enrollment would cause the assisted living program to exceed any 1071
limit on the number of individuals who may participate in the 1072
program as set by the United States secretary of health and human 1073
services when the medicaid waiver authorizing the program is 1074
approved. ~~Each~~ 1075

(D) Each quarter, the state administrative agency shall 1076
certify to the director of budget and management the estimated 1077
increase in costs of the assisted living program resulting from 1078
enrollment of individuals in the assisted living program pursuant 1079
to this section. 1080

Section 2. That existing sections 173.401, 3702.51, 3702.59, 1081
5111.65, 5111.651, 5111.68, 5111.681, 5111.685, 5111.686, 1082
5111.688, and 5111.894 of the Revised Code are hereby repealed. 1083

Section 3. That Section 209.20 of Am. Sub. H.B. 1 of the 1084
128th General Assembly be amended to read as follows: 1085

Sec. 209.20. LONG-TERM CARE 1086

Pursuant to an interagency agreement, the Department of Job and Family Services shall designate the Department of Aging to perform assessments under section 5111.204 of the Revised Code. The Department of Aging shall provide long-term care consultations under section 173.42 of the Revised Code to assist individuals in planning for their long-term health care needs. The foregoing appropriation items 490423, Long Term Care Budget - State, and 490623, Long Term Care Budget, may be used to provide the preadmission screening and resident review (PASRR), which includes screening, assessments, and determinations made under sections 5111.02, 5111.204, 5119.061, and 5123.021 of the Revised Code.

The foregoing appropriation items 490423, Long Term Care Budget - State, and 490623, Long Term Care Budget, may be used to assess and provide long-term care consultations to clients regardless of Medicaid eligibility.

The Director of Aging shall adopt rules under section 111.15 of the Revised Code governing the nonwaiver funded PASSPORT program, including client eligibility. The foregoing appropriation item 490423, Long Term Care Budget - State, may be used by the Department of Aging to provide nonwaiver funded PASSPORT services to persons the Department has determined to be eligible to participate in the nonwaiver funded PASSPORT Program, including those persons not yet determined to be financially eligible to participate in the Medicaid waiver component of the PASSPORT Program by a county department of job and family services.

The Department of Aging shall administer the Medicaid waiver-funded PASSPORT Home Care Program, the Choices Program, the Assisted Living Program, and the PACE Program as delegated by the Department of Job and Family Services in an interagency agreement. The foregoing appropriation item 490423, Long Term Care Budget - State, shall be used to provide the required state match for federal Medicaid funds supporting the Medicaid Waiver-funded

PASSPORT Home Care Program, the Choices Program, the Assisted Living Program, and the PACE Program. The foregoing appropriation items 490423, Long Term Care Budget - State, and 490623, Long Term Care Budget, may also be used to support the Department of Aging's administrative costs associated with operating the PASSPORT, Choices, Assisted Living, and PACE programs.

The foregoing appropriation item 490623, Long Term Care Budget, shall be used to provide the federal matching share for all program costs determined by the Department of Job and Family Services to be eligible for Medicaid reimbursement.

HOME FIRST PROGRAM

(A) As used in this section, "Long Term Care Budget Services" includes the following existing programs: PASSPORT, Assisted Living, Residential State Supplement, and PACE.

(B) On ~~a quarterly basis, on~~ receipt of the certified expenditures related to sections 173.401, 173.351, 173.501, and 5111.894 of the Revised Code, the Director of Budget and Management may do all of the following for fiscal years 2010 and 2011:

(1) Transfer cash from the Nursing Facility Stabilization Fund (Fund 5R20), used by the Department of Job and Family Services, to the PASSPORT/Residential State Supplement Fund (Fund 4J40), used by the Department of Aging. The

~~The~~ transferred cash is hereby appropriated to appropriation item 490610, PASSPORT/Residential State Supplement.

(2) ~~If receipts credited to~~ Authorize expenditures from the PASSPORT Fund (Fund 3C40) for amounts that exceed the amounts appropriated from receipts credited to the fund, ~~the Director of Aging may request the Director of Budget and Management to~~ authorize expenditures from the fund in excess of the amounts appropriated. ~~Upon the approval of the Director of Budget and~~

Management, the Any additional authorized amounts are hereby 1150
appropriated. 1151

(3) ~~If receipts credited to~~ Authorize expenditures from the 1152
Interagency Reimbursement Fund (Fund 3G50) for amounts that exceed 1153
the amounts appropriated from receipts credited to the fund, ~~the~~ 1154
~~Director of Job and Family Services may request the Director of~~ 1155
~~Budget and Management to authorize expenditures from the fund in~~ 1156
~~excess of the amounts appropriated. Upon the approval of the~~ 1157
~~Director of Budget and Management, the~~ Any additional authorized 1158
amounts are hereby appropriated. 1159

(C) Not later than thirty days after the Director of Budget 1160
and Management receives certification of expenditures specified in 1161
division (B) of this section, the Executive Director of Executive 1162
Medicaid Management Administration shall submit a report to the 1163
General Assembly in accordance with section 101.68 of the Revised 1164
Code and to the chairs and ranking minority members of the 1165
committees of the House of Representatives and Senate to which the 1166
biennial budget bill is referred. The report shall describe and 1167
document the criteria and data the Office of Budget and Management 1168
uses to justify a transfer of funds under division (B) of this 1169
section, including spending and utilization trends for PASSPORT, 1170
assisted living, and nursing facility services. In addition to 1171
providing the information for the transfer of funds, the report 1172
shall include the following: 1173

(1) In the case of reports for transfers that occur during 1174
fiscal year 2010, the descriptions and documents of the criteria 1175
and data used to justify other such transfers that previously 1176
occurred during that fiscal year; 1177

(2) In the case of reports for transfers that occur during 1178
fiscal year 2011, the descriptions and documents of the criteria 1179
and data used to justify other such transfers that previously 1180
occurred during that fiscal year and fiscal year 2010. 1181

The Director of Budget and Management shall provide the 1182
Executive Director of the Executive Medicaid Management 1183
Administration with all information the Executive Director needs 1184
to prepare the reports required by this division. 1185

(D) The individuals placed in Long Term Care Budget Services 1186
pursuant to this section shall be in addition to the individuals 1187
placed in Long Term Care Budget Services during fiscal years 2010 1188
and 2011 before any transfers to appropriation item 490423, Long 1189
Term Care Budget-State, are made under this section. 1190

ALLOCATION OF PACE SLOTS 1191

In order to effectively administer and manage growth within 1192
the PACE Program, the Director of Aging may, as the director deems 1193
appropriate and to the extent funding is available, expand the 1194
PACE Program to regions of Ohio beyond those currently served by 1195
the PACE Program. In implementing the expansion, the Director may 1196
not decrease the number of residents of Cuyahoga and Hamilton 1197
counties and parts of Butler, Clermont, and Warren counties who 1198
are participating in the PACE Program below the number of 1199
residents of those counties and parts of counties who were 1200
enrolled in the PACE Program on July 1, 2008. 1201

Section 4. That existing Section 209.20 of Am. Sub. H.B. 1 of 1202
the 128th General Assembly is hereby repealed. 1203

Section 5. During fiscal years 2012 and 2013, on receipt of 1204
certified expenditures related to sections 173.401, 173.351, 1205
173.501, and 5111.894 of the Revised Code, the Director of Budget 1206
and Management shall transfer cash from the Nursing Facility 1207
Stabilization Fund (Fund 5R20), used by the Department of Job and 1208
Family Services, to the PASSPORT/Residential State Supplement Fund 1209
(Fund 4J40), used by the Department of Aging. 1210

If receipts credited to the PASSPORT Fund (Fund 3C40) exceed 1211

the amounts appropriated from the fund in fiscal years 2012 and 1212
2013, the Director of Aging shall request the Director of Budget 1213
and Management to authorize expenditures from the fund in excess 1214
of the amounts appropriated. 1215

If receipts credited to the Interagency Reimbursement Fund 1216
(Fund 3G50) exceed the amounts appropriated from the fund in 1217
fiscal years 2012 and 2013, the Director of Job and Family 1218
Services shall request the Director of Budget and Management to 1219
authorize expenditures from the fund in excess of the amounts 1220
appropriated. 1221