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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, Adams, R., Amstutz, Bacon, Balderson, Batchelder, Beck, Belcher, Boose, Boyd, Burke, Carney, Celeste, Chandler, Combs, Daniels, DeBose, DeGeeter, Gardner, Gerberry, Goodwin, Hall, Heard, Hite, Koziura, Luckie, Lundy, Maag, Martin, Mecklenborg, Moran, Morgan, Oelslager, Otterman, Patten, Pryor, Reece, Sayre, Sears, Skindell, Slesnick, Stewart, Szollosi, Uecker, Walter, Winburn, Zehringer

A B I L L

To amend sections 173.401, 173.501, 3702.51, 3702.59, 5111.65, 5111.651, 5111.68, 5111.681, 5111.685, 5111.686, 5111.688, 5111.874, 5111.875, and 5111.894; to amend, for the purpose of adopting a new section number as indicated in parentheses, section 5111.688 (5111.689); and to enact new section 5111.688 and section 173.404 of the Revised Code; and to amend Section 209.20 of Am. Sub. H.B. 1 of the 128th General Assembly to revise the waiting list provisions of the PASSPORT, PACE, and Assisted Living programs, to revise the law governing the collection of

long-term care facilities' Medicaid debts, and to revise the law governing the reasons for denying a Certificate of Need application.

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

Section 1. That sections 173.401, 173.501, 3702.51, 3702.59, 5111.65, 5111.651, 5111.68, 5111.681, 5111.685, 5111.686, 5111.688, 5111.874, 5111.875, and 5111.894 be amended; section 5111.688 (5111.689) be amended for the purpose of adopting a new section number as indicated in parentheses; and new section 5111.688 and section 173.404 of the Revised Code be enacted to read as follows:

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

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

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

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

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

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

(B) ~~The director of job and family services shall submit to~~

~~the United States secretary of health and human services an amendment to the PASSPORT waiver that authorizes additional enrollments in the PASSPORT program pursuant to this section. Beginning with the month following the month in which the United States secretary approves the amendment and each~~ The department shall establish a home first component of the PASSPORT program under which eligible individuals may be enrolled in the PASSPORT program in accordance with this section. An individual is eligible for the PASSPORT program's home first component if all of the following apply:

(1) The individual is eligible for the PASSPORT program.

(2) The individual is on the unified waiting list established under section 173.404 of the Revised Code.

(3) At least one of the following applies:

(a) The individual has been admitted to a nursing facility.

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

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

(d) Both of the following apply:

(i) The individual is the subject of a report made under section 5101.61 of the Revised Code regarding abuse, neglect, or exploitation or such a report referred to a county department of

job and family services under section 5126.31 of the Revised Code or has made a request to a county department for protective services as defined in section 5101.60 of the Revised Code.

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

(C) Each month ~~thereafter~~, each area agency on aging shall ~~determine whether~~ identify individuals ~~who reside~~ residing in the area that the ~~area~~ agency ~~on aging~~ serves ~~and~~ who are ~~on a waiting list~~ eligible for the home first component of the PASSPORT program ~~have been admitted to a nursing facility~~. ~~If~~ When an area agency on aging ~~determines that~~ identifies such an individual ~~has been admitted to a nursing facility~~, the agency shall notify the long-term care consultation program administrator serving the area in which the individual resides ~~about the determination~~. The administrator shall determine whether the PASSPORT program is appropriate for the individual and whether the individual would rather participate in the PASSPORT program than continue ~~residing~~ or begin to reside in ~~the~~ a nursing facility. If the administrator determines that the PASSPORT program is appropriate for the individual and the individual would rather participate in the PASSPORT program than continue ~~residing~~ or begin to reside in ~~the~~ a nursing facility, the administrator shall so notify the department of aging. On receipt of the notice from the administrator, the department ~~of aging~~ shall approve the individual's enrollment in the PASSPORT program regardless of the ~~PASSPORT program's~~ unified waiting list ~~and even though the enrollment causes enrollment in the program to exceed the limit that would otherwise apply~~ established under section 173.404 of the Revised Code, unless the enrollment would cause the PASSPORT

program to exceed any limit on the number of individuals who may be enrolled in the program as set by the United States secretary of health and human services in the PASSPORT waiver.

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

Sec. 173.404. (A) As used in this section:

(1) "Department of aging-administered medicaid waiver component" means each of the following:

(a) The PASSPORT program created under section 173.40 of the Revised Code;

(b) The choices program created under section 173.403 of the Revised Code;

(c) The assisted living program created under section 5111.89 of the Revised Code.

(2) "PACE program" means the component of the medicaid program the department of aging administers pursuant to section 173.50 of the Revised Code.

(B) The department of aging shall establish a unified waiting list for department of aging-administered medicaid waiver components and the PACE program. Only individuals eligible for a department of aging-administered medicaid waiver component or the PACE program may be placed on the unified waiting list.

Sec. 173.501. (A) As used in this section:

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

"PACE provider" has the same meaning as in 42 U.S.C.

1396u-4(a)(3).

(B) The department of aging shall establish a home first component of the PACE program under which eligible individuals may be enrolled in the PACE program in accordance with this section. An individual is eligible for the PACE program's home first component if all of the following apply:

(1) The individual is eligible for the PACE program.

(2) The individual is on the unified waiting list established under section 173.404 of the Revised Code.

(3) At least one of the following applies:

(a) The individual has been admitted to a nursing facility.

(b) A physician has determined and documented in writing that the individual has a medical condition that, unless the individual is enrolled in home and community-based services such as the PACE program, will require the individual to be admitted to a nursing facility within thirty days of the physician's determination.

(c) The individual has been hospitalized and a physician has determined and documented in writing that, unless the individual is enrolled in home and community-based services such as the PACE program, the individual is to be transported directly from the hospital to a nursing facility and admitted.

(d) Both of the following apply:

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

(ii) A county department of job and family services and an area agency on aging have jointly documented in writing that,

unless the individual is enrolled in home and community-based services such as the PACE program, the individual should be admitted to a nursing facility.

(C) Each month, the department of aging shall ~~determine whether~~ identify individuals who are ~~on a waiting list~~ eligible for the home first component of the PACE program ~~have been admitted to a nursing facility~~. ~~If~~ When the department ~~determines that~~ identifies such an individual ~~has been admitted to a nursing facility~~, the department shall notify the PACE provider serving the area in which the individual resides ~~about the determination~~. The PACE provider shall determine whether the PACE program is appropriate for the individual and whether the individual would rather participate in the PACE program than continue ~~residing~~ or begin to reside in ~~the~~ a nursing facility. If the PACE provider determines that the PACE program is appropriate for the individual and the individual would rather participate in the PACE program than continue ~~residing~~ or begin to reside in ~~the~~ a nursing facility, the PACE provider shall so notify the department of aging. On receipt of the notice from the PACE provider, the department of aging shall approve the individual's enrollment in the PACE program in accordance with priorities established in rules adopted under section 173.50 of the Revised Code. ~~Each~~

(D) Each quarter, the department of aging shall certify to the director of budget and management the estimated increase in costs of the PACE program resulting from enrollment of individuals in the PACE program pursuant to this section.

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

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

(B) "Person" means any individual, corporation, business trust, estate, firm, partnership, association, joint stock company, insurance company, government unit, or other entity.

(C) "Certificate of need" means a written approval granted by the director of health to an applicant to authorize conducting a reviewable activity.

(D) "Health service area" means a geographic region designated by the director of health under section 3702.58 of the Revised Code.

(E) "Health service" means a clinically related service, such as a diagnostic, treatment, rehabilitative, or preventive service.

(F) "Health service agency" means an agency designated to serve a health service area in accordance with section 3702.58 of the Revised Code.

(G) "Health care facility" means:

(1) A hospital registered under section 3701.07 of the Revised Code;

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

(3) A county home or a county nursing home as defined in section 5155.31 of the Revised Code that is certified under Title XVIII or XIX of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended;

(4) A freestanding dialysis center;

(5) A freestanding inpatient rehabilitation facility;

(6) An ambulatory surgical facility;

(7) A freestanding cardiac catheterization facility;

(8) A freestanding birthing center;

(9) A freestanding or mobile diagnostic imaging center;

(10) A freestanding radiation therapy center.

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

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

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

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

(K) "Health maintenance organization" means a public or private organization organized under the law of any state that is

qualified under section 1310(d) of Title XIII of the "Public Health Service Act," 87 Stat. 931 (1973), 42 U.S.C. 300e-9.

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

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

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

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

(N) "Political subdivision" means a municipal corporation, township, county, school district, and all other bodies corporate and politic responsible for governmental activities only in

geographic areas smaller than that of the state to which the sovereign immunity of the state attaches.

(O) "Affected person" means:

(1) An applicant for a certificate of need, including an applicant whose application was reviewed comparatively with the application in question;

(2) The person that requested the reviewability ruling in question;

(3) Any person that resides or regularly uses health care facilities within the geographic area served or to be served by the health care services that would be provided under the certificate of need or reviewability ruling in question;

(4) Any health care facility that is located in the health service area where the health care services would be provided under the certificate of need or reviewability ruling in question;

(5) Third-party payers that reimburse health care facilities for services in the health service area where the health care services would be provided under the certificate of need or reviewability ruling in question;

(6) Any other person who testified at a public hearing held under division (B) of section 3702.52 of the Revised Code or submitted written comments in the course of review of the certificate of need application in question.

(P) "Osteopathic hospital" means a hospital registered under section 3701.07 of the Revised Code that advocates osteopathic principles and the practice and perpetuation of osteopathic medicine by doing any of the following:

(1) Maintaining a department or service of osteopathic medicine or a committee on the utilization of osteopathic principles and methods, under the supervision of an osteopathic

physician;

(2) Maintaining an active medical staff, the majority of which is comprised of osteopathic physicians;

(3) Maintaining a medical staff executive committee that has osteopathic physicians as a majority of its members.

(Q) "Ambulatory surgical facility" has the same meaning as in section 3702.30 of the Revised Code.

(R) Except as provided in division (S) of this section, "reviewable activity" means any of the following activities:

(1) The establishment, development, or construction of a new long-term care facility;

(2) The replacement of an existing long-term care facility;

(3) The renovation of a long-term care facility that involves a capital expenditure of two million dollars or more, not including expenditures for equipment, staffing, or operational costs;

(4) Either of the following changes in long-term care bed capacity:

(a) An increase in bed capacity;

(b) A relocation of beds from one physical facility or site to another, excluding the relocation of beds within a long-term care facility or among buildings of a long-term care facility at the same site.

(5) Any change in the health services, bed capacity, or site, or any other failure to conduct the reviewable activity in substantial accordance with the approved application for which a certificate of need concerning long-term care beds was granted, if the change is made within five years after the implementation of the reviewable activity for which the certificate was granted;

(6) The expenditure of more than one hundred ten per cent of the maximum expenditure specified in a certificate of need concerning long-term care beds.

(S) "Reviewable activity" does not include any of the following activities:

(1) Acquisition of computer hardware or software;

(2) Acquisition of a telephone system;

(3) Construction or acquisition of parking facilities;

(4) Correction of cited deficiencies that are in violation of federal, state, or local fire, building, or safety laws and rules and that constitute an imminent threat to public health or safety;

(5) Acquisition of an existing health care facility that does not involve a change in the number of the beds, by service, or in the number or type of health services;

(6) Correction of cited deficiencies identified by accreditation surveys of the joint commission on accreditation of healthcare organizations or of the American osteopathic association;

(7) Acquisition of medical equipment to replace the same or similar equipment for which a certificate of need has been issued if the replaced equipment is removed from service;

(8) Mergers, consolidations, or other corporate reorganizations of health care facilities that do not involve a change in the number of beds, by service, or in the number or type of health services;

(9) Construction, repair, or renovation of bathroom facilities;

(10) Construction of laundry facilities, waste disposal facilities, dietary department projects, heating and air conditioning projects, administrative offices, and portions of

medical office buildings used exclusively for physician services;

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

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

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

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

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

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

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

(3) A distinct portion of a hospital, if the hospital is registered under section 3701.07 of the Revised Code as a children's hospital and the children's hospital meets all the requirements of division (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 3702.592, 3702.593, and 3702.594 of the Revised Code.

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

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

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

~~(3)~~(c) 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~~ any of the following occurred:

(i) The facility was cited 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 that is not immediate jeopardy~~.

~~(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~~.

~~(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.

(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:

(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~~

~~that is not immediate jeopardy.~~

~~(6) 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 than two nursing homes operated in this state by the applicant or the person who operates the facility in which the beds are being placed or, if the applicant or person operates more than twenty nursing homes in this state, more than ten per cent of those nursing homes, were each cited on;~~

(ii) 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;~~

(iii) 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.

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

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

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

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

(1) Is operated exclusively by a religious order;

(2) 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;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

operator:

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

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

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

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

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

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

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

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

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

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

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

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

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

to another of the operator's facilities;

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

(e) Any action the department of developmental disabilities takes regarding the facility's license under section 5123.19 of the Revised Code.

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

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

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

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

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

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

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

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

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

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

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

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

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

(5) Other amounts the department determines are applicable.

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

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

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

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

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

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

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

(1) If the exiting operator, entering operator, or affiliated operator assumes liability for 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, the department ~~may choose~~ shall not ~~to~~ make the withholding ~~under division (A) of this section if an entering operator does both of the following:~~

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

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

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

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

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

(1) If the exiting operator or affiliated operator assumes liability for 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, the department shall not make the withholding.

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

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

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

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

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

(b) Whichever of the following apply:

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

(ii) If the exiting operator or affiliated operator has not assumed liability under any other successor liability agreements, zero.

(E) A successor liability agreement executed under this section must comply with all of the following:

(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:

(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;

(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.

(2) It may not require the operator who executes the successor liability agreement to furnish a surety bond.

(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:

(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;

(b) The amount for which the operator who executes the successor liability agreement assumes liability under the

agreement.

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

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

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

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

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

Sec. 5111.685. The department of job and family services shall determine the actual amount of debt an exiting operator owes the department and the United States centers for medicare and medicaid services 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~~ an initial debt summary report on this matter not later than ~~ninety~~ sixty days after the date the exiting operator files the properly completed cost report required by section 5111.682 of the Revised Code with the department or, if the department waives the cost report requirement for the exiting operator, ~~ninety~~ sixty days after the date the department waives the cost report requirement. ~~The report shall include the department's findings and the amount of debt the department determines the exiting operator owes the department and United States centers for medicare and medicaid services under the medicaid program. Only the parts of the report that are subject to an adjudication as specified in section 5111.30 of the Revised Code are subject to an adjudication conducted~~ The initial debt summary report becomes the final debt summary report thirty-one days after the department issues the initial debt summary report unless the exiting operator, or an affiliated operator who executes a successor liability agreement under section 5111.681 of the Revised Code, requests a review before that date.

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

initial debt summary report. The department shall conduct the review on receipt of a timely request and issue a revised debt summary report. If the department has withheld money from payment due the exiting operator under division (A) of section 5111.681 of the Revised Code, the department shall issue the revised debt summary report not later than ninety days after the date the department receives the timely request for the review unless the department and exiting operator or affiliated operator agree to a later date. The exiting operator or affiliated operator may submit information to the department explaining what the operator contests before and during the review, including documentation of the amount of any debt the department owes the operator. The exiting operator or affiliated operator may submit additional information to the department not later than thirty days after the department issues the revised debt summary report. The revised debt summary report becomes the final debt summary report thirty-one days after the department issues the revised debt summary report unless the exiting operator or affiliated operator timely submits additional information to the department. If the exiting operator or affiliated operator timely submits additional information to the department, the department shall consider the additional information and issue a final debt summary report not later than sixty days after the department issues the revised debt summary report unless the department and exiting operator or affiliated operator agree to a later date.

Each debt summary report the department issues under this section 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. The department shall explain its findings and determination in each debt summary report.

The exiting operator, and an affiliated operator who executes

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.

Sec. 5111.686. The department of job and family services shall release the actual amount withheld under division (A) of section 5111.681 of the Revised Code, less any amount the exiting operator owes the department and United States centers for medicare and medicaid services under the medicaid program, as follows:

(A) ~~Ninety-one days after the date the exiting operator files a properly completed cost report required by section 5111.682 of the Revised Code unless~~ 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 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;

(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 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:

(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;

(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.

(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;

(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:

(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;

(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.

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

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

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

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

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

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

Sec. 5111.874. (A) As used in sections 5111.874 to 5111.8710 of the Revised Code:

"Home and community-based services" has the same meaning as in section 5123.01 of the Revised Code.

"ICF/MR services" means intermediate care facility for the mentally retarded services covered by the medicaid program that an intermediate care facility for the mentally retarded provides to a resident of the facility who is a medicaid recipient eligible for medicaid-covered intermediate care facility for the mentally retarded services.

"Intermediate care facility for the mentally retarded" means an intermediate care facility for the mentally retarded that is certified as in compliance with applicable standards for the medicaid program by the director of health in accordance with Title XIX of the "Social Security Act," 79 Stat. 286 (1965), 42 U.S.C. 1396, as amended, and licensed as a residential facility under section 5123.19 of the Revised Code.

"Residential facility" has the same meaning as in section 5123.19 of the Revised Code.

(B) For the purpose of increasing the number of slots available for home and community-based services and subject to

sections 5111.877 and 5111.878 of the Revised Code, the operator of an intermediate care facility for the mentally retarded may convert all of the beds in the facility from providing ICF/MR services to providing home and community-based services if all of the following requirements are met:

(1) The operator provides the directors of health, job and family services, and developmental disabilities at least ninety days' notice of the operator's intent to relinquish the facility's certification as an intermediate care facility for the mentally retarded and to begin providing home and community-based services.

(2) The operator complies with the requirements of sections 5111.65 to ~~5111.688~~ 5111.689 of the Revised Code regarding a voluntary termination as defined in section 5111.65 of the Revised Code if those requirements are applicable.

(3) The operator notifies each of the facility's residents that the facility is to cease providing ICF/MR services and inform each resident that the resident may do either of the following:

(a) Continue to receive ICF/MR services by transferring to another facility that is an intermediate care facility for the mentally retarded willing and able to accept the resident if the resident continues to qualify for ICF/MR services;

(b) Begin to receive home and community-based services instead of ICF/MR services from any provider of home and community-based services that is willing and able to provide the services to the resident if the resident is eligible for the services and a slot for the services is available to the resident.

(4) The operator meets the requirements for providing home and community-based services, including the following:

(a) Such requirements applicable to a residential facility if the operator maintains the facility's license as a residential facility;

(b) Such requirements applicable to a facility that is not licensed as a residential facility if the operator surrenders the facility's residential facility license under section 5123.19 of the Revised Code.

(5) The director of developmental disabilities approves the conversion.

(C) The notice to the director of developmental disabilities under division (B)(1) of this section shall specify whether the operator wishes to surrender the facility's license as a residential facility under section 5123.19 of the Revised Code.

(D) If the director of developmental disabilities approves a conversion under division (B) of this section, the director of health shall terminate the certification of the intermediate care facility for the mentally retarded to be converted. The director of health shall notify the director of job and family services of the termination. On receipt of the director of health's notice, the director of job and family services shall terminate the operator's medicaid provider agreement that authorizes the operator to provide ICF/MR services at the facility. The operator is not entitled to notice or a hearing under Chapter 119. of the Revised Code before the director of job and family services terminates the medicaid provider agreement.

Sec. 5111.875. (A) For the purpose of increasing the number of slots available for home and community-based services and subject to sections 5111.877 and 5111.878 of the Revised Code, a person who acquires, through a request for proposals issued by the director of developmental disabilities, a residential facility that is an intermediate care facility for the mentally retarded and for which the license as a residential facility was previously surrendered or revoked may convert some or all of the facility's beds from providing ICF/MR services to providing home and

community-based services if all of the following requirements are met:

(1) The person provides the directors of health, job and family services, and developmental disabilities at least ninety days' notice of the person's intent to make the conversion.

(2) The person complies with the requirements of sections 5111.65 to ~~5111.688~~ 5111.689 of the Revised Code regarding a voluntary termination as defined in section 5111.65 of the Revised Code if those requirements are applicable.

(3) If the person intends to convert all of the facility's beds, the person notifies each of the facility's residents that the facility is to cease providing ICF/MR services and informs each resident that the resident may do either of the following:

(a) Continue to receive ICF/MR services by transferring to another facility that is an intermediate care facility for the mentally retarded willing and able to accept the resident if the resident continues to qualify for ICF/MR services;

(b) Begin to receive home and community-based services instead of ICF/MR services from any provider of home and community-based services that is willing and able to provide the services to the resident if the resident is eligible for the services and a slot for the services is available to the resident.

(4) If the person intends to convert some but not all of the facility's beds, the person notifies each of the facility's residents that the facility is to convert some of its beds from providing ICF/MR services to providing home and community-based services and inform each resident that the resident may do either of the following:

(a) Continue to receive ICF/MR services from any provider of ICF/MR services that is willing and able to provide the services

to the resident if the resident continues to qualify for ICF/MR services;

(b) Begin to receive home and community-based services instead of ICF/MR services from any provider of home and community-based services that is willing and able to provide the services to the resident if the resident is eligible for the services and a slot for the services is available to the resident.

(5) The person meets the requirements for providing home and community-based services at a residential facility.

(B) The notice provided to the directors under division (A)(1) of this section shall specify whether some or all of the facility's beds are to be converted. If some but not all of the beds are to be converted, the notice shall specify how many of the facility's beds are to be converted and how many of the beds are to continue to provide ICF/MR services.

(C) On receipt of a notice under division (A)(1) of this section, the director of health shall do the following:

(1) Terminate the certification of the intermediate care facility for the mentally retarded if the notice specifies that all of the facility's beds are to be converted;

(2) Reduce the facility's certified capacity by the number of beds being converted if the notice specifies that some but not all of the beds are to be converted.

(D) The director of health shall notify the director of job and family services of the termination or reduction under division (C) of this section. On receipt of the director of health's notice, the director of job and family services shall do the following:

(1) Terminate the person's medicaid provider agreement that authorizes the person to provide ICF/MR services at the facility

if the facility's certification was terminated;

(2) Amend the person's medicaid provider agreement to reflect the facility's reduced certified capacity if the facility's certified capacity is reduced.

The person is not entitled to notice or a hearing under Chapter 119. of the Revised Code before the director of job and family services terminates or amends the medicaid provider agreement.

Sec. 5111.894. ~~The state administrative agency may establish one or more waiting lists for the assisted living program. Only individuals eligible for the medicaid program may be placed on a waiting list.~~ (A) The state administrative agency shall establish a home first component of the assisted living program under which eligible individuals may be enrolled in the assisted living program in accordance with this section. An individual is eligible for the assisted living program's home first component if all of the following apply:

(1) The individual is eligible for the assisted living program.

(2) The individual is on the unified waiting list established under section 173.404 of the Revised Code.

(3) At least one of the following applies:

(a) The individual has been admitted to a nursing facility.

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

(c) The individual has been hospitalized and a physician has

determined and documented in writing that, unless the individual is enrolled in home and community-based services such as the assisted living program, the individual is to be transported directly from the hospital to a nursing facility admitted.

(d) Both of the following apply:

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

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

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

(B) Each month, each area agency on aging shall ~~determine whether any individual who resides~~ identify individuals residing in the area that the area agency on aging serves ~~and is on a waiting list~~ who are eligible for the home first component of the assisted living program ~~has been admitted to a nursing facility~~. ~~If~~ When an area agency on aging ~~determines that~~ identifies such an individual ~~has been admitted to a nursing facility~~ and determines that there is a vacancy in a residential care facility

participating in the assisted living program that is acceptable to the individual, the agency shall notify the long-term care consultation program administrator serving the area in which the individual resides ~~about the determination~~. The administrator shall determine whether the assisted living program is appropriate for the individual and whether the individual would rather participate in the assisted living program than continue ~~residing~~ or begin to reside in ~~the~~ a nursing facility. If the administrator determines that the assisted living program is appropriate for the individual and the individual would rather participate in the assisted living program than continue ~~residing~~ or begin to reside in ~~the~~ a nursing facility, the administrator shall so notify the state administrative ~~agency.~~

~~On~~ agency. On receipt of the notice from the administrator, the state administrative agency shall approve the individual's enrollment in the assisted living program regardless of ~~any~~ the unified waiting list ~~for the assisted living program~~ established under section 173.404 of the Revised Code, unless the enrollment would cause the assisted living program to exceed any limit on the number of individuals who may participate in the program as set by the United States secretary of health and human services when the medicaid waiver authorizing the program is approved. ~~Each~~

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

Section 2. That existing sections 173.401, 173.501, 3702.51, 3702.59, 5111.65, 5111.651, 5111.68, 5111.681, 5111.685, 5111.686, 5111.688, 5111.874, 5111.875, and 5111.894 of the Revised Code are hereby repealed.

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

Sec. 209.20. LONG-TERM CARE

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, in consultation with the Directors of Aging and Job and Family Services, 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 appropriated.

(3) ~~If receipts credited to~~ Authorize expenditures from the Interagency Reimbursement Fund (Fund 3G50) for amounts that exceed the amounts appropriated from receipts credited to the fund~~, the Director of Job and Family Services 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 appropriated.

(C) Not later than thirty days after the Director of Budget and Management receives certification of expenditures specified in division (B) of this section, the Executive Director of Executive Medicaid Management Administration shall submit a report to the General Assembly in accordance with section 101.68 of the Revised Code and to the chairs and ranking minority members of the committees of the House of Representatives and Senate to which the biennial budget bill is referred. The report shall describe and document the criteria and data the Department of Aging, Department of Job and Family Services, and Office of Budget and Management use to justify a transfer of funds under division (B) of this section, including spending and utilization trends for PASSPORT, PACE, assisted living, and nursing facility services. In addition to providing the information for the transfer of funds, the report shall include the following:

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

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

The Directors of Aging, Job and Family Services, and Budget and Management shall provide the Executive Director of the Executive Medicaid Management Administration with all information the Executive Director needs to prepare the reports required by this division.

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

ALLOCATION OF PACE SLOTS

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

Section 4. That existing Section 209.20 of Am. Sub. H.B. 1 of

the 128th General Assembly is hereby repealed.

Section 5. During fiscal years 2012 and 2013, on receipt of certified expenditures related to sections 173.401, 173.351, 173.501, and 5111.894 of the Revised Code, the Director of Budget and Management shall 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.

If receipts credited to the PASSPORT Fund (Fund 3C40) exceed the amounts appropriated from the fund in fiscal years 2012 and 2013, the Director of Aging shall request the Director of Budget and Management to authorize expenditures from the fund in excess of the amounts appropriated.

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

Section 6. (A) As used in this section, "population" means that shown by the 2000 regular federal census.

(B) Until December 31, 2010, the Director of Health shall accept, for review under section 3702.52 of the Revised Code, certificate of need applications for an increase in beds in an existing nursing home if all of the following conditions are met:

(1) The proposed increase is attributable solely to a relocation of beds registered under section 3701.07 of the Revised Code as long-term care beds from an existing hospital located in a county with a population of at least forty thousand persons and

not more than forty-five thousand persons to an existing nursing home located in a county that has a population of at least one million persons and not more than one million one hundred thousand persons and is contiguous to the county from which the beds are to be relocated.

(2) Not more than fifteen beds are proposed for relocation.

(3) After the proposed relocation, there will be existing long-term care beds, as defined in section 3702.51 of the Revised Code, remaining in the county from which the beds are relocated.

(4) The beds are proposed to be licensed as nursing home beds under Chapter 3721. of the Revised Code.

(C) In reviewing a certificate of need application accepted under this section, the Director shall not deny the application on the grounds that the existing hospital from which the beds are to be relocated is not providing services in all or part of the long-term care beds at the hospital or has not provided services in all or part of those long-term care beds for at least three hundred sixty-five days within the twenty-four months immediately preceding the date the certificate of need application is filed with the Director, as otherwise required by a rule adopted under section 3702.57 of the Revised Code.