

**As Reported by the House Aging and Disability Services
Committee**

**128th General Assembly
Regular Session
2009-2010**

Sub. 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, 173.501, 3702.51, 3702.59,	1
5111.65, 5111.651, 5111.68, 5111.681, 5111.685,	2
5111.686, 5111.688, 5111.874, 5111.875, and	3
5111.894; to amend, for the purpose of adopting a	4
new section number as indicated in parentheses,	5
section 5111.688 (5111.689); and to enact new	6
section 5111.688 and section 173.404 of the	7
Revised Code; and to amend Section 209.20 of Am.	8
Sub. H.B. 1 of the 128th General Assembly to	9
revise the waiting list provisions of the	10
PASSPORT, PACE, and Assisted Living programs, to	11
revise the law governing the collection of	12
long-term care facilities' Medicaid debts, and to	13
revise the law governing the reasons for denying a	14
Certificate of Need application.	15

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

Section 1. That sections 173.401, 173.501, 3702.51, 3702.59, 16
5111.65, 5111.651, 5111.68, 5111.681, 5111.685, 5111.686, 17
5111.688, 5111.874, 5111.875, and 5111.894 be amended; section 18
5111.688 (5111.689) be amended for the purpose of adopting a new 19
section number as indicated in parentheses; and new section 20
5111.688 and section 173.404 of the Revised Code be enacted to 21
read as follows: 22

Sec. 173.401. (A) As used in this section: 23

"Area agency on aging" has the same meaning as in section 24
173.14 of the Revised Code. 25

"Long-term care consultation program" means the program the 26
department of aging is required to develop under section 173.42 of 27
the Revised Code. 28

"Long-term care consultation program administrator" or 29
"administrator" means the department of aging or, if the 30
department contracts with an area agency on aging or other entity 31
to administer the long-term care consultation program for a 32
particular area, that agency or entity. 33

"Nursing facility" has the same meaning as in section 5111.20 34
of the Revised Code. 35

"PASSPORT waiver" means the federal medicaid waiver granted 36
by the United States secretary of health and human services that 37
authorizes the PASSPORT program. 38

~~(B) The director of job and family services shall submit to 39
the United States secretary of health and human services an 40
amendment to the PASSPORT waiver that authorizes additional 41
enrollments in the PASSPORT program pursuant to this section. 42
Beginning with the month following the month in which the United 43
States secretary approves the amendment and each The department 44
shall establish a home first component of the PASSPORT program 45~~

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: 46
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(1) The individual is eligible for the PASSPORT program. 50

(2) The individual is on the unified waiting list established under section 173.404 of the Revised Code. 51
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(3) At least one of the following applies: 53

(a) The individual has been admitted to a nursing facility. 54

(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. 55
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(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. 61
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(d) Both of the following apply: 66

(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. 67
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(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 73
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services such as the PASSPORT program, the individual should be 76
admitted to a nursing facility. 77

(C) Each month ~~thereafter~~, each area agency on aging shall 78
~~determine whether~~ identify individuals ~~who reside~~ residing in the 79
area that the area agency on aging serves and who are ~~on a waiting~~ 80
~~list~~ eligible for the home first component of the PASSPORT program 81
~~have been admitted to a nursing facility.~~ If ~~When~~ an area agency 82
on aging ~~determines that~~ identifies such an individual ~~has been~~ 83
~~admitted to a nursing facility,~~ the agency shall notify the 84
long-term care consultation program administrator serving the area 85
in which the individual resides ~~about the determination.~~ The 86
administrator shall determine whether the PASSPORT program is 87
appropriate for the individual and whether the individual would 88
rather participate in the PASSPORT program than continue ~~residing~~ 89
or begin to reside in ~~the~~ a nursing facility. If the administrator 90
determines that the PASSPORT program is appropriate for the 91
individual and the individual would rather participate in the 92
PASSPORT program than continue ~~residing~~ or begin to reside in ~~the~~ 93
a nursing facility, the administrator shall so notify the 94
department of aging. On receipt of the notice from the 95
administrator, the department ~~of aging~~ shall approve the 96
individual's enrollment in the PASSPORT program regardless of the 97
PASSPORT program's unified waiting list and ~~even though the~~ 98
~~enrollment causes enrollment in the program to exceed the limit~~ 99
~~that would otherwise apply~~ established under section 173.404 of 100
the Revised Code, unless the enrollment would cause the PASSPORT 101
program to exceed any limit on the number of individuals who may 102
be enrolled in the program as set by the United States secretary 103
of health and human services in the PASSPORT waiver. 104

(D) Each quarter, the department of aging shall certify to 105
the director of budget and management the estimated increase in 106
costs of the PASSPORT program resulting from enrollment of 107

individuals in the PASSPORT program pursuant to this section. 108

Sec. 173.404. (A) As used in this section: 109

(1) "Department of aging-administered medicaid waiver component" means each of the following: 110
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(a) The PASSPORT program created under section 173.40 of the Revised Code; 112
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(b) The choices program created under section 173.403 of the Revised Code; 114
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(c) The assisted living program created under section 5111.89 of the Revised Code. 116
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(2) "PACE program" means the component of the medicaid program the department of aging administers pursuant to section 173.50 of the Revised Code. 118
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(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. 121
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Sec. 173.501. (A) As used in this section: 126

"Nursing facility" has the same meaning as in section 5111.20 of the Revised Code. 127
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"PACE provider" has the same meaning as in 42 U.S.C. 129
1396u-4(a)(3). 130

(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: 131
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<u>(1) The individual is eligible for the PACE program.</u>	136
<u>(2) The individual is on the unified waiting list established under section 173.404 of the Revised Code.</u>	137 138
<u>(3) At least one of the following applies:</u>	139
<u>(a) The individual has been admitted to a nursing facility.</u>	140
<u>(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.</u>	141 142 143 144 145
<u>(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.</u>	146 147 148 149 150
<u>(d) Both of the following apply:</u>	151
<u>(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.</u>	152 153 154 155 156 157
<u>(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.</u>	158 159 160 161 162
<u>(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</u>	163 164 165

~~admitted to a nursing facility. If~~ When the department determines 166
~~that identifies~~ such an individual ~~has been admitted to a nursing~~ 167
~~facility,~~ the department shall notify the PACE provider serving 168
the area in which the individual resides ~~about the determination.~~ 169
The PACE provider shall determine whether the PACE program is 170
appropriate for the individual and whether the individual would 171
rather participate in the PACE program than continue ~~residing or~~ 172
begin to reside in ~~the~~ a nursing facility. If the PACE provider 173
determines that the PACE program is appropriate for the individual 174
and the individual would rather participate in the PACE program 175
than continue ~~residing or begin to reside~~ in ~~the~~ a nursing 176
facility, the PACE provider shall so notify the department of 177
aging. On receipt of the notice from the PACE provider, the 178
department of aging shall approve the individual's enrollment in 179
the PACE program in accordance with priorities established in 180
rules adopted under section 173.50 of the Revised Code. ~~Each~~ 181

(D) Each quarter, the department of aging shall certify to 182
the director of budget and management the estimated increase in 183
costs of the PACE program resulting from enrollment of individuals 184
in the PACE program pursuant to this section. 185

Sec. 3702.51. As used in sections 3702.51 to 3702.62 of the 186
Revised Code: 187

(A) "Applicant" means any person that submits an application 188
for a certificate of need and who is designated in the application 189
as the applicant. 190

(B) "Person" means any individual, corporation, business 191
trust, estate, firm, partnership, association, joint stock 192
company, insurance company, government unit, or other entity. 193

(C) "Certificate of need" means a written approval granted by 194
the director of health to an applicant to authorize conducting a 195
reviewable activity. 196

(D) "Health service area" means a geographic region	197
designated by the director of health under section 3702.58 of the	198
Revised Code.	199
(E) "Health service" means a clinically related service, such	200
as a diagnostic, treatment, rehabilitative, or preventive service.	201
(F) "Health service agency" means an agency designated to	202
serve a health service area in accordance with section 3702.58 of	203
the Revised Code.	204
(G) "Health care facility" means:	205
(1) A hospital registered under section 3701.07 of the	206
Revised Code;	207
(2) A nursing home licensed under section 3721.02 of the	208
Revised Code, or by a political subdivision certified under	209
section 3721.09 of the Revised Code;	210
(3) A county home or a county nursing home as defined in	211
section 5155.31 of the Revised Code that is certified under Title	212
XVIII or XIX of the "Social Security Act," 49 Stat. 620 (1935), 42	213
U.S.C.A. 301, as amended;	214
(4) A freestanding dialysis center;	215
(5) A freestanding inpatient rehabilitation facility;	216
(6) An ambulatory surgical facility;	217
(7) A freestanding cardiac catheterization facility;	218
(8) A freestanding birthing center;	219
(9) A freestanding or mobile diagnostic imaging center;	220
(10) A freestanding radiation therapy center.	221
A health care facility does not include the offices of	222
private physicians and dentists whether for individual or group	223
practice, residential facilities licensed under section 5123.19 of	224
the Revised Code, or an institution for the sick that is operated	225

exclusively for patients who use spiritual means for healing and 226
for whom the acceptance of medical care is inconsistent with their 227
religious beliefs, accredited by a national accrediting 228
organization, exempt from federal income taxation under section 229
501 of the Internal Revenue Code of 1986, 100 Stat. 2085, 26 230
U.S.C.A. 1, as amended, and providing twenty-four hour nursing 231
care pursuant to the exemption in division (E) of section 4723.32 232
of the Revised Code from the licensing requirements of Chapter 233
4723. of the Revised Code. 234

(H) "Medical equipment" means a single unit of medical 235
equipment or a single system of components with related functions 236
that is used to provide health services. 237

(I) "Third-party payer" means a health insuring corporation 238
licensed under Chapter 1751. of the Revised Code, a health 239
maintenance organization as defined in division (K) of this 240
section, an insurance company that issues sickness and accident 241
insurance in conformity with Chapter 3923. of the Revised Code, a 242
state-financed health insurance program under Chapter 3701., 243
4123., or 5111. of the Revised Code, or any self-insurance plan. 244

(J) "Government unit" means the state and any county, 245
municipal corporation, township, or other political subdivision of 246
the state, or any department, division, board, or other agency of 247
the state or a political subdivision. 248

(K) "Health maintenance organization" means a public or 249
private organization organized under the law of any state that is 250
qualified under section 1310(d) of Title XIII of the "Public 251
Health Service Act," 87 Stat. 931 (1973), 42 U.S.C. 300e-9. 252

(L) "Existing health care facility" means either of the 253
following: 254

(1) A health care facility that is licensed or otherwise 255
authorized to operate in this state in accordance with applicable 256

law, including a county home or a county nursing home that is 257
certified as of February 1, 2008, under Title XVIII or Title XIX 258
of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C. 301, 259
as amended, is staffed and equipped to provide health care 260
services, and is actively providing health services; 261

(2) A health care facility that is licensed or otherwise 262
authorized to operate in this state in accordance with applicable 263
law, including a county home or a county nursing home that is 264
certified as of February 1, 2008, under Title XVIII or Title XIX 265
of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C. 301, 266
as amended, or that has beds registered under section 3701.07 of 267
the Revised Code as skilled nursing beds or long-term care beds 268
and has provided services for at least three hundred sixty-five 269
consecutive days within the twenty-four months immediately 270
preceding the date a certificate of need application is filed with 271
the director of health. 272

(M) "State" means the state of Ohio, including, but not 273
limited to, the general assembly, the supreme court, the offices 274
of all elected state officers, and all departments, boards, 275
offices, commissions, agencies, institutions, and other 276
instrumentalities of the state of Ohio. "State" does not include 277
political subdivisions. 278

(N) "Political subdivision" means a municipal corporation, 279
township, county, school district, and all other bodies corporate 280
and politic responsible for governmental activities only in 281
geographic areas smaller than that of the state to which the 282
sovereign immunity of the state attaches. 283

(O) "Affected person" means: 284

(1) An applicant for a certificate of need, including an 285
applicant whose application was reviewed comparatively with the 286
application in question; 287

(2) The person that requested the reviewability ruling in question;	288 289
(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;	290 291 292 293
(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;	294 295 296
(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;	297 298 299 300
(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.	301 302 303 304
(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:	305 306 307 308
(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;	309 310 311 312
(2) Maintaining an active medical staff, the majority of which is comprised of osteopathic physicians;	313 314
(3) Maintaining a medical staff executive committee that has osteopathic physicians as a majority of its members.	315 316
(Q) "Ambulatory surgical facility" has the same meaning as in	317

section 3702.30 of the Revised Code.	318
(R) Except as provided in division (S) of this section,	319
"reviewable activity" means any of the following activities:	320
(1) The establishment, development, or construction of a new long-term care facility;	321 322
(2) The replacement of an existing long-term care facility;	323
(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;	324 325 326 327
(4) Either of the following changes in long-term care bed capacity:	328 329
(a) An increase in bed capacity;	330
(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.	331 332 333 334
(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;	335 336 337 338 339 340
(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.	341 342 343
(S) "Reviewable activity" does not include any of the following activities:	344 345
(1) Acquisition of computer hardware or software;	346

(2) Acquisition of a telephone system;	347
(3) Construction or acquisition of parking facilities;	348
(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;	349 350 351
(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;	352 353 354
(6) Correction of cited deficiencies identified by accreditation surveys of the joint commission on accreditation of healthcare organizations or of the American osteopathic association;	355 356 357 358
(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;	359 360 361
(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;	362 363 364 365
(9) Construction, repair, or renovation of bathroom facilities;	366 367
(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;	368 369 370 371
(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	372 373 374 375 376

premarket approval has been granted by the United States food and 377
drug administration to provide services for which patients or 378
reimbursement entities will be charged shall be a reviewable 379
activity. 380

(12) Removal of asbestos from a health care facility. 381

Only that portion of a project that meets the requirements of 382
this division is not a reviewable activity. 383

(T) "Small rural hospital" means a hospital that is located 384
within a rural area, has fewer than one hundred beds, and to which 385
fewer than four thousand persons were admitted during the most 386
recent calendar year. 387

(U) "Children's hospital" means any of the following: 388

(1) A hospital registered under section 3701.07 of the 389
Revised Code that provides general pediatric medical and surgical 390
care, and in which at least seventy-five per cent of annual 391
inpatient discharges for the preceding two calendar years were 392
individuals less than eighteen years of age; 393

(2) A distinct portion of a hospital registered under section 394
3701.07 of the Revised Code that provides general pediatric 395
medical and surgical care, has a total of at least one hundred 396
fifty registered pediatric special care and pediatric acute care 397
beds, and in which at least seventy-five per cent of annual 398
inpatient discharges for the preceding two calendar years were 399
individuals less than eighteen years of age; 400

(3) A distinct portion of a hospital, if the hospital is 401
registered under section 3701.07 of the Revised Code as a 402
children's hospital and the children's hospital meets all the 403
requirements of division (U)(1) of this section. 404

(V) "Long-term care facility" means any of the following: 405

(1) A nursing home licensed under section 3721.02 of the 406

Revised Code or by a political subdivision certified under section 407
3721.09 of the Revised Code; 408

(2) The portion of any facility, including a county home or 409
county nursing home, that is certified as a skilled nursing 410
facility or a nursing facility under Title XVIII or XIX of the 411
"Social Security Act"; 412

(3) The portion of any hospital that contains beds registered 413
under section 3701.07 of the Revised Code as skilled nursing beds 414
or long-term care beds. 415

(W) "Long-term care bed" means a bed in a long-term care 416
facility. 417

(X) "Freestanding birthing center" means any facility in 418
which deliveries routinely occur, regardless of whether the 419
facility is located on the campus of another health care facility, 420
and which is not licensed under Chapter 3711. of the Revised Code 421
as a level one, two, or three maternity unit or a limited 422
maternity unit. 423

(Y)(1) "Reviewability ruling" means a ruling issued by the 424
director of health under division (A) of section 3702.52 of the 425
Revised Code as to whether a particular proposed project is or is 426
not a reviewable activity. 427

(2) "Nonreviewability ruling" means a ruling issued under 428
that division that a particular proposed project is not a 429
reviewable activity. 430

(Z)(1) "Metropolitan statistical area" means an area of this 431
state designated a metropolitan statistical area or primary 432
metropolitan statistical area in United States office of 433
management and budget bulletin no. 93-17, June 30, 1993, and its 434
attachments. 435

(2) "Rural area" means any area of this state not located 436

within a metropolitan statistical area. 437

(AA) "County nursing home" has the same meaning as in section 438
5155.31 of the Revised Code. 439

(BB) "Principal participant" means both of the following: 440

(1) A person who has an ownership or controlling interest of 441
at least five per cent in an applicant, in a health care facility 442
that is the subject of an application for a certificate of need, 443
or in the owner or operator of the applicant or such a facility; 444

(2) An officer, director, trustee, or general partner of an 445
applicant, of a health care facility that is the subject of an 446
application for a certificate of need, or of the owner or operator 447
of the applicant or such a facility. 448

(CC) "Actual harm but not immediate jeopardy deficiency" 449
means a deficiency that, under 42 C.F.R. 488.404, either 450
constitutes a pattern of deficiencies resulting in actual harm 451
that is not immediate jeopardy or represents widespread 452
deficiencies resulting in actual harm that is not immediate 453
jeopardy. 454

(DD) "Immediate jeopardy deficiency" means a deficiency that, 455
under 42 C.F.R. 488.404, either constitutes a pattern of 456
deficiencies resulting in immediate jeopardy to resident health or 457
safety or represents widespread deficiencies resulting in 458
immediate jeopardy to resident health or safety. 459

Sec. 3702.59. (A) The director of health shall accept for 460
review certificate of need applications as provided in sections 461
3702.592, 3702.593, and 3702.594 of the Revised Code. 462

(B)(1) The director shall not approve an application for a 463
certificate of need for the addition of long-term care beds to an 464
existing health care facility or for the development of a new 465
health care facility if any of the following apply: 466

~~(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 499
resident health or safety or are widespread deficiencies resulting 500
in immediate jeopardy to resident health or safety. 501~~

~~(5) During the period that precedes the filing of the 502
application and is encompassed by the three most recent standard 503
surveys of the existing health care facility in which the beds are 504
being placed, more (iii) The facility was cited on two separate 505
occasions for final, nonappealable actual harm but not immediate 506
jeopardy deficiencies and on one occasion for a final, 507
nonappealable immediate jeopardy deficiency. 508~~

~~(d) More than two nursing homes owned or operated in this 509
state by the applicant or the person who operates the facility in 510
which the beds are being placed a principal participant or, if the 511
applicant or person a principal participant owns or operates more 512
than twenty nursing homes in this state, more than ten per cent of 513
those nursing homes, were each cited on during the period that 514
precedes the filing of the application for the certificate of need 515
and is encompassed by the three most recent standard surveys of 516
the nursing homes that were so cited in any of the following 517
manners: 518~~

~~(i) On three or more separate occasions for final, 519
nonappealable actual harm but not immediate jeopardy deficiencies 520
that, under 42 C.F.R. 488.404, either constitute a pattern of 521
deficiencies resulting in actual harm that is not immediate 522
jeopardy or are widespread deficiencies resulting in actual harm 523
that is not immediate jeopardy. 524~~

~~(6) During the period that precedes the filing of the 525
application and is encompassed by the three most recent standard 526
surveys of the existing health care facility in which the beds are 527
being placed, more than two nursing homes operated in this state 528
by the applicant or the person who operates the facility in which 529
the beds are being placed or, if the applicant or person operates 530~~

~~more than twenty nursing homes in this state, more than ten per cent of those nursing homes, were each cited on;~~ 531
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~~(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;~~ 533
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~~(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.~~ 539
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~~(7) During the sixty month period preceding the filing of the application, the applicant has violated this chapter on two or more separate occasions.~~ 542
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~~(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.~~ 545
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(C) The director also shall accept for review any application 562
for the conversion of infirmary beds to long-term care beds if the 563
infirmary meets all of the following conditions: 564

(1) Is operated exclusively by a religious order; 565

(2) Provides care exclusively to members of religious orders 566
who take vows of celibacy and live by virtue of their vows within 567
the orders as if related; 568

(3) Was providing care exclusively to members of such a 569
religious order on January 1, 1994. 570

At no time shall individuals other than those described in 571
division (C)(2) of this section be admitted to a facility to use 572
beds for which a certificate of need is approved under this 573
division. 574

Sec. 5111.65. As used in sections 5111.65 to ~~5111.688~~ 575
5111.689 of the Revised Code: 576

(A) "Affiliated operator" means an operator affiliated with 577
either of the following: 578

(1) The exiting operator for whom the affiliated operator is 579
to assume liability for the entire amount of the exiting 580
operator's debt under the medicaid program or the portion of the 581
debt that represents the franchise permit fee the exiting operator 582
owes; 583

(2) The entering operator involved in the change of operator 584
with the exiting operator specified in division (A)(1) of this 585
section. 586

(B) "Change of operator" means an entering operator becoming 587
the operator of a nursing facility or intermediate care facility 588
for the mentally retarded in the place of the exiting operator. 589

(1) Actions that constitute a change of operator include the 590

following:	591
(a) A change in an exiting operator's form of legal organization, including the formation of a partnership or corporation from a sole proprietorship;	592 593 594
(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;	595 596 597 598 599
(c) A lease of the facility to the entering operator or the exiting operator's termination of the exiting operator's lease;	600 601
(d) If the exiting operator is a partnership, dissolution of the partnership;	602 603
(e) If the exiting operator is a partnership, a change in composition of the partnership unless both of the following apply:	604 605
(i) The change in composition does not cause the partnership's dissolution under state law.	606 607
(ii) The partners agree that the change in composition does not constitute a change in operator.	608 609
(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.	610 611 612 613
(2) The following, alone, do not constitute a change of operator:	614 615
(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;	616 617 618 619
(b) A change of ownership, lease, or termination of a lease	620

of real property or personal property associated with a nursing 621
facility or intermediate care facility for the mentally retarded 622
if an entering operator does not become the operator in place of 623
an exiting operator; 624

(c) If the operator is a corporation, a change of one or more 625
members of the corporation's governing body or transfer of 626
ownership of one or more shares of the corporation's stock, if the 627
same corporation continues to be the operator. 628

~~(B)~~(C) "Effective date of a change of operator" means the day 629
the entering operator becomes the operator of the nursing facility 630
or intermediate care facility for the mentally retarded. 631

~~(C)~~(D) "Effective date of a facility closure" means the last 632
day that the last of the residents of the nursing facility or 633
intermediate care facility for the mentally retarded resides in 634
the facility. 635

~~(D)~~(E) "Effective date of a voluntary termination" means the 636
day the intermediate care facility for the mentally retarded 637
ceases to accept medicaid patients. 638

~~(E)~~(F) "Effective date of a voluntary withdrawal of 639
participation" means the day the nursing facility ceases to accept 640
new medicaid patients other than the individuals who reside in the 641
nursing facility on the day before the effective date of the 642
voluntary withdrawal of participation. 643

~~(F)~~(G) "Entering operator" means the person or government 644
entity that will become the operator of a nursing facility or 645
intermediate care facility for the mentally retarded when a change 646
of operator occurs. 647

~~(G)~~(H) "Exiting operator" means any of the following: 648

(1) An operator that will cease to be the operator of a 649
nursing facility or intermediate care facility for the mentally 650

retarded on the effective date of a change of operator; 651

(2) An operator that will cease to be the operator of a 652
nursing facility or intermediate care facility for the mentally 653
retarded on the effective date of a facility closure; 654

(3) An operator of an intermediate care facility for the 655
mentally retarded that is undergoing or has undergone a voluntary 656
termination; 657

(4) An operator of a nursing facility that is undergoing or 658
has undergone a voluntary withdrawal of participation. 659

~~(H)~~(I)(1) "Facility closure" means discontinuance of the use 660
of the building, or part of the building, that houses the facility 661
as a nursing facility or intermediate care facility for the 662
mentally retarded that results in the relocation of all of the 663
facility's residents. A facility closure occurs regardless of any 664
of the following: 665

(a) The operator completely or partially replacing the 666
facility by constructing a new facility or transferring the 667
facility's license to another facility; 668

(b) The facility's residents relocating to another of the 669
operator's facilities; 670

(c) Any action the department of health takes regarding the 671
facility's certification under Title XIX of the "Social Security 672
Act," 79 Stat. 286 (1965), 42 U.S.C. 1396, as amended, that may 673
result in the transfer of part of the facility's survey findings 674
to another of the operator's facilities; 675

(d) Any action the department of health takes regarding the 676
facility's license under Chapter 3721. of the Revised Code; 677

(e) Any action the department of developmental disabilities 678
takes regarding the facility's license under section 5123.19 of 679
the Revised Code. 680

(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 711
change of operator, the department of job and family services 712
shall ~~determine~~ estimate the amount of any overpayments made under 713
the medicaid program to the exiting operator, including 714
overpayments the exiting operator disputes, and other actual and 715
potential debts the exiting operator owes or may owe to the 716
department and United States centers for medicare and medicaid 717
services under the medicaid program, including a franchise permit
fee. ~~In determining~~ 719

(B) In estimating the exiting operator's other actual and 720
potential debts to the department and the United States centers
for medicare and medicaid services under the medicaid program, the 721
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 725
methodology shall provide for estimating all of the following that 726
the department determines ~~is~~ are applicable: 727

(1) Refunds due the department under section 5111.27 of the 728
Revised Code; 729

(2) Interest owed to the department and United States centers 730
for medicare and medicaid services; 731

(3) Final civil monetary and other penalties for which all 732
right of appeal has been exhausted; 733

(4) Money owed the department and United States centers for 734
medicare and medicaid services from any outstanding final fiscal 735
audit, including a final fiscal audit for the last fiscal year or 736
portion thereof in which the exiting operator participated in the 737
medicaid program; 738

(5) Other amounts the department determines are applicable. 739

~~(B) If the department is unable to determine the amount of~~ 740

~~the overpayments and other debts for any period before the~~ 741
~~effective date of the entering operator's provider agreement or~~ 742
~~the effective date of the facility closure, voluntary termination,~~ 743
~~or voluntary withdrawal of participation, the department shall~~ 744
~~make a reasonable estimate of the overpayments and other debts for~~ 745
~~the period. The department shall make the estimate using~~ 746
~~information available to the department, including prior~~ 747
~~determinations of overpayments and other debts.~~ 748

(C) The department shall provide the exiting operator written 749
notice of the department's estimate under division (A) of this 750
section not later than thirty days after the department receives 751
the notice under section 5111.66 of the Revised Code of the 752
facility closure, voluntary termination, or voluntary withdrawal 753
of participation or the notice under section 5111.67 of the 754
Revised Code of the change of operator. The department's written 755
notice shall include the basis for the estimate. 756

Sec. 5111.681. (A) Except as provided in ~~division~~ divisions 757
(B) and (C) of this section, the department of job and family 758
services ~~shall~~ may withhold ~~the greater of the following~~ from 759
payment due an exiting operator under the medicaid program~~+~~ 760

~~(1) The the total amount of any overpayments made under the~~ 761
~~medicaid program to the exiting operator, including overpayments~~ 762
~~the exiting operator disputes, and other actual and potential~~ 763
~~debts, including any unpaid penalties, specified in the notice~~ 764
~~provided under division (C) of section 5111.68 of the Revised Code~~ 765
~~that the exiting operator owes or may owe to the department and~~ 766
United States centers for medicare and medicaid services under the 767
medicaid program~~+~~ 768

~~(2) An amount equal to the average amount of monthly payments~~ 769
~~to the exiting operator under the medicaid program for the~~ 770
~~twelve month period immediately preceding the month that includes~~ 771

~~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.~~ 772
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(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: 775
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(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: 781
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~~(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;~~ 789
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~~(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.~~ 792
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(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 795
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assumes liability. 803

(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: 804
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(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. 811
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(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. 817
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(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: 825
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(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 829
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closure, or change of operator; 834

(2) During the twelve-month period preceding the month in 835
which the department receives the notice of the voluntary 836
termination, voluntary withdrawal of participation, or facility 837
closure under section 5111.66 of the Revised Code or the notice of 838
the change of operator under section 5111.67 of the Revised Code, 839
the average monthly medicaid payment made to the exiting operator 840
or affiliated operator pursuant to the exiting operator's or 841
affiliated operator's one or more provider agreements, other than 842
the provider agreement for the nursing facility or intermediate 843
care facility for the mentally retarded that is the subject of the 844
voluntary termination, voluntary withdrawal of participation, 845
facility closure, or change of operator, must equal at least 846
ninety per cent of the sum of the following: 847

(a) The average monthly medicaid payment made to the exiting 848
operator pursuant to the exiting operator's provider agreement for 849
the nursing facility or intermediate care facility for the 850
mentally retarded that is the subject of the voluntary 851
termination, voluntary withdrawal of participation, facility 852
closure, or change of operator; 853

(b) Whichever of the following apply: 854

(i) If the exiting operator or affiliated operator has 855
assumed liability under one or more other successor liability 856
agreements, the total amount for which the exiting operator or 857
affiliated operator has assumed liability under the other 858
successor liability agreements; 859

(ii) If the exiting operator or affiliated operator has not 860
assumed liability under any other successor liability agreements, 861
zero. 862

(E) A successor liability agreement executed under this 863
section must comply with all of the following: 864

(1) It must provide for the operator who executes the 865
successor liability agreement to assume liability for either of 866
the following as specified in the agreement: 867

(a) The total, actual amount of debt the exiting operator 868
owes the department and the United States centers for medicare and 869
medicaid services under the medicaid program as determined under 870
section 5111.685 of the Revised Code; 871

(b) The portion of the amount specified in division (E)(1)(a) 872
of this section that represents the franchise permit fee the 873
exiting operator owes. 874

(2) It may not require the operator who executes the 875
successor liability agreement to furnish a surety bond. 876

(3) It must provide that the department, after determining 877
under section 5111.685 of the Revised Code the actual amount of 878
debt the exiting operator owes the department and United States 879
centers for medicare and medicaid services under the medicaid 880
program, may deduct the lesser of the following from medicaid 881
payments made to the operator who executes the successor liability 882
agreement: 883

(a) The total, actual amount of debt the exiting operator 884
owes the department and the United States centers for medicare and 885
medicaid services under the medicaid program as determined under 886
section 5111.685 of the Revised Code; 887

(b) The amount for which the operator who executes the 888
successor liability agreement assumes liability under the 889
agreement. 890

(4) It must provide that the deductions authorized by 891
division (E)(3) of this section are to be made for a number of 892
months, not to exceed six, agreed to by the operator who executes 893
the successor liability agreement and the department or, if the 894
operator who executes the successor liability agreement and 895

department cannot agree on a number of months that is less than 896
six, a greater number of months determined by the attorney general 897
pursuant to a claims collection process authorized by statute of 898
this state. 899

(5) It must provide that, if the attorney general determines 900
the number of months for which the deductions authorized by 901
division (E)(3) of this section are to be made, the operator who 902
executes the successor liability agreement shall pay, in addition 903
to the amount collected pursuant to the attorney general's claims 904
collection process, the part of the amount so collected that, if 905
not for division (G) of this section, would be required by section 906
109.081 of the Revised Code to be paid into the attorney general 907
claims fund. 908

(F) Execution of a successor liability agreement does not 909
waive an exiting operator's right to contest the amount specified 910
in the notice the department provides the exiting operator under 911
division (C) of section 5111.68 of the Revised Code. 912

(G) Notwithstanding section 109.081 of the Revised Code, the 913
entire amount that the attorney general, whether by employees or 914
agents of the attorney general or by special counsel appointed 915
pursuant to section 109.08 of the Revised Code, collects under a 916
successor liability agreement, other than the additional amount 917
the operator who executes the agreement is required by division 918
(E)(5) of this section to pay, shall be paid to the department of 919
job and family services for deposit into the appropriate fund. The 920
additional amount that the operator is required to pay shall be 921
paid into the state treasury to the credit of the attorney general 922
claims fund created under section 109.081 of the Revised Code. 923

Sec. 5111.685. The department of job and family services 924
shall determine the actual amount of debt an exiting operator owes 925
the department and the United States centers for medicare and 926

medicaid services under the medicaid program by completing all 927
final fiscal audits not already completed and performing all other 928
appropriate actions the department determines to be necessary. The 929
department shall issue ~~a~~ an initial debt summary report on this 930
matter not later than ~~ninety~~ sixty days after the date the exiting 931
operator files the properly completed cost report required by 932
section 5111.682 of the Revised Code with the department or, if 933
the department waives the cost report requirement for the exiting 934
operator, ~~ninety~~ sixty days after the date the department waives 935
the cost report requirement. ~~The report shall include the~~ 936
~~department's findings and the amount of debt the department~~ 937
~~determines the exiting operator owes the department and United~~ 938
~~States centers for medicare and medicaid services under the~~ 939
~~medicaid program. Only the parts of the report that are subject to~~ 940
~~an adjudication as specified in section 5111.30 of the Revised~~ 941
~~Code are subject to an adjudication conducted~~ The initial debt 942
summary report becomes the final debt summary report thirty-one 943
days after the department issues the initial debt summary report 944
unless the exiting operator, or an affiliated operator who 945
executes a successor liability agreement under section 5111.681 of 946
the Revised Code, requests a review before that date. 947

The exiting operator, and an affiliated operator who executes 948
a successor liability agreement under section 5111.681 of the 949
Revised Code, may request a review to contest any of the 950
department's findings included in the initial debt summary report. 951
The request for the review must be submitted to the department not 952
later than thirty days after the date the department issues the 953
initial debt summary report. The department shall conduct the 954
review on receipt of a timely request and issue a revised debt 955
summary report. If the department has withheld money from payment 956
due the exiting operator under division (A) of section 5111.681 of 957
the Revised Code, the department shall issue the revised debt 958
summary report not later than ninety days after the date the 959

department receives the timely request for the review unless the 960
department and exiting operator or affiliated operator agree to a 961
later date. The exiting operator or affiliated operator may submit 962
information to the department explaining what the operator 963
contests before and during the review, including documentation of 964
the amount of any debt the department owes the operator. The 965
exiting operator or affiliated operator may submit additional 966
information to the department not later than thirty days after the 967
department issues the revised debt summary report. The revised 968
debt summary report becomes the final debt summary report 969
thirty-one days after the department issues the revised debt 970
summary report unless the exiting operator or affiliated operator 971
timely submits additional information to the department. If the 972
exiting operator or affiliated operator timely submits additional 973
information to the department, the department shall consider the 974
additional information and issue a final debt summary report not 975
later than sixty days after the department issues the revised debt 976
summary report unless the department and exiting operator or 977
affiliated operator agree to a later date. 978

Each debt summary report the department issues under this 979
section shall include the department's findings and the amount of 980
debt the department determines the exiting operator owes the 981
department and United States centers for medicare and medicaid 982
services under the medicaid program. The department shall explain 983
its findings and determination in each debt summary report. 984

The exiting operator, and an affiliated operator who executes 985
a successor liability agreement under section 5111.681 of the 986
Revised Code, may request, in accordance with Chapter 119. of the 987
Revised Code, an adjudication regarding a finding in a final debt 988
summary report that pertains to an audit or alleged overpayment 989
made under the medicaid program to the exiting operator. The 990
adjudication shall be consolidated with any other uncompleted 991

adjudication that concerns a matter addressed in the final debt 992
summary report. 993

Sec. 5111.686. The department of job and family services 994
shall release the actual amount withheld under division (A) of 995
section 5111.681 of the Revised Code, less any amount the exiting 996
operator owes the department and United States centers for 997
medicare and medicaid services under the medicaid program, as 998
follows: 999

(A) ~~Ninety one days after the date the exiting operator files~~ 1000
~~a properly completed cost report required by section 5111.682 of~~ 1001
~~the Revised Code unless~~ Unless the department issues the initial 1002
debt summary report required by section 5111.685 of the Revised 1003
Code not later than ~~ninety~~ sixty days after the date the exiting 1004
operator files the properly completed cost report required by 1005
section 5111.682 of the Revised Code, sixty-one days after the 1006
date the exiting operator files the properly completed cost 1007
report; 1008

(B) ~~Not later than thirty days after the exiting operator~~ 1009
~~agrees to a final fiscal audit resulting from the report required~~ 1010
~~by section 5111.685 of the Revised Code if~~ If the department 1011
issues the initial debt summary report required by section 1012
5111.685 of the Revised Code not later than ~~ninety~~ sixty days 1013
after the date the exiting operator files a properly completed 1014
cost report required by section 5111.682 of the Revised Code, not 1015
later than the following: 1016

(1) Thirty days after the deadline for requesting an 1017
adjudication under section 5111.685 of the Revised Code regarding 1018
the final debt summary report if the exiting operator, and an 1019
affiliated operator who executes a successor liability agreement 1020
under section 5111.681 of the Revised Code, fail to request the 1021
adjudication on or before the deadline; 1022

(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. 1023
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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; 1029
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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: 1037
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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; 1045
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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 1051
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adjudication on or before the deadline for requesting the 1055
adjudication. 1056

Sec. 5111.688. (A) All amounts withheld under section 1057
5111.681 of the Revised Code from payment due an exiting operator 1058
under the medicaid program shall be deposited into the medicaid 1059
payment withholding fund created by the controlling board pursuant 1060
to section 131.35 of the Revised Code. Money in the fund shall be 1061
used as follows: 1062

(1) To pay an exiting operator when a withholding is released 1063
to the exiting operator under section 5111.686 or 5111.687 of the 1064
Revised Code; 1065

(2) To pay the department of job and family services and 1066
United States centers for medicare and medicaid services the 1067
amount an exiting operator owes the department and United States 1068
centers under the medicaid program. 1069

(B) Amounts paid from the medicaid payment withholding fund 1070
pursuant to division (A)(2) of this section shall be deposited 1071
into the appropriate department fund. 1072

Sec. ~~5111.688~~ 5111.689. The director of job and family 1073
services shall adopt rules under section 5111.02 of the Revised 1074
Code to implement sections 5111.65 to ~~5111.688~~ 5111.689 of the 1075
Revised Code, including rules applicable to an exiting operator 1076
that provides written notification under section 5111.66 of the 1077
Revised Code of a voluntary withdrawal of participation. Rules 1078
adopted under this section shall comply with section 1919(c)(2)(F) 1079
of the "Social Security Act," 79 Stat. 286 (1965), 42 U.S.C. 1080
1396r(c)(2)(F), regarding restrictions on transfers or discharges 1081
of nursing facility residents in the case of a voluntary 1082
withdrawal of participation. The rules may prescribe a medicaid 1083
reimbursement methodology and other procedures that are applicable 1084

after the effective date of a voluntary withdrawal of 1085
participation that differ from the reimbursement methodology and 1086
other procedures that would otherwise apply. 1087

Sec. 5111.874. (A) As used in sections 5111.874 to 5111.8710 1088
of the Revised Code: 1089

"Home and community-based services" has the same meaning as 1090
in section 5123.01 of the Revised Code. 1091

"ICF/MR services" means intermediate care facility for the 1092
mentally retarded services covered by the medicaid program that an 1093
intermediate care facility for the mentally retarded provides to a 1094
resident of the facility who is a medicaid recipient eligible for 1095
medicaid-covered intermediate care facility for the mentally 1096
retarded services. 1097

"Intermediate care facility for the mentally retarded" means 1098
an intermediate care facility for the mentally retarded that is 1099
certified as in compliance with applicable standards for the 1100
medicaid program by the director of health in accordance with 1101
Title XIX of the "Social Security Act," 79 Stat. 286 (1965), 42 1102
U.S.C. 1396, as amended, and licensed as a residential facility 1103
under section 5123.19 of the Revised Code. 1104

"Residential facility" has the same meaning as in section 1105
5123.19 of the Revised Code. 1106

(B) For the purpose of increasing the number of slots 1107
available for home and community-based services and subject to 1108
sections 5111.877 and 5111.878 of the Revised Code, the operator 1109
of an intermediate care facility for the mentally retarded may 1110
convert all of the beds in the facility from providing ICF/MR 1111
services to providing home and community-based services if all of 1112
the following requirements are met: 1113

(1) The operator provides the directors of health, job and 1114

family services, and developmental disabilities at least ninety 1115
days' notice of the operator's intent to relinquish the facility's 1116
certification as an intermediate care facility for the mentally 1117
retarded and to begin providing home and community-based services. 1118

(2) The operator complies with the requirements of sections 1119
5111.65 to ~~5111.688~~ 5111.689 of the Revised Code regarding a 1120
voluntary termination as defined in section 5111.65 of the Revised 1121
Code if those requirements are applicable. 1122

(3) The operator notifies each of the facility's residents 1123
that the facility is to cease providing ICF/MR services and inform 1124
each resident that the resident may do either of the following: 1125

(a) Continue to receive ICF/MR services by transferring to 1126
another facility that is an intermediate care facility for the 1127
mentally retarded willing and able to accept the resident if the 1128
resident continues to qualify for ICF/MR services; 1129

(b) Begin to receive home and community-based services 1130
instead of ICF/MR services from any provider of home and 1131
community-based services that is willing and able to provide the 1132
services to the resident if the resident is eligible for the 1133
services and a slot for the services is available to the resident. 1134

(4) The operator meets the requirements for providing home 1135
and community-based services, including the following: 1136

(a) Such requirements applicable to a residential facility if 1137
the operator maintains the facility's license as a residential 1138
facility; 1139

(b) Such requirements applicable to a facility that is not 1140
licensed as a residential facility if the operator surrenders the 1141
facility's residential facility license under section 5123.19 of 1142
the Revised Code. 1143

(5) The director of developmental disabilities approves the 1144

conversion. 1145

(C) The notice to the director of developmental disabilities 1146
under division (B)(1) of this section shall specify whether the 1147
operator wishes to surrender the facility's license as a 1148
residential facility under section 5123.19 of the Revised Code. 1149

(D) If the director of developmental disabilities approves a 1150
conversion under division (B) of this section, the director of 1151
health shall terminate the certification of the intermediate care 1152
facility for the mentally retarded to be converted. The director 1153
of health shall notify the director of job and family services of 1154
the termination. On receipt of the director of health's notice, 1155
the director of job and family services shall terminate the 1156
operator's medicaid provider agreement that authorizes the 1157
operator to provide ICF/MR services at the facility. The operator 1158
is not entitled to notice or a hearing under Chapter 119. of the 1159
Revised Code before the director of job and family services 1160
terminates the medicaid provider agreement. 1161

Sec. 5111.875. (A) For the purpose of increasing the number 1162
of slots available for home and community-based services and 1163
subject to sections 5111.877 and 5111.878 of the Revised Code, a 1164
person who acquires, through a request for proposals issued by the 1165
director of developmental disabilities, a residential facility 1166
that is an intermediate care facility for the mentally retarded 1167
and for which the license as a residential facility was previously 1168
surrendered or revoked may convert some or all of the facility's 1169
beds from providing ICF/MR services to providing home and 1170
community-based services if all of the following requirements are 1171
met: 1172

(1) The person provides the directors of health, job and 1173
family services, and developmental disabilities at least ninety 1174
days' notice of the person's intent to make the conversion. 1175

(2) The person complies with the requirements of sections 1176
5111.65 to ~~5111.688~~ 5111.689 of the Revised Code regarding a 1177
voluntary termination as defined in section 5111.65 of the Revised 1178
Code if those requirements are applicable. 1179

(3) If the person intends to convert all of the facility's 1180
beds, the person notifies each of the facility's residents that 1181
the facility is to cease providing ICF/MR services and informs 1182
each resident that the resident may do either of the following: 1183

(a) Continue to receive ICF/MR services by transferring to 1184
another facility that is an intermediate care facility for the 1185
mentally retarded willing and able to accept the resident if the 1186
resident continues to qualify for ICF/MR services; 1187

(b) Begin to receive home and community-based services 1188
instead of ICF/MR services from any provider of home and 1189
community-based services that is willing and able to provide the 1190
services to the resident if the resident is eligible for the 1191
services and a slot for the services is available to the resident. 1192

(4) If the person intends to convert some but not all of the 1193
facility's beds, the person notifies each of the facility's 1194
residents that the facility is to convert some of its beds from 1195
providing ICF/MR services to providing home and community-based 1196
services and inform each resident that the resident may do either 1197
of the following: 1198

(a) Continue to receive ICF/MR services from any provider of 1199
ICF/MR services that is willing and able to provide the services 1200
to the resident if the resident continues to qualify for ICF/MR 1201
services; 1202

(b) Begin to receive home and community-based services 1203
instead of ICF/MR services from any provider of home and 1204
community-based services that is willing and able to provide the 1205
services to the resident if the resident is eligible for the 1206

services and a slot for the services is available to the resident. 1207

(5) The person meets the requirements for providing home and 1208
community-based services at a residential facility. 1209

(B) The notice provided to the directors under division 1210
(A)(1) of this section shall specify whether some or all of the 1211
facility's beds are to be converted. If some but not all of the 1212
beds are to be converted, the notice shall specify how many of the 1213
facility's beds are to be converted and how many of the beds are 1214
to continue to provide ICF/MR services. 1215

(C) On receipt of a notice under division (A)(1) of this 1216
section, the director of health shall do the following: 1217

(1) Terminate the certification of the intermediate care 1218
facility for the mentally retarded if the notice specifies that 1219
all of the facility's beds are to be converted; 1220

(2) Reduce the facility's certified capacity by the number of 1221
beds being converted if the notice specifies that some but not all 1222
of the beds are to be converted. 1223

(D) The director of health shall notify the director of job 1224
and family services of the termination or reduction under division 1225
(C) of this section. On receipt of the director of health's 1226
notice, the director of job and family services shall do the 1227
following: 1228

(1) Terminate the person's medicaid provider agreement that 1229
authorizes the person to provide ICF/MR services at the facility 1230
if the facility's certification was terminated; 1231

(2) Amend the person's medicaid provider agreement to reflect 1232
the facility's reduced certified capacity if the facility's 1233
certified capacity is reduced. 1234

The person is not entitled to notice or a hearing under 1235
Chapter 119. of the Revised Code before the director of job and 1236

family services terminates or amends the medicaid provider 1237
agreement. 1238

~~Sec. 5111.894. The state administrative agency may establish 1239
one or more waiting lists for the assisted living program. Only 1240
individuals eligible for the medicaid program may be placed on a 1241
waiting list. (A) The state administrative agency shall establish 1242
a home first component of the assisted living program under which 1243
eligible individuals may be enrolled in the assisted living 1244
program in accordance with this section. An individual is eligible 1245
for the assisted living program's home first component if all of 1246
the following apply: 1247~~

~~(1) The individual is eligible for the assisted living 1248
program. 1249~~

~~(2) The individual is on the unified waiting list established 1250
under section 173.404 of the Revised Code. 1251~~

~~(3) At least one of the following applies: 1252~~

~~(a) The individual has been admitted to a nursing facility. 1253~~

~~(b) A physician has determined and documented in writing that 1254
the individual has a medical condition that, unless the individual 1255
is enrolled in home and community-based services such as the 1256
assisted living program, will require the individual to be 1257
admitted to a nursing facility within thirty days of the 1258
physician's determination. 1259~~

~~(c) The individual has been hospitalized and a physician has 1260
determined and documented in writing that, unless the individual 1261
is enrolled in home and community-based services such as the 1262
assisted living program, the individual is to be transported 1263
directly from the hospital to a nursing facility admitted. 1264~~

~~(d) Both of the following apply: 1265~~

~~(i) The individual is the subject of a report made under 1266~~

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. 1267
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(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. 1272
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(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. 1277
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(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.~~ 1284
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~~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 1289
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participating in the assisted living program that is acceptable to the individual, the agency shall notify the long-term care 1292
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consultation program administrator serving the area in which the individual resides ~~about the determination.~~ The administrator 1294
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shall determine whether the assisted living program is appropriate 1296
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for the individual and whether the individual would rather 1297
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participate in the assisted living program than continue ~~residing~~ 1298

or begin to reside in ~~the~~ a nursing facility. If the administrator 1299
determines that the assisted living program is appropriate for the 1300
individual and the individual would rather participate in the 1301
assisted living program than continue ~~residing~~ or begin to reside 1302
in ~~the~~ a nursing facility, the administrator shall so notify the 1303
state administrative ~~agency~~. 1304

~~On~~ agency. On receipt of the notice from the administrator, 1305
the state administrative agency shall approve the individual's 1306
enrollment in the assisted living program regardless of ~~any~~ the 1307
unified waiting list ~~for the assisted living program~~ established 1308
under section 173.404 of the Revised Code, unless the enrollment 1309
would cause the assisted living program to exceed any limit on the 1310
number of individuals who may participate in the program as set by 1311
the United States secretary of health and human services when the 1312
medicaid waiver authorizing the program is approved. ~~Each~~ 1313

(C) Each quarter, the state administrative agency shall 1314
certify to the director of budget and management the estimated 1315
increase in costs of the assisted living program resulting from 1316
enrollment of individuals in the assisted living program pursuant 1317
to this section. 1318

Section 2. That existing sections 173.401, 173.501, 3702.51, 1319
3702.59, 5111.65, 5111.651, 5111.68, 5111.681, 5111.685, 5111.686, 1320
5111.688, 5111.874, 5111.875, and 5111.894 of the Revised Code are 1321
hereby repealed. 1322

Section 3. That Section 209.20 of Am. Sub. H.B. 1 of the 1323
128th General Assembly be amended to read as follows: 1324

Sec. 209.20. LONG-TERM CARE 1325

Pursuant to an interagency agreement, the Department of Job 1326
and Family Services shall designate the Department of Aging to 1327

perform assessments under section 5111.204 of the Revised Code. 1328
The Department of Aging shall provide long-term care consultations 1329
under section 173.42 of the Revised Code to assist individuals in 1330
planning for their long-term health care needs. The foregoing 1331
appropriation items 490423, Long Term Care Budget - State, and 1332
490623, Long Term Care Budget, may be used to provide the 1333
preadmission screening and resident review (PASRR), which includes 1334
screening, assessments, and determinations made under sections 1335
5111.02, 5111.204, 5119.061, and 5123.021 of the Revised Code. 1336

The foregoing appropriation items 490423, Long Term Care 1337
Budget - State, and 490623, Long Term Care Budget, may be used to 1338
assess and provide long-term care consultations to clients 1339
regardless of Medicaid eligibility. 1340

The Director of Aging shall adopt rules under section 111.15 1341
of the Revised Code governing the nonwaiver funded PASSPORT 1342
program, including client eligibility. The foregoing appropriation 1343
item 490423, Long Term Care Budget - State, may be used by the 1344
Department of Aging to provide nonwaiver funded PASSPORT services 1345
to persons the Department has determined to be eligible to 1346
participate in the nonwaiver funded PASSPORT Program, including 1347
those persons not yet determined to be financially eligible to 1348
participate in the Medicaid waiver component of the PASSPORT 1349
Program by a county department of job and family services. 1350

The Department of Aging shall administer the Medicaid 1351
waiver-funded PASSPORT Home Care Program, the Choices Program, the 1352
Assisted Living Program, and the PACE Program as delegated by the 1353
Department of Job and Family Services in an interagency agreement. 1354
The foregoing appropriation item 490423, Long Term Care Budget - 1355
State, shall be used to provide the required state match for 1356
federal Medicaid funds supporting the Medicaid Waiver-funded 1357
PASSPORT Home Care Program, the Choices Program, the Assisted 1358
Living Program, and the PACE Program. The foregoing appropriation 1359

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. 1391

(3) ~~If receipts credited to~~ Authorize expenditures from the 1392
Interagency Reimbursement Fund (Fund 3G50) for amounts that exceed 1393
the amounts appropriated from receipts credited to the fund, ~~the~~ 1394
~~Director of Job and Family Services may request the Director of~~ 1395
~~Budget and Management to authorize expenditures from the fund in~~ 1396
~~excess of the amounts appropriated. Upon the approval of the~~ 1397
~~Director of Budget and Management,~~ Any additional authorized 1398
amounts are hereby appropriated. 1399

(C) Not later than thirty days after the Director of Budget 1400
and Management receives certification of expenditures specified in 1401
division (B) of this section, the Executive Director of Executive 1402
Medicaid Management Administration shall submit a report to the 1403
General Assembly in accordance with section 101.68 of the Revised 1404
Code and to the chairs and ranking minority members of the 1405
committees of the House of Representatives and Senate to which the 1406
biennial budget bill is referred. The report shall describe and 1407
document the criteria and data the Department of Aging, Department 1408
of Job and Family Services, and Office of Budget and Management 1409
use to justify a transfer of funds under division (B) of this 1410
section, including spending and utilization trends for PASSPORT, 1411
PACE, assisted living, and nursing facility services. In addition 1412
to providing the information for the transfer of funds, the report 1413
shall include the following: 1414

(1) In the case of reports for transfers that occur during 1416
fiscal year 2010, the descriptions and documents of the criteria 1417
and data used to justify other such transfers that previously 1418
occurred during that fiscal year; 1419

(2) In the case of reports for transfers that occur during 1420
fiscal year 2011, the descriptions and documents of the criteria 1421

and data used to justify other such transfers that previously 1422
occurred during that fiscal year and fiscal year 2010. 1423

The Directors of Aging, Job and Family Services, and Budget 1424
and Management shall provide the Executive Director of the 1425
Executive Medicaid Management Administration with all information 1426
the Executive Director needs to prepare the reports required by 1427
this division. 1428

(D) The individuals placed in Long Term Care Budget Services 1429
pursuant to this section shall be in addition to the individuals 1430
placed in Long Term Care Budget Services during fiscal years 2010 1431
and 2011 before any transfers to appropriation item 490423, Long 1432
Term Care Budget-State, are made under this section. 1433

ALLOCATION OF PACE SLOTS 1434

In order to effectively administer and manage growth within 1435
the PACE Program, the Director of Aging may, as the director deems 1436
appropriate and to the extent funding is available, expand the 1437
PACE Program to regions of Ohio beyond those currently served by 1438
the PACE Program. In implementing the expansion, the Director may 1439
not decrease the number of residents of Cuyahoga and Hamilton 1440
counties and parts of Butler, Clermont, and Warren counties who 1441
are participating in the PACE Program below the number of 1442
residents of those counties and parts of counties who were 1443
enrolled in the PACE Program on July 1, 2008. 1444

Section 4. That existing Section 209.20 of Am. Sub. H.B. 1 of 1445
the 128th General Assembly is hereby repealed. 1446

Section 5. During fiscal years 2012 and 2013, on receipt of 1447
certified expenditures related to sections 173.401, 173.351, 1448
173.501, and 5111.894 of the Revised Code, the Director of Budget 1449
and Management shall transfer cash from the Nursing Facility 1450
Stabilization Fund (Fund 5R20), used by the Department of Job and 1451

Family Services, to the PASSPORT/Residential State Supplement Fund 1452
(Fund 4J40), used by the Department of Aging. 1453

If receipts credited to the PASSPORT Fund (Fund 3C40) exceed 1454
the amounts appropriated from the fund in fiscal years 2012 and 1455
2013, the Director of Aging shall request the Director of Budget 1456
and Management to authorize expenditures from the fund in excess 1457
of the amounts appropriated. 1458

If receipts credited to the Interagency Reimbursement Fund 1459
(Fund 3G50) exceed the amounts appropriated from the fund in 1460
fiscal years 2012 and 2013, the Director of Job and Family 1461
Services shall request the Director of Budget and Management to 1462
authorize expenditures from the fund in excess of the amounts 1463
appropriated. 1464