As Introduced

128th General Assembly
Regular Session
2009-2010

S. B. No. 134

Senator Miller, R.

A BILL

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5168.09, 5168.10, and 5169.99, and to repeal 294
section 5111.012 of the Revised Code; to amend 295
Section 7 of Am. Sub. H.B. 468 of the 126th 296
General Assembly; to create the Department of 297
Health Care Administration; to transfer the 298
Medicaid Program, Children's Health Insurance 299
Program, Children's Buy-In Program, Hospital Care 300
Assurance Program, Disability Medical Assistance 301
Program, Ohio's Best Rx Program, and Residential 302
State Supplement Program to the new department; to 303
require the new department to create a central 304
pharmaceutical purchasing office; and to make an 305
appropriation. 306

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

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(5168.01), 5115.11 (5168.02), 5115.12 (5168.05), 5115.13 522
(5168.07), 5115.14 (5168.06) be amended for the purpose of 523
adopting a new section number as indicated in parentheses, and 524
that sections 117.54, 117.55, 117.56, 117.57, 329.043, 5160.01, 525
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5168.10, and 5169.99 of the Revised Code be enacted to read as 537
follows: 538

539

540

Sec. 9.231. (A)(1) Subject to divisions (A)(2) and (3) of 541
this section, a governmental entity shall not disburse money 542
totaling twenty-five thousand dollars or more to any person for 543
the provision of services for the primary benefit of individuals 544
or the public and not for the primary benefit of a governmental 545
entity or the employees of a governmental entity, unless the 546
contracting authority of the governmental entity first enters into 547
a written contract with the person that is signed by the person or 548

by an officer or agent of the person authorized to legally bind the person and that embodies all of the requirements and conditions set forth in sections 9.23 to 9.236 of the Revised Code. If the disbursement of money occurs over the course of a governmental entity's fiscal year, rather than in a lump sum, the contracting authority of the governmental entity shall enter into the written contract with the person at the point during the governmental entity's fiscal year that at least seventy-five thousand dollars has been disbursed by the governmental entity to the person. Thereafter, the contracting authority of the governmental entity shall enter into the written contract with the person at the beginning of the governmental entity's fiscal year, if, during the immediately preceding fiscal year, the governmental entity disbursed to that person an aggregate amount totaling at least seventy-five thousand dollars. 549 550 551 552 553 554 555 556 557 558 559 560 561 562 563

(2) If the money referred to in division (A)(1) of this section is disbursed by or through more than one state agency to the person for the provision of services to the same population, the contracting authorities of those agencies shall determine which one of them will enter into the written contract with the person. 564 565 566 567 568 569

(3) The requirements and conditions set forth in divisions (A), (B), (C), and (F) of section 9.232, divisions (A)(1) and (2) and (B) of section 9.234, divisions (A)(2) and (B) of section 9.235, and sections 9.233 and 9.236 of the Revised Code do not apply with respect to the following: 570 571 572 573 574

(a) Contracts to which all of the following apply: 575

(i) The amount received for the services is a set fee for each time the services are provided, is determined in accordance with a fixed rate per unit of time or per service, or is a capitated rate, and the fee or rate is established by competitive bidding or by a market rate survey of similar services provided in 576 577 578 579 580

a defined market area. The market rate survey may be one conducted by or on behalf of the governmental entity or an independent survey accepted by the governmental entity as statistically valid and reliable. 581 582 583 584

(ii) The services are provided in accordance with standards established by state or federal law, or by rules or regulations adopted thereunder, for their delivery, which standards are enforced by the federal government, a governmental entity, or an accrediting organization recognized by the federal government or a governmental entity. 585 586 587 588 589 590

(iii) Payment for the services is made after the services are delivered and upon submission to the governmental entity of an invoice or other claim for payment as required by any applicable local, state, or federal law or, if no such law applies, by the terms of the contract. 591 592 593 594 595

(b) Contracts under which the services are reimbursed through or in a manner consistent with a federal program that meets all of the following requirements: 596 597 598

(i) The program calculates the reimbursement rate on the basis of the previous year's experience or in accordance with an alternative method set forth in rules adopted by the Ohio department of job and family services. 599 600 601 602

(ii) The reimbursement rate is derived from a breakdown of direct and indirect costs. 603 604

(iii) The program's guidelines describe types of expenditures that are allowable and not allowable under the program and delineate which costs are acceptable as direct costs for purposes of calculating the reimbursement rate. 605 606 607 608

(iv) The program includes a uniform cost reporting system with specific audit requirements. 609 610

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

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

(B) Division (A) of this section does not apply if the money is disbursed to a person pursuant to a contract with the United States or a governmental entity under any of the following circumstances:

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

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

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

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

(c) Services, other than administrative or management services or any of the services described in division (B)(2)(a) or (b) of this section, that are commonly purchased by the public at an hourly rate or at a set fee for each time the services are

provided, unless the services are performed for the benefit of children, persons who are eligible for the services by reason of advanced age, medical condition, or financial need, or persons who are confined in a detention facility as defined in section 2921.01 of the Revised Code, and the services are intended to help promote the health, safety, or welfare of those children or persons;

(d) Educational services provided by a school to children eligible to attend that school. For purposes of division (B)(2)(d) of this section, "school" means any school operated by a school district board of education, any community school established under Chapter 3314. of the Revised Code, or any nonpublic school for which the state board of education prescribes minimum education standards under section 3301.07 of the Revised Code.

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

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

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

(h) Services, including administrative and management services, provided under the children's buy-in program established under sections ~~5101.5211~~ 5167.35 to ~~5101.5216~~ 5167.40 of the Revised Code.

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

of a natural or man-made emergency. 673

(C) With respect to a nonprofit association, corporation, or organization established for the purpose of providing educational, technical, consulting, training, financial, or other services to its members in exchange for membership dues and other fees, any of the services provided to a member that is a governmental entity shall, for purposes of this section, be considered services "for the primary benefit of a governmental entity or the employees of a governmental entity. 674 675 676 677 678 679 680 681

Sec. 9.239. (A) There is hereby created the government contracting advisory council. The attorney general and auditor of state shall consult with the council on the performance of their rule-making functions under sections 9.237 and 9.238 of the Revised Code and shall consider any recommendations of the council. ~~The director of job and family services shall annually report to the council the cost methodology of the medicaid-funded services described in division (A)(3)(d) of section 9.231 of the Revised Code.~~ The council shall consist of the following members or their designees: 682 683 684 685 686 687 688 689 690 691

(1) The attorney general; 692

(2) The auditor of state; 693

(3) The director of administrative services; 694

(4) The director of aging; 695

(5) The director of alcohol and drug addiction services; 696

(6) The director of budget and management; 697

(7) The director of development; 698

(8) The director of job and family services; 699

(9) The director of mental health; 700

(10) The director of mental retardation and developmental 701

disabilities; 702

(11) The director of rehabilitation and correction; 703

(12) The administrator of workers' compensation; 704

(13) The executive director of the county commissioners' association of Ohio; 705 706

(14) The president of the Ohio grantmakers forum; 707

(15) The president of the Ohio chamber of commerce; 708

(16) The president of the Ohio state bar association; 709

(17) The president of the Ohio society of certified public accountants; 710 711

(18) The executive director of the Ohio association of nonprofit organizations; 712 713

(19) The president of the Ohio united way; 714

(20) One additional member appointed by the attorney general; 715

(21) One additional member appointed by the auditor of state. 716

(B) If an agency or organization represented on the council ceases to exist in the form it has on ~~the effective date of this section~~ September 29, 2005, the successor agency or organization shall be represented in its place. If there is no successor agency or organization, or if it is not clear what agency or organization is the successor, the attorney general shall designate an agency or organization to be represented in place of the agency or organization originally represented on the council. 717 718 719 720 721 722 723 724

(C) The two members appointed to the council shall serve three-year terms. Original appointments shall be made not later than sixty days after ~~the effective date of this section~~ September 29, 2005. Vacancies on the council shall be filled in the same manner as the original appointment. 725 726 727 728 729

(D) The attorney general or the attorney general's designee 730

shall be the chairperson of the council. The council shall meet at least once every two years to review the rules adopted under sections 9.237 and 9.238 of the Revised Code and to make recommendations to the attorney general and auditor of state regarding the adoption, amendment, or repeal of those rules. The council shall also meet at other times as requested by the attorney general or auditor of state. 731 732 733 734 735 736 737

(E) Members of the council shall serve without compensation or reimbursement. 738 739

(F) The office of the attorney general shall provide necessary staff, facilities, supplies, and services to the council. 740 741 742

(G) Sections 101.82 to 101.87 of the Revised Code do not apply to the council. 743 744

Sec. 9.24. (A) Except as may be allowed under division (F) of this section, no state agency and no political subdivision shall award a contract as described in division (G)(1) of this section for goods, services, or construction, paid for in whole or in part with state funds, to a person against whom a finding for recovery has been issued by the auditor of state on and after January 1, 2001, if the finding for recovery is unresolved. 745 746 747 748 749 750 751

A contract is considered to be awarded when it is entered into or executed, irrespective of whether the parties to the contract have exchanged any money. 752 753 754

(B) For purposes of this section, a finding for recovery is unresolved unless one of the following criteria applies: 755 756

(1) The money identified in the finding for recovery is paid in full to the state agency or political subdivision to whom the money was owed; 757 758 759

(2) The debtor has entered into a repayment plan that is 760

approved by the attorney general and the state agency or political subdivision to whom the money identified in the finding for recovery is owed. A repayment plan may include a provision permitting a state agency or political subdivision to withhold payment to a debtor for goods, services, or construction provided to or for the state agency or political subdivision pursuant to a contract that is entered into with the debtor after the date the finding for recovery was issued. 761 762 763 764 765 766 767 768

(3) The attorney general waives a repayment plan described in division (B)(2) of this section for good cause; 769 770

(4) The debtor and state agency or political subdivision to whom the money identified in the finding for recovery is owed have agreed to a payment plan established through an enforceable settlement agreement. 771 772 773 774

(5) The state agency or political subdivision desiring to enter into a contract with a debtor certifies, and the attorney general concurs, that all of the following are true: 775 776 777

(a) Essential services the state agency or political subdivision is seeking to obtain from the debtor cannot be provided by any other person besides the debtor; 778 779 780

(b) Awarding a contract to the debtor for the essential services described in division (B)(5)(a) of this section is in the best interest of the state; 781 782 783

(c) Good faith efforts have been made to collect the money identified in the finding of recovery. 784 785

(6) The debtor has commenced an action to contest the finding for recovery and a final determination on the action has not yet been reached. 786 787 788

(C) The attorney general shall submit an initial report to the auditor of state, not later than December 1, 2003, indicating 789 790

the status of collection for all findings for recovery issued by the auditor of state for calendar years 2001, 2002, and 2003. Beginning on January 1, 2004, the attorney general shall submit to the auditor of state, on the first day of every January, April, July, and October, a list of all findings for recovery that have been resolved in accordance with division (B) of this section during the calendar quarter preceding the submission of the list and a description of the means of resolution. The attorney general shall notify the auditor of state when a judgment is issued against an entity described in division (F)(1) of this section. 791 792 793 794 795 796 797 798 799 800

(D) The auditor of state shall maintain a database, accessible to the public, listing persons against whom an unresolved finding for recovery has been issued, and the amount of the money identified in the unresolved finding for recovery. The auditor of state shall have this database operational on or before January 1, 2004. The initial database shall contain the information required under this division for calendar years 2001, 2002, and 2003. 801 802 803 804 805 806 807 808

Beginning January 15, 2004, the auditor of state shall update the database by the fifteenth day of every January, April, July, and October to reflect resolved findings for recovery that are reported to the auditor of state by the attorney general on the first day of the same month pursuant to division (C) of this section. 809 810 811 812 813 814

(E) Before awarding a contract as described in division (G)(1) of this section for goods, services, or construction, paid for in whole or in part with state funds, a state agency or political subdivision shall verify that the person to whom the state agency or political subdivision plans to award the contract has no unresolved finding for recovery issued against the person. A state agency or political subdivision shall verify that the person does not appear in the database described in division (D) 815 816 817 818 819 820 821 822

of this section or shall obtain other proof that the person has no unresolved finding for recovery issued against the person.

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

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

(2) To ~~medicaid~~ provider agreements under ~~Chapter 5111. of the Revised Code~~ the medicaid program, payments or provider agreements under disability assistance medical assistance ~~established under Chapter 5115. of the Revised Code~~, or payments or provider agreements under the children's buy-in program ~~established under sections 5101.5211 to 5101.5216 of the Revised Code~~.

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

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

or (b) of this section. 854

(a) The cost for the goods, services, or construction provided under the contract is estimated to exceed twenty-five thousand dollars. 855 856 857

(b) The aggregate cost for the goods, services, or construction provided under multiple contracts entered into by the particular state agency and a single person or the particular political subdivision and a single person within the fiscal year preceding the fiscal year within which a contract is being entered into by that same state agency and the same single person or the same political subdivision and the same single person, exceeded fifty thousand dollars. 858 859 860 861 862 863 864 865

(c) The contract is a renewal of a contract previously entered into and renewed pursuant to that preceding contract. 866 867

(2) This section does not apply to employment contracts. 868

(H) As used in this section: 869

(1) "State agency" has the same meaning as in section 9.66 of the Revised Code. 870 871

(2) "Political subdivision" means a political subdivision as defined in section 9.82 of the Revised Code that has received more than fifty thousand dollars of state money in the current fiscal year or the preceding fiscal year. 872 873 874 875

(3) "Finding for recovery" means a determination issued by the auditor of state, contained in a report the auditor of state gives to the attorney general pursuant to section 117.28 of the Revised Code, that public money has been illegally expended, public money has been collected but not been accounted for, public money is due but has not been collected, or public property has been converted or misappropriated. 876 877 878 879 880 881 882

(4) "Debtor" means a person against whom a finding for 883

recovery has been issued.

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

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

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

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

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

(B) The committee shall consist of the following members of the general assembly: the chairperson of the senate's standing committee with primary responsibility for health legislation, the

chairperson of the house of representatives' standing committee 914
with primary responsibility for health legislation, four members 915
of the house of representatives appointed by the speaker of the 916
house of representatives, and four members of the senate appointed 917
by the president of the senate. Not more than two members 918
appointed by the speaker of the house of representatives and not 919
more than two members appointed by the president of the senate may 920
be of the same political party. Except in 1995, appointments shall 921
be made not later than fifteen days after the commencement of the 922
first regular session of each general assembly. The chairpersons 923
of the standing committees with primary responsibility for health 924
legislation shall serve as co-chairpersons of the committee. 925

926

Each member of the committee shall hold office during the 927
general assembly in which the member is appointed and until a 928
successor has been appointed, notwithstanding the adjournment sine 929
die of the general assembly in which the member was appointed or 930
the expiration of the member's term as a member of the general 931
assembly. Any vacancies occurring among the members of the 932
committee shall be filled in the manner of the original 933
appointment. 934

The committee shall meet at least quarterly and at the call 935
of the co-chairpersons. The co-chairpersons shall determine the 936
time, place, and agenda for each meeting of the committee. 937

The committee has the same powers as other standing or select 938
committees of the general assembly. The committee may request 939
assistance from the legislative service commission ~~and the~~ 940
~~legislative budget office of the legislative service commission~~. 941

Sec. 101.391. (A) There is hereby created the joint 942
legislative committee on medicaid technology and reform. The 943
committee may review or study any matter that it considers 944

relevant to the operation of the medicaid program ~~established under Chapter 5111. of the Revised Code~~, with priority given to the study or review of mechanisms to enhance the program's effectiveness through improved technology systems and program reform. 945 946 947 948 949

(B) The committee shall consist of five members of the house of representatives appointed by the speaker of the house of representatives and five members of the senate appointed by the president of the senate. Not more than three members appointed by the speaker of the house of representatives and not more than three members appointed by the president of the senate may be of the same political party. 950 951 952 953 954 955 956

Each member of the committee shall hold office during the general assembly in which the member is appointed and until a successor has been appointed, notwithstanding the adjournment sine die of the general assembly in which the member was appointed or the expiration of the member's term as a member of the general assembly. Any vacancies occurring among the members of the committee shall be filled in the manner of the original appointment. 957 958 959 960 961 962 963 964

(C) The committee has the same powers as other standing or select committees of the general assembly. The committee may employ an executive director. 965 966 967

Sec. 103.144. As used in sections 103.144 to 103.146 of the Revised Code: 968 969

(A) "Mandated benefit" means the following, when considered in the context of a sickness and accident insurance policy or a health insuring corporation policy, contract, or agreement: 970 971 972

(1) Any required coverage for a specific medical or health-related service, treatment, medication, or practice; 973 974

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

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

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

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

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

(B) "Mandated benefit" does not include any required coverage or offer of coverage, any required expansion of, or addition to, existing coverage, or any mandated reimbursement amount to specific providers, as described in division (A) of this section, within the context of any public health benefits arrangement, including but not limited to, the coverage of beneficiaries enrolled in ~~Title XVIII of~~ the ~~"Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended~~ <u>medicare program</u>, pursuant to a medicare risk contract or medicare cost contract, or to the coverage of ~~beneficiaries enrolled in Title XIX of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended, known as~~ <u>recipients of</u> the ~~medical assistance program or~~ medicaid~~, provided by the Ohio department of job and family services under Chapter 5111. of the Revised Code~~ <u>program</u>.

Sec. 109.572. (A)(1) Upon receipt of a request pursuant to section 121.08, 3301.32, 3301.541, or 3319.39 of the Revised Code, a completed form prescribed pursuant to division (C)(1) of this section, and a set of fingerprint impressions obtained in the

manner described in division (C)(2) of this section, the superintendent of the bureau of criminal identification and investigation shall conduct a criminal records check in the manner described in division (B) of this section to determine whether any information exists that indicates that the person who is the subject of the request previously has been convicted of or pleaded guilty to any of the following: 1005 1006 1007 1008 1009 1010 1011

(a) A violation of section 2903.01, 2903.02, 2903.03, 2903.04, 2903.11, 2903.12, 2903.13, 2903.16, 2903.21, 2903.34, 2905.01, 2905.02, 2905.05, 2907.02, 2907.03, 2907.04, 2907.05, 2907.06, 2907.07, 2907.08, 2907.09, 2907.21, 2907.22, 2907.23, 2907.25, 2907.31, 2907.32, 2907.321, 2907.322, 2907.323, 2911.01, 2911.02, 2911.11, 2911.12, 2919.12, 2919.22, 2919.24, 2919.25, 2923.12, 2923.13, 2923.161, 2925.02, 2925.03, 2925.04, 2925.05, 2925.06, or 3716.11 of the Revised Code, felonious sexual penetration in violation of former section 2907.12 of the Revised Code, a violation of section 2905.04 of the Revised Code as it existed prior to July 1, 1996, a violation of section 2919.23 of the Revised Code that would have been a violation of section 2905.04 of the Revised Code as it existed prior to July 1, 1996, had the violation been committed prior to that date, or a violation of section 2925.11 of the Revised Code that is not a minor drug possession offense; 1012 1013 1014 1015 1016 1017 1018 1019 1020 1021 1022 1023 1024 1025 1026 1027

(b) A violation of an existing or former law of this state, any other state, or the United States that is substantially equivalent to any of the offenses listed in division (A)(1)(a) of this section. 1028 1029 1030 1031

(2) On receipt of a request pursuant to section 5123.081 of the Revised Code with respect to an applicant for employment in any position with the department of mental retardation and developmental disabilities, pursuant to section 5126.28 of the Revised Code with respect to an applicant for employment in any 1032 1033 1034 1035 1036

position with a county board of mental retardation and developmental disabilities, or pursuant to section 5126.281 of the Revised Code with respect to an applicant for employment in a direct services position with an entity contracting with a county board for employment, a completed form prescribed pursuant to division (C)(1) of this section, and a set of fingerprint impressions obtained in the manner described in division (C)(2) of this section, the superintendent of the bureau of criminal identification and investigation shall conduct a criminal records check. The superintendent shall conduct the criminal records check in the manner described in division (B) of this section to determine whether any information exists that indicates that the person who is the subject of the request has been convicted of or pleaded guilty to any of the following: 1037 1038 1039 1040 1041 1042 1043 1044 1045 1046 1047 1048 1049 1050

(a) A violation of section 2903.01, 2903.02, 2903.03, 2903.04, 2903.11, 2903.12, 2903.13, 2903.16, 2903.21, 2903.34, 2903.341, 2905.01, 2905.02, 2905.04, 2905.05, 2907.02, 2907.03, 2907.04, 2907.05, 2907.06, 2907.07, 2907.08, 2907.09, 2907.12, 2907.21, 2907.22, 2907.23, 2907.25, 2907.31, 2907.32, 2907.321, 2907.322, 2907.323, 2911.01, 2911.02, 2911.11, 2911.12, 2919.12, 2919.22, 2919.24, 2919.25, 2923.12, 2923.13, 2923.161, 2925.02, 2925.03, or 3716.11 of the Revised Code; 1051 1052 1053 1054 1055 1056 1057 1058

(b) An existing or former municipal ordinance or law of this state, any other state, or the United States that is substantially equivalent to any of the offenses listed in division (A)(2)(a) of this section. 1059 1060 1061 1062

(3) On receipt of a request pursuant to section 173.27, 173.394, 3712.09, 3721.121, or 3722.151 of the Revised Code, a completed form prescribed pursuant to division (C)(1) of this section, and a set of fingerprint impressions obtained in the manner described in division (C)(2) of this section, the superintendent of the bureau of criminal identification and 1063 1064 1065 1066 1067 1068

investigation shall conduct a criminal records check with respect to any person who has applied for employment in a position for which a criminal records check is required by those sections. The superintendent shall conduct the criminal records check in the manner described in division (B) of this section to determine whether any information exists that indicates that the person who is the subject of the request previously has been convicted of or pleaded guilty to any of the following: 1069 1070 1071 1072 1073 1074 1075 1076

(a) A violation of section 2903.01, 2903.02, 2903.03, 2903.04, 2903.11, 2903.12, 2903.13, 2903.16, 2903.21, 2903.34, 2905.01, 2905.02, 2905.11, 2905.12, 2907.02, 2907.03, 2907.05, 2907.06, 2907.07, 2907.08, 2907.09, 2907.12, 2907.25, 2907.31, 2907.32, 2907.321, 2907.322, 2907.323, 2911.01, 2911.02, 2911.11, 2911.12, 2911.13, 2913.02, 2913.03, 2913.04, 2913.11, 2913.21, 2913.31, 2913.40, 2913.43, 2913.47, 2913.51, 2919.25, 2921.36, 2923.12, 2923.13, 2923.161, 2925.02, 2925.03, 2925.11, 2925.13, 2925.22, 2925.23, or 3716.11 of the Revised Code; 1077 1078 1079 1080 1081 1082 1083 1084 1085

(b) An existing or former law of this state, any other state, or the United States that is substantially equivalent to any of the offenses listed in division (A)(3)(a) of this section. 1086 1087 1088

(4) On receipt of a request pursuant to section 3701.881 of the Revised Code with respect to an applicant for employment with a home health agency as a person responsible for the care, custody, or control of a child, a completed form prescribed pursuant to division (C)(1) of this section, and a set of fingerprint impressions obtained in the manner described in division (C)(2) of this section, the superintendent of the bureau of criminal identification and investigation shall conduct a criminal records check. The superintendent shall conduct the criminal records check in the manner described in division (B) of this section to determine whether any information exists that indicates that the person who is the subject of the request 1089 1090 1091 1092 1093 1094 1095 1096 1097 1098 1099 1100

previously has been convicted of or pleaded guilty to any of the 1101
following: 1102

(a) A violation of section 2903.01, 2903.02, 2903.03, 1103
2903.04, 2903.11, 2903.12, 2903.13, 2903.16, 2903.21, 2903.34, 1104
2905.01, 2905.02, 2905.04, 2905.05, 2907.02, 2907.03, 2907.04, 1105
2907.05, 2907.06, 2907.07, 2907.08, 2907.09, 2907.12, 2907.21, 1106
2907.22, 2907.23, 2907.25, 2907.31, 2907.32, 2907.321, 2907.322, 1107
2907.323, 2911.01, 2911.02, 2911.11, 2911.12, 2919.12, 2919.22, 1108
2919.24, 2919.25, 2923.12, 2923.13, 2923.161, 2925.02, 2925.03, 1109
2925.04, 2925.05, 2925.06, or 3716.11 of the Revised Code or a 1110
violation of section 2925.11 of the Revised Code that is not a 1111
minor drug possession offense; 1112

(b) An existing or former law of this state, any other state, 1113
or the United States that is substantially equivalent to any of 1114
the offenses listed in division (A)(4)(a) of this section. 1115

(5) On receipt of a request pursuant to section ~~5111.032~~ 1116
5163.032, ~~5111.033~~ 5163.033, or ~~5111.034~~ 5163.034 of the Revised 1117
Code, a completed form prescribed pursuant to division (C)(1) of 1118
this section, and a set of fingerprint impressions obtained in the 1119
manner described in division (C)(2) of this section, the 1120
superintendent of the bureau of criminal identification and 1121
investigation shall conduct a criminal records check. The 1122
superintendent shall conduct the criminal records check in the 1123
manner described in division (B) of this section to determine 1124
whether any information exists that indicates that the person who 1125
is the subject of the request previously has been convicted of, 1126
has pleaded guilty to, or has been found eligible for intervention 1127
in lieu of conviction for any of the following: 1128

(a) A violation of section 2903.01, 2903.02, 2903.03, 1129
2903.04, 2903.041, 2903.11, 2903.12, 2903.13, 2903.16, 2903.21, 1130
2903.34, 2905.01, 2905.02, 2905.05, 2905.11, 2905.12, 2907.02, 1131
2907.03, 2907.04, 2907.05, 2907.06, 2907.07, 2907.08, 2907.09, 1132

2907.21, 2907.22, 2907.23, 2907.24, 2907.25, 2907.31, 2907.32, 2907.321, 2907.322, 2907.323, 2911.01, 2911.02, 2911.11, 2911.12, 2911.13, 2913.02, 2913.03, 2913.04, 2913.11, 2913.21, 2913.31, 2913.40, 2913.43, 2913.47, 2913.48, 2913.49, 2913.51, 2917.11, 2919.12, 2919.22, 2919.24, 2919.25, 2921.13, 2921.36, 2923.02, 2923.12, 2923.13, 2923.161, 2923.32, 2925.02, 2925.03, 2925.04, 2925.05, 2925.06, 2925.11, 2925.13, 2925.14, 2925.22, 2925.23, or 3716.11 of the Revised Code, felonious sexual penetration in violation of former section 2907.12 of the Revised Code, a violation of section 2905.04 of the Revised Code as it existed prior to July 1, 1996, a violation of section 2919.23 of the Revised Code that would have been a violation of section 2905.04 of the Revised Code as it existed prior to July 1, 1996, had the violation been committed prior to that date; 1133 1134 1135 1136 1137 1138 1139 1140 1141 1142 1143 1144 1145 1146

(b) An existing or former law of this state, any other state, or the United States that is substantially equivalent to any of the offenses listed in division (A)(5)(a) of this section. 1147 1148 1149

(6) On receipt of a request pursuant to section 3701.881 of the Revised Code with respect to an applicant for employment with a home health agency in a position that involves providing direct care to an older adult, a completed form prescribed pursuant to division (C)(1) of this section, and a set of fingerprint impressions obtained in the manner described in division (C)(2) of this section, the superintendent of the bureau of criminal identification and investigation shall conduct a criminal records check. The superintendent shall conduct the criminal records check in the manner described in division (B) of this section to determine whether any information exists that indicates that the person who is the subject of the request previously has been convicted of or pleaded guilty to any of the following: 1150 1151 1152 1153 1154 1155 1156 1157 1158 1159 1160 1161 1162

(a) A violation of section 2903.01, 2903.02, 2903.03, 2903.04, 2903.11, 2903.12, 2903.13, 2903.16, 2903.21, 2903.34, 1163 1164

2905.01, 2905.02, 2905.11, 2905.12, 2907.02, 2907.03, 2907.05, 2907.06, 2907.07, 2907.08, 2907.09, 2907.12, 2907.25, 2907.31, 2907.32, 2907.321, 2907.322, 2907.323, 2911.01, 2911.02, 2911.11, 2911.12, 2911.13, 2913.02, 2913.03, 2913.04, 2913.11, 2913.21, 2913.31, 2913.40, 2913.43, 2913.47, 2913.51, 2919.25, 2921.36, 2923.12, 2923.13, 2923.161, 2925.02, 2925.03, 2925.11, 2925.13, 2925.22, 2925.23, or 3716.11 of the Revised Code; 1165 1166 1167 1168 1169 1170 1171

(b) An existing or former law of this state, any other state, or the United States that is substantially equivalent to any of the offenses listed in division (A)(6)(a) of this section. 1172 1173 1174

(7) When conducting a criminal records check upon a request pursuant to section 3319.39 of the Revised Code for an applicant who is a teacher, in addition to the determination made under division (A)(1) of this section, the superintendent shall determine whether any information exists that indicates that the person who is the subject of the request previously has been convicted of or pleaded guilty to any offense specified in section 3319.31 of the Revised Code. 1175 1176 1177 1178 1179 1180 1181 1182

(8) On receipt of a request pursuant to section 2151.86 of the Revised Code, a completed form prescribed pursuant to division (C)(1) of this section, and a set of fingerprint impressions obtained in the manner described in division (C)(2) of this section, the superintendent of the bureau of criminal identification and investigation shall conduct a criminal records check in the manner described in division (B) of this section to determine whether any information exists that indicates that the person who is the subject of the request previously has been convicted of or pleaded guilty to any of the following: 1183 1184 1185 1186 1187 1188 1189 1190 1191 1192

(a) A violation of section 959.13, 2903.01, 2903.02, 2903.03, 2903.04, 2903.11, 2903.12, 2903.13, 2903.15, 2903.16, 2903.21, 2903.211, 2903.22, 2903.34, 2905.01, 2905.02, 2905.05, 2907.02, 2907.03, 2907.04, 2907.05, 2907.06, 2907.07, 2907.08, 2907.09, 1193 1194 1195 1196

2907.21, 2907.22, 2907.23, 2907.25, 2907.31, 2907.32, 2907.321, 2907.322, 2907.323, 2909.02, 2909.03, 2909.22, 2909.23, 2909.24, 2911.01, 2911.02, 2911.11, 2911.12, 2913.49, 2917.01, 2917.02, 2919.12, 2919.22, 2919.24, 2919.25, 2923.12, 2923.13, 2923.161, 2925.02, 2925.03, 2925.04, 2925.05, 2925.06, 2927.12, or 3716.11 of the Revised Code, a violation of section 2905.04 of the Revised Code as it existed prior to July 1, 1996, a violation of section 2919.23 of the Revised Code that would have been a violation of section 2905.04 of the Revised Code as it existed prior to July 1, 1996, had the violation been committed prior to that date, a violation of section 2925.11 of the Revised Code that is not a minor drug possession offense, two or more OVI or OVUAC violations committed within the three years immediately preceding the submission of the application or petition that is the basis of the request, or felonious sexual penetration in violation of former section 2907.12 of the Revised Code; 1197 1198 1199 1200 1201 1202 1203 1204 1205 1206 1207 1208 1209 1210 1211 1212

(b) A violation of an existing or former law of this state, any other state, or the United States that is substantially equivalent to any of the offenses listed in division (A)(8)(a) of this section. 1213 1214 1215 1216

(9) Upon receipt of a request pursuant to section 5104.012 or 5104.013 of the Revised Code, a completed form prescribed pursuant to division (C)(1) of this section, and a set of fingerprint impressions obtained in the manner described in division (C)(2) of this section, the superintendent of the bureau of criminal identification and investigation shall conduct a criminal records check in the manner described in division (B) of this section to determine whether any information exists that indicates that the person who is the subject of the request has been convicted of or pleaded guilty to any of the following: 1217 1218 1219 1220 1221 1222 1223 1224 1225 1226

(a) A violation of section 2903.01, 2903.02, 2903.03, 2903.04, 2903.11, 2903.12, 2903.13, 2903.16, 2903.21, 2903.22, 1227 1228

2903.34, 2905.01, 2905.02, 2905.05, 2907.02, 2907.03, 2907.04, 1229
2907.05, 2907.06, 2907.07, 2907.08, 2907.09, 2907.21, 2907.22, 1230
2907.23, 2907.25, 2907.31, 2907.32, 2907.321, 2907.322, 2907.323, 1231
2911.01, 2911.02, 2911.11, 2911.12, 2913.02, 2913.03, 2913.04, 1232
2913.041, 2913.05, 2913.06, 2913.11, 2913.21, 2913.31, 2913.32, 1233
2913.33, 2913.34, 2913.40, 2913.41, 2913.42, 2913.43, 2913.44, 1234
2913.441, 2913.45, 2913.46, 2913.47, 2913.48, 2913.49, 2919.12, 1235
2919.22, 2919.24, 2919.25, 2921.11, 2921.13, 2923.01, 2923.12, 1236
2923.13, 2923.161, 2925.02, 2925.03, 2925.04, 2925.05, 2925.06, or 1237
3716.11 of the Revised Code, felonious sexual penetration in 1238
violation of former section 2907.12 of the Revised Code, a 1239
violation of section 2905.04 of the Revised Code as it existed 1240
prior to July 1, 1996, a violation of section 2919.23 of the 1241
Revised Code that would have been a violation of section 2905.04 1242
of the Revised Code as it existed prior to July 1, 1996, had the 1243
violation been committed prior to that date, a violation of 1244
section 2925.11 of the Revised Code that is not a minor drug 1245
possession offense, a violation of section 2923.02 or 2923.03 of 1246
the Revised Code that relates to a crime specified in this 1247
division, or a second violation of section 4511.19 of the Revised 1248
Code within five years of the date of application for licensure or 1249
certification. 1250

(b) A violation of an existing or former law of this state, 1251
any other state, or the United States that is substantially 1252
equivalent to any of the offenses or violations described in 1253
division (A)(9)(a) of this section. 1254

(10) Upon receipt of a request pursuant to section 5153.111 1255
of the Revised Code, a completed form prescribed pursuant to 1256
division (C)(1) of this section, and a set of fingerprint 1257
impressions obtained in the manner described in division (C)(2) of 1258
this section, the superintendent of the bureau of criminal 1259
identification and investigation shall conduct a criminal records 1260

check in the manner described in division (B) of this section to determine whether any information exists that indicates that the person who is the subject of the request previously has been convicted of or pleaded guilty to any of the following: 1261 1262 1263 1264

(a) A violation of section 2903.01, 2903.02, 2903.03, 2903.04, 2903.11, 2903.12, 2903.13, 2903.16, 2903.21, 2903.34, 2905.01, 2905.02, 2905.05, 2907.02, 2907.03, 2907.04, 2907.05, 2907.06, 2907.07, 2907.08, 2907.09, 2907.21, 2907.22, 2907.23, 2907.25, 2907.31, 2907.32, 2907.321, 2907.322, 2907.323, 2909.02, 2909.03, 2911.01, 2911.02, 2911.11, 2911.12, 2919.12, 2919.22, 2919.24, 2919.25, 2923.12, 2923.13, 2923.161, 2925.02, 2925.03, 2925.04, 2925.05, 2925.06, or 3716.11 of the Revised Code, felonious sexual penetration in violation of former section 2907.12 of the Revised Code, a violation of section 2905.04 of the Revised Code as it existed prior to July 1, 1996, a violation of section 2919.23 of the Revised Code that would have been a violation of section 2905.04 of the Revised Code as it existed prior to July 1, 1996, had the violation been committed prior to that date, or a violation of section 2925.11 of the Revised Code that is not a minor drug possession offense; 1265 1266 1267 1268 1269 1270 1271 1272 1273 1274 1275 1276 1277 1278 1279 1280

(b) A violation of an existing or former law of this state, any other state, or the United States that is substantially equivalent to any of the offenses listed in division (A)(10)(a) of this section. 1281 1282 1283 1284

(11) On receipt of a request for a criminal records check from an individual pursuant to section 4749.03 or 4749.06 of the Revised Code, accompanied by a completed copy of the form prescribed in division (C)(1) of this section and a set of fingerprint impressions obtained in a manner described in division (C)(2) of this section, the superintendent of the bureau of criminal identification and investigation shall conduct a criminal records check in the manner described in division (B) of this 1285 1286 1287 1288 1289 1290 1291 1292

section to determine whether any information exists indicating that the person who is the subject of the request has been convicted of or pleaded guilty to a felony in this state or in any other state. If the individual indicates that a firearm will be carried in the course of business, the superintendent shall require information from the federal bureau of investigation as described in division (B)(2) of this section. The superintendent shall report the findings of the criminal records check and any information the federal bureau of investigation provides to the director of public safety. 1293 1294 1295 1296 1297 1298 1299 1300 1301 1302

(12) On receipt of a request pursuant to section 1321.37, 1322.03, 1322.031, or 4763.05 of the Revised Code, a completed form prescribed pursuant to division (C)(1) of this section, and a set of fingerprint impressions obtained in the manner described in division (C)(2) of this section, the superintendent of the bureau of criminal identification and investigation shall conduct a criminal records check with respect to any person who has applied for a license, permit, or certification from the department of commerce or a division in the department. The superintendent shall conduct the criminal records check in the manner described in division (B) of this section to determine whether any information exists that indicates that the person who is the subject of the request previously has been convicted of or pleaded guilty to any of the following: a violation of section 2913.02, 2913.11, 2913.31, 2913.51, or 2925.03 of the Revised Code; any other criminal offense involving theft, receiving stolen property, embezzlement, forgery, fraud, passing bad checks, money laundering, or drug trafficking, or any criminal offense involving money or securities, as set forth in Chapters 2909., 2911., 2913., 2915., 2921., 2923., and 2925. of the Revised Code; or any existing or former law of this state, any other state, or the United States that is substantially equivalent to those offenses. 1303 1304 1305 1306 1307 1308 1309 1310 1311 1312 1313 1314 1315 1316 1317 1318 1319 1320 1321 1322 1323 1324

1325

(13) On receipt of a request for a criminal records check from the treasurer of state under section 113.041 of the Revised Code or from an individual under section 4701.08, 4715.101, 4717.061, 4725.121, 4725.501, 4729.071, 4730.101, 4730.14, 4730.28, 4731.081, 4731.15, 4731.171, 4731.222, 4731.281, 4731.296, 4731.531, 4732.091, 4734.202, 4740.061, 4741.10, 4755.70, 4757.101, 4759.061, 4760.032, 4760.06, 4761.051, 4762.031, 4762.06, or 4779.091 of the Revised Code, accompanied by a completed form prescribed under division (C)(1) of this section and a set of fingerprint impressions obtained in the manner described in division (C)(2) of this section, the superintendent of the bureau of criminal identification and investigation shall conduct a criminal records check in the manner described in division (B) of this section to determine whether any information exists that indicates that the person who is the subject of the request has been convicted of or pleaded guilty to any criminal offense in this state or any other state. The superintendent shall send the results of a check requested under section 113.041 of the Revised Code to the treasurer of state and shall send the results of a check requested under any of the other listed sections to the licensing board specified by the individual in the request. 1326–1347

(14) On receipt of a request pursuant to section 1121.23, 1155.03, 1163.05, 1315.141, 1733.47, or 1761.26 of the Revised Code, a completed form prescribed pursuant to division (C)(1) of this section, and a set of fingerprint impressions obtained in the manner described in division (C)(2) of this section, the superintendent of the bureau of criminal identification and investigation shall conduct a criminal records check in the manner described in division (B) of this section to determine whether any information exists that indicates that the person who is the subject of the request previously has been convicted of or pleaded guilty to any criminal offense under any existing or former law of 1348–1358

this state, any other state, or the United States. 1359

(15) Not later than thirty days after the date the superintendent receives a request of a type described in division (A)(1), (2), (3), (4), (5), (6), (7), (8), (9), (10), (11), (12), or (14) of this section, the completed form, and the fingerprint impressions, the superintendent shall send the person, board, or entity that made the request any information, other than information the dissemination of which is prohibited by federal law, the superintendent determines exists with respect to the person who is the subject of the request that indicates that the person previously has been convicted of or pleaded guilty to any offense listed or described in division (A)(1), (2), (3), (4), (5), (6), (7), (8), (9), (10), (11), (12), or (14) of this section, as appropriate. The superintendent shall send the person, board, or entity that made the request a copy of the list of offenses specified in division (A)(1), (2), (3), (4), (5), (6), (7), (8), (9), (10), (11), (12), or (14) of this section, as appropriate. If the request was made under section 3701.881 of the Revised Code with regard to an applicant who may be both responsible for the care, custody, or control of a child and involved in providing direct care to an older adult, the superintendent shall provide a list of the offenses specified in divisions (A)(4) and (6) of this section. 1360 1361 1362 1363 1364 1365 1366 1367 1368 1369 1370 1371 1372 1373 1374 1375 1376 1377 1378 1379 1380 1381

Not later than thirty days after the superintendent receives a request for a criminal records check pursuant to section 113.041 of the Revised Code, the completed form, and the fingerprint impressions, the superintendent shall send the treasurer of state any information, other than information the dissemination of which is prohibited by federal law, the superintendent determines exist with respect to the person who is the subject of the request that indicates that the person previously has been convicted of or pleaded guilty to any criminal offense in this state or any other 1382 1383 1384 1385 1386 1387 1388 1389 1390

state. 1391

(B) The superintendent shall conduct any criminal records 1392
check requested under section 113.041, 121.08, 173.27, 173.394, 1393
1121.23, 1155.03, 1163.05, 1315.141, 1322.03, 1322.031, 1733.47, 1394
1761.26, 2151.86, 3301.32, 3301.541, 3319.39, 3701.881, 3712.09, 1395
3721.121, 3722.151, 4701.08, 4715.101, 4717.061, 4725.121, 1396
4725.501, 4729.071, 4730.101, 4730.14, 4730.28, 4731.081, 4731.15, 1397
4731.171, 4731.222, 4731.281, 4731.296, 4731.531, 4732.091, 1398
4734.202, 4740.061, 4741.10, 4749.03, 4749.06, 4755.70, 4757.101, 1399
4759.061, 4760.032, 4760.06, 4761.051, 4762.031, 4762.06, 4763.05, 1400
4779.091, 5104.012, 5104.013, ~~5111.032~~ 5163.032, ~~5111.033~~ 1401
5163.033, ~~5111.034~~ 5163.034, 5123.081, 5126.28, 5126.281, or 1402
5153.111 of the Revised Code as follows: 1403

(1) The superintendent shall review or cause to be reviewed 1404
any relevant information gathered and compiled by the bureau under 1405
division (A) of section 109.57 of the Revised Code that relates to 1406
the person who is the subject of the request, including, if the 1407
criminal records check was requested under section 113.041, 1408
121.08, 173.27, 173.394, 1121.23, 1155.03, 1163.05, 1315.141, 1409
1321.37, 1322.03, 1322.031, 1733.47, 1761.26, 2151.86, 3301.32, 1410
3301.541, 3319.39, 3701.881, 3712.09, 3721.121, 3722.151, 4749.03, 1411
4749.06, 4763.05, 5104.012, 5104.013, ~~5111.032~~ 5163.032, ~~5111.033~~ 1412
5163.033, ~~5111.034~~ 5163.034, 5123.081, 5126.28, 5126.281, or 1413
5153.111 of the Revised Code, any relevant information contained 1414
in records that have been sealed under section 2953.32 of the 1415
Revised Code; 1416

(2) If the request received by the superintendent asks for 1417
information from the federal bureau of investigation, the 1418
superintendent shall request from the federal bureau of 1419
investigation any information it has with respect to the person 1420
who is the subject of the request, including fingerprint-based 1421
checks of national crime information databases as described in 42 1422

U.S.C. 671 if the request is made pursuant to section 2151.86, 1423
5104.012, or 5104.013 of the Revised Code or if any other Revised 1424
Code section requires fingerprint-based checks of that nature, and 1425
shall review or cause to be reviewed any information the 1426
superintendent receives from that bureau. 1427

(3) The superintendent or the superintendent's designee may 1428
request criminal history records from other states or the federal 1429
government pursuant to the national crime prevention and privacy 1430
compact set forth in section 109.571 of the Revised Code. 1431

(C)(1) The superintendent shall prescribe a form to obtain 1432
the information necessary to conduct a criminal records check from 1433
any person for whom a criminal records check is requested under 1434
section 113.041 of the Revised Code or required by section 121.08, 1435
173.27, 173.394, 1121.23, 1155.03, 1163.05, 1315.141, 1322.03, 1436
1322.031, 1733.47, 1761.26, 2151.86, 3301.32, 3301.541, 3319.39, 1437
3701.881, 3712.09, 3721.121, 3722.151, 4701.08, 4715.101, 1438
4717.061, 4725.121, 4725.501, 4729.071, 4730.101, 4730.14, 1439
4730.28, 4731.081, 4731.15, 4731.171, 4731.222, 4731.281, 1440
4731.296, 4731.531, 4732.091, 4734.202, 4740.061, 4741.10, 1441
4749.03, 4749.06, 4755.70, 4757.101, 4759.061, 4760.032, 4760.06, 1442
4761.051, 4762.031, 4762.06, 4763.05, 4779.091, 5104.012, 1443
5104.013, ~~5111.032~~ 5163.032, ~~5111.033~~ 5163.033, ~~5111.034~~ 5163.034, 1444
5123.081, 5126.28, 5126.281, or 5153.111 of the Revised Code. The 1445
form that the superintendent prescribes pursuant to this division 1446
may be in a tangible format, in an electronic format, or in both 1447
tangible and electronic formats. 1448

(2) The superintendent shall prescribe standard impression 1449
sheets to obtain the fingerprint impressions of any person for 1450
whom a criminal records check is requested under section 113.041 1451
of the Revised Code or required by section 121.08, 173.27, 1452
173.394, 1121.23, 1155.03, 1163.05, 1315.141, 1322.03, 1322.031, 1453
1733.47, 1761.26, 2151.86, 3301.32, 3301.541, 3319.39, 3701.881, 1454

3712.09, 3721.121, 3722.151, 4701.08, 4715.101, 4717.061, 4725.121, 4725.501, 4729.071, 4730.101, 4730.14, 4730.28, 4731.081, 4731.15, 4731.171, 4731.222, 4731.281, 4731.296, 4731.531, 4732.091, 4734.202, 4740.061, 4741.10, 4749.03, 4749.06, 4755.70, 4757.101, 4759.061, 4760.032, 4760.06, 4761.051, 4762.031, 4762.06, 4763.05, 4779.091, 5104.012, 5104.013, ~~5111.032~~ 5163.032, ~~5111.033~~ 5163.033, ~~5111.034~~ 5163.034, 5123.081, 5126.28, 5126.281, or 5153.111 of the Revised Code. Any person for whom a records check is requested under or required by any of those sections shall obtain the fingerprint impressions at a county sheriff's office, municipal police department, or any other entity with the ability to make fingerprint impressions on the standard impression sheets prescribed by the superintendent. The office, department, or entity may charge the person a reasonable fee for making the impressions. The standard impression sheets the superintendent prescribes pursuant to this division may be in a tangible format, in an electronic format, or in both tangible and electronic formats.

(3) Subject to division (D) of this section, the superintendent shall prescribe and charge a reasonable fee for providing a criminal records check requested under section 113.041, 121.08, 173.27, 173.394, 1121.23, 1155.03, 1163.05, 1315.141, 1322.03, 1322.031, 1733.47, 1761.26, 2151.86, 3301.32, 3301.541, 3319.39, 3701.881, 3712.09, 3721.121, 3722.151, 4701.08, 4715.101, 4717.061, 4725.121, 4725.501, 4729.071, 4730.101, 4730.14, 4730.28, 4731.081, 4731.15, 4731.171, 4731.222, 4731.281, 4731.296, 4731.531, 4732.091, 4734.202, 4740.061, 4741.10, 4749.03, 4749.06, 4755.70, 4757.101, 4759.061, 4760.032, 4760.06, 4761.051, 4762.031, 4762.06, 4763.05, 4779.091, 5104.012, 5104.013, ~~5111.032~~ 5163.032, ~~5111.033~~ 5163.033, ~~5111.034~~ 5163.034, 5123.081, 5126.28, 5126.281, or 5153.111 of the Revised Code. The person making a criminal records request under any of those

sections shall pay the fee prescribed pursuant to this division. A 1488
person making a request under section 3701.881 of the Revised Code 1489
for a criminal records check for an applicant who may be both 1490
responsible for the care, custody, or control of a child and 1491
involved in providing direct care to an older adult shall pay one 1492
fee for the request. In the case of a request under section 1493
1121.23, 1155.03, 1163.05, 1315.141, 1733.47, 1761.26, or ~~5111.032~~ 1494
5163.032 of the Revised Code, the fee shall be paid in the manner 1495
specified in that section. 1496

1497

(4) The superintendent of the bureau of criminal 1498
identification and investigation may prescribe methods of 1499
forwarding fingerprint impressions and information necessary to 1500
conduct a criminal records check, which methods shall include, but 1501
not be limited to, an electronic method. 1502

(D) A determination whether any information exists that 1503
indicates that a person previously has been convicted of or 1504
pleaded guilty to any offense listed or described in division 1505
(A)(1)(a) or (b), (A)(2)(a) or (b), (A)(3)(a) or (b), (A)(4)(a) or 1506
(b), (A)(5)(a) or (b), (A)(6)(a) or (b), (A)(7), (A)(8)(a) or (b), 1507
(A)(9)(a) or (b), (A)(10)(a) or (b), (A)(12), or (A)(14) of this 1508
section, or that indicates that a person previously has been 1509
convicted of or pleaded guilty to any criminal offense in this 1510
state or any other state regarding a criminal records check of a 1511
type described in division (A)(13) of this section, and that is 1512
made by the superintendent with respect to information considered 1513
in a criminal records check in accordance with this section is 1514
valid for the person who is the subject of the criminal records 1515
check for a period of one year from the date upon which the 1516
superintendent makes the determination. During the period in which 1517
the determination in regard to a person is valid, if another 1518
request under this section is made for a criminal records check 1519

for that person, the superintendent shall provide the information 1520
that is the basis for the superintendent's initial determination 1521
at a lower fee than the fee prescribed for the initial criminal 1522
records check. 1523

(E) As used in this section: 1524

(1) "Criminal records check" means any criminal records check 1525
conducted by the superintendent of the bureau of criminal 1526
identification and investigation in accordance with division (B) 1527
of this section. 1528

(2) "Minor drug possession offense" has the same meaning as 1529
in section 2925.01 of the Revised Code. 1530

(3) "Older adult" means a person age sixty or older. 1531

(4) "OVI or OVUAC violation" means a violation of section 1532
4511.19 of the Revised Code or a violation of an existing or 1533
former law of this state, any other state, or the United States 1534
that is substantially equivalent to section 4511.19 of the Revised 1535
Code. 1536

Sec. 109.85. (A) Upon the written request of the governor, 1537
the general assembly, the auditor of state, the director of ~~job~~ 1538
~~and family services~~ health care administration, the director of 1539
health, or the director of budget and management, or upon the 1540
attorney general's becoming aware of criminal or improper activity 1541
related to Chapter 3721. and the ~~medical assistance~~ medicaid 1542
program ~~established under section 5111.01 of the Revised Code~~, the 1543
attorney general shall investigate any criminal or civil violation 1544
of law related to Chapter 3721. of the Revised Code or the ~~medical~~ 1545
~~assistance~~ medicaid program. 1546

(B) When it appears to the attorney general, as a result of 1547
an investigation under division (A) of this section, that there is 1548
cause to prosecute for the commission of a crime or to pursue a 1549

civil remedy, the attorney general may refer the evidence to the 1550
prosecuting attorney having jurisdiction of the matter, or to a 1551
regular grand jury drawn and impaneled pursuant to sections 1552
2939.01 to 2939.24 of the Revised Code, or to a special grand jury 1553
drawn and impaneled pursuant to section 2939.17 of the Revised 1554
Code, or the attorney general may initiate and prosecute any 1555
necessary criminal or civil actions in any court or tribunal of 1556
competent jurisdiction in this state. When proceeding under this 1557
section, the attorney general, and any assistant or special 1558
counsel designated by the attorney general for that purpose, have 1559
all rights, privileges, and powers of prosecuting attorneys. The 1560
attorney general shall have exclusive supervision and control of 1561
all investigations and prosecutions initiated by the attorney 1562
general under this section. The forfeiture provisions of Chapter 1563
2981. of the Revised Code apply in relation to any such criminal 1564
action initiated and prosecuted by the attorney general. 1565

(C) Nothing in this section shall prevent a county 1566
prosecuting attorney from investigating and prosecuting criminal 1567
activity related to Chapter 3721. of the Revised Code and the 1568
~~medical assistance~~ medicaid program ~~established under section~~ 1569
~~5111.01 of the Revised Code~~. The forfeiture provisions of Chapter 1570
2981. of the Revised Code apply in relation to any prosecution of 1571
criminal activity related to the ~~medical assistance~~ medicaid 1572
program undertaken by the prosecuting attorney. 1573

Sec. 117.10. The auditor of state shall audit all public 1574
offices as provided in this chapter. The auditor of state also may 1575
audit the accounts of private institutions, associations, boards, 1576
and corporations receiving public money for their use and may 1577
require of them annual reports in such form as the auditor of 1578
state prescribes. 1579

If the auditor of state performs or contracts for the 1580

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

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

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

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

Sec. 117.54. The auditor of state may enter into agreements with the director of health care administration, director of job and family services, and comparable officers of other states for the exchange of names, current or most recent addresses, and social security numbers of medicaid recipients and participants and recipients of Title IV-A programs as defined in section 5101.80 of the Revised Code.

Sec. 117.55. The auditor of state shall retain, for not less than two years, at least one copy of all materials containing information received under sections 117.54, 117.56, 145.27, 742.41, 3307.21, 3309.22, 4123.27, 5101.181, 5101.182, 5160.43, 5160.44, and 5505.04 of the Revised Code. The auditor of state

shall review the information to determine whether overpayments were made to participants and recipients of public assistance under Chapters 5107., 5108., and 5115. of the Revised Code and whether benefits were incorrectly paid on behalf of medicaid recipients and disability medical assistance recipients. The auditor of state shall initiate action leading to prosecution, where warranted, of participants and recipients who received overpayments or had benefits incorrectly paid on their behalf by forwarding the name of each such participant or recipient, together with other pertinent information, to the following: 1611 1612 1613 1614 1615 1616 1617 1618 1619 1620

(A) The attorney general; 1621

(B) The director of job and family services or director of health care administration, as appropriate; 1622 1623

(C) In the case of public assistance under Chapters 5107., 5108., and 5115. of the Revised Code, the district director of job and family services of the district through which the public assistance was received; 1624 1625 1626 1627

(D) The county director of job and family services and county prosecutor of the county through which the public assistance, medicaid, or disability medical assistance was received. 1628 1629 1630

Sec. 117.56. The auditor of state and the attorney general and persons acting at their direction may examine any records, whether in computer or printed format, in the possession of the department of health care administration, the department of job and family services, or a county department of job and family services. The auditor of state and attorney general shall provide safeguards that restrict access to the records to purposes directly connected with an audit or investigation, prosecution, or criminal or civil proceeding conducted in connection with the administration of the medicaid program, the disability medical assistance program, or a public assistance program under Chapter 1631 1632 1633 1634 1635 1636 1637 1638 1639 1640 1641

5107., 5108., or 5115. of the Revised Code. Persons acting under this section shall comply with the rules of the director of job and family services restricting the disclosure of information regarding participants and recipients of public assistance and rules of the director of health care administration restricting the disclosure of information regarding medicaid and disability medical assistance recipients. A person determined to have failed to comply with these rules shall thereafter be disqualified from acting as an agent or employee or in any other capacity under appointment or employment of any state board, commission, or agency. 1642 1643 1644 1645 1646 1647 1648 1649 1650 1651 1652

Sec. 117.57. The auditor of state is responsible for the costs incurred by the auditor of state in carrying out the auditor of state's duties under sections 117.55 and 117.56 of the Revised Code. 1653 1654 1655 1656

Sec. 119.01. As used in sections 119.01 to 119.13 of the Revised Code: 1657 1658

(A)(1) "Agency" means, except as limited by this division, any official, board, or commission having authority to promulgate rules or make adjudications in the civil service commission, the division of liquor control, the department of taxation, the industrial commission, the bureau of workers' compensation, the functions of any administrative or executive officer, department, division, bureau, board, or commission of the government of the state specifically made subject to sections 119.01 to 119.13 of the Revised Code, and the licensing functions of any administrative or executive officer, department, division, bureau, board, or commission of the government of the state having the authority or responsibility of issuing, suspending, revoking, or canceling licenses. 1659 1660 1661 1662 1663 1664 1665 1666 1667 1668 1669 1670 1671

Except as otherwise provided in division (I) of this section, sections 119.01 to 119.13 of the Revised Code do not apply to the public utilities commission. Sections 119.01 to 119.13 of the Revised Code do not apply to the utility radiological safety board; to the controlling board; to actions of the superintendent of financial institutions and the superintendent of insurance in the taking possession of, and rehabilitation or liquidation of, the business and property of banks, savings and loan associations, savings banks, credit unions, insurance companies, associations, reciprocal fraternal benefit societies, and bond investment companies; to any action taken by the division of securities under section 1707.201 of the Revised Code; or to any action that may be taken by the superintendent of financial institutions under section 1113.03, 1121.06, 1121.10, 1125.09, 1125.12, 1125.18, 1157.01, 1157.02, 1157.10, 1165.01, 1165.02, 1165.10, 1349.33, 1733.35, 1733.361, 1733.37, or 1761.03 of the Revised Code. 1672 1673 1674 1675 1676 1677 1678 1679 1680 1681 1682 1683 1684 1685 1686 1687

Sections 119.01 to 119.13 of the Revised Code do not apply to actions of the industrial commission or the bureau of workers' compensation under sections 4123.01 to 4123.94 of the Revised Code with respect to all matters of adjudication, or to the actions of the industrial commission, bureau of workers' compensation board of directors, and bureau of workers' compensation under division (D) of section 4121.32, sections 4123.29, 4123.34, 4123.341, 4123.342, 4123.40, 4123.411, 4123.44, 4123.442, 4127.07, divisions (B), (C), and (E) of section 4131.04, and divisions (B), (C), and (E) of section 4131.14 of the Revised Code with respect to all matters concerning the establishment of premium, contribution, and assessment rates. 1688 1689 1690 1691 1692 1693 1694 1695 1696 1697 1698 1699

(2) "Agency" also means any official or work unit having authority to promulgate rules or make adjudications in the department of job and family services, but only with respect to both of the following: 1700 1701 1702 1703

(a) The adoption, amendment, or rescission of rules that section 5101.09 of the Revised Code requires be adopted in accordance with this chapter; 1704 1705 1706

(b) The issuance, suspension, revocation, or cancellation of licenses. 1707 1708

(B) "License" means any license, permit, certificate, commission, or charter issued by any agency. "License" does not include any arrangement whereby a person, institution, or entity furnishes medicaid services under a provider agreement with the department of ~~job and family services pursuant to Title XIX of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C. 301, as amended~~ health care administration. 1709 1710 1711 1712 1713 1714 1715

(C) "Rule" means any rule, regulation, or standard, having a general and uniform operation, adopted, promulgated, and enforced by any agency under the authority of the laws governing such agency, and includes any appendix to a rule. "Rule" does not include any internal management rule of an agency unless the internal management rule affects private rights and does not include any guideline adopted pursuant to section 3301.0714 of the Revised Code. 1716 1717 1718 1719 1720 1721 1722 1723

(D) "Adjudication" means the determination by the highest or ultimate authority of an agency of the rights, duties, privileges, benefits, or legal relationships of a specified person, but does not include the issuance of a license in response to an application with respect to which no question is raised, nor other acts of a ministerial nature. 1724 1725 1726 1727 1728 1729

(E) "Hearing" means a public hearing by any agency in compliance with procedural safeguards afforded by sections 119.01 to 119.13 of the Revised Code. 1730 1731 1732

(F) "Person" means a person, firm, corporation, association, or partnership. 1733 1734

(G) "Party" means the person whose interests are the subject of an adjudication by an agency. 1735 1736

(H) "Appeal" means the procedure by which a person, aggrieved by a finding, decision, order, or adjudication of any agency, invokes the jurisdiction of a court. 1737 1738 1739

(I) "Rule-making agency" means any board, commission, department, division, or bureau of the government of the state that is required to file proposed rules, amendments, or rescissions under division (D) of section 111.15 of the Revised Code and any agency that is required to file proposed rules, amendments, or rescissions under divisions (B) and (H) of section 119.03 of the Revised Code. "Rule-making agency" includes the public utilities commission. "Rule-making agency" does not include any state-supported college or university. 1740 1741 1742 1743 1744 1745 1746 1747 1748

(J) "Substantive revision" means any addition to, elimination from, or other change in a rule, an amendment of a rule, or a rescission of a rule, whether of a substantive or procedural nature, that changes any of the following: 1749 1750 1751 1752

(1) That which the rule, amendment, or rescission permits, authorizes, regulates, requires, prohibits, penalizes, rewards, or otherwise affects; 1753 1754 1755

(2) The scope or application of the rule, amendment, or rescission. 1756 1757

(K) "Internal management rule" means any rule, regulation, or standard governing the day-to-day staff procedures and operations within an agency. 1758 1759 1760

Sec. 121.02. The following administrative departments and their respective directors are hereby created: 1761 1762

(A) The office of budget and management, which shall be administered by the director of budget and management; 1763 1764

(B) The department of commerce, which shall be administered by the director of commerce; 1765 1766

(C) The department of administrative services, which shall be administered by the director of administrative services; 1767 1768

(D) The department of transportation, which shall be administered by the director of transportation; 1769 1770

(E) The department of agriculture, which shall be administered by the director of agriculture; 1771 1772

(F) The department of natural resources, which shall be administered by the director of natural resources; 1773 1774

(G) The department of health, which shall be administered by the director of health; 1775 1776

(H) The department of job and family services, which shall be administered by the director of job and family services; 1777 1778

(I) Until July 1, 1997, the department of liquor control, which shall be administered by the director of liquor control; 1779 1780

(J) The department of public safety, which shall be administered by the director of public safety; 1781 1782

(K) The department of mental health, which shall be administered by the director of mental health; 1783 1784

(L) The department of mental retardation and developmental disabilities, which shall be administered by the director of mental retardation and developmental disabilities; 1785 1786 1787

(M) The department of insurance, which shall be administered by the superintendent of insurance as director thereof; 1788 1789

(N) The department of development, which shall be administered by the director of development; 1790 1791

(O) The department of youth services, which shall be administered by the director of youth services; 1792 1793

(P) The department of rehabilitation and correction, which shall be administered by the director of rehabilitation and correction; 1794 1795 1796

(Q) The environmental protection agency, which shall be administered by the director of environmental protection; 1797 1798

(R) The department of aging, which shall be administered by the director of aging; 1799 1800

(S) The department of alcohol and drug addiction services, which shall be administered by the director of alcohol and drug addiction services; 1801 1802 1803

(T) The department of veterans services, which shall be administered by the director of veterans services; 1804 1805

(U) The department of health care administration, which shall be administered by the director of health care administration. 1806 1807

The director of each department shall exercise the powers and perform the duties vested by law in such department. 1808 1809

Sec. 121.03. The following administrative department heads shall be appointed by the governor, with the advice and consent of the senate, and shall hold their offices during the term of the appointing governor, and are subject to removal at the pleasure of the governor. 1810 1811 1812 1813 1814

(A) The director of budget and management; 1815

(B) The director of commerce; 1816

(C) The director of transportation; 1817

(D) The director of agriculture; 1818

(E) The director of job and family services; 1819

(F) Until July 1, 1997, the director of liquor control; 1820

(G) The director of public safety; 1821

(H) The superintendent of insurance; 1822

(I) The director of development; 1823

(J) The tax commissioner; 1824

(K) The director of administrative services; 1825

(L) The director of natural resources; 1826

(M) The director of mental health; 1827

(N) The director of mental retardation and developmental 1828
disabilities; 1829

(O) The director of health; 1830

(P) The director of youth services; 1831

(Q) The director of rehabilitation and correction; 1832

(R) The director of environmental protection; 1833

(S) The director of aging; 1834

(T) The director of alcohol and drug addiction services; 1835

(U) The administrator of workers' compensation who meets the 1836
qualifications required under division (A) of section 4121.121 of 1837
the Revised Code; 1838

(V) The director of veterans services who meets the 1839
qualifications required under section 5902.01 of the Revised Code; 1840

(W) The director of health care administration. 1841

Sec. 122.15. As used in sections 122.15 to 122.154 of the 1842
Revised Code: 1843

(A) "Edison center" means a cooperative research and 1844
development facility that receives funding through the Thomas Alva 1845
Edison grant program under division (C) of section 122.33 of the 1846
Revised Code. 1847

(B) "Ohio entity" means any corporation, limited liability 1848

company, or unincorporated business organization, including a general or limited partnership, that has its principal place of business located in this state and has at least fifty per cent of its gross assets and fifty per cent of its employees located in this state. If a corporation, limited liability company, or unincorporated business organization is a member of an affiliated group, the gross assets and the number of employees of all of the members of that affiliated group, wherever those assets and employees are located, shall be included for the purpose of determining the percentage of the corporation's, company's, or organization's gross assets and employees that are located in this state. 1849 1850 1851 1852 1853 1854 1855 1856 1857 1858 1859 1860

(C) "Qualified trade or business" means any trade or business that primarily involves research and development, technology transfer, bio-technology, information technology, or the application of new technology developed through research and development or acquired through technology transfer. "Qualified trade or business" does not include any of the following: 1861 1862 1863 1864 1865 1866

(1) Any trade or business involving the performance of services in the field of law, engineering, architecture, accounting, actuarial science, performing arts, consulting, athletics, financial services, or brokerage services, or any trade or business where the principal asset of the trade or business is the reputation or skill of one or more of its employees; 1867 1868 1869 1870 1871 1872

(2) Any banking, insurance, financing, leasing, rental, investing, or similar business; 1873 1874

(3) Any farming business, including the business of raising or harvesting trees; 1875 1876

(4) Any business involving the production or extraction of products of a character with respect to which a deduction is allowable under section 611, 613, or 613A of the "Internal Revenue 1877 1878 1879

Code of 1986," 100 Stat. 2085, 26 U.S.C.A. 611, 613, or 613A;

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

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

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

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

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

(E) "Insider" means an individual who owns, controls, or holds power to vote five per cent or more of the outstanding securities of a business. For purposes of determining whether an investor is an insider, the percentage of voting power in the Ohio entity held by a person related to the investor shall be added to the investor's percentage of voting power in the same Ohio entity, if the investor claimed the person related to the investor as a

dependent or a spouse on the investor's federal income tax return for the previous tax year. 1911 1912

(F) "Related to" means being the spouse, parent, child, or sibling of an individual. 1913 1914

(G) "Research and development" means designing, creating, or formulating new or enhanced products, equipment, or processes, and conducting scientific or technological inquiry and experimentation in the physical sciences with the goal of increasing scientific knowledge that may reveal the bases for new or enhanced products, equipment, or processes. 1915 1916 1917 1918 1919 1920

(H) "State tax liability" means any tax liability incurred under division (D) of section 5707.03, section 5727.24, 5727.38, or 5747.02, or Chapter 5733. of the Revised Code. 1921 1922 1923

(I) "Technology transfer" means the transfer of technology from one sector of the economy to another, including the transfer of military technology to civilian applications, civilian technology to military applications, or technology from public or private research laboratories to military or civilian applications. 1924 1925 1926 1927 1928 1929

(J) "Affiliated group" means two or more persons related in such a way that one of the persons owns or controls the business operations of another of those persons. In the case of a corporation issuing capital stock, one corporation owns or controls the business operations of another corporation if it owns more than fifty per cent of the other corporation's capital stock with voting rights. In the case of a limited liability company, one person owns or controls the business operations of the company if that person's membership interest, as defined in section 1705.01 of the Revised Code, is greater than fifty per cent of combined membership interest of all persons owning such interests in the company. In the case of an unincorporated business 1930 1931 1932 1933 1934 1935 1936 1937 1938 1939 1940 1941

organization, one person owns or controls the business operations of the organization if, under the articles of organization or other instrument governing the affairs of the organization, that person has a beneficial interest in the organization's profits, surpluses, losses, or other distributions greater than fifty per cent of the combined beneficial interests of all persons having such an interest in the organization. 1942 1943 1944 1945 1946 1947 1948

(K) "Money" means United States currency, or a check, draft, or cashier's check for United States currency, payable on demand and drawn on a bank. 1949 1950 1951

(L) "EDGE business enterprise" means an Ohio entity certified by the director of administrative services as a participant in the encouraging diversity, growth, and equity program established by the governor's executive order 2002-17T. 1952 1953 1954 1955

(M) "Distressed area" has the same meaning as in section 122.23 of the Revised Code. 1956 1957

Sec. 124.30. (A) Positions in the classified service may be filled without competition as follows: 1958 1959

(1) Whenever there are urgent reasons for filling a vacancy in any position in the classified service and the director of administrative services is unable to certify to the appointing authority, upon its request, a list of persons eligible for appointment to the position after a competitive examination, the appointing authority may fill the position by noncompetitive examination. 1960 1961 1962 1963 1964 1965 1966

A temporary appointment may be made without regard to the rules of sections 124.01 to 124.64 of the Revised Code. Except as otherwise provided in this division, the temporary appointment may not continue longer than one hundred twenty days, and in no case shall successive temporary appointments be made. A temporary 1967 1968 1969 1970 1971

appointment longer than one hundred twenty days may be made if necessary by reason of sickness, disability, or other approved leave of absence of regular officers or employees, in which case it may continue during the period of sickness, disability, or other approved leave of absence, subject to the rules of the director. 1972 1973 1974 1975 1976 1977

(2) In case of a vacancy in a position in the classified service where peculiar and exceptional qualifications of a scientific, managerial, professional, or educational character are required, and upon satisfactory evidence that for specified reasons competition in this special case is impracticable and that the position can best be filled by a selection of some designated person of high and recognized attainments in those qualities, the director may suspend the provisions of sections 124.01 to 124.64 of the Revised Code that require competition in this special case, but no suspension shall be general in its application. All such cases of suspension shall be reported in the annual report of the director with the reasons for each suspension. The director shall suspend the provisions when the director of job and family services or director of health care administration provides the certification under section 5101.051 or 5160.05 of the Revised Code that a position with the department of job and family services or department of health care administration can best be filled if the provisions are suspended. 1978 1979 1980 1981 1982 1983 1984 1985 1986 1987 1988 1989 1990 1991 1992 1993 1994 1995

(3) The acceptance or refusal by an eligible person of a temporary appointment shall not affect the person's standing on the eligible list for permanent appointment, nor shall the period of temporary service be counted as a part of the probationary service in case of subsequent appointment to a permanent position. 1996 1997 1998 1999 2000

(B) Persons who receive temporary or intermittent appointments are in the unclassified civil service and serve at the pleasure of their appointing authority. 2001 2002 2003

Sec. 124.301. The director of administrative services shall waive any residency requirement for the civil service established by a rule adopted under division (A) of section 124.09 of the Revised Code if the director of job and family services <u>or director of health care administration</u> provides the director certification under section 5101.051 <u>or 5160.05</u> of the Revised Code that a position with the department of job and family services <u>or department of health care administration</u> can best be filled if the residency requirement is waived. 2004 2005 2006 2007 2008 2009 2010 2011 2012

Sec. 127.16. (A) Upon the request of either a state agency or the director of budget and management and after the controlling board determines that an emergency or a sufficient economic reason exists, the controlling board may approve the making of a purchase without competitive selection as provided in division (B) of this section. 2013 2014 2015 2016 2017 2018

(B) Except as otherwise provided in this section, no state agency, using money that has been appropriated to it directly, shall: 2019 2020 2021

(1) Make any purchase from a particular supplier, that would amount to fifty thousand dollars or more when combined with both the amount of all disbursements to the supplier during the fiscal year for purchases made by the agency and the amount of all outstanding encumbrances for purchases made by the agency from the supplier, unless the purchase is made by competitive selection or with the approval of the controlling board; 2022 2023 2024 2025 2026 2027 2028

(2) Lease real estate from a particular supplier, if the lease would amount to seventy-five thousand dollars or more when combined with both the amount of all disbursements to the supplier during the fiscal year for real estate leases made by the agency and the amount of all outstanding encumbrances for real estate 2029 2030 2031 2032 2033

leases made by the agency from the supplier, unless the lease is 2034
made by competitive selection or with the approval of the 2035
controlling board. 2036

(C) Any person who authorizes a purchase in violation of 2037
division (B) of this section shall be liable to the state for any 2038
state funds spent on the purchase, and the attorney general shall 2039
collect the amount from the person. 2040

(D) Nothing in division (B) of this section shall be 2041
construed as: 2042

(1) A limitation upon the authority of the director of 2043
transportation as granted in sections 5501.17, 5517.02, and 2044
5525.14 of the Revised Code; 2045

(2) Applying to medicaid provider agreements under Chapter 2046
~~5111.~~ 5163. or 5164. of the Revised Code or payments or provider 2047
agreements under the disability medical assistance program 2048
established under Chapter ~~5115.~~ 5168. of the Revised Code; 2049

(3) Applying to the purchase of examinations from a sole 2050
supplier by a state licensing board under Title XLVII of the 2051
Revised Code; 2052

(4) Applying to entertainment contracts for the Ohio state 2053
fair entered into by the Ohio expositions commission, provided 2054
that the controlling board has given its approval to the 2055
commission to enter into such contracts and has approved a total 2056
budget amount for such contracts as agreed upon by commission 2057
action, and that the commission causes to be kept itemized records 2058
of the amounts of money spent under each contract and annually 2059
files those records with the clerk of the house of representatives 2060
and the clerk of the senate following the close of the fair; 2061

(5) Limiting the authority of the chief of the division of 2062
mineral resources management to contract for reclamation work with 2063
an operator mining adjacent land as provided in section 1513.27 of 2064

the Revised Code;

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

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

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

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

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

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

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

(13) Applying to dues or fees paid for membership in an organization or association; 2096 2097

(14) Applying to purchases of utility services pursuant to section 9.30 of the Revised Code; 2098 2099

(15) Applying to purchases made in accordance with rules adopted by the department of administrative services of motor vehicle, aviation, or watercraft fuel, or emergency repairs of such vehicles; 2100 2101 2102 2103

(16) Applying to purchases of tickets for passenger air transportation; 2104 2105

(17) Applying to purchases necessary to provide public notifications required by law or to provide notifications of job openings; 2106 2107 2108

(18) Applying to the judicial branch of state government; 2109

(19) Applying to purchases of liquor for resale by the division of liquor control; 2110 2111

(20) Applying to purchases of motor courier and freight services made in accordance with department of administrative services rules; 2112 2113 2114

(21) Applying to purchases from the United States postal service and purchases of stamps and postal meter replenishment from vendors at rates established by the United States postal service; 2115 2116 2117 2118

(22) Applying to purchases of books, periodicals, pamphlets, newspapers, maintenance subscriptions, and other published materials; 2119 2120 2121

(23) Applying to purchases from other state agencies, including state-assisted institutions of higher education; 2122 2123

(24) Limiting the authority of the director of environmental protection to enter into contracts under division (D) of section 2124 2125

3745.14 of the Revised Code to conduct compliance reviews, as 2126
defined in division (A) of that section; 2127

(25) Applying to purchases from a qualified nonprofit agency 2128
pursuant to sections 125.60 to 125.6012 or 4115.31 to 4115.35 of 2129
the Revised Code; 2130

(26) Applying to payments by the department of job and family 2131
services to the United States department of health and human 2132
services for printing and mailing notices pertaining to the tax 2133
refund offset program of the internal revenue service of the 2134
United States department of the treasury; 2135

(27) Applying to contracts entered into by the department of 2136
mental retardation and developmental disabilities under section 2137
5123.18 of the Revised Code; 2138

(28) Applying to payments made by the department of mental 2139
health under a physician recruitment program authorized by section 2140
5119.101 of the Revised Code; 2141

(29) Applying to contracts entered into with persons by the 2142
director of commerce for unclaimed funds collection and remittance 2143
efforts as provided in division (F) of section 169.03 of the 2144
Revised Code. The director shall keep an itemized accounting of 2145
unclaimed funds collected by those persons and amounts paid to 2146
them for their services. 2147

(30) Applying to purchases made by a state institution of 2148
higher education in accordance with the terms of a contract 2149
between the vendor and an inter-university purchasing group 2150
comprised of purchasing officers of state institutions of higher 2151
education; 2152

(31) Applying to the department of ~~job and family services'~~ 2153
health care administration's purchases of health assistance 2154
services under the children's health insurance program ~~part I~~ 2155
~~provided for under section 5101.50 of the Revised Code, the~~ 2156

~~children's health insurance program part II provided for under section 5101.51 of the Revised Code, or the children's health insurance program part III provided for under section 5101.52 of the Revised Code,~~ or the children's buy-in program ~~provided for under sections 5101.5211 to 5101.5216 of the Revised Code~~; 2157 2158 2159 2160 2161

(32) Applying to payments by the attorney general from the reparations fund to hospitals and other emergency medical facilities for performing medical examinations to collect physical evidence pursuant to section 2907.28 of the Revised Code; 2162 2163 2164 2165

(33) Applying to contracts with a contracting authority or administrative receiver under division (B) of section 5126.056 of the Revised Code; 2166 2167 2168

(34) Applying to reimbursements paid to the United States department of veterans affairs for pharmaceutical and patient supply purchases made on behalf of the Ohio veterans' home agency; 2169 2170 2171

(35) Applying to agreements entered into with terminal distributors of dangerous drugs under section 173.79 of the Revised Code; 2172 2173 2174

(36) Applying to payments by the superintendent of the bureau of criminal identification and investigation to the federal bureau of investigation for criminal records checks pursuant to section 109.572 of the Revised Code. 2175 2176 2177 2178

(E) When determining whether a state agency has reached the cumulative purchase thresholds established in divisions (B)(1) and (2) of this section, all of the following purchases by such agency shall not be considered: 2179 2180 2181 2182

(1) Purchases made through competitive selection or with controlling board approval; 2183 2184

(2) Purchases listed in division (D) of this section; 2185

(3) For the purposes of the threshold of division (B)(1) of 2186

this section only, leases of real estate. 2187

(F) As used in this section, "competitive selection," "purchase," "supplies," and "services" have the same meanings as in section 125.01 of the Revised Code. 2188 2189 2190

Sec. 131.23. The various political subdivisions of this state may issue bonds, and any indebtedness created by that issuance shall not be subject to the limitations or included in the calculation of indebtedness prescribed by sections 133.05, 133.06, 133.07, and 133.09 of the Revised Code, but the bonds may be issued only under the following conditions: 2191 2192 2193 2194 2195 2196

(A) The subdivision desiring to issue the bonds shall obtain from the county auditor a certificate showing the total amount of delinquent taxes due and unpayable to the subdivision at the last semiannual tax settlement. 2197 2198 2199 2200

(B) The fiscal officer of that subdivision shall prepare a statement, from the books of the subdivision, verified by the fiscal officer under oath, which shall contain the following facts of the subdivision: 2201 2202 2203 2204

(1) The total bonded indebtedness; 2205

(2) The aggregate amount of notes payable or outstanding accounts of the subdivision, incurred prior to the commencement of the current fiscal year, which shall include all evidences of indebtedness issued by the subdivision except notes issued in anticipation of bond issues and the indebtedness of any nontax-supported public utility; 2206 2207 2208 2209 2210 2211

(3) Except in the case of school districts, the aggregate current year's requirement for disability financial assistance ~~and disability medical assistance~~ provided under Chapter ~~5115.~~ <u>5168.</u> of the Revised Code <u>and the disability medical assistance program</u> that the subdivision is unable to finance except by the issue of 2212 2213 2214 2215 2216

bonds; 2217

(4) The indebtedness outstanding through the issuance of any bonds or notes pledged or obligated to be paid by any delinquent taxes; 2218 2219 2220

(5) The total of any other indebtedness; 2221

(6) The net amount of delinquent taxes unpledged to pay any bonds, notes, or certificates, including delinquent assessments on improvements on which the bonds have been paid; 2222 2223 2224

(7) The budget requirements for the fiscal year for bond and note retirement; 2225 2226

(8) The estimated revenue for the fiscal year. 2227

(C) The certificate and statement provided for in divisions (A) and (B) of this section shall be forwarded to the tax commissioner together with a request for authority to issue bonds of the subdivision in an amount not to exceed seventy per cent of the net unobligated delinquent taxes and assessments due and owing to the subdivision, as set forth in division (B)(6) of this section. 2228 2229 2230 2231 2232 2233 2234

(D) No subdivision may issue bonds under this section in excess of a sufficient amount to pay the indebtedness of the subdivision as shown by division (B)(2) of this section and, except in the case of school districts, to provide funds for disability financial assistance and disability medical assistance, as shown by division (B)(3) of this section. 2235 2236 2237 2238 2239 2240

(E) The tax commissioner shall grant to the subdivision authority requested by the subdivision as restricted by divisions (C) and (D) of this section and shall make a record of the certificate, statement, and grant in a record book devoted solely to such recording and which shall be open to inspection by the public. 2241 2242 2243 2244 2245 2246

(F) The commissioner shall immediately upon issuing the authority provided in division (E) of this section notify the proper authority having charge of the retirement of bonds of the subdivision by forwarding a copy of the grant of authority and of the statement provided for in division (B) of this section. 2247 2248 2249 2250 2251

(G) Upon receipt of authority, the subdivision shall proceed according to law to issue the amount of bonds authorized by the commissioner, and authorized by the taxing authority, provided the taxing authority of that subdivision may submit, by resolution, to the electors of that subdivision the question of issuing the bonds. The resolution shall make the declarations and statements required by section 133.18 of the Revised Code. The county auditor and taxing authority shall thereupon proceed as set forth in divisions (C) and (D) of that section. The election on the question of issuing the bonds shall be held under divisions (E), (F), and (G) of that section, except that publication of the notice of the election shall be made on two separate days prior to the election in one or more newspapers of general circulation in the subdivision, and, if the board of elections operates and maintains a web site, notice of the election also shall be posted on that web site for thirty days prior to the election. The bonds may be exchanged at their face value with creditors of the subdivision in liquidating the indebtedness described and enumerated in division (B)(2) of this section or may be sold as provided in Chapter 133. of the Revised Code, and in either event shall be uncontestable. 2252 2253 2254 2255 2256 2257 2258 2259 2260 2261 2262 2263 2264 2265 2266 2267 2268 2269 2270 2271 2272

(H) The per cent of delinquent taxes and assessments collected for and to the credit of the subdivision after the exchange or sale of bonds as certified by the commissioner shall be paid to the authority having charge of the sinking fund of the subdivision, which money shall be placed in a separate fund for the purpose of retiring the bonds so issued. The proper authority 2273 2274 2275 2276 2277 2278

of the subdivisions shall provide for the levying of a tax sufficient in amount to pay the debt charges on all such bonds issued under this section. 2279 2280 2281

(I) This section is for the sole purpose of assisting the various subdivisions in paying their unsecured indebtedness, and providing funds for disability financial assistance and the disability medical assistance program. The bonds issued under authority of this section shall not be used for any other purpose, and any exchange for other purposes, or the use of the money derived from the sale of the bonds by the subdivision for any other purpose, is misapplication of funds. 2282 2283 2284 2285 2286 2287 2288 2289

(J) The bonds authorized by this section shall be redeemable or payable in not to exceed ten years from date of issue and shall not be subject to or considered in calculating the net indebtedness of the subdivision. The budget commission of the county in which the subdivision is located shall annually allocate such portion of the then delinquent levy due the subdivision which is unpledged for other purposes to the payment of debt charges on the bonds issued under authority of this section. 2290 2291 2292 2293 2294 2295 2296 2297

(K) The issue of bonds under this section shall be governed by Chapter 133. of the Revised Code, respecting the terms used, forms, manner of sale, and redemption except as otherwise provided in this section. 2298 2299 2300 2301

The board of county commissioners of any county may issue bonds authorized by this section and distribute the proceeds of the bond issues to any or all of the cities and townships of the county, according to their relative needs for disability financial assistance and the disability medical assistance program as determined by the county. 2302 2303 2304 2305 2306 2307

All sections of the Revised Code inconsistent with or prohibiting the exercise of the authority conferred by this 2308 2309

section are inoperative respecting bonds issued under this section. 2310 2311

Sec. 145.27. (A)(1) As used in this division, "personal history record" means information maintained by the public employees retirement board on an individual who is a member, former member, contributor, former contributor, retirant, or beneficiary that includes the address, telephone number, social security number, record of contributions, correspondence with the public employees retirement system, or other information the board determines to be confidential. 2312 2313 2314 2315 2316 2317 2318 2319

(2) The records of the board shall be open to public inspection, except that the following shall be excluded, except with the written authorization of the individual concerned: 2320 2321 2322

(a) The individual's statement of previous service and other information as provided for in section 145.16 of the Revised Code; 2323 2324

(b) The amount of a monthly allowance or benefit paid to the individual; 2325 2326

(c) The individual's personal history record. 2327

(B) All medical reports and recommendations required by this chapter are privileged, except that copies of such medical reports or recommendations shall be made available to the personal physician, attorney, or authorized agent of the individual concerned upon written release from the individual or the individual's agent, or when necessary for the proper administration of the fund, to the board assigned physician. 2328 2329 2330 2331 2332 2333 2334

(C) Any person who is a member or contributor of the system shall be furnished with a statement of the amount to the credit of the individual's account upon written request. The board is not required to answer more than one such request of a person in any one year. The board may issue annual statements of accounts to 2335 2336 2337 2338 2339

members and contributors. 2340

(D) Notwithstanding the exceptions to public inspection in division (A)(2) of this section, the board may furnish the following information: 2341 2342 2343

(1) If a member, former member, contributor, former contributor, or retirant is subject to an order issued under section 2907.15 of the Revised Code or an order issued under division (A) or (B) of section 2929.192 of the Revised Code or is convicted of or pleads guilty to a violation of section 2921.41 of the Revised Code, on written request of a prosecutor as defined in section 2935.01 of the Revised Code, the board shall furnish to the prosecutor the information requested from the individual's personal history record. 2344 2345 2346 2347 2348 2349 2350 2351 2352

(2) Pursuant to a court or administrative order issued pursuant to Chapter 3119., 3121., 3123., or 3125. of the Revised Code, the board shall furnish to a court or child support enforcement agency the information required under that section. 2353 2354 2355 2356

(3) At the written request of any person, the board shall provide to the person a list of the names and addresses of members, former members, contributors, former contributors, retirants, or beneficiaries. The costs of compiling, copying, and mailing the list shall be paid by such person. 2357 2358 2359 2360 2361

(4) Within fourteen days after receiving ~~from the director of job and family services~~ a list of the names and social security numbers of recipients of public assistance pursuant to section 5101.181 of the Revised Code <u>or a list of the names and social security numbers of public medical assistance recipients pursuant to section 5160.43 of the Revised Code</u>, the board shall inform the auditor of state of the name, current or most recent employer address, and social security number of each member whose name and social security number are the same as that of a person whose name 2362 2363 2364 2365 2366 2367 2368 2369 2370

or social security number ~~was submitted by the director~~ is included on the list. The board and its employees shall, except for purposes of furnishing the auditor of state with information required by this section, preserve the confidentiality of recipients of public assistance in compliance with ~~division (A) of~~ section 5101.181 of the Revised Code and preserve the confidentiality of public medical assistance recipients with section 5160.43 of the Revised Code.

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

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

(6) At the request of any person, the board shall make available to the person copies of all documents, including resumes, in the board's possession regarding filling a vacancy of an employee member or retirant member of the board. The person who made the request shall pay the cost of compiling, copying, and mailing the documents. The information described in division (D)(6) of this section is a public record.

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

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

(1) A former member receiving benefits pursuant to section 145.32, 145.33, 145.331, 145.34, or 145.46 of the Revised Code for whom eligibility is established more than five years after June 13, 1981, and who, at the time of establishing eligibility, has accrued less than ten years' service credit, exclusive of credit obtained pursuant to section 145.297 or 145.298 of the Revised Code, credit obtained after January 29, 1981, pursuant to section 145.293 or 145.301 of the Revised Code, and credit obtained after May 4, 1992, pursuant to section 145.28 of the Revised Code; 2401 2402 2403 2404 2405 2406 2407 2408 2409

(2) The spouse of the former member; 2410

(3) The beneficiary of the former member receiving benefits pursuant to section 145.46 of the Revised Code. 2411 2412

(B) The public employees retirement board may enter into agreements with insurance companies, health insuring corporations, or government agencies authorized to do business in the state for issuance of a policy or contract of health, medical, hospital, or surgical benefits, or any combination thereof, for those individuals receiving age and service retirement or a disability or survivor benefit subscribing to the plan, or for PERS retirants employed under section 145.38 of the Revised Code, for coverage of benefits in accordance with division (D)(2) of section 145.38 of the Revised Code. Notwithstanding any other provision of this chapter, the policy or contract may also include coverage for any eligible individual's spouse and dependent children and for any of the individual's sponsored dependents as the board determines appropriate. If all or any portion of the policy or contract premium is to be paid by any individual receiving age and service retirement or a disability or survivor benefit, the individual shall, by written authorization, instruct the board to deduct the premium agreed to be paid by the individual to the company, corporation, or agency. 2413 2414 2415 2416 2417 2418 2419 2420 2421 2422 2423 2424 2425 2426 2427 2428 2429 2430 2431

The board may contract for coverage on the basis of part or 2432

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

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

(C) The board shall, beginning the month following receipt of satisfactory evidence of the payment for coverage, pay monthly to each recipient of service retirement, or a disability or survivor benefit under the public employees retirement system who is eligible for medical insurance coverage under part B of ~~Title XVIII of "The Social Security Act," 79 Stat. 301 (1965), 42 U.S.C.A. 1395j, as amended~~ the medicare program, an amount determined by the board for such coverage that is not less than ninety-six dollars and forty cents, except that the board shall make no such payment to any ineligible individual or pay an amount that exceeds the amount paid by the recipient for the coverage.

At the request of the board, the recipient shall certify to the retirement system the amount paid by the recipient for coverage described in this division.

(D) The board shall establish by rule requirements for the coordination of any coverage, payment, or benefit provided under this section or section 145.325 of the Revised Code with any

similar coverage, payment, or benefit made available to the same 2465
individual by the Ohio police and fire pension fund, state 2466
teachers retirement system, school employees retirement system, or 2467
state highway patrol retirement system. 2468

(E) The board shall make all other necessary rules pursuant 2469
to the purpose and intent of this section. 2470

Sec. 149.431. (A) Any governmental entity or agency and any 2471
nonprofit corporation or association, except a corporation 2472
organized pursuant to Chapter 1719. of the Revised Code prior to 2473
January 1, 1980 or organized pursuant to Chapter 3941. of the 2474
Revised Code, that enters into a contract or other agreement with 2475
the federal government, a unit of state government, or a political 2476
subdivision or taxing unit of this state for the provision of 2477
services shall keep accurate and complete financial records of any 2478
moneys expended in relation to the performance of the services 2479
pursuant to such contract or agreement according to generally 2480
accepted accounting principles. Such contract or agreement and 2481
such financial records shall be deemed to be public records as 2482
defined in division (A)(1) of section 149.43 of the Revised Code 2483
and are subject to the requirements of division (B) of that 2484
section, except that: 2485

(1) Any information directly or indirectly identifying a 2486
present or former individual patient or client or ~~his~~ such an 2487
individual patient's or client's diagnosis, prognosis, or medical 2488
treatment, treatment for a mental or emotional disorder, treatment 2489
for mental retardation or a developmental disability, treatment 2490
for drug abuse or alcoholism, or counseling for personal or social 2491
problems is not a public record; 2492

(2) If disclosure of the contract or agreement or financial 2493
records is requested at a time when confidential professional 2494
services are being provided to a patient or client whose 2495

confidentiality might be violated if disclosure were made at that 2496
time, disclosure may be deferred if reasonable times are 2497
established when the contract or agreement or financial records 2498
will be disclosed. 2499

(3) Any nonprofit corporation or association that receives 2500
both public and private funds in fulfillment of any such contract 2501
or other agreement is not required to keep as public records the 2502
financial records of any private funds expended in relation to the 2503
performance of services pursuant to the contract or agreement. 2504

(B) Any nonprofit corporation or association that receives 2505
more than fifty per cent of its gross receipts excluding moneys 2506
received pursuant to ~~Title XVIII of~~ the ~~"Social Security Act," 49~~ 2507
~~Stat. 620 (1935), 42 U.S.C. 301, as amended~~ medicare program, in a 2508
calendar year in fulfillment of a contract or other agreement for 2509
services with a governmental entity shall maintain information 2510
setting forth the compensation of any individual serving the 2511
nonprofit corporation or association in an executive or 2512
administrative capacity. Such information shall be deemed to be 2513
public records as defined in division (A)(1) of section 149.43 of 2514
the Revised Code and is subject to the requirements of division 2515
(B) of that section. 2516

Nothing in this section shall be construed to otherwise limit 2517
the provisions of section 149.43 of the Revised Code. 2518

Sec. 169.02. Subject to division (B) of section 169.01 of the 2519
Revised Code, the following constitute unclaimed funds: 2520

(A) Except as provided in division (R) of this section, any 2521
demand, savings, or matured time deposit account, or matured 2522
certificate of deposit, together with any interest or dividend on 2523
it, less any lawful claims, that is held or owed by a holder which 2524
is a financial organization, unclaimed for a period of five years; 2525

(B) Any funds paid toward the purchase of withdrawable shares or other interest in a financial organization, and any interest or dividends on them, less any lawful claims, that is held or owed by a holder which is a financial organization, unclaimed for a period of five years; 2526 2527 2528 2529 2530

(C) Except as provided in division (A) of section 3903.45 of the Revised Code, moneys held or owed by a holder, including a fraternal association, providing life insurance, including annuity or endowment coverage, unclaimed for three years after becoming payable as established from the records of such holder under any life or endowment insurance policy or annuity contract that has matured or terminated. An insurance policy, the proceeds of which are payable on the death of the insured, not matured by proof of death of the insured is deemed matured and the proceeds payable if such policy was in force when the insured attained the limiting age under the mortality table on which the reserve is based. 2531 2532 2533 2534 2535 2536 2537 2538 2539 2540 2541

Moneys otherwise payable according to the records of such holder are deemed payable although the policy or contract has not been surrendered as required. 2542 2543 2544

(D) Any deposit made to secure payment or any sum paid in advance for utility services of a public utility and any amount refundable from rates or charges collected by a public utility for utility services held or owed by a holder, less any lawful claims, that has remained unclaimed for one year after the termination of the services for which the deposit or advance payment was made or one year from the date the refund was payable, whichever is earlier; 2545 2546 2547 2548 2549 2550 2551 2552

(E) Except as provided in division (R) of this section, any certificates, securities as defined in section 1707.01 of the Revised Code, nonwithdrawable shares, other instruments evidencing ownership, or rights to them or funds paid toward the purchase of them, or any dividend, capital credit, profit, distribution, 2553 2554 2555 2556 2557

interest, or payment on principal or other sum, held or owed by a holder, including funds deposited with a fiscal agent or fiduciary for payment of them, and instruments representing an ownership interest, unclaimed for five years. Any underlying share or other intangible instrument representing an ownership interest in a business association, in which the issuer has recorded on its books the issuance of the share but has been unable to deliver the certificate to the shareholder, constitutes unclaimed funds if such underlying share is unclaimed for five years. In addition, an underlying share constitutes unclaimed funds if a dividend, distribution, or other sum payable as a result of the underlying share has remained unclaimed by the owner for five years. 2558 2559 2560 2561 2562 2563 2564 2565 2566 2567 2568 2569

This division shall not prejudice the rights of fiscal agents or fiduciaries for payment to return the items described in this division to their principals, according to the terms of an agency or fiduciary agreement, but such a return shall constitute the principal as the holder of the items and shall not interrupt the period for computing the time for which the items have remained unclaimed. 2570 2571 2572 2573 2574 2575 2576

In the case of any such funds accruing and held or owed by a corporation under division (E) of section 1701.24 of the Revised Code, such corporation shall comply with this chapter, subject to the limitation contained in section 1701.34 of the Revised Code. The period of time for which such funds have gone unclaimed specified in section 1701.34 of the Revised Code shall be computed, with respect to dividends or distributions, commencing as of the dates when such dividends or distributions would have been payable to the shareholder had such shareholder surrendered the certificates for cancellation and exchange by the date specified in the order relating to them. 2577 2578 2579 2580 2581 2582 2583 2584 2585 2586 2587

Capital credits of a cooperative which after January 1, 1972, have been allocated to members and which by agreement are 2588 2589

expressly required to be paid if claimed after death of the owner are deemed payable, for the purpose of this chapter, fifteen years after either the termination of service by the cooperative to the owner or upon the nonactivity as provided in division (B) of section 169.01 of the Revised Code, whichever occurs later, provided that this provision does not apply if the payment is not mandatory. 2590 2591 2592 2593 2594 2595 2596

(F) Any sum payable on certified checks or other written instruments certified or issued and representing funds held or owed by a holder, less any lawful claims, that are unclaimed for five years from the date payable or from the date of issuance if payable on demand; except that the unclaimed period for money orders that are not third party bank checks is seven years, and the unclaimed period for traveler's checks is fifteen years, from the date payable or from the date of issuance if payable on demand. 2597 2598 2599 2600 2601 2602 2603 2604 2605

As used in this division, "written instruments" include, but are not limited to, certified checks, cashier's checks, bills of exchange, letters of credit, drafts, money orders, and traveler's checks. 2606 2607 2608 2609

If there is no address of record for the owner or other person entitled to the funds, such address is presumed to be the address where the instrument was certified or issued. 2610 2611 2612

(G) Except as provided in division (R) of this section, all moneys, rights to moneys, or other intangible property, arising out of the business of engaging in the purchase or sale of securities, or otherwise dealing in intangibles, less any lawful claims, that are held or owed by a holder and are unclaimed for five years from the date of transaction. 2613 2614 2615 2616 2617 2618

(H) Except as provided in division (A) of section 3903.45 of the Revised Code, all moneys, rights to moneys, and other 2619 2620

intangible property distributable in the course of dissolution or liquidation of a holder that are unclaimed for one year after the date set by the holder for distribution; 2621 2622 2623

(I) All moneys, rights to moneys, or other intangible property removed from a safe-deposit box or other safekeeping repository located in this state or removed from a safe-deposit box or other safekeeping repository of a holder, on which the lease or rental period has expired, or any amount arising from the sale of such property, less any lawful claims, that are unclaimed for three years from the date on which the lease or rental period expired; 2624 2625 2626 2627 2628 2629 2630 2631

(J) Subject to division (M)(2) of this section, all moneys, rights to moneys, or other intangible property, and any income or increment on them, held or owed by a holder which is a fiduciary for the benefit of another, or a fiduciary or custodian of a qualified retirement plan or individual retirement arrangement under section 401 or 408 of the Internal Revenue Code, unclaimed for three years after the final date for distribution; 2632 2633 2634 2635 2636 2637 2638

(K) All moneys, rights to moneys, or other intangible property held or owed in this state or held for or owed to an owner whose last known address is within this state, by the United States government or any state, as those terms are described in division (E) of section 169.01 of the Revised Code, unclaimed by the owner for three years, excluding any property in the control of any court in a proceeding in which a final adjudication has not been made; 2639 2640 2641 2642 2643 2644 2645 2646

(L) Amounts payable pursuant to the terms of any policy of insurance, other than life insurance, or any refund available under such a policy, held or owed by any holder, unclaimed for three years from the date payable or distributable; 2647 2648 2649 2650

(M)(1) Subject to division (M)(2) of this section, any funds 2651

constituting rents or lease payments due, any deposit made to secure payment of rents or leases, or any sum paid in advance for rents, leases, possible damage to property, unused services, performance requirements, or any other purpose, held or owed by a holder unclaimed for one year; 2652 2653 2654 2655 2656

(2) Any escrow funds, security deposits, or other moneys that are received by a licensed broker in a fiduciary capacity and that, pursuant to division (A)(26) of section 4735.18 of the Revised Code, are required to be deposited into and maintained in a special or trust, noninterest-bearing bank account separate and distinct from any personal or other account of the licensed broker, held or owed by the licensed broker unclaimed for two years. 2657 2658 2659 2660 2661 2662 2663 2664

(N) Any sum greater than fifty dollars payable as wages, any sum payable as salaries or commissions, any sum payable for services rendered, funds owed or held as royalties, oil and mineral proceeds, funds held for or owed to suppliers, and moneys owed under pension and profit-sharing plans, held or owed by any holder unclaimed for one year from date payable or distributable, and all other credits held or owed, or to be refunded to a retail customer, by any holder unclaimed for three years from date payable or distributable; 2665 2666 2667 2668 2669 2670 2671 2672 2673

(O) Amounts held in respect of or represented by lay-aways sold after January 1, 1972, less any lawful claims, when such lay-aways are unclaimed for three years after the sale of them; 2674 2675 2676

(P) All moneys, rights to moneys, and other intangible property not otherwise constituted as unclaimed funds by this section, including any income or increment on them, less any lawful claims, which are held or owed by any holder, other than a holder which holds a permit issued pursuant to Chapter 3769. of the Revised Code, and which have remained unclaimed for three years after becoming payable or distributable; 2677 2678 2679 2680 2681 2682 2683

(Q) All moneys that arise out of a sale held pursuant to section 5322.03 of the Revised Code, that are held by a holder for delivery on demand to the appropriate person pursuant to division (I) of that section, and that are unclaimed for two years after the date of the sale. 2684 2685 2686 2687 2688

(R)(1) Any funds that are subject to an agreement between the holder and owner providing for automatic reinvestment and that constitute dividends, distributions, or other sums held or owed by a holder in connection with a security as defined in section 1707.01 of the Revised Code, an ownership interest in an investment company registered under the "Investment Company Act of 1940," 54 Stat. 789, 15 U.S.C. 80a-1, as amended, or a certificate of deposit, unclaimed for a period of five years. 2689 2690 2691 2692 2693 2694 2695 2696

(2) The five-year period under division (R)(1) of this section commences from the date a second shareholder notification or communication mailing to the owner of the funds is returned to the holder as undeliverable by the United States postal service or other carrier. The notification or communication mailing by the holder shall be no less frequent than quarterly. 2697 2698 2699 2700 2701 2702

All moneys in a personal allowance account, as defined by rules adopted by the director of ~~job and family services~~ health care administration, up to and including the maximum resource limitation, of a medicaid patient who has died after receiving care in a long-term care facility, and for whom there is no identifiable heir or sponsor, are not subject to this chapter. 2703 2704 2705 2706 2707 2708

Sec. 173.14. As used in sections 173.14 to 173.27 of the Revised Code: 2709 2710

(A)(1) Except as otherwise provided in division (A)(2) of this section, "long-term care facility" includes any residential facility that provides personal care services for more than twenty-four hours for two or more unrelated adults, including all 2711 2712 2713 2714

of the following: 2715

(a) A "nursing home," "residential care facility," or "home 2716
for the aging" as defined in section 3721.01 of the Revised Code; 2717

(b) A facility authorized to provide extended care services 2718
under ~~Title XVIII of~~ the ~~"Social Security Act," 49 Stat. 620~~ 2719
~~(1935), 42 U.S.C. 301, as amended~~ medicare program; 2720

(c) A county home or district home operated pursuant to 2721
Chapter 5155. of the Revised Code; 2722

(d) An "adult care facility" as defined in section 3722.01 of 2723
the Revised Code; 2724

(e) A facility approved by the veterans administration under 2725
section 104(a) of the "Veterans Health Care Amendments of 1983," 2726
97 Stat. 993, 38 U.S.C. 630, as amended, and used exclusively for 2727
the placement and care of veterans; 2728

(f) An adult foster home certified under section 173.36 of 2729
the Revised Code. 2730

(2) "Long-term care facility" does not include a "residential 2731
facility" as defined in section 5119.22 of the Revised Code or a 2732
"residential facility" as defined in section 5123.19 of the 2733
Revised Code. 2734

(B) "Resident" means a resident of a long-term care facility 2735
and, where appropriate, includes a prospective, previous, or 2736
deceased resident of a long-term care facility. 2737

(C) "Community-based long-term care services" means health 2738
and social services provided to persons in their own homes or in 2739
community care settings, and includes any of the following: 2740

(1) Case management; 2741

(2) Home health care; 2742

(3) Homemaker services; 2743

(4) Chore services; 2744

(5) Respite care; 2745

(6) Adult day care; 2746

(7) Home-delivered meals; 2747

(8) Personal care; 2748

(9) Physical, occupational, and speech therapy; 2749

(10) Transportation; 2750

(11) Any other health and social services provided to persons that allow them to retain their independence in their own homes or in community care settings. 2751 2752 2753

(D) "Recipient" means a recipient of community-based long-term care services and, where appropriate, includes a prospective, previous, or deceased recipient of community-based long-term care services. 2754 2755 2756 2757

(E) "Sponsor" means an adult relative, friend, or guardian who has an interest in or responsibility for the welfare of a resident or a recipient. 2758 2759 2760

(F) "Personal care services" has the same meaning as in section 3721.01 of the Revised Code. 2761 2762

(G) "Regional long-term care ombudsperson program" means an entity, either public or private and nonprofit, designated as a regional long-term care ombudsperson program by the state long-term care ombudsperson. 2763 2764 2765 2766

(H) "Representative of the office of the state long-term care ombudsperson program" means the state long-term care ombudsperson or a member of the ombudsperson's staff, or a person certified as a representative of the office under section 173.21 of the Revised Code. 2767 2768 2769 2770 2771

(I) "Area agency on aging" means an area agency on aging 2772

established under the "Older Americans Act of 1965," 79 Stat. 219, 42 U.S.C.A. 3001, as amended. 2773 2774

Sec. 173.20. (A) If consent is given and unless otherwise prohibited by law, a representative of the office of the state long-term care ~~ombudsman~~ ombudsperson program shall have access to any records, including medical records, of a resident or a recipient that are reasonably necessary for investigation of a complaint. Consent may be given in any of the following ways: 2775 2776 2777 2778 2779 2780

(1) In writing by the resident or recipient; 2781

(2) Orally by the resident or recipient, witnessed in writing at the time it is given by one other person, and, if the records involved are being maintained by a long-term care provider, also by an employee of the long-term care provider designated under division (E)(1) of this section; 2782 2783 2784 2785 2786

(3) In writing by the guardian of the resident or recipient; 2787

(4) In writing by the attorney in fact of the resident or recipient, if the resident or recipient has authorized the attorney in fact to give such consent; 2788 2789 2790

(5) In writing by the executor or administrator of the estate of a deceased resident or recipient. 2791 2792

(B) If consent to access to records is not refused by a resident or recipient or ~~his~~ the resident's or recipient's legal representative but cannot be obtained and any of the following circumstances exist, a representative of the office of the state long-term care ~~ombudsman~~ ombudsperson program, on approval of the state long-term care ~~ombudsman~~ ombudsperson, may inspect the records of a resident or a recipient, including medical records, that are reasonably necessary for investigation of a complaint: 2793 2794 2795 2796 2797 2798 2799 2800

(1) The resident or recipient is unable to express written or oral consent and there is no guardian or attorney in fact; 2801 2802

(2) There is a guardian or attorney in fact, but ~~he~~ the guardian or attorney in fact cannot be contacted within three working days; 2803 2804 2805

(3) There is a guardianship or durable power of attorney, but its existence is unknown by the long-term care provider and the representative of the office at the time of the investigation; 2806 2807 2808

(4) There is no executor or administrator of the estate of a deceased resident or recipient. 2809 2810

(C) If a representative of the office of the state long-term care ~~ombudsman~~ ombudsperson program has been refused access to records by a guardian or attorney in fact, but has reasonable cause to believe that the guardian or attorney in fact is not acting in the best interests of the resident or recipient, the representative may, on approval of the state long-term care ~~ombudsman~~ ombudsperson, inspect the records of the resident or recipient, including medical records, that are reasonably necessary for investigation of a complaint. 2811 2812 2813 2814 2815 2816 2817 2818 2819

(D) A representative of the office of the state long-term care ~~ombudsman~~ ombudsperson program shall have access to any records of a long-term care provider reasonably necessary to an investigation conducted under this section, including but not limited to: incident reports, dietary records, policies and procedures of a facility required to be maintained under section ~~5111.21~~ 5164.02 of the Revised Code, admission agreements, staffing schedules, any document depicting the actual staffing pattern of the provider, any financial records that are matters of public record, resident council and grievance committee minutes, and any waiting list maintained by a facility in accordance with section ~~5111.31~~ 5164.033 of the Revised Code, or any similar records or lists maintained by a provider of community-based long-term care services. Pursuant to division (E)(2) of this section, a representative shall be permitted to make or obtain 2820 2821 2822 2823 2824 2825 2826 2827 2828 2829 2830 2831 2832 2833 2834

copies of any of these records after giving the long-term care 2835
provider twenty-four hours' notice. A long-term care provider may 2836
impose a charge for providing copies of records under this 2837
division that does not exceed the actual and necessary expense of 2838
making the copies. 2839

The state ~~ombudsman~~ ombudsperson shall take whatever action 2840
is necessary to ensure that any copy of a record made or obtained 2841
under this division is returned to the long-term care provider no 2842
later than three years after the date the investigation for which 2843
the copy was made or obtained is completed. 2844

(E)(1) Each long-term care provider shall designate one or 2845
more of its employees to be responsible for witnessing the giving 2846
of oral consent under division (A) of this section. In the event 2847
that a designated employee is not available when a resident or 2848
recipient attempts to give oral consent, the provider shall 2849
designate another employee to witness the consent. 2850

(2) Each long-term care provider shall designate one or more 2851
of its employees to be responsible for releasing records for 2852
copying to representatives of the office of the long-term care 2853
~~ombudsman~~ ombudsperson program who request permission to make or 2854
obtain copies of records specified in division (D) of this 2855
section. In the event that a designated employee is not available 2856
when a representative of the office makes the request, the 2857
long-term care provider shall designate another employee to 2858
release the records for copying. 2859

(F) A long-term care provider or any employee of such a 2860
provider is immune from civil or criminal liability or action 2861
taken pursuant to a professional disciplinary procedure for the 2862
release or disclosure of records to a representative of the office 2863
pursuant to this section. 2864

(G) A state or local government agency or entity with records 2865

relevant to a complaint or investigation being conducted by a 2866
representative of the office shall provide the representative 2867
access to the records. 2868

(H) The state ~~ombudsman~~ ombudsperson, with the approval of 2869
the director of aging, may issue a subpoena to compel any person 2870
~~he~~ the ombudsperson reasonably believes may be able to provide 2871
information to appear before ~~him~~ the ombudsperson or ~~his~~ the 2872
ombudsperson's designee and give sworn testimony and to produce 2873
documents, books, records, papers, or other evidence the state 2874
~~ombudsman~~ ombudsperson believes is relevant to the investigation. 2875
On the refusal of a witness to be sworn or to answer any question 2876
put to ~~him~~ the witness, or if a person disobeys a subpoena, the 2877
~~ombudsman~~ ombudsperson shall apply to the Franklin county court of 2878
common pleas for a contempt order, as in the case of disobedience 2879
of the requirements of a subpoena issued from the court, or a 2880
refusal to testify in the court. 2881

(I) The state ~~ombudsman~~ ombudsperson may petition the court 2882
of common pleas in the county in which a long-term care facility 2883
is located to issue an injunction against any long-term care 2884
facility in violation of sections 3721.10 to 3721.17 of the 2885
Revised Code. 2886

(J) Any suspected violation of Chapter 3721. of the Revised 2887
Code discovered during the course of an investigation may be 2888
reported to the department of health. Any suspected criminal 2889
violation discovered during the course of an investigation shall 2890
be reported to the attorney general or other appropriate law 2891
enforcement authorities. 2892

(K) The department of aging shall adopt rules in accordance 2893
with Chapter 119. of the Revised Code for referral by the state 2894
~~ombudsman~~ ombudsperson and regional long-term care ~~ombudsman~~ 2895
ombudsperson programs of complaints to other public agencies or 2896
entities. A public agency or entity to which a complaint is 2897

referred shall keep the state ~~ombudsman~~ ombudsperson or regional 2898
program handling the complaint advised and notified in writing in 2899
a timely manner of the disposition of the complaint to the extent 2900
permitted by law. 2901

Sec. 173.21. (A) The office of the state long-term care 2902
~~ombudsman~~ ombudsperson program, through the state long-term care 2903
~~ombudsman~~ ombudsperson and the regional long-term care ~~ombudsman~~ 2904
ombudsperson programs, shall require each representative of the 2905
office to complete a training and certification program in 2906
accordance with this section and to meet the continuing education 2907
requirements established under this section. 2908

(B) The department of aging shall adopt rules under Chapter 2909
119. of the Revised Code specifying the content of training 2910
programs for representatives of the office of the state long-term 2911
care ~~ombudsman~~ ombudsperson program. Training for representatives 2912
other than those who are volunteers providing services through 2913
regional long-term care ~~ombudsman~~ ombudsperson programs shall 2914
include instruction regarding federal, state, and local laws, 2915
rules, and policies on long-term care facilities and 2916
community-based long-term care services; investigative techniques; 2917
and other topics considered relevant by the department and shall 2918
consist of the following: 2919

(1) A minimum of forty clock hours of basic instruction, 2920
which shall be completed before the trainee is permitted to handle 2921
complaints without the supervision of a representative of the 2922
office certified under this section; 2923

(2) An additional sixty clock hours of instruction, which 2924
shall be completed within the first fifteen months of employment; 2925

(3) An internship of twenty clock hours, which shall be 2926
completed within the first twenty-four months of employment, 2927
including instruction in, and observation of, basic nursing care 2928

and long-term care provider operations and procedures. The 2929
internship shall be performed at a site that has been approved as 2930
an internship site by the state long-term care ~~ombudsman~~ 2931
ombudsperson. 2932

(4) One of the following, which shall be completed within the 2933
first twenty-four months of employment: 2934

(a) Observation of a survey conducted by the director of 2935
health to certify a facility to receive funds under sections 2936
~~5111.20~~ 5164.01 to ~~5111.32~~ 5164.35 of the Revised Code; 2937

(b) Observation of an inspection conducted by the director of 2938
health to license an adult care facility under section 3722.04 of 2939
the Revised Code. 2940

(5) Any other training considered appropriate by the 2941
department. 2942

(C) Persons who for a period of at least six months prior to 2943
June 11, 1990, served as ombudsmen through the long-term care 2944
~~ombudsman~~ ombudsperson program established by the department of 2945
aging under division (M) of section 173.01 of the Revised Code 2946
shall not be required to complete a training program. These 2947
persons and persons who complete a training program shall take an 2948
examination administered by the department of aging. On attainment 2949
of a passing score, the person shall be certified by the 2950
department as a representative of the office. The department shall 2951
issue the person an identification card, which the representative 2952
shall show at the request of any person with whom ~~he~~ the 2953
representative deals while performing ~~his~~ the representative's 2954
duties and which ~~he~~ shall ~~surrender~~ be surrendered at the time ~~he~~ 2955
the representative separates from the office. 2956

(D) The state ~~ombudsman~~ ombudsperson and each regional 2957
program shall conduct training programs for volunteers on their 2958
respective staffs in accordance with the rules of the department 2959

of aging adopted under division (B) of this section. Training programs may be conducted that train volunteers to complete some, but not all, of the duties of a representative of the office. Each regional office shall bear the cost of training its representatives who are volunteers. On completion of a training program, the representative shall take an examination administered by the department of aging. On attainment of a passing score, ~~he~~ a volunteer shall be certified by the department as a representative authorized to perform services specified in the certification. The department shall issue an identification card, which the representative shall show at the request of any person with whom ~~he~~ the representative deals while performing ~~his~~ the representative's duties and which ~~he~~ shall ~~surrender~~ be surrendered at the time ~~he~~ the representative separates from the office. Except as a supervised part of a training program, no volunteer shall perform any duty unless he is certified as a representative having received appropriate training for that duty. 2960-2976

(E) The state ~~ombudsman~~ ombudsperson shall provide technical assistance to regional programs conducting training programs for volunteers and shall monitor the training programs. 2977-2979

(F) Prior to scheduling an observation of a certification survey or licensing inspection for purposes of division (B)(4) of this section, the state ~~ombudsman~~ ombudsperson shall obtain permission to have the survey or inspection observed from both the director of health and the long-term care facility at which the survey or inspection is to take place. 2980-2985

(G) The department of aging shall establish continuing education requirements for representatives of the office. 2986-2987

Sec. 173.26. (A) Each of the following facilities shall annually pay to the department of aging six dollars for each bed maintained by the facility for use by a resident during any part 2988-2990

of the previous year: 2991

(1) Nursing homes, residential care facilities, and homes for the aging as defined in section 3721.01 of the Revised Code; 2992 2993

(2) Facilities authorized to provide extended care services under ~~Title XVIII of~~ the ~~"Social Security Act," 49 Stat. 620 (1935), 42 U.S.C. 301, as amended~~ medicare program; 2994 2995 2996

(3) County homes and district homes operated pursuant to Chapter 5155. of the Revised Code; 2997 2998

(4) Adult care facilities as defined in section 3722.01 of the Revised Code; 2999 3000

(5) Facilities approved by the Veterans Administration under Section 104(a) of the "Veterans Health Care Amendments of 1983," 97 Stat. 993, 38 U.S.C. 630, as amended, and used exclusively for the placement and care of veterans. 3001 3002 3003 3004

The department shall, by rule adopted in accordance with Chapter 119. of the Revised Code, establish deadlines for payments required by this section. A facility that fails, within ninety days after the established deadline, to pay a payment required by this section shall be assessed at two times the original invoiced payment. 3005 3006 3007 3008 3009 3010

(B) All money collected under this section shall be deposited in the state treasury to the credit of the office of the state long-term care ombudsperson program fund, which is hereby created. Money credited to the fund shall be used solely to pay the costs of operating the regional long-term care ombudsperson programs. 3011 3012 3013 3014 3015

(C) The state long-term care ombudsperson and the regional programs may solicit and receive contributions to support the operation of the office or a regional program, except that no contribution shall be solicited or accepted that would interfere with the independence or objectivity of the office or program. 3016 3017 3018 3019 3020

Sec. 173.394. (A) As used in this section: 3021

(1) "Applicant" means a person who is under final consideration for employment with a community-based long-term care agency in a full-time, part-time, or temporary position that involves providing direct care to an individual. "Applicant" does not include a person who provides direct care as a volunteer without receiving or expecting to receive any form of remuneration other than reimbursement for actual expenses. 3022 3023 3024 3025 3026 3027 3028

(2) "Criminal records check" has the same meaning as in section 109.572 of the Revised Code. 3029 3030

(B)(1) Except as provided in division (I) of this section, the chief administrator of a community-based long-term care agency shall request that the superintendent of the bureau of criminal identification and investigation conduct a criminal records check with respect to each applicant. If an applicant for whom a criminal records check request is required under this division does not present proof of having been a resident of this state for the five-year period immediately prior to the date the criminal records check is requested or provide evidence that within that five-year period the superintendent has requested information about the applicant from the federal bureau of investigation in a criminal records check, the chief administrator shall request that the superintendent obtain information from the federal bureau of investigation as part of the criminal records check of the applicant. Even if an applicant for whom a criminal records check request is required under this division presents proof of having been a resident of this state for the five-year period, the chief administrator may request that the superintendent include information from the federal bureau of investigation in the criminal records check. 3031 3032 3033 3034 3035 3036 3037 3038 3039 3040 3041 3042 3043 3044 3045 3046 3047 3048 3049 3050

(2) A person required by division (B)(1) of this section to 3051

request a criminal records check shall do both of the following: 3052

(a) Provide to each applicant for whom a criminal records check request is required under that division a copy of the form prescribed pursuant to division (C)(1) of section 109.572 of the Revised Code and a standard fingerprint impression sheet prescribed pursuant to division (C)(2) of that section, and obtain the completed form and impression sheet from the applicant; 3053 3054 3055 3056 3057 3058

(b) Forward the completed form and impression sheet to the superintendent of the bureau of criminal identification and investigation. 3059 3060 3061

(3) An applicant provided the form and fingerprint impression sheet under division (B)(2)(a) of this section who fails to complete the form or provide fingerprint impressions shall not be employed in any position for which a criminal records check is required by this section. 3062 3063 3064 3065 3066

(C)(1) Except as provided in rules adopted by the department of aging in accordance with division (F) of this section and subject to division (C)(2) of this section, no community-based long-term care agency shall employ a person in a position that involves providing direct care to an individual if the person has been convicted of or pleaded guilty to any of the following: 3067 3068 3069 3070 3071 3072

(a) A violation of section 2903.01, 2903.02, 2903.03, 2903.04, 2903.11, 2903.12, 2903.13, 2903.16, 2903.21, 2903.34, 2905.01, 2905.02, 2905.11, 2905.12, 2907.02, 2907.03, 2907.05, 2907.06, 2907.07, 2907.08, 2907.09, 2907.12, 2907.25, 2907.31, 2907.32, 2907.321, 2907.322, 2907.323, 2911.01, 2911.02, 2911.11, 2911.12, 2911.13, 2913.02, 2913.03, 2913.04, 2913.11, 2913.21, 2913.31, 2913.40, 2913.43, 2913.47, 2913.51, 2919.25, 2921.36, 2923.12, 2923.13, 2923.161, 2925.02, 2925.03, 2925.11, 2925.13, 2925.22, 2925.23, or 3716.11 of the Revised Code. 3073 3074 3075 3076 3077 3078 3079 3080 3081

(b) A violation of an existing or former law of this state, 3082

any other state, or the United States that is substantially equivalent to any of the offenses listed in division (C)(1)(a) of this section. 3083 3084 3085

(2)(a) A community-based long-term care agency may employ conditionally an applicant for whom a criminal records check request is required under division (B) of this section prior to obtaining the results of a criminal records check regarding the individual, provided that the agency shall request a criminal records check regarding the individual in accordance with division (B)(1) of this section not later than five business days after the individual begins conditional employment. In the circumstances described in division (I)(2) of this section, a community-based long-term care agency may employ conditionally an applicant who has been referred to the agency by an employment service that supplies full-time, part-time, or temporary staff for positions involving the direct care of individuals and for whom, pursuant to that division, a criminal records check is not required under division (B) of this section. 3086 3087 3088 3089 3090 3091 3092 3093 3094 3095 3096 3097 3098 3099 3100

(b) A community-based long-term care agency that employs an individual conditionally under authority of division (C)(2)(a) of this section shall terminate the individual's employment if the results of the criminal records check request under division (B) of this section or described in division (I)(2) of this section, other than the results of any request for information from the federal bureau of investigation, are not obtained within the period ending sixty days after the date the request is made. Regardless of when the results of the criminal records check are obtained, if the results indicate that the individual has been convicted of or pleaded guilty to any of the offenses listed or described in division (C)(1) of this section, the agency shall terminate the individual's employment unless the agency chooses to employ the individual pursuant to division (F) of this section. 3101 3102 3103 3104 3105 3106 3107 3108 3109 3110 3111 3112 3113 3114

Termination of employment under this division shall be considered 3115
just cause for discharge for purposes of division (D)(2) of 3116
section 4141.29 of the Revised Code if the individual makes any 3117
attempt to deceive the agency about the individual's criminal 3118
record. 3119

(D)(1) Each community-based long-term care agency shall pay 3120
to the bureau of criminal identification and investigation the fee 3121
prescribed pursuant to division (C)(3) of section 109.572 of the 3122
Revised Code for each criminal records check conducted pursuant to 3123
a request made under division (B) of this section. 3124

(2) A community-based long-term care agency may charge an 3125
applicant a fee not exceeding the amount the agency pays under 3126
division (D)(1) of this section. An agency may collect a fee only 3127
if both of the following apply: 3128

(a) The agency notifies the person at the time of initial 3129
application for employment of the amount of the fee and that, 3130
unless the fee is paid, the person will not be considered for 3131
employment; 3132

(b) The medicaid program ~~established under Chapter 5111. of~~ 3133
~~the Revised Code~~ does not reimburse the agency the fee it pays 3134
under division (D)(1) of this section. 3135

(E) The report of any criminal records check conducted 3136
pursuant to a request made under this section is not a public 3137
record for the purposes of section 149.43 of the Revised Code and 3138
shall not be made available to any person other than the 3139
following: 3140

(1) The individual who is the subject of the criminal records 3141
check or the individual's representative; 3142

(2) The chief administrator of the agency requesting the 3143
criminal records check or the administrator's representative; 3144

(3) The administrator of any other facility, agency, or program that provides direct care to individuals that is owned or operated by the same entity that owns or operates the community-based long-term care agency; 3145 3146 3147 3148

(4) The director of aging or a person authorized by the director to monitor a community-based long-term care agency's compliance with this section; 3149 3150 3151

(5) A court, hearing officer, or other necessary individual involved in a case dealing with a denial of employment of the applicant or dealing with employment or unemployment benefits of the applicant; 3152 3153 3154 3155

(6) Any person to whom the report is provided pursuant to, and in accordance with, division (I)(1) or (2) of this section. 3156 3157

(F) The department of aging shall adopt rules in accordance with Chapter 119. of the Revised Code to implement this section. The rules shall specify circumstances under which a community-based long-term care agency may employ a person who has been convicted of or pleaded guilty to an offense listed or described in division (C)(1) of this section but meets personal character standards set by the department. 3158 3159 3160 3161 3162 3163 3164

(G) The chief administrator of a community-based long-term care agency shall inform each person, at the time of initial application for a position that involves providing direct care to an individual, that the person is required to provide a set of fingerprint impressions and that a criminal records check is required to be conducted if the person comes under final consideration for employment. 3165 3166 3167 3168 3169 3170 3171

(H) In a tort or other civil action for damages that is brought as the result of an injury, death, or loss to person or property caused by an individual who a community-based long-term care agency employs in a position that involves providing direct 3172 3173 3174 3175

care to individuals, all of the following shall apply: 3176

(1) If the agency employed the individual in good faith and reasonable reliance on the report of a criminal records check requested under this section, the agency shall not be found negligent solely because of its reliance on the report, even if the information in the report is determined later to have been incomplete or inaccurate; 3177 3178 3179 3180 3181 3182

(2) If the agency employed the individual in good faith on a conditional basis pursuant to division (C)(2) of this section, the agency shall not be found negligent solely because it employed the individual prior to receiving the report of a criminal records check requested under this section; 3183 3184 3185 3186 3187

(3) If the agency in good faith employed the individual according to the personal character standards established in rules adopted under division (F) of this section, the agency shall not be found negligent solely because the individual prior to being employed had been convicted of or pleaded guilty to an offense listed or described in division (C)(1) of this section. 3188 3189 3190 3191 3192 3193

(I)(1) The chief administrator of a community-based long-term care agency is not required to request that the superintendent of the bureau of criminal identification and investigation conduct a criminal records check of an applicant if the applicant has been referred to the agency by an employment service that supplies full-time, part-time, or temporary staff for positions involving the direct care of individuals and both of the following apply: 3194 3195 3196 3197 3198 3199 3200 3201

(a) The chief administrator receives from the employment service or the applicant a report of the results of a criminal records check regarding the applicant that has been conducted by the superintendent within the one-year period immediately preceding the applicant's referral; 3202 3203 3204 3205 3206

(b) The report of the criminal records check demonstrates that the person has not been convicted of or pleaded guilty to an offense listed or described in division (C)(1) of this section, or the report demonstrates that the person has been convicted of or pleaded guilty to one or more of those offenses, but the community-based long-term care agency chooses to employ the individual pursuant to division (F) of this section. 3207 3208 3209 3210 3211 3212 3213

(2) The chief administrator of a community-based long-term care agency is not required to request that the superintendent of the bureau of criminal identification and investigation conduct a criminal records check of an applicant and may employ the applicant conditionally as described in this division, if the applicant has been referred to the agency by an employment service that supplies full-time, part-time, or temporary staff for positions involving the direct care of individuals and if the chief administrator receives from the employment service or the applicant a letter from the employment service that is on the letterhead of the employment service, dated, and signed by a supervisor or another designated official of the employment service and that states that the employment service has requested the superintendent to conduct a criminal records check regarding the applicant, that the requested criminal records check will include a determination of whether the applicant has been convicted of or pleaded guilty to any offense listed or described in division (C)(1) of this section, that, as of the date set forth on the letter, the employment service had not received the results of the criminal records check, and that, when the employment service receives the results of the criminal records check, it promptly will send a copy of the results to the community-based long-term care agency. If a community-based long-term care agency employs an applicant conditionally in accordance with this division, the employment service, upon its receipt of the results of the criminal records check, promptly shall send a copy of the 3214 3215 3216 3217 3218 3219 3220 3221 3222 3223 3224 3225 3226 3227 3228 3229 3230 3231 3232 3233 3234 3235 3236 3237 3238 3239

results to the community-based long-term care agency, and division (C)(2)(b) of this section applies regarding the conditional employment.

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

Sec. 173.401. (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. 3270 3271

"Nursing facility" has the same meaning as in section ~~5111.20~~ 5164.01 of the Revised Code. 3272 3273

"PASSPORT program" means the program created under section 173.40 of the Revised Code. 3274 3275

"PASSPORT waiver" means the federal medicaid waiver granted by the United States secretary of health and human services that authorizes the PASSPORT program. 3276 3277 3278

(B) The director of ~~job and family services~~ health care administration shall submit to the United States secretary of health and human services an amendment to the 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 month thereafter, each area agency on aging shall determine whether individuals who reside in the area that the area agency on aging serves and are on a waiting list for the PASSPORT program have been admitted to a nursing facility. If an area agency on aging determines that 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 in the 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 in the 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 3279 3280 3281 3282 3283 3284 3285 3286 3287 3288 3289 3290 3291 3292 3293 3294 3295 3296 3297 3298 3299 3300 3301

individual's enrollment in the PASSPORT program regardless of the 3302
PASSPORT program's waiting list and even though the enrollment 3303
causes enrollment in the program to exceed the limit that would 3304
otherwise apply. Each quarter, the department of aging shall 3305
certify to the director of budget and management the estimated 3306
increase in costs of the PASSPORT program resulting from 3307
enrollment of individuals in the PASSPORT program pursuant to this 3308
section. 3309

(C) Not later than the last day of each calendar year, the 3310
director of ~~job and family services~~ <u>health care administration</u> 3311
shall submit to the general assembly a report regarding the number 3312
of individuals enrolled in the PASSPORT program pursuant to this 3313
section and the costs incurred and savings achieved as a result of 3314
the enrollments. 3315

Sec. 173.42. (A) As used in this section: 3316

(1) "Area agency on aging" means a public or private 3317
nonprofit entity designated under section 173.011 of the Revised 3318
Code to administer programs on behalf of the department of aging. 3319

(2) "Long-term care consultation" means the process used to 3320
provide services under the long-term care consultation program 3321
established pursuant to this section, including, but not limited 3322
to, such services as the provision of information about long-term 3323
care options and costs, the assessment of an individual's 3324
functional capabilities, and the conduct of all or part of the 3325
reviews, assessments, and determinations specified in sections 3326
~~5111.202, 5111.204,~~ 5119.061, ~~and~~ 5123.021<u>, 5164.45, and 5164.47</u> 3327
of the Revised Code and the rules adopted under those sections. 3328

(3) ~~"Medicaid" means the medical assistance program~~ 3329
~~established under Chapter 5111. of the Revised Code.~~ 3330

~~(4)~~ "Nursing facility" has the same meaning as in section 3331

~~5111.20~~ 5164.01 of the Revised Code. 3332

~~(5)~~(4) "Representative" means a person acting on behalf of an 3333
individual seeking a long-term care consultation, applying for 3334
admission to a nursing facility, or residing in a nursing 3335
facility. A representative may be a family member, attorney, 3336
hospital social worker, or any other person chosen to act on 3337
behalf of the individual. 3338

(B) The department of aging shall develop a long-term care 3339
consultation program whereby individuals or their representatives 3340
are provided with long-term care consultations and receive through 3341
these professional consultations information about options 3342
available to meet long-term care needs and information about 3343
factors to consider in making long-term care decisions. The 3344
long-term care consultations provided under the program may be 3345
provided at any appropriate time, as permitted or required under 3346
this section and the rules adopted under it, including either 3347
prior to or after the individual who is the subject of a 3348
consultation has been admitted to a nursing facility. 3349

(C) The long-term care consultation program shall be 3350
administered by the department of aging, except that the 3351
department may enter into a contract with an area agency on aging 3352
or other entity selected by the department under which the program 3353
for a particular area is administered by the area agency on aging 3354
or other entity pursuant to the contract. 3355

(D) The long-term care consultations provided for purposes of 3356
the program shall be provided by individuals certified by the 3357
department under section 173.43 of the Revised Code. 3358

(E) The information provided through a long-term care 3359
consultation shall be appropriate to the individual's needs and 3360
situation and shall address all of the following: 3361

(1) The availability of any long-term care options open to 3362

the individual;

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

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

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

(F) An individual's long-term care consultation may include an assessment of the individual's functional capabilities. The consultation may incorporate portions of the determinations required under sections ~~5111.202,~~ 5119.061, ~~and~~ 5123.021, and 5164.45 of the Revised Code and may be provided concurrently with the assessment required under section ~~5111.204~~ 5164.47 of the Revised Code.

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

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

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

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

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

(2) In addition to the individuals included in the categories specified in division (G)(1) of this section, long-term care

consultations may be provided to nursing facility residents who have not applied and have not indicated an intention to apply for medicaid. The purpose of the consultations provided to these individuals shall be to determine continued need for nursing facility services, to provide information on alternative services, and to make referrals to alternative services. 3393 3394 3395 3396 3397 3398

(H)(1) When a long-term care consultation is required to be provided pursuant to division (G)(1) of this section, the consultation shall be provided as follows or pursuant to division (H)(2) or (3) of this section: 3399 3400 3401 3402

(a) If the individual for whom the consultation is being provided has applied for medicaid and the consultation is being provided concurrently with the assessment required under section ~~5111.204~~ 5164.47 of the Revised Code, the consultation shall be completed in accordance with the applicable time frames specified in that section for providing a level of care determination based on the assessment. 3403 3404 3405 3406 3407 3408 3409

(b) In all other cases, the consultation shall be provided not later than five calendar days after the department or the program administrator under contract with the department receives notice of the reason for which the consultation is required to be provided pursuant to division (G)(1) of this section. 3410 3411 3412 3413 3414

(2) An individual or the individual's representative may request that a long-term care consultation be provided on a date that is later than the date required under division (H)(1)(a) or (b) of this section. 3415 3416 3417 3418

(3) If a long-term care consultation cannot be completed within the number of days required by division (H)(1) or (2) of this section, the department or the program administrator under contract with the department may do any of the following: 3419 3420 3421 3422

(a) Exempt the individual from the consultation pursuant to 3423

rules that may be adopted under division (L) of this section; 3424

(b) In the case of an applicant for admission to a nursing facility, provide the consultation after the individual is admitted to the nursing facility; 3425 3426 3427

(c) In the case of a resident of a nursing facility, provide the consultation as soon as practicable. 3428 3429

(I) An individual is not required to be provided a long-term care consultation under this section if any of the following apply: 3430 3431 3432

(1) The individual or the individual's representative chooses to forego participation in the consultation pursuant to criteria specified in rules adopted under division (L) of this section; 3433 3434 3435

(2) The individual is to receive care in a nursing facility under a contract for continuing care as defined in section 173.13 of the Revised Code; 3436 3437 3438

(3) The individual has a contractual right to admission to a nursing facility operated as part of a system of continuing care in conjunction with one or more facilities that provide a less intensive level of services, including a residential care facility licensed under Chapter 3721. of the Revised Code, an adult care facility licensed under Chapter 3722. of the Revised Code, or an independent living arrangement; 3439 3440 3441 3442 3443 3444 3445

(4) The individual is to receive continual care in a home for the aged exempt from taxation under section 5701.13 of the Revised Code; 3446 3447 3448

(5) The individual is seeking admission to a facility that is not a nursing facility with a provider agreement under section ~~5111.22~~ 5164.03 of the Revised Code; 3449 3450 3451

(6) The individual is to be transferred from another nursing facility; 3452 3453

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

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

(J) At the conclusion of an individual's long-term care consultation, the department or the program administrator under contract with the department shall provide the individual or individual's representative with a written summary of options and resources available to meet the individual's needs. Even though the summary may specify that a source of long-term care other than care in a nursing facility is appropriate and available, the individual is not required to seek an alternative source of long-term care and may be admitted to or continue to reside in a nursing facility.

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

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

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

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

available; 3485

(3) Criteria under which an individual or the individual's representative may choose to forego participation in a long-term care consultation; 3486 3487 3488

(4) Criteria for exempting individuals from the long-term care consultation requirement; 3489 3490

(5) Circumstances under which it may be appropriate to provide an individual's long-term care consultation after the individual's admission to a nursing facility rather than before admission; 3491 3492 3493 3494

(6) Criteria for identifying nursing facility residents who would benefit from the provision of a long-term care consultation. 3495 3496

(M) The director of aging may fine a nursing facility an amount determined by rules the director shall adopt in accordance with Chapter 119. of the Revised Code if the nursing facility admits or retains an individual, without evidence that a long-term care consultation has been provided, as required by this section. 3497 3498 3499 3500 3501

In accordance with section ~~5111.62~~ 5164.78 of the Revised Code, all fines collected under this division shall be deposited into the state treasury to the credit of the residents protection fund. 3502 3503 3504 3505

Sec. 173.45. As used in this section and in sections 173.46 to 173.49 of the Revised Code: 3506 3507

(A) "Long-term care facility" means a nursing home or residential care facility. 3508 3509

(B) "Nursing home" and "residential care facility" have the same meanings as in section 3721.01 of the Revised Code. 3510 3511

(C) "Nursing facility" has the same meaning as in section ~~5111.20~~ 5164.01 of the Revised Code. 3512 3513

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

(B)(1) The department may charge fees for the conduct of annual customer satisfaction surveys. The department may contract with any person or government entity to collect the fees on its behalf. All fees collected under this section shall be deposited in accordance with section 173.48 of the Revised Code.

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

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

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

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

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

Sec. 173.50. (A) Pursuant to a contract entered into with the department of ~~job and family services~~ health care administration as an interagency agreement under section ~~5111.91~~ 5161.05 of the Revised Code, the department of aging shall carry out the day-to-day administration of the component of the medicaid program ~~established under Chapter 5111. of the Revised Code~~ known as the program of all-inclusive care for the elderly or PACE. The

department of aging shall carry out its PACE administrative duties 3544
in accordance with the provisions of the interagency agreement and 3545
all applicable federal laws, including the "Social Security Act," 3546
79 Stat. 286 (1965), 42 U.S.C. 1396u-4, as amended. 3547

(B) The department of aging may adopt rules in accordance 3548
with Chapter 119. of the Revised Code regarding the PACE program, 3549
subject to both of the following: 3550

(1) The rules shall be authorized by rules adopted by the 3551
department of job and family services. 3552

(2) The rules shall address only those issues that are not 3553
addressed in rules adopted by the department of job and family 3554
services for the PACE program. 3555

Sec. 173.99. (A) A long-term care provider, person employed 3556
by a long-term care provider, other entity, or employee of such 3557
other entity that violates division (C) of section 173.24 of the 3558
Revised Code is subject to a fine not to exceed one thousand 3559
dollars for each violation. 3560

(B) Whoever violates division (C) of section 173.23 of the 3561
Revised Code is guilty of registering a false complaint, a 3562
misdemeanor of the first degree. 3563

(C) A long-term care provider, other entity, or person 3564
employed by a long-term care provider or other entity that 3565
violates division (E) of section 173.19 of the Revised Code by 3566
denying a representative of the office of the state long-term care 3567
ombudsperson program the access required by that division is 3568
subject to a fine not to exceed five hundred dollars for each 3569
violation. 3570

(D) Whoever violates division (C) of section 173.44 of the 3571
Revised Code is subject to a fine of one hundred dollars. 3572

~~(E) Whoever violates division (B) of section 173.90 of the~~ 3573

~~Revised Code is guilty of a misdemeanor of the first degree.~~ 3574

Sec. 317.08. (A) Except as provided in divisions (C) and (D) of this section, the county recorder shall keep six separate sets of records as follows: 3575 3576 3577

(1) A record of deeds, in which shall be recorded all deeds and other instruments of writing for the absolute and unconditional sale or conveyance of lands, tenements, and hereditaments; all notices as provided in sections 5301.47 to 5301.56 of the Revised Code; all judgments or decrees in actions brought under section 5303.01 of the Revised Code; all declarations and bylaws, and all amendments to declarations and bylaws, as provided in Chapter 5311. of the Revised Code; affidavits as provided in sections 5301.252 and 5301.56 of the Revised Code; all certificates as provided in section 5311.17 of the Revised Code; all articles dedicating archaeological preserves accepted by the director of the Ohio historical society under section 149.52 of the Revised Code; all articles dedicating nature preserves accepted by the director of natural resources under section 1517.05 of the Revised Code; all agreements for the registration of lands as archaeological or historic landmarks under section 149.51 or 149.55 of the Revised Code; all conveyances of conservation easements and agricultural easements under section 5301.68 of the Revised Code; all instruments extinguishing agricultural easements under section 901.21 or 5301.691 of the Revised Code or pursuant to terms of such an easement granted to a charitable organization under section 5301.68 of the Revised Code; all instruments or orders described in division (B)(2)(b) of section 5301.56 of the Revised Code; all no further action letters issued under section 122.654 or 3746.11 of the Revised Code; all covenants not to sue issued under section 3746.12 of the Revised Code, including all covenants not to sue issued pursuant to section 122.654 of the Revised Code; any 3578 3579 3580 3581 3582 3583 3584 3585 3586 3587 3588 3589 3590 3591 3592 3593 3594 3595 3596 3597 3598 3599 3600 3601 3602 3603 3604 3605

restrictions on the use of property contained in a no further action letter issued under section 122.654 of the Revised Code, any restrictions on the use of property identified pursuant to division (C)(3)(a) of section 3746.10 of the Revised Code, and any restrictions on the use of property contained in a deed or other instrument as provided in division (E) or (F) of section 3737.882 of the Revised Code; any easement executed or granted under section 3734.22, 3734.24, 3734.25, or 3734.26 of the Revised Code; any environmental covenant entered into in accordance with sections 5301.80 to 5301.92 of the Revised Code; all memoranda of trust, as described in division (A) of section 5301.255 of the Revised Code, that describe specific real property; and all agreements entered into under division (A) of section 1506.44 of the Revised Code; 3606 3607 3608 3609 3610 3611 3612 3613 3614 3615 3616 3617 3618 3619

(2) A record of mortgages, in which shall be recorded all of the following: 3620 3621

(a) All mortgages, including amendments, supplements, modifications, and extensions of mortgages, or other instruments of writing by which lands, tenements, or hereditaments are or may be mortgaged or otherwise conditionally sold, conveyed, affected, or encumbered; 3622 3623 3624 3625 3626

(b) All executory installment contracts for the sale of land executed after September 29, 1961, that by their terms are not required to be fully performed by one or more of the parties to them within one year of the date of the contracts; 3627 3628 3629 3630

(c) All options to purchase real estate, including supplements, modifications, and amendments of the options, but no option of that nature shall be recorded if it does not state a specific day and year of expiration of its validity; 3631 3632 3633 3634

(d) Any tax certificate sold under section 5721.33 of the Revised Code, or memorandum of it, that is presented for filing of 3635 3636

record. 3637

(3) A record of powers of attorney, including all memoranda of trust, as described in division (A) of section 5301.255 of the Revised Code, that do not describe specific real property; 3638 3639 3640

(4) A record of plats, in which shall be recorded all plats and maps of town lots, of the subdivision of town lots, and of other divisions or surveys of lands, any center line survey of a highway located within the county, the plat of which shall be furnished by the director of transportation or county engineer, and all drawings and amendments to drawings, as provided in Chapter 5311. of the Revised Code; 3641 3642 3643 3644 3645 3646 3647

(5) A record of leases, in which shall be recorded all leases, memoranda of leases, and supplements, modifications, and amendments of leases and memoranda of leases; 3648 3649 3650

(6) A record of declarations executed pursuant to section 2133.02 of the Revised Code and durable powers of attorney for health care executed pursuant to section 1337.12 of the Revised Code. 3651 3652 3653 3654

(B) All instruments or memoranda of instruments entitled to record shall be recorded in the proper record in the order in which they are presented for record. The recorder may index, keep, and record in one volume unemployment compensation liens, internal revenue tax liens and other liens in favor of the United States as described in division (A) of section 317.09 of the Revised Code, personal tax liens, mechanic's liens, agricultural product liens, notices of liens, certificates of satisfaction or partial release of estate tax liens, discharges of recognizances, excise and franchise tax liens on corporations, broker's liens, and liens provided for in sections 1513.33, 1513.37, 3752.13, ~~5111.022~~ 5163.08, and 5311.18 of the Revised Code. 3655 3656 3657 3658 3659 3660 3661 3662 3663 3664 3665 3666

The recording of an option to purchase real estate, including 3667

any supplement, modification, and amendment of the option, under 3668
this section shall serve as notice to any purchaser of an interest 3669
in the real estate covered by the option only during the period of 3670
the validity of the option as stated in the option. 3671

(C) In lieu of keeping the six separate sets of records 3672
required in divisions (A)(1) to (6) of this section and the 3673
records required in division (D) of this section, a county 3674
recorder may record all the instruments required to be recorded by 3675
this section in two separate sets of record books. One set shall 3676
be called the "official records" and shall contain the instruments 3677
listed in divisions (A)(1), (2), (3), (5), and (6) and (D) of this 3678
section. The second set of records shall contain the instruments 3679
listed in division (A)(4) of this section. 3680

(D) Except as provided in division (C) of this section, the 3681
county recorder shall keep a separate set of records containing 3682
all corrupt activity lien notices filed with the recorder pursuant 3683
to section 2923.36 of the Revised Code and a separate set of 3684
records containing all medicaid fraud lien notices filed with the 3685
recorder pursuant to section 2933.75 of the Revised Code. 3686

Sec. 317.36. (A) The county recorder shall collect the low- 3687
and moderate-income housing trust fund fee as specified in 3688
sections 317.114, 317.32, 1563.42, 1702.59, 2505.13, 4141.23, 3689
4509.60, ~~5111.022~~ 5163.08, 5310.15, 5719.07, 5727.56, 5733.18, 3690
5733.22, 6101.09, and 6115.09 of the Revised Code. The amount of 3691
any housing trust fund fee the recorder is authorized to collect 3692
is equal to the amount of any base fee the recorder is authorized 3693
to collect for services. The housing trust fund fee shall be 3694
collected in addition to the base fee. 3695

(B) The recorder shall certify the amounts collected as 3696
housing trust fund fees pursuant to division (A) of this section 3697
into the county treasury as housing trust fund fees to be paid to 3698

the treasurer of state pursuant to section 319.63 of the Revised Code. 3699 3700

Sec. 323.01. Except as otherwise provided, as used in Chapter 323. of the Revised Code: 3701 3702

(A) "Subdivision" means any county, township, school district, or municipal corporation. 3703 3704

(B) "Municipal corporation" includes charter municipalities. 3705

(C) "Taxes" means the total amount of all charges against an entry appearing on a tax list and the duplicate thereof that was prepared and certified in accordance with section 319.28 of the Revised Code, including taxes levied against real estate; taxes on property whose value is certified pursuant to section 5727.23 of the Revised Code; recoupment charges applied pursuant to section 5713.35 of the Revised Code; all assessments; penalties and interest charged pursuant to section 323.121 of the Revised Code; charges added pursuant to section 319.35 of the Revised Code; and all of such charges which remain unpaid from any previous tax year. 3706 3707 3708 3709 3710 3711 3712 3713 3714 3715 3716

(D) "Current taxes" means all taxes charged against an entry on the general tax list and duplicate of real and public utility property that have not appeared on such list and duplicate for any prior tax year and any penalty thereon charged by division (A) of section 323.121 of the Revised Code. Current taxes, whether or not they have been certified delinquent, become delinquent taxes if they remain unpaid after the last day prescribed for payment of the second installment of current taxes without penalty. 3717 3718 3719 3720 3721 3722 3723 3724

(E) "Delinquent taxes" means: 3725

(1) Any taxes charged against an entry on the general tax list and duplicate of real and public utility property that were charged against an entry on such list and duplicate for a prior 3726 3727 3728

tax year and any penalties and interest charged against such taxes. 3729 3730

(2) Any current taxes charged on the general tax list and duplicate of real and public utility property that remain unpaid after the last day prescribed for payment of the second installment of such taxes without penalty, whether or not they have been certified delinquent, and any penalties and interest charged against such taxes. 3731 3732 3733 3734 3735 3736

(F) "Current tax year" means, with respect to particular taxes, the calendar year in which the first installment of taxes is due prior to any extension granted under section 323.17 of the Revised Code. 3737 3738 3739 3740

(G) "Liquidated claim" means: 3741

(1) Any sum of money due and payable, upon a written contractual obligation executed between the subdivision and the taxpayer, but excluding any amount due on general and special assessment bonds and notes; 3742 3743 3744 3745

(2) Any sum of money due and payable, for disability financial assistance ~~or disability medical assistance~~ provided under Chapter 5115. of the Revised Code or the disability medical assistance program that is furnished to or in behalf of a subdivision, provided that such claim is recognized by a resolution or ordinance of the legislative body of such subdivision; 3746 3747 3748 3749 3750 3751 3752

(3) Any sum of money advanced and paid to or received and used by a subdivision, pursuant to a resolution or ordinance of such subdivision or its predecessor in interest, and the moral obligation to repay which sum, when in funds, shall be recognized by resolution or ordinance by the subdivision. 3753 3754 3755 3756 3757

Sec. 329.04. (A) The county department of job and family 3758

services shall have, exercise, and perform the following powers 3759
and duties: 3760

(1) Perform any duties assigned by the state department of 3761
job and family services regarding the provision of public family 3762
services, including the provision of the following services to 3763
prevent or reduce economic or personal dependency and to 3764
strengthen family life: 3765

(a) Services authorized by a Title IV-A program, as defined 3766
in section 5101.80 of the Revised Code; 3767

(b) Social services authorized by Title XX of the "Social 3768
Security Act" and provided for by section 5101.46 or 5101.461 of 3769
the Revised Code; 3770

(c) If the county department is designated as the child 3771
support enforcement agency, services authorized by Title IV-D of 3772
the "Social Security Act" and provided for by Chapter 3125. of the 3773
Revised Code. The county department may perform the services 3774
itself or contract with other government entities, and, pursuant 3775
to division (C) of section 2301.35 and section 2301.42 of the 3776
Revised Code, private entities, to perform the Title IV-D 3777
services. 3778

(d) Duties assigned under section ~~5111.98~~ 5161.02 of the 3779
Revised Code. 3780

(2) Administer disability financial assistance, as required 3781
by the state department of job and family services under section 3782
5115.03 of the Revised Code; 3783

(3) Administer disability medical assistance program, as 3784
required by the ~~state~~ department of ~~job and family services under~~ 3785
~~section 5115.13 of the Revised Code~~ health care administration; 3786

(4) Administer burials insofar as the administration of 3787
burials was, prior to September 12, 1947, imposed upon the board 3788

of county commissioners and if otherwise required by state law; 3789

(5) Cooperate with state and federal authorities in any 3790
matter relating to family services and to act as the agent of such 3791
authorities; 3792

(6) Submit an annual account of its work and expenses to the 3793
board of county commissioners and to the state department of job 3794
and family services at the close of each fiscal year; 3795

(7) Exercise any powers and duties relating to family 3796
services duties or workforce development activities imposed upon 3797
the county department of job and family services by law, by 3798
resolution of the board of county commissioners, or by order of 3799
the governor, when authorized by law, to meet emergencies during 3800
war or peace; 3801

(8) ~~Determine the~~ Make eligibility determinations for ~~medical~~ 3802
~~assistance of recipients of aid under Title XVI of the "Social~~ 3803
~~Security Act"~~ the medicaid program in accordance with rules 3804
adopted under section 5162.20 of the Revised Code; 3805

(9) If assigned by the ~~state~~ director of ~~job and family~~ 3806
~~services~~ health care administration under section ~~5101.515~~ 5167.15 3807
or ~~5101.525~~ 5167.26 of the Revised Code, determine applicants' 3808
eligibility for health assistance under the children's health 3809
insurance program part II or part III; 3810

(10) Enter into a plan of cooperation with the board of 3811
county commissioners under section 307.983, consult with the board 3812
in the development of the transportation work plan developed under 3813
section 307.985, establish with the board procedures under section 3814
307.986 for providing services to children whose families relocate 3815
frequently, and comply with the contracts the board enters into 3816
under sections 307.981 and 307.982 of the Revised Code that affect 3817
the county department; 3818

(11) For the purpose of complying with a grant agreement the 3819

board of county commissioners enters into under sections 307.98 and 5101.21 of the Revised Code, exercise the powers and perform the duties the grant agreement assigns to the county department; 3820 3821 3822

(12) If the county department is designated as the workforce development agency, provide the workforce development activities specified in the contract required by section 330.05 of the Revised Code. 3823 3824 3825 3826

(B) The powers and duties of a county department of job and family services are, and shall be exercised and performed, under the control and direction of the board of county commissioners. The board may assign to the county department any power or duty of the board regarding family services duties and workforce development activities. If the new power or duty necessitates the state department of job and family services changing its federal cost allocation plan, the county department may not implement the power or duty unless the United States department of health and human services approves the changes. 3827 3828 3829 3830 3831 3832 3833 3834 3835 3836

Sec. 329.043. With regard to applicants for and recipients of disability financial assistance or disability medical assistance, each county department of job and family services shall do all of the following: 3837 3838 3839 3840

(A) Identify applicants and recipients who might be eligible for benefits under the supplemental security income program; 3841 3842

(B) Assist applicants and recipients in securing documentation of disabling conditions or refer them for such assistance to a person or government entity with which the department of job and family services or county department has contracted under section 5115.20 of the Revised Code; 3843 3844 3845 3846 3847

(C) Inform applicants and recipients of available sources of representation, which may include a person or government entity 3848 3849

with which the department of job and family services or county department has contracted under section 5115.20 of the Revised Code, and of their right to represent themselves in reconsiderations and appeals of social security administration decisions that deny them supplemental security income benefits. The county department may require the applicants and recipients, as a condition of eligibility for disability financial assistance or disability medical assistance, to pursue reconsiderations and appeals of social security administration decisions that deny them supplemental security income benefits, and shall assist applicants and recipients as necessary to obtain such benefits or refer them to a person or government entity with which the department or county department has contracted under section 5115.20 of the Revised Code. 3850 3851 3852 3853 3854 3855 3856 3857 3858 3859 3860 3861 3862 3863

(D) Require applicants and recipients who, in the judgment of the county department, are or may be aged, blind, or disabled, to apply for the medicaid program, make determinations when appropriate as to eligibility for medicaid, and refer their applications when necessary to the disability determination unit established in accordance with section 5162.17 of the Revised Code for expedited review; 3864 3865 3866 3867 3868 3869 3870

(E) Require each applicant and recipient who in the judgment of the department of job and family services or the county department might be eligible for supplemental security income benefits, as a condition of eligibility for disability financial assistance or disability medical assistance, to execute a written authorization for the secretary of health and human services to withhold benefits due that individual and pay to the director of job and family services, director of health care administration, or either director's designee an amount sufficient to reimburse the state and county shares of interim assistance furnished to the individual. For the purposes of this division, "benefits" and 3871 3872 3873 3874 3875 3876 3877 3878 3879 3880 3881

"interim assistance" have the meanings given in Title XVI of the 3882
"Social Security Act of 1935." 3883

Sec. 329.051. The county department of job and family 3884
services shall make voter registration applications as prescribed 3885
by the secretary of state under section 3503.10 of the Revised 3886
Code available to persons who are applying for, receiving 3887
assistance from, or participating in any of the following: 3888

(A) The disability financial assistance program established 3889
under Chapter 5115. of the Revised Code; 3890

(B) The disability medical assistance program ~~established~~ 3891
~~under Chapter 5115. of the Revised Code~~; 3892

(C) The ~~medical assistance~~ medicaid program ~~established under~~ 3893
~~Chapter 5111. of the Revised Code~~; 3894

(D) The Ohio works first program established under Chapter 3895
5107. of the Revised Code; 3896

(E) The prevention, retention, and contingency program 3897
established under Chapter 5108. of the Revised Code. 3898

Sec. 329.06. (A) Except as provided in division (C) of this 3899
section and section 6301.08 of the Revised Code, the board of 3900
county commissioners shall establish a county family services 3901
planning committee. The board shall appoint a member to represent 3902
the county department of job and family services; an employee in 3903
the classified civil service of the county department of job and 3904
family services, if there are any such employees; and a member to 3905
represent the public. The board shall appoint other individuals to 3906
the committee in such a manner that the committee's membership is 3907
broadly representative of the groups of individuals and the public 3908
and private entities that have an interest in the family services 3909
provided in the county. The board shall make appointments in a 3910
manner that reflects the ethnic and racial composition of the 3911

county. The following groups and entities may be represented on the committee: 3912 3913

(1) Consumers of family services; 3914

(2) The public children services agency; 3915

(3) The child support enforcement agency; 3916

(4) The county family and children first council; 3917

(5) Public and private colleges and universities; 3918

(6) Public entities that provide family services, including boards of health, boards of education, the county board of mental retardation and developmental disabilities, and the board of alcohol, drug addiction, and mental health services that serves the county; 3919 3920 3921 3922 3923

(7) Private nonprofit and for-profit entities that provide family services in the county or that advocate for consumers of family services in the county, including entities that provide services to or advocate for victims of domestic violence; 3924 3925 3926 3927

(8) Labor organizations; 3928

(9) Any other group or entity that has an interest in the family services provided in the county, including groups or entities that represent any of the county's business, urban, and rural sectors. 3929 3930 3931 3932

(B) The county family services planning committee shall do all of the following: 3933 3934

(1) Serve as an advisory body to the board of county commissioners with regard to the family services provided in the county, including assistance under Chapters 5107. and 5108. of the Revised Code, publicly funded child care under Chapter 5104. of the Revised Code, and social services provided under section 5101.46 of the Revised Code; 3935 3936 3937 3938 3939 3940

(2) At least once a year, review and analyze the county department of job and family services' implementation of the programs established under Chapters 5107. and 5108. of the Revised Code. In its review, the committee shall use information available to it to examine all of the following: 3941 3942 3943 3944 3945

(a) Return of assistance groups to participation in either program after ceasing to participate; 3946 3947

(b) Teen pregnancy rates among the programs' participants; 3948

(c) The other types of assistance the programs' participants receive, including ~~medical assistance under Chapter 5111. of the Revised Code~~ <u>medicaid</u>, publicly funded child care under Chapter 5104. of the Revised Code, food stamp benefits under section 5101.54 of the Revised Code, and energy assistance under Chapter 5117. of the Revised Code; 3949 3950 3951 3952 3953 3954

(d) Other issues the committee considers appropriate. 3955

The committee shall make recommendations to the board of county commissioners and county department of job and family services regarding the committee's findings. 3956 3957 3958

(3) Conduct public hearings on proposed county profiles for the provision of social services under section 5101.46 of the Revised Code; 3959 3960 3961

(4) At the request of the board, make recommendations and provide assistance regarding the family services provided in the county; 3962 3963 3964

(5) At any other time the committee considers appropriate, consult with the board and make recommendations regarding the family services provided in the county. The committee's recommendations may address the following: 3965 3966 3967 3968

(a) Implementation and administration of family service programs; 3969 3970

(b) Use of federal, state, and local funds available for family service programs; 3971 3972

(c) Establishment of goals to be achieved by family service programs; 3973 3974

(d) Evaluation of the outcomes of family service programs; 3975

(e) Any other matter the board considers relevant to the provision of family services. 3976 3977

(C) If there is a committee in existence in a county on October 1, 1997, that the board of county commissioners determines is capable of fulfilling the responsibilities of a county family services planning committee, the board may designate the committee as the county's family services planning committee and the committee shall serve in that capacity. 3978 3979 3980 3981 3982 3983

Sec. 329.14. (A) An individual whose household income does not exceed two hundred per cent of the federal poverty line is eligible to participate in an individual development account program established by the county department of job and family services of the county in which the individual resides. An eligible individual seeking to be a participant in the program shall enter into an agreement with the fiduciary organization administering the program. The agreement shall specify the terms and conditions of uses of funds deposited, financial documentation required to be maintained by the participant, expectations and responsibilities of the participant, and services to be provided by the fiduciary organization. 3984 3985 3986 3987 3988 3989 3990 3991 3992 3993 3994 3995

(B) A participant may deposit earned income, as defined in 26 U.S.C. 911(d)(2), as amended, into the account. The fiduciary organization may deposit into the account an amount not exceeding four times the amount deposited by the participant except that a fiduciary organization may not, pursuant to an agreement with an 3996 3997 3998 3999 4000

employer, deposit an amount into an account held by a participant who is employed by the employer. An account may have no more than ten thousand dollars in it at any time. 4001 4002 4003

(C) Notwithstanding eligibility requirements established in or pursuant to Chapter 5107.~~,~~ <u>or</u> 5108.~~, or 5111.~~ of the Revised Code <u>or for the medicaid program</u>, to the extent permitted by federal statutes and regulations, money in an individual development account, including interest, is exempt from consideration in determining whether the participant or a member of the participant's assistance group is eligible for assistance under Chapter 5107.~~,~~ <u>or</u> 5108.~~, or 5111.~~ of the Revised Code <u>or the medicaid program</u> and the amount of assistance the participant or assistance group is eligible to receive. 4004 4005 4006 4007 4008 4009 4010 4011 4012 4013

(D)(1) Except as provided in division (D)(2) of this section, an individual development account program participant may use money in the account only for the following purposes: 4014 4015 4016

(a) Postsecondary educational expenses paid directly from the account to an eligible education institution or vendor; 4017 4018

(b) Qualified acquisition expenses of a principal residence, as defined in 26 U.S.C. 1034, as amended, paid directly from the account to the person or government entity to which the expenses are due; 4019 4020 4021 4022

(c) Qualified business capitalization expenses made in accordance with a qualified business plan that has been approved by a financial institution or by a nonprofit microenterprise program having demonstrated business expertise and paid directly from the account to the person to whom the expenses are due. 4023 4024 4025 4026 4027

(2) A fiduciary organization shall permit a participant to withdraw money deposited by the participant if it is needed to deal with a personal emergency of the participant or a member of the participant's family or household. Withdrawal shall result in 4028 4029 4030 4031

the loss of any matching funds in an amount equal to the amount of the withdrawal. 4032 4033

(3) Regardless of the reason for the withdrawal, a withdrawal from an individual development account may be made only with the approval of the fiduciary organization. 4034 4035 4036

Sec. 340.03. (A) Subject to rules issued by the director of mental health after consultation with relevant constituencies as required by division (A)(11) of section 5119.06 of the Revised Code, with regard to mental health services, the board of alcohol, drug addiction, and mental health services shall: 4037 4038 4039 4040 4041

(1) Serve as the community mental health planning agency for the county or counties under its jurisdiction, and in so doing it shall: 4042 4043 4044

(a) Evaluate the need for facilities and community mental health services; 4045 4046

(b) In cooperation with other local and regional planning and funding bodies and with relevant ethnic organizations, assess the community mental health needs, set priorities, and develop plans for the operation of facilities and community mental health services; 4047 4048 4049 4050 4051

(c) In accordance with guidelines issued by the director of mental health after consultation with board representatives, develop and submit to the department of mental health, no later than six months prior to the conclusion of the fiscal year in which the board's current plan is scheduled to expire, a community mental health plan listing community mental health needs, including the needs of all residents of the district now residing in state mental institutions and severely mentally disabled adults, children, and adolescents; all children subject to a determination made pursuant to section 121.38 of the Revised Code; 4052 4053 4054 4055 4056 4057 4058 4059 4060 4061

and all the facilities and community mental health services that are or will be in operation or provided during the period for which the plan will be in operation in the service district to meet such needs. 4062 4063 4064 4065

The plan shall include, but not be limited to, a statement of which of the services listed in section 340.09 of the Revised Code the board intends to make available. The board must include crisis intervention services for individuals in an emergency situation in the plan and explain how the board intends to make such services available. The plan must also include an explanation of how the board intends to make any payments that it may be required to pay under section 5119.62 of the Revised Code, a statement of the inpatient and community-based services the board proposes that the department operate, an assessment of the number and types of residential facilities needed, such other information as the department requests, and a budget for moneys the board expects to receive. The board shall also submit an allocation request for state and federal funds. Within sixty days after the department's determination that the plan and allocation request are complete, the department shall approve or disapprove the plan and request, in whole or in part, according to the criteria developed pursuant to section 5119.61 of the Revised Code. The department's statement of approval or disapproval shall specify the inpatient and the community-based services that the department will operate for the board. Eligibility for state and federal funding shall be contingent upon an approved plan or relevant part of a plan. 4066 4067 4068 4069 4070 4071 4072 4073 4074 4075 4076 4077 4078 4079 4080 4081 4082 4083 4084 4085 4086 4087

If the director disapproves all or part of any plan, the director shall inform the board of the reasons for the disapproval and of the criteria that must be met before the plan may be approved. The director shall provide the board an opportunity to present its case on behalf of the plan. The director shall give the board a reasonable time in which to meet the criteria, and 4088 4089 4090 4091 4092 4093

shall offer the board technical assistance to help it meet the criteria. 4094 4095

If the approval of a plan remains in dispute thirty days prior to the conclusion of the fiscal year in which the board's current plan is scheduled to expire, the board or the director may request that the dispute be submitted to a mutually agreed upon third-party mediator with the cost to be shared by the board and the department. The mediator shall issue to the board and the department recommendations for resolution of the dispute. Prior to the conclusion of the fiscal year in which the current plan is scheduled to expire, the director, taking into consideration the recommendations of the mediator, shall make a final determination and approve or disapprove the plan, in whole or in part. 4096 4097 4098 4099 4100 4101 4102 4103 4104 4105 4106

If a board determines that it is necessary to amend a plan or an allocation request that has been approved under division (A)(1)(c) of this section, the board shall submit a proposed amendment to the director. The director may approve or disapprove all or part of the amendment. If the director does not approve all or part of the amendment within thirty days after it is submitted, the amendment or part of it shall be considered to have been approved. The director shall inform the board of the reasons for disapproval of all or part of an amendment and of the criteria that must be met before the amendment may be approved. The director shall provide the board an opportunity to present its case on behalf of the amendment. The director shall give the board a reasonable time in which to meet the criteria, and shall offer the board technical assistance to help it meet the criteria. 4107 4108 4109 4110 4111 4112 4113 4114 4115 4116 4117 4118 4119 4120

The board shall implement the plan approved by the department. 4121 4122

(d) Receive, compile, and transmit to the department of mental health applications for state reimbursement; 4123 4124

(e) Promote, arrange, and implement working agreements with social agencies, both public and private, and with judicial agencies. 4125 4126 4127

(2) Investigate, or request another agency to investigate, any complaint alleging abuse or neglect of any person receiving services from a community mental health agency as defined in section 5122.01 of the Revised Code, or from a residential facility licensed under section 5119.22 of the Revised Code. If the investigation substantiates the charge of abuse or neglect, the board shall take whatever action it determines is necessary to correct the situation, including notification of the appropriate authorities. Upon request, the board shall provide information about such investigations to the department. 4128 4129 4130 4131 4132 4133 4134 4135 4136 4137

(3) For the purpose of section 5119.611 of the Revised Code, cooperate with the director of mental health in visiting and evaluating whether the services of a community mental health agency satisfy the certification standards established by rules adopted under that section; 4138 4139 4140 4141 4142

(4) In accordance with criteria established under division (G) of section 5119.61 of the Revised Code, review and evaluate the quality, effectiveness, and efficiency of services provided through its community mental health plan and submit its findings and recommendations to the department of mental health; 4143 4144 4145 4146 4147

(5) In accordance with section 5119.22 of the Revised Code, review applications for residential facility licenses and recommend to the department of mental health approval or disapproval of applications; 4148 4149 4150 4151

(6) Audit, in accordance with rules adopted by the auditor of state pursuant to section 117.20 of the Revised Code, at least annually all programs and services provided under contract with the board. In so doing, the board may contract for or employ the 4152 4153 4154 4155

services of private auditors. A copy of the fiscal audit report shall be provided to the director of mental health, the auditor of state, and the county auditor of each county in the board's district. 4156 4157 4158 4159

(7) Recruit and promote local financial support for mental health programs from private and public sources; 4160 4161

(8)(a) Enter into contracts with public and private facilities for the operation of facility services included in the board's community mental health plan and enter into contracts with public and private community mental health agencies for the provision of community mental health services that are listed in section 340.09 of the Revised Code and included in the board's community mental health plan. The board may not contract with a community mental health agency to provide community mental health services included in the board's community mental health plan unless the services are certified by the director of mental health under section 5119.611 of the Revised Code. Section 307.86 of the Revised Code does not apply to contracts entered into under this division. In contracting with a community mental health agency, a board shall consider the cost effectiveness of services provided by that agency and the quality and continuity of care, and may review cost elements, including salary costs, of the services to be provided. A utilization review process shall be established as part of the contract for services entered into between a board and a community mental health agency. The board may establish this process in a way that is most effective and efficient in meeting local needs. In the case of a contract with a community mental health facility, as defined in section ~~5111.023~~ 5163.20 of the Revised Code, to provide services listed in division (B) of that section, the contract shall provide for the facility to be paid in accordance with the contract entered into between the departments of ~~job and family services~~ health care administration and mental 4162 4163 4164 4165 4166 4167 4168 4169 4170 4171 4172 4173 4174 4175 4176 4177 4178 4179 4180 4181 4182 4183 4184 4185 4186 4187

health under section ~~5111.91~~ 5161.05 of the Revised Code and any rules adopted under division (A) of section 5119.61 of the Revised Code. 4188 4189 4190

If either the board or a facility or community mental health agency with which the board contracts under division (A)(8)(a) of this section proposes not to renew the contract or proposes substantial changes in contract terms, the other party shall be given written notice at least one hundred twenty days before the expiration date of the contract. During the first sixty days of this one hundred twenty-day period, both parties shall attempt to resolve any dispute through good faith collaboration and negotiation in order to continue to provide services to persons in need. If the dispute has not been resolved sixty days before the expiration date of the contract, either party may notify the department of mental health of the unresolved dispute. The director may require both parties to submit the dispute to a third party with the cost to be shared by the board and the facility or community mental health agency. The third party shall issue to the board, the facility or agency, and the department recommendations on how the dispute may be resolved twenty days prior to the expiration date of the contract, unless both parties agree to a time extension. The director shall adopt rules establishing the procedures of this dispute resolution process. 4191 4192 4193 4194 4195 4196 4197 4198 4199 4200 4201 4202 4203 4204 4205 4206 4207 4208 4209 4210

(b) With the prior approval of the director of mental health, a board may operate a facility or provide a community mental health service as follows, if there is no other qualified private or public facility or community mental health agency that is immediately available and willing to operate such a facility or provide the service: 4211 4212 4213 4214 4215 4216

(i) In an emergency situation, any board may operate a facility or provide a community mental health service in order to provide essential services for the duration of the emergency; 4217 4218 4219

(ii) In a service district with a population of at least one hundred thousand but less than five hundred thousand, a board may operate a facility or provide a community mental health service for no longer than one year; 4220 4221 4222 4223

(iii) In a service district with a population of less than one hundred thousand, a board may operate a facility or provide a community mental health service for no longer than one year, except that such a board may operate a facility or provide a community mental health service for more than one year with the prior approval of the director and the prior approval of the board of county commissioners, or of a majority of the boards of county commissioners if the district is a joint-county district. 4224 4225 4226 4227 4228 4229 4230 4231

The director shall not give a board approval to operate a facility or provide a community mental health service under division (A)(8)(b)(ii) or (iii) of this section unless the director determines that it is not feasible to have the department operate the facility or provide the service. 4232 4233 4234 4235 4236

The director shall not give a board approval to operate a facility or provide a community mental health service under division (A)(8)(b)(iii) of this section unless the director determines that the board will provide greater administrative efficiency and more or better services than would be available if the board contracted with a private or public facility or community mental health agency. 4237 4238 4239 4240 4241 4242 4243

The director shall not give a board approval to operate a facility previously operated by a person or other government entity unless the board has established to the director's satisfaction that the person or other government entity cannot effectively operate the facility or that the person or other government entity has requested the board to take over operation of the facility. The director shall not give a board approval to provide a community mental health service previously provided by a 4244 4245 4246 4247 4248 4249 4250 4251

community mental health agency unless the board has established to the director's satisfaction that the agency cannot effectively provide the service or that the agency has requested the board take over providing the service. 4252 4253 4254 4255

The director shall review and evaluate a board's operation of a facility and provision of community mental health service under division (A)(8)(b) of this section. 4256 4257 4258

Nothing in division (A)(8)(b) of this section authorizes a board to administer or direct the daily operation of any facility or community mental health agency, but a facility or agency may contract with a board to receive administrative services or staff direction from the board under the direction of the governing body of the facility or agency. 4259 4260 4261 4262 4263 4264

(9) Approve fee schedules and related charges or adopt a unit cost schedule or other methods of payment for contract services provided by community mental health agencies in accordance with guidelines issued by the department as necessary to comply with state and federal laws pertaining to financial assistance; 4265 4266 4267 4268 4269

(10) Submit to the director and the county commissioners of the county or counties served by the board, and make available to the public, an annual report of the programs under the jurisdiction of the board, including a fiscal accounting; 4270 4271 4272 4273

(11) Establish, to the extent resources are available, a community support system, which provides for treatment, support, and rehabilitation services and opportunities. The essential elements of the system include, but are not limited to, the following components in accordance with section 5119.06 of the Revised Code: 4274 4275 4276 4277 4278 4279

(a) To locate persons in need of mental health services to inform them of available services and benefits mechanisms; 4280 4281

(b) Assistance for clients to obtain services necessary to 4282

meet basic human needs for food, clothing, shelter, medical care, personal safety, and income; 4283 4284

(c) Mental health care, including, but not limited to, outpatient, partial hospitalization, and, where appropriate, inpatient care; 4285 4286 4287

(d) Emergency services and crisis intervention; 4288

(e) Assistance for clients to obtain vocational services and opportunities for jobs; 4289 4290

(f) The provision of services designed to develop social, community, and personal living skills; 4291 4292

(g) Access to a wide range of housing and the provision of residential treatment and support; 4293 4294

(h) Support, assistance, consultation, and education for families, friends, consumers of mental health services, and others; 4295 4296 4297

(i) Recognition and encouragement of families, friends, neighborhood networks, especially networks that include racial and ethnic minorities, churches, community organizations, and meaningful employment as natural supports for consumers of mental health services; 4298 4299 4300 4301 4302

(j) Grievance procedures and protection of the rights of consumers of mental health services; 4303 4304

(k) Case management, which includes continual individualized assistance and advocacy to ensure that needed services are offered and procured. 4305 4306 4307

(12) Designate the treatment program, agency, or facility for each person involuntarily committed to the board pursuant to Chapter 5122. of the Revised Code and authorize payment for such treatment. The board shall provide the least restrictive and most appropriate alternative that is available for any person 4308 4309 4310 4311 4312

involuntarily committed to it and shall assure that the services listed in section 340.09 of the Revised Code are available to severely mentally disabled persons residing within its service district. The board shall establish the procedure for authorizing payment for services, which may include prior authorization in appropriate circumstances. The board may provide for services directly to a severely mentally disabled person when life or safety is endangered and when no community mental health agency is available to provide the service. 4313 4314 4315 4316 4317 4318 4319 4320 4321

(13) Establish a method for evaluating referrals for involuntary commitment and affidavits filed pursuant to section 5122.11 of the Revised Code in order to assist the probate division of the court of common pleas in determining whether there is probable cause that a respondent is subject to involuntary hospitalization and what alternative treatment is available and appropriate, if any; 4322 4323 4324 4325 4326 4327 4328

(14) Ensure that apartments or rooms built, subsidized, renovated, rented, owned, or leased by the board or a community mental health agency have been approved as meeting minimum fire safety standards and that persons residing in the rooms or apartments are receiving appropriate and necessary services, including culturally relevant services, from a community mental health agency. This division does not apply to residential facilities licensed pursuant to section 5119.22 of the Revised Code. 4329 4330 4331 4332 4333 4334 4335 4336 4337

(15) Establish a mechanism for involvement of consumer recommendation and advice on matters pertaining to mental health services in the alcohol, drug addiction, and mental health service district; 4338 4339 4340 4341

(16) Perform the duties under section 3722.18 of the Revised Code required by rules adopted under section 5119.61 of the Revised Code regarding referrals by the board or mental health 4342 4343 4344

agencies under contract with the board of individuals with mental illness or severe mental disability to adult care facilities and effective arrangements for ongoing mental health services for the individuals. The board is accountable in the manner specified in the rules for ensuring that the ongoing mental health services are effectively arranged for the individuals. 4345 4346 4347 4348 4349 4350

(B) The board shall establish such rules, operating procedures, standards, and bylaws, and perform such other duties as may be necessary or proper to carry out the purposes of this chapter. 4351 4352 4353 4354

(C) A board of alcohol, drug addiction, and mental health services may receive by gift, grant, devise, or bequest any moneys, lands, or property for the benefit of the purposes for which the board is established, and may hold and apply it according to the terms of the gift, grant, or bequest. All money received, including accrued interest, by gift, grant, or bequest shall be deposited in the treasury of the county, the treasurer of which is custodian of the alcohol, drug addiction, and mental health services funds to the credit of the board and shall be available for use by the board for purposes stated by the donor or grantor. 4355 4356 4357 4358 4359 4360 4361 4362 4363 4364 4365

(D) No board member or employee of a board of alcohol, drug addiction, and mental health services shall be liable for injury or damages caused by any action or inaction taken within the scope of the board member's official duties or the employee's employment, whether or not such action or inaction is expressly authorized by this section, section 340.033, or any other section of the Revised Code, unless such action or inaction constitutes willful or wanton misconduct. Chapter 2744. of the Revised Code applies to any action or inaction by a board member or employee of a board taken within the scope of the board member's official duties or employee's employment. For the purposes of this 4366 4367 4368 4369 4370 4371 4372 4373 4374 4375 4376

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

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

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

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

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

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

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

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

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

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

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

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

state correctional institution or is in the custody of a law 4437
enforcement officer without endangering the life or health of the 4438
person. 4439

(B) If a physician employed by or under contract to a county, 4440
the department of youth services, or the department of 4441
rehabilitation and correction to provide medical services to 4442
persons confined in the county jail or state correctional 4443
institution determines that a person who is confined in the county 4444
jail or a state correctional institution or who is in the custody 4445
of a law enforcement officer prior to the person's confinement in 4446
the county jail or a state correctional institution requires 4447
necessary care that the physician cannot provide, the necessary 4448
care shall be provided by a medical provider. The county, the 4449
department of youth services, or the department of rehabilitation 4450
and correction shall pay a medical provider for necessary care an 4451
amount not exceeding the authorized reimbursement rate for the 4452
same service established by the department of ~~job and family~~ 4453
~~services~~ health care administration under the ~~medical assistance~~ 4454
medicaid program. 4455

Sec. 505.84. As used in this section, "authorized medicare 4456
reimbursement rate" means such rate established for the locality 4457
under ~~Title XVIII of~~ the ~~"Social Security Act," 49 Stat. 620~~ 4458
~~(1935), 42 U.S.C.A. 301, as amended~~ medicare program. 4459

A board of township trustees may establish reasonable charges 4460
for the use of fire and rescue services, ambulance services, or 4461
emergency medical services. The board may establish different 4462
charges for township residents and nonresidents, and may, in its 4463
discretion, waive all or part of the charge for any resident. The 4464
charge for ambulance transportation for nonresidents shall be an 4465
amount not less than the authorized medicare reimbursement rate, 4466
except that, if prior to September 9, 1988, the board had 4467

different charges for residents and nonresidents and the charge for nonresidents was less than the authorized medicare reimbursement rate, the board may charge nonresidents less than the authorized medicare reimbursement rate. 4468 4469 4470 4471

Charges collected under this section shall be kept in a separate fund designated as "the fire and rescue services, ambulance services, and emergency medical services fund," and shall be appropriated and administered by the board. The fund shall be used for the payment of the costs of the management, maintenance, and operation of fire and rescue services, ambulance services, and emergency medical services in the township. If the fire and rescue services, ambulance services, and emergency medical services are discontinued in the township, any balance remaining in the fund shall be paid into the general fund of the township. 4472 4473 4474 4475 4476 4477 4478 4479 4480 4481 4482

Sec. 742.41. (A) As used in this section: 4483

(1) "Other system retirant" has the same meaning as in section 742.26 of the Revised Code. 4484 4485

(2) "Personal history record" includes a member's, former member's, or other system retirant's name, address, telephone number, social security number, record of contributions, correspondence with the Ohio police and fire pension fund, status of any application for benefits, and any other information deemed confidential by the trustees of the fund. 4486 4487 4488 4489 4490 4491

(B) The treasurer of state shall furnish annually to the board of trustees of the fund a sworn statement of the amount of the funds in the treasurer of state's custody belonging to the Ohio police and fire pension fund. The records of the fund shall be open for public inspection except for the following, which shall be excluded, except with the written authorization of the individual concerned: 4492 4493 4494 4495 4496 4497 4498

(1) The individual's personal history record; 4499

(2) Any information identifying, by name and address, the amount of a monthly allowance or benefit paid to the individual. 4500 4501

(C) All medical reports and recommendations required are privileged, except that copies of such medical reports or recommendations shall be made available to the personal physician, attorney, or authorized agent of the individual concerned upon written release received from the individual or the individual's agent or, when necessary for the proper administration of the fund, to the board-assigned physician. 4502 4503 4504 4505 4506 4507 4508

(D) Any person who is a member of the fund or an other system retirant shall be furnished with a statement of the amount to the credit of the person's individual account upon the person's written request. The fund need not answer more than one such request of a person in any one year. 4509 4510 4511 4512 4513

(E) Notwithstanding the exceptions to public inspection in division (B) of this section, the fund may furnish the following information: 4514 4515 4516

(1) If a member, former member, or other system retirant is subject to an order issued under section 2907.15 of the Revised Code or an order issued under division (A) or (B) of section 2929.192 of the Revised Code or is convicted of or pleads guilty to a violation of section 2921.41 of the Revised Code, on written request of a prosecutor as defined in section 2935.01 of the Revised Code, the fund shall furnish to the prosecutor the information requested from the individual's personal history record. 4517 4518 4519 4520 4521 4522 4523 4524 4525

(2) Pursuant to a court order issued pursuant to Chapter 3119., 3121., 3123., or 3125. of the Revised Code, the fund shall furnish to a court or child support enforcement agency the information required under that section. 4526 4527 4528 4529

(3) At the request of any organization or association of members of the fund, the fund shall provide a list of the names and addresses of members of the fund and other system retirants. The fund shall comply with the request of such organization or association at least once a year and may impose a reasonable charge for the list.

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

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

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

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

available to the person copies of all documents, including resumes, in the fund's possession regarding filling a vacancy of a police officer employee member, firefighter employee member, police retirant member, or firefighter retirant member of the board of trustees. The person who made the request shall pay the cost of compiling, copying, and mailing the documents. The information described in this division is a public record. 4562 4563 4564 4565 4566 4567 4568

(F) A statement that contains information obtained from the fund's records that is signed by the secretary of the board of trustees of the Ohio police and fire pension fund and to which the board's official seal is affixed, or copies of the fund's records to which the signature and seal are attached, shall be received as true copies of the fund's records in any court or before any officer of this state. 4569 4570 4571 4572 4573 4574 4575

Sec. 955.201. (A) As used in this section and in section 955.202 of the Revised Code, "Ohio pet fund" means a nonprofit corporation organized by that name under Chapter 1702. of the Revised Code that consists of humane societies, veterinarians, animal shelters, companion animal breeders, dog wardens, and similar individuals and entities. 4576 4577 4578 4579 4580 4581

(B) The Ohio pet fund shall do all of the following: 4582

(1) Establish eligibility criteria for organizations that may receive financial assistance from the pets program funding board created in section 955.202 of the Revised Code. Those organizations may include any of the following: 4583 4584 4585 4586

(a) An animal shelter as defined in section 4729.01 of the Revised Code; 4587 4588

(b) A local nonprofit veterinary association that operates a program for the sterilization of dogs and cats; 4589 4590

(c) A charitable organization that is exempt from federal 4591

income taxation under subsection 501(c)(3) of the Internal Revenue Code and the primary purpose of which is to support programs for the sterilization of dogs and cats and educational programs concerning the proper veterinary care of those animals. 4592 4593 4594 4595

(2) Establish procedures for applying for financial assistance from the pets program funding board. Application procedures shall require eligible organizations to submit detailed proposals that outline the intended uses of the moneys sought. 4596 4597 4598 4599

(3) Establish eligibility criteria for sterilization and educational programs for which moneys from the pets program funding board may be used and, consistent with division (C) of this section, establish eligibility criteria for individuals who seek sterilization for their dogs and cats from eligible organizations; 4600 4601 4602 4603 4604 4605

(4) Establish procedures for the disbursement of moneys the pets program funding board receives from license plate contributions pursuant to division (C) of section 4503.551 of the Revised Code; 4606 4607 4608 4609

(5) Advertise or otherwise provide notification of the availability of financial assistance from the pets program funding board for eligible organizations; 4610 4611 4612

(6) Design markings to be inscribed on "pets" license plates under section 4503.551 of the Revised Code. 4613 4614

(C)(1) The owner of a dog or cat is eligible for dog or cat sterilization services from an eligible organization when those services are subsidized in whole or in part by money from the pets program funding board if any of the following applies: 4615 4616 4617 4618

(a) The income of the owner's family does not exceed one hundred fifty per cent of the federal poverty guideline. 4619 4620

(b) The owner, or any member of the owner's family who 4621

resides with the owner, is a recipient or beneficiary of one of the following government assistance programs:

(i) Low-income housing assistance under the "United States Housing Act of 1937," 42 U.S.C.A. 1437f, as amended, known as the federal section 8 housing program;

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

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

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

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

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

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

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

(c) The owner of the dog or cat submits to the eligible organization operating the sterilization program either of the following: 4652 4653 4654

(i) A certificate of adoption showing that the dog or cat was adopted from a licensed animal shelter, a municipal, county, or regional pound, or a holding and impoundment facility that contracts with a municipal corporation; 4655 4656 4657 4658

(ii) A certificate of adoption showing that the dog or cat was adopted through a nonprofit corporation operating an animal adoption referral service whose holding facility, if any, is licensed in accordance with state law or a municipal ordinance. 4659 4660 4661 4662

(2) The Ohio pet fund shall determine the type of documentary evidence that must be presented by the owner of a dog or cat to show that the income of the owner's family does not exceed one hundred fifty per cent of the federal poverty guideline or that the owner is eligible under division (C)(1)(b) of this section. 4663 4664 4665 4666 4667

(D) As used in division (C) of this section, "federal poverty guideline" means the official poverty guideline as revised annually by the United States department of health and human services in accordance with section 673(2) of the "Omnibus Budget Reconciliation Act of 1981," 95 Stat. 511, 42 U.S.C.A. 9902, as amended, for a family size equal to the size of the family of the person whose income is being determined. 4668 4669 4670 4671 4672 4673 4674

Sec. 1337.11. As used in sections 1337.11 to 1337.17 of the Revised Code: 4675 4676

(A) "Adult" means a person who is eighteen years of age or older. 4677 4678

(B) "Attending physician" means the physician to whom a principal or the family of a principal has assigned primary responsibility for the treatment or care of the principal or, if 4679 4680 4681

the responsibility has not been assigned, the physician who has accepted that responsibility. 4682 4683

(C) "Comfort care" means any of the following: 4684

(1) Nutrition when administered to diminish the pain or discomfort of a principal, but not to postpone death; 4685 4686

(2) Hydration when administered to diminish the pain or discomfort of a principal, but not to postpone death; 4687 4688

(3) Any other medical or nursing procedure, treatment, intervention, or other measure that is taken to diminish the pain or discomfort of a principal, but not to postpone death. 4689 4690 4691

(D) "Consulting physician" means a physician who, in conjunction with the attending physician of a principal, makes one or more determinations that are required to be made by the attending physician, or to be made by the attending physician and one other physician, by an applicable provision of sections 1337.11 to 1337.17 of the Revised Code, to a reasonable degree of medical certainty and in accordance with reasonable medical standards. 4692 4693 4694 4695 4696 4697 4698 4699

(E) "Declaration for mental health treatment" has the same meaning as in section 2135.01 of the Revised Code. 4700 4701

(F) "Guardian" means a person appointed by a probate court pursuant to Chapter 2111. of the Revised Code to have the care and management of the person of an incompetent. 4702 4703 4704

(G) "Health care" means any care, treatment, service, or procedure to maintain, diagnose, or treat an individual's physical or mental condition or physical or mental health. 4705 4706 4707

(H) "Health care decision" means informed consent, refusal to give informed consent, or withdrawal of informed consent to health care. 4708 4709 4710

(I) "Health care facility" means any of the following: 4711

(1) A hospital; 4712

(2) A hospice care program or other institution that specializes in comfort care of patients in a terminal condition or in a permanently unconscious state; 4713 4714 4715

(3) A nursing home; 4716

(4) A home health agency; 4717

(5) An intermediate care facility for the mentally retarded; 4718

(6) A regulated community mental health organization. 4719

(J) "Health care personnel" means physicians, nurses, physician assistants, emergency medical technicians-basic, emergency medical technicians-intermediate, emergency medical technicians-paramedic, medical technicians, dietitians, other authorized persons acting under the direction of an attending physician, and administrators of health care facilities. 4720 4721 4722 4723 4724 4725

(K) "Home health agency" has the same meaning as in section 3701.881 of the Revised Code. 4726 4727

(L) "Hospice care program" has the same meaning as in section 3712.01 of the Revised Code. 4728 4729

(M) "Hospital" has the same meanings as in sections 3701.01, 3727.01, and 5122.01 of the Revised Code. 4730 4731

(N) "Hydration" means fluids that are artificially or technologically administered. 4732 4733

(O) "Incompetent" has the same meaning as in section 2111.01 of the Revised Code. 4734 4735

(P) "Intermediate care facility for the mentally retarded" has the same meaning as in section ~~5111.20~~ 5164.01 of the Revised Code. 4736 4737 4738

(Q) "Life-sustaining treatment" means any medical procedure, treatment, intervention, or other measure that, when administered 4739 4740

to a principal, will serve principally to prolong the process of dying. 4741 4742

(R) "Medical claim" has the same meaning as in section 2305.113 of the Revised Code. 4743 4744

(S) "Mental health treatment" has the same meaning as in section 2135.01 of the Revised Code. 4745 4746

(T) "Nursing home" has the same meaning as in section 3721.01 of the Revised Code. 4747 4748

(U) "Nutrition" means sustenance that is artificially or technologically administered. 4749 4750

(V) "Permanently unconscious state" means a state of permanent unconsciousness in a principal that, to a reasonable degree of medical certainty as determined in accordance with reasonable medical standards by the principal's attending physician and one other physician who has examined the principal, is characterized by both of the following: 4751 4752 4753 4754 4755 4756

(1) Irreversible unawareness of one's being and environment. 4757

(2) Total loss of cerebral cortical functioning, resulting in the principal having no capacity to experience pain or suffering. 4758 4759

(W) "Person" has the same meaning as in section 1.59 of the Revised Code and additionally includes political subdivisions and governmental agencies, boards, commissions, departments, institutions, offices, and other instrumentalities. 4760 4761 4762 4763

(X) "Physician" means a person who is authorized under Chapter 4731. of the Revised Code to practice medicine and surgery or osteopathic medicine and surgery. 4764 4765 4766

(Y) "Political subdivision" and "state" have the same meanings as in section 2744.01 of the Revised Code. 4767 4768

(Z) "Professional disciplinary action" means action taken by the board or other entity that regulates the professional conduct 4769 4770

of health care personnel, including the state medical board and the board of nursing. 4771 4772

(AA) "Regulated community mental health organization" means a residential facility as defined and licensed under section 5119.22 of the Revised Code or a community mental health agency as defined in section 5122.01 of the Revised Code. 4773 4774 4775 4776

(BB) "Terminal condition" means an irreversible, incurable, and untreatable condition caused by disease, illness, or injury from which, to a reasonable degree of medical certainty as determined in accordance with reasonable medical standards by a principal's attending physician and one other physician who has examined the principal, both of the following apply: 4777 4778 4779 4780 4781 4782

(1) There can be no recovery. 4783

(2) Death is likely to occur within a relatively short time if life-sustaining treatment is not administered. 4784 4785

(CC) "Tort action" means a civil action for damages for injury, death, or loss to person or property, other than a civil action for damages for a breach of contract or another agreement between persons. 4786 4787 4788 4789

Sec. 1347.08. (A) Every state or local agency that maintains a personal information system, upon the request and the proper identification of any person who is the subject of personal information in the system, shall: 4790 4791 4792 4793

(1) Inform the person of the existence of any personal information in the system of which the person is the subject; 4794 4795

(2) Except as provided in divisions (C) and (E)(2) of this section, permit the person, the person's legal guardian, or an attorney who presents a signed written authorization made by the person, to inspect all personal information in the system of which the person is the subject; 4796 4797 4798 4799 4800

(3) Inform the person about the types of uses made of the personal information, including the identity of any users usually granted access to the system. 4801 4802 4803

(B) Any person who wishes to exercise a right provided by this section may be accompanied by another individual of the person's choice. 4804 4805 4806

(C)(1) A state or local agency, upon request, shall disclose medical, psychiatric, or psychological information to a person who is the subject of the information or to the person's legal guardian, unless a physician, psychiatrist, or psychologist determines for the agency that the disclosure of the information is likely to have an adverse effect on the person, in which case the information shall be released to a physician, psychiatrist, or psychologist who is designated by the person or by the person's legal guardian. 4807 4808 4809 4810 4811 4812 4813 4814 4815

(2) Upon the signed written request of either a licensed attorney at law or a licensed physician designated by the inmate, together with the signed written request of an inmate of a correctional institution under the administration of the department of rehabilitation and correction, the department shall disclose medical information to the designated attorney or physician as provided in division (C) of section 5120.21 of the Revised Code. 4816 4817 4818 4819 4820 4821 4822 4823

(D) If an individual who is authorized to inspect personal information that is maintained in a personal information system requests the state or local agency that maintains the system to provide a copy of any personal information that the individual is authorized to inspect, the agency shall provide a copy of the personal information to the individual. Each state and local agency may establish reasonable fees for the service of copying, upon request, personal information that is maintained by the agency. 4824 4825 4826 4827 4828 4829 4830 4831 4832

(E)(1) This section regulates access to personal information that is maintained in a personal information system by persons who are the subject of the information, but does not limit the authority of any person, including a person who is the subject of personal information maintained in a personal information system, to inspect or have copied, pursuant to section 149.43 of the Revised Code, a public record as defined in that section. 4833 4834 4835 4836 4837 4838 4839

(2) This section does not provide a person who is the subject of personal information maintained in a personal information system, the person's legal guardian, or an attorney authorized by the person, with a right to inspect or have copied, or require an agency that maintains a personal information system to permit the inspection of or to copy, a confidential law enforcement investigatory record or trial preparation record, as defined in divisions (A)(2) and (4) of section 149.43 of the Revised Code. 4840 4841 4842 4843 4844 4845 4846 4847

(F) This section does not apply to any of the following: 4848

(1) The contents of an adoption file maintained by the department of health under section 3705.12 of the Revised Code; 4849 4850

(2) Information contained in the putative father registry established by section 3107.062 of the Revised Code, regardless of whether the information is held by the department of job and family services or, pursuant to section 3111.69 of the Revised Code, the office of child support in the department or a child support enforcement agency; 4851 4852 4853 4854 4855 4856

(3) Papers, records, and books that pertain to an adoption and that are subject to inspection in accordance with section 3107.17 of the Revised Code; 4857 4858 4859

(4) Records listed in division (A) of section 3107.42 of the Revised Code or specified in division (A) of section 3107.52 of the Revised Code; 4860 4861 4862

(5) Records that identify an individual described in division 4863

(A)(1) of section 3721.031 of the Revised Code, or that would tend to identify such an individual;

(6) Files and records that have been expunged under division (D)(1) of section 3721.23 of the Revised Code;

(7) Records that identify an individual described in division (A)(1) of section 3721.25 of the Revised Code, or that would tend to identify such an individual;

(8) Records that identify an individual described in division (A)(1) of section ~~5111.61~~ 5164.77 of the Revised Code, or that would tend to identify such an individual;

(9) Test materials, examinations, or evaluation tools used in an examination for licensure as a nursing home administrator that the board of examiners of nursing home administrators administers under section 4751.04 of the Revised Code or contracts under that section with a private or government entity to administer;

(10) Information contained in a database established and maintained pursuant to section 5101.13 of the Revised Code.

Sec. 1731.04. (A) An agreement between an alliance and an insurer referred to in division (B) of section 1731.01 of the Revised Code shall contain at least the following:

(1) A provision requiring the insurer to offer and sell to small employers served or to be served by an alliance one or more health benefit plan options for coverage of their eligible employees and the eligible dependents and members of the families of the eligible employees and, if applicable, such members' eligible retirees and the eligible dependents and members of the families of the retirees, subject to such conditions and restrictions as may be set forth or incorporated into the agreement;

(2) A brief description of each type of health benefit plan

option that is to be so offered and the conditions for the modification, continuation, and termination of the coverage and benefits thereunder; 4894 4895 4896

(3) A statement of the eligibility requirements that an employee or retiree must meet in order for the employee or retiree to be eligible to obtain and retain coverage under any health benefit plan option so offered and, if one of such requirements is that an employee must regularly work for a minimum number of hours per week, a statement of such minimum number of hours, which minimum shall not exceed twenty-five hours per week; 4897 4898 4899 4900 4901 4902 4903

(4) A description of any pre-existing condition and waiting period rules; 4904 4905

(5) A statement of the premium rates or other charges that apply to each health benefit plan option or a formula or method of determining the rates or charges; 4906 4907 4908

(6) A provision prescribing the minimum employer contribution toward premiums or other charges required in order to permit a small employer to obtain coverage under a health benefit plan option offered under an alliance program; 4909 4910 4911 4912

(7) A provision requiring that each health benefit plan under the alliance program must provide for the continuation of coverage of participants of an enrolled small employer so long as the small employer determines that such person is a qualified beneficiary entitled to such coverage pursuant to Part 6 of Title I of the "Federal Employee Retirement Income Security Act of 1974," 88 Stat. 832, 29 U.S.C.A. 1001, and the laws of this state, and regulations or rulings interpreting such provisions. Such coverage provided by the insurer under the plan to participants shall comply with the "Federal Employee Retirement Income Security Act of 1974" and the relevant statutes, regulations, and rulings interpreting that act, including provisions regarding types of 4913 4914 4915 4916 4917 4918 4919 4920 4921 4922 4923 4924

coverage to be provided, apportionments of limitations on coverage, apportionments of deductibles, and the rights of qualified beneficiaries to elect coverage options relating to types of coverage and otherwise. 4925 4926 4927 4928

(B) An agreement between an alliance and an insurer referred to in division (B) of section 1731.01 of the Revised Code may contain provisions relating to, but not limited to, any of the following: 4929 4930 4931 4932

(1) The application and enrollment process for a small employer and related provisions pertaining to historical experience, health statements, and underwriting standards; 4933 4934 4935

(2) The minimum number of those employees eligible to be participants that are required to participate in order to permit a small employer to obtain coverage under a health benefit plan option offered under the alliance program, which may vary with the number of employees or those eligible to be participants in respect of the small employer; 4936 4937 4938 4939 4940 4941

(3) A procedure for allowing an enrolled small employer to change from one plan option to another under the alliance program, subject to qualifying by size or otherwise under the alliance program; 4942 4943 4944 4945

(4) The application of any risk-related pooling or grouping programs and related premiums, conditions, reviews, and alternatives offered by the insurer; 4946 4947 4948

(5) The availability of a medicare supplement coverage option for eligible participants who are covered by Parts A and B of the medicare~~, Title XVIII of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301~~ program; 4949 4950 4951 4952

(6) Relevant experience periods, enrollment periods, and contract periods; 4953 4954

(7) Effective dates for coverage of eligible participants; 4955

(8) Conditions under which denial or withdrawal of coverage of participants or small employers and their employees may occur by reason of falsification or misrepresentation of material facts or criminal conduct toward the insurer, small employer, or alliance under the program; 4956 4957 4958 4959 4960

(9) Premium rate structures, which may be uniform or make provision for age-specific rates, differentials based on number of participants of an enrolled small employer, products and plan options selected, and other factors, rate adjustments based on consumer price indices, utilization, or other relevant factors, notification of rate adjustments, and arbitration; 4961 4962 4963 4964 4965 4966

(10) Any responsibilities of the alliance for billing, collection, and transmittal of premiums; 4967 4968

(11) Inclusion under the alliance program of small employers that are members of other organizations described in division (A)(1) of section 1731.01 of the Revised Code that contract with the alliance for this purpose, and conditions pertaining to those small employer members and to their employees and retirees, and dependents and family members of those employees or retirees, as applicable under the alliance program; 4969 4970 4971 4972 4973 4974 4975

(12) The agreement of the insurer to offer and sell one or more health benefit plans to small employer members of another small employer health care alliance that contracts with the alliance for this purpose; 4976 4977 4978 4979

(13) Use of the health benefit plan options of the insurer in the alliance program and use of the names of the alliance and the insurer; 4980 4981 4982

(14) Indemnification from claims and liability by reason of acts or omissions of others; 4983 4984

(15) Ownership, use, availability, and maintenance of confidentiality of data and records relating to the alliance program; 4985 4986 4987

(16) Utilization reports to be provided to the alliance by the insurer; 4988 4989

(17) Such other provisions as may be agreed upon by the alliance and the insurer to better provide for the articulation, promotion, financing, and operation of the alliance program or a health benefit plan under the program in furtherance of the public purposes stated in section 1731.02 of the Revised Code. 4990 4991 4992 4993 4994

(C) Neither an alliance program nor an agreement between an alliance and an insurer is itself a policy or contract of insurance, or a certificate, indorsement, rider, or application forming any part of a policy, contract, or certificate of insurance. Chapters 3905., 3933., and 3959. of the Revised Code do not apply to an alliance program or to an agreement between an alliance and an insurer thereunder, as such, or to the functions of the alliance under an alliance program. 4995 4996 4997 4998 4999 5000 5001 5002

Sec. 1739.061. (A)(1) This section applies to both of the following: 5003 5004

(a) A multiple employer welfare arrangement that issues or requires the use of a standardized identification card or an electronic technology for submission and routing of prescription drug claims; 5005 5006 5007 5008

(b) A person or entity that a multiple employer welfare arrangement contracts with to issue a standardized identification card or an electronic technology described in division (A)(1)(a) of this section. 5009 5010 5011 5012

(2) Notwithstanding division (A)(1) of this section, this section does not apply to the issuance or required use of a 5013 5014

standardized identification card or an electronic technology for the submission and routing of prescription drug claims in connection with any of the following:

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

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

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

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

(1) The standardized identification card or the electronic technology shall be in a format and contain information fields approved by the national council for prescription drug programs or a successor organization, as specified in the council's or successor organization's pharmacy identification card

implementation guide in effect on the first day of October most immediately preceding the issuance or required use of the standardized identification card or the electronic technology. 5046 5047 5048

(2) If the multiple employer welfare arrangement or person under contract with it to issue a standardized identification card or an electronic technology requires the information for the submission and routing of a claim, the standardized identification card or the electronic technology shall contain any of the following information: 5049 5050 5051 5052 5053 5054

(a) The name of the multiple employer welfare arrangement; 5055

(b) The individual's name, group number, and identification number; 5056 5057

(c) A telephone number to inquire about pharmacy-related issues; 5058 5059

(d) The issuer's international identification number, labeled as "ANSI BIN" or "RxBIN"; 5060 5061

(e) The processor's control number, labeled as "RxPCN"; 5062

(f) The individual's pharmacy benefits group number if different from the insured's medical group number, labeled as "RxGrp." 5063 5064 5065

(C) If the standardized identification card or the electronic technology issued or required to be used as provided in division (A)(1) of this section is also used for submission and routing of nonpharmacy claims, the designation "Rx" is required to be included as part of the labels identified in divisions (B)(2)(d) and (e) of this section if the issuer's international identification number or the processor's control number is different for medical and pharmacy claims. 5066 5067 5068 5069 5070 5071 5072 5073

(D) Each multiple employer welfare arrangement described in division (A) of this section shall annually file a certificate 5074 5075

with the superintendent of insurance certifying that it or any person it contracts with to issue a standardized identification card or electronic technology for submission and routing of prescription drug claims complies with this section. 5076 5077 5078 5079

(E)(1) Except as provided in division (E)(2) of this section, if there is a change in the information contained in the standardized identification card or the electronic technology issued to an individual, the multiple employer welfare arrangement or person under contract with it to issue a standardized identification card or an electronic technology shall issue a new card or electronic technology to the individual. 5080 5081 5082 5083 5084 5085 5086

(2) A multiple employer welfare arrangement or person under contract with it is not required under division (E)(1) of this section to issue a new card or electronic technology to an individual more than once during a twelve-month period. 5087 5088 5089 5090

(F) Nothing in this section shall be construed as requiring a multiple employer welfare arrangement to produce more than one standardized identification card or one electronic technology for use by individuals accessing health care benefits provided under a multiple employer welfare arrangement. 5091 5092 5093 5094 5095

Sec. 1751.01. As used in this chapter: 5096

(A)(1) "Basic health care services" means the following services when medically necessary: 5097 5098

(a) Physician's services, except when such services are supplemental under division (B) of this section; 5099 5100

(b) Inpatient hospital services; 5101

(c) Outpatient medical services; 5102

(d) Emergency health services; 5103

(e) Urgent care services; 5104

(f) Diagnostic laboratory services and diagnostic and therapeutic radiologic services; 5105 5106

(g) Diagnostic and treatment services, other than prescription drug services, for biologically based mental illnesses; 5107 5108 5109

(h) Preventive health care services, including, but not limited to, voluntary family planning services, infertility services, periodic physical examinations, prenatal obstetrical care, and well-child care; 5110 5111 5112 5113

(i) Routine patient care for patients enrolled in an eligible cancer clinical trial pursuant to section 3923.80 of the Revised Code. 5114 5115 5116

"Basic health care services" does not include experimental procedures. 5117 5118

Except as provided by divisions (A)(2) and (3) of this section in connection with the offering of coverage for diagnostic and treatment services for biologically based mental illnesses, a health insuring corporation shall not offer coverage for a health care service, defined as a basic health care service by this division, unless it offers coverage for all listed basic health care services. However, this requirement does not apply to the coverage of beneficiaries enrolled in medicare pursuant to a medicare contract, or to the coverage of beneficiaries enrolled in the federal employee health benefits program pursuant to 5 U.S.C.A. 8905, or to the coverage of medicaid recipients, or to the coverage of participants of the children's buy-in program, or to the coverage of beneficiaries under any federal health care program regulated by a federal regulatory body, or to the coverage of beneficiaries under any contract covering officers or employees of the state that has been entered into by the department of administrative services. 5119 5120 5121 5122 5123 5124 5125 5126 5127 5128 5129 5130 5131 5132 5133 5134 5135

(2) A health insuring corporation may offer coverage for diagnostic and treatment services for biologically based mental illnesses without offering coverage for all other basic health care services. A health insuring corporation may offer coverage for diagnostic and treatment services for biologically based mental illnesses alone or in combination with one or more supplemental health care services. However, a health insuring corporation that offers coverage for any other basic health care service shall offer coverage for diagnostic and treatment services for biologically based mental illnesses in combination with the offer of coverage for all other listed basic health care services. 5136 5137 5138 5139 5140 5141 5142 5143 5144 5145 5146

(3) A health insuring corporation that offers coverage for basic health care services is not required to offer coverage for diagnostic and treatment services for biologically based mental illnesses in combination with the offer of coverage for all other listed basic health care services if all of the following apply: 5147 5148 5149 5150 5151

(a) The health insuring corporation submits documentation certified by an independent member of the American academy of actuaries to the superintendent of insurance showing that incurred claims for diagnostic and treatment services for biologically based mental illnesses for a period of at least six months independently caused the health insuring corporation's costs for claims and administrative expenses for the coverage of basic health care services to increase by more than one per cent per year. 5152 5153 5154 5155 5156 5157 5158 5159 5160

(b) The health insuring corporation submits a signed letter from an independent member of the American academy of actuaries to the superintendent of insurance opining that the increase in costs described in division (A)(3)(a) of this section could reasonably justify an increase of more than one per cent in the annual premiums or rates charged by the health insuring corporation for the coverage of basic health care services. 5161 5162 5163 5164 5165 5166 5167

(c) The superintendent of insurance makes the following determinations from the documentation and opinion submitted pursuant to divisions (A)(3)(a) and (b) of this section: 5168 5169 5170

(i) Incurred claims for diagnostic and treatment services for biologically based mental illnesses for a period of at least six months independently caused the health insuring corporation's costs for claims and administrative expenses for the coverage of basic health care services to increase by more than one per cent per year. 5171 5172 5173 5174 5175 5176

(ii) The increase in costs reasonably justifies an increase of more than one per cent in the annual premiums or rates charged by the health insuring corporation for the coverage of basic health care services. 5177 5178 5179 5180

Any determination made by the superintendent under this division is subject to Chapter 119. of the Revised Code. 5181 5182

(B)(1) "Supplemental health care services" means any health care services other than basic health care services that a health insuring corporation may offer, alone or in combination with either basic health care services or other supplemental health care services, and includes: 5183 5184 5185 5186 5187

(a) Services of facilities for intermediate or long-term care, or both; 5188 5189

(b) Dental care services; 5190

(c) Vision care and optometric services including lenses and frames; 5191 5192

(d) Podiatric care or foot care services; 5193

(e) Mental health services, excluding diagnostic and treatment services for biologically based mental illnesses; 5194 5195

(f) Short-term outpatient evaluative and crisis-intervention mental health services; 5196 5197

(g) Medical or psychological treatment and referral services for alcohol and drug abuse or addiction; 5198 5199

(h) Home health services; 5200

(i) Prescription drug services; 5201

(j) Nursing services; 5202

(k) Services of a dietitian licensed under Chapter 4759. of the Revised Code; 5203 5204

(l) Physical therapy services; 5205

(m) Chiropractic services; 5206

(n) Any other category of services approved by the superintendent of insurance. 5207 5208

(2) If a health insuring corporation offers prescription drug services under this division, the coverage shall include prescription drug services for the treatment of biologically based mental illnesses on the same terms and conditions as other physical diseases and disorders. 5209 5210 5211 5212 5213

(C) "Specialty health care services" means one of the supplemental health care services listed in division (B) of this section, when provided by a health insuring corporation on an outpatient-only basis and not in combination with other supplemental health care services. 5214 5215 5216 5217 5218

(D) "Biologically based mental illnesses" means schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, and panic disorder, as these terms are defined in the most recent edition of the diagnostic and statistical manual of mental disorders published by the American psychiatric association. 5219 5220 5221 5222 5223 5224 5225

(E) ~~"Children's buy-in program" has the same meaning as in section 5101.5211 of the Revised Code.~~ 5226 5227

~~(F)~~ "Closed panel plan" means a health care plan that requires enrollees to use participating providers.

~~(G)~~(F) "Compensation" means remuneration for the provision of health care services, determined on other than a fee-for-service or discounted-fee-for-service basis.

~~(H)~~(G) "Contractual periodic prepayment" means the formula for determining the premium rate for all subscribers of a health insuring corporation.

~~(I)~~(H) "Corporation" means a corporation formed under Chapter 1701. or 1702. of the Revised Code or the similar laws of another state.

~~(J)~~(I) "Emergency health services" means those health care services that must be available on a seven-days-per-week, twenty-four-hours-per-day basis in order to prevent jeopardy to an enrollee's health status that would occur if such services were not received as soon as possible, and includes, where appropriate, provisions for transportation and indemnity payments or service agreements for out-of-area coverage.

~~(K)~~(J) "Enrollee" means any natural person who is entitled to receive health care benefits provided by a health insuring corporation.

~~(L)~~(K) "Evidence of coverage" means any certificate, agreement, policy, or contract issued to a subscriber that sets out the coverage and other rights to which such person is entitled under a health care plan.

~~(M)~~(L) "Health care facility" means any facility, except a health care practitioner's office, that provides preventive, diagnostic, therapeutic, acute convalescent, rehabilitation, mental health, mental retardation, intermediate care, or skilled nursing services.

~~(N)~~(M) "Health care services" means basic, supplemental, and 5258
specialty health care services. 5259

~~(O)~~(N) "Health delivery network" means any group of providers 5260
or health care facilities, or both, or any representative thereof, 5261
that have entered into an agreement to offer health care services 5262
in a panel rather than on an individual basis. 5263

~~(P)~~(O) "Health insuring corporation" means a corporation, as 5264
defined in division ~~(I)~~(H) of this section, that, pursuant to a 5265
policy, contract, certificate, or agreement, pays for, reimburses, 5266
or provides, delivers, arranges for, or otherwise makes available, 5267
basic health care services, supplemental health care services, or 5268
specialty health care services, or a combination of basic health 5269
care services and either supplemental health care services or 5270
specialty health care services, through either an open panel plan 5271
or a closed panel plan. 5272

"Health insuring corporation" does not include a limited 5273
liability company formed pursuant to Chapter 1705. of the Revised 5274
Code, an insurer licensed under Title XXXIX of the Revised Code if 5275
that insurer offers only open panel plans under which all 5276
providers and health care facilities participating receive their 5277
compensation directly from the insurer, a corporation formed by or 5278
on behalf of a political subdivision or a department, office, or 5279
institution of the state, or a public entity formed by or on 5280
behalf of a board of county commissioners, a county board of 5281
mental retardation and developmental disabilities, an alcohol and 5282
drug addiction services board, a board of alcohol, drug addiction, 5283
and mental health services, or a community mental health board, as 5284
those terms are used in Chapters 340. and 5126. of the Revised 5285
Code. Except as provided by division (D) of section 1751.02 of the 5286
Revised Code, or as otherwise provided by law, no board, 5287
commission, agency, or other entity under the control of a 5288
political subdivision may accept insurance risk in providing for 5289

health care services. However, nothing in this division shall be 5290
construed as prohibiting such entities from purchasing the 5291
services of a health insuring corporation or a third-party 5292
administrator licensed under Chapter 3959. of the Revised Code. 5293

~~(Q)~~(P) "Intermediary organization" means a health delivery 5294
network or other entity that contracts with licensed health 5295
insuring corporations or self-insured employers, or both, to 5296
provide health care services, and that enters into contractual 5297
arrangements with other entities for the provision of health care 5298
services for the purpose of fulfilling the terms of its contracts 5299
with the health insuring corporations and self-insured employers. 5300

~~(R)~~(Q) "Intermediate care" means residential care above the 5301
level of room and board for patients who require personal 5302
assistance and health-related services, but who do not require 5303
skilled nursing care. 5304

~~(S) "Medicaid" has the same meaning as in section 5111.01 of~~ 5305
~~the Revised Code.~~ 5306

~~(T)~~(R) "Medical record" means the personal information that 5307
relates to an individual's physical or mental condition, medical 5308
history, or medical treatment. 5309

~~(U) "Medicare" means the program established under Title~~ 5310
~~XVIII of the "Social Security Act" 49 Stat. 620 (1935), 42 U.S.C.~~ 5311
~~1395, as amended.~~ 5312

~~(V)~~(S)(1) "Open panel plan" means a health care plan that 5313
provides incentives for enrollees to use participating providers 5314
and that also allows enrollees to use providers that are not 5315
participating providers. 5316

(2) No health insuring corporation may offer an open panel 5317
plan, unless the health insuring corporation is also licensed as 5318
an insurer under Title XXXIX of the Revised Code, the health 5319
insuring corporation, on June 4, 1997, holds a certificate of 5320

authority or license to operate under Chapter 1736. or 1740. of the Revised Code, or an insurer licensed under Title XXXIX of the Revised Code is responsible for the out-of-network risk as evidenced by both an evidence of coverage filing under section 1751.11 of the Revised Code and a policy and certificate filing under section 3923.02 of the Revised Code. 5321 5322 5323 5324 5325 5326

~~(W)~~(T) "Panel" means a group of providers or health care facilities that have joined together to deliver health care services through a contractual arrangement with a health insuring corporation, employer group, or other payor. 5327 5328 5329 5330

~~(X)~~(U) "Person" has the same meaning as in section 1.59 of the Revised Code, and, unless the context otherwise requires, includes any insurance company holding a certificate of authority under Title XXXIX of the Revised Code, any subsidiary and affiliate of an insurance company, and any government agency. 5331 5332 5333 5334 5335

~~(Y)~~(V) "Premium rate" means any set fee regularly paid by a subscriber to a health insuring corporation. A "premium rate" does not include a one-time membership fee, an annual administrative fee, or a nominal access fee, paid to a managed health care system under which the recipient of health care services remains solely responsible for any charges accessed for those services by the provider or health care facility. 5336 5337 5338 5339 5340 5341 5342

~~(Z)~~(W) "Primary care provider" means a provider that is designated by a health insuring corporation to supervise, coordinate, or provide initial care or continuing care to an enrollee, and that may be required by the health insuring corporation to initiate a referral for specialty care and to maintain supervision of the health care services rendered to the enrollee. 5343 5344 5345 5346 5347 5348 5349

~~(AA)~~(X) "Provider" means any natural person or partnership of natural persons who are licensed, certified, accredited, or 5350 5351

otherwise authorized in this state to furnish health care services, or any professional association organized under Chapter 1785. of the Revised Code, provided that nothing in this chapter or other provisions of law shall be construed to preclude a health insuring corporation, health care practitioner, or organized health care group associated with a health insuring corporation from employing certified nurse practitioners, certified nurse anesthetists, clinical nurse specialists, certified nurse midwives, dietitians, physician assistants, dental assistants, dental hygienists, optometric technicians, or other allied health personnel who are licensed, certified, accredited, or otherwise authorized in this state to furnish health care services. 5352 5353 5354 5355 5356 5357 5358 5359 5360 5361 5362 5363

~~(BB)~~<u>(Y)</u> "Provider sponsored organization" means a corporation, as defined in division ~~(I)~~<u>(H)</u> of this section, that is at least eighty per cent owned or controlled by one or more hospitals, as defined in section 3727.01 of the Revised Code, or one or more physicians licensed to practice medicine or surgery or osteopathic medicine and surgery under Chapter 4731. of the Revised Code, or any combination of such physicians and hospitals. Such control is presumed to exist if at least eighty per cent of the voting rights or governance rights of a provider sponsored organization are directly or indirectly owned, controlled, or otherwise held by any combination of the physicians and hospitals described in this division. 5364 5365 5366 5367 5368 5369 5370 5371 5372 5373 5374 5375

~~(CC)~~<u>(Z)</u> "Solicitation document" means the written materials provided to prospective subscribers or enrollees, or both, and used for advertising and marketing to induce enrollment in the health care plans of a health insuring corporation. 5376 5377 5378 5379

~~(DD)~~<u>(AA)</u> "Subscriber" means a person who is responsible for making payments to a health insuring corporation for participation in a health care plan, or an enrollee whose employment or other status is the basis of eligibility for enrollment in a health 5380 5381 5382 5383

insuring corporation. 5384

~~(EE)~~(BB) "Urgent care services" means those health care services that are appropriately provided for an unforeseen condition of a kind that usually requires medical attention without delay but that does not pose a threat to the life, limb, or permanent health of the injured or ill person, and may include such health care services provided out of the health insuring corporation's approved service area pursuant to indemnity payments or service agreements. 5385 5386 5387 5388 5389 5390 5391 5392

Sec. 1751.11. (A) Every subscriber of a health insuring corporation is entitled to an evidence of coverage for the health care plan under which health care benefits are provided. 5393 5394 5395

(B) Every subscriber of a health insuring corporation that offers basic health care services is entitled to an identification card or similar document that specifies the health insuring corporation's name as stated in its articles of incorporation, and any trade or fictitious names used by the health insuring corporation. The identification card or document shall list at least one toll-free telephone number that provides the subscriber with access, to information on a twenty-four-hours-per-day, seven-days-per-week basis, as to how health care services may be obtained. The identification card or document shall also list at least one toll-free number that, during normal business hours, provides the subscriber with access to information on the coverage available under the subscriber's health care plan and information on the health care plan's internal and external review processes. 5396 5397 5398 5399 5400 5401 5402 5403 5404 5405 5406 5407 5408 5409

(C) No evidence of coverage, or amendment to the evidence of coverage, shall be delivered, issued for delivery, renewed, or used, until the form of the evidence of coverage or amendment has been filed by the health insuring corporation with the superintendent of insurance. If the superintendent does not 5410 5411 5412 5413 5414

disapprove the evidence of coverage or amendment within sixty days after it is filed it shall be deemed approved, unless the superintendent sooner gives approval for the evidence of coverage or amendment. With respect to an amendment to an approved evidence of coverage, the superintendent only may disapprove provisions amended or added to the evidence of coverage. If the superintendent determines within the sixty-day period that any evidence of coverage or amendment fails to meet the requirements of this section, the superintendent shall so notify the health insuring corporation and it shall be unlawful for the health insuring corporation to use such evidence of coverage or amendment. At any time, the superintendent, upon at least thirty days' written notice to a health insuring corporation, may withdraw an approval, deemed or actual, of any evidence of coverage or amendment on any of the grounds stated in this section. Such disapproval shall be effected by a written order, which shall state the grounds for disapproval and shall be issued in accordance with Chapter 119. of the Revised Code. 5415 5416 5417 5418 5419 5420 5421 5422 5423 5424 5425 5426 5427 5428 5429 5430 5431 5432

(D) No evidence of coverage or amendment shall be delivered, issued for delivery, renewed, or used: 5433 5434

(1) If it contains provisions or statements that are inequitable, untrue, misleading, or deceptive; 5435 5436

(2) Unless it contains a clear, concise, and complete statement of the following: 5437 5438

(a) The health care services and insurance or other benefits, if any, to which an enrollee is entitled under the health care plan; 5439 5440 5441

(b) Any exclusions or limitations on the health care services, type of health care services, benefits, or type of benefits to be provided, including copayments and deductibles; 5442 5443 5444

(c) An enrollee's personal financial obligation for 5445

noncovered services; 5446

(d) Where and in what manner general information and information as to how health care services may be obtained is available, including a toll-free telephone number; 5447 5448 5449

(e) The premium rate with respect to individual and conversion contracts, and relevant copayment and deductible provisions with respect to all contracts. The statement of the premium rate, however, may be contained in a separate insert. 5450 5451 5452 5453

(f) The method utilized by the health insuring corporation for resolving enrollee complaints; 5454 5455

(g) The utilization review, internal review, and external review procedures established under sections 1751.77 to 1751.85 of the Revised Code. 5456 5457 5458

(3) Unless it provides for the continuation of an enrollee's coverage, in the event that the enrollee's coverage under the group policy, contract, certificate, or agreement terminates while the enrollee is receiving inpatient care in a hospital. This continuation of coverage shall terminate at the earliest occurrence of any of the following: 5459 5460 5461 5462 5463 5464

(a) The enrollee's discharge from the hospital; 5465

(b) The determination by the enrollee's attending physician that inpatient care is no longer medically indicated for the enrollee; however, nothing in division (D)(3)(b) of this section precludes a health insuring corporation from engaging in utilization review as described in the evidence of coverage. 5466 5467 5468 5469 5470

(c) The enrollee's reaching the limit for contractual benefits; 5471 5472

(d) The effective date of any new coverage. 5473

(4) Unless it contains a provision that states, in substance, that the health insuring corporation is not a member of any 5474 5475

guaranty fund, and that in the event of the health insuring 5476
corporation's insolvency, an enrollee is protected only to the 5477
extent that the hold harmless provision required by section 5478
1751.13 of the Revised Code applies to the health care services 5479
rendered; 5480

(5) Unless it contains a provision that states, in substance, 5481
that in the event of the insolvency of the health insuring 5482
corporation, an enrollee may be financially responsible for health 5483
care services rendered by a provider or health care facility that 5484
is not under contract to the health insuring corporation, whether 5485
or not the health insuring corporation authorized the use of the 5486
provider or health care facility. 5487

(E) Notwithstanding divisions (C) and (D) of this section, a 5488
health insuring corporation may use an evidence of coverage that 5489
provides for the coverage of beneficiaries enrolled in medicare 5490
pursuant to a medicare contract, or an evidence of coverage that 5491
provides for the coverage of beneficiaries enrolled in the federal 5492
employees health benefits program pursuant to 5 U.S.C.A. 8905, or 5493
an evidence of coverage that provides for the coverage of medicaid 5494
recipients, or an evidence of coverage that provides for coverage 5495
of participants of the children's buy-in program, or an evidence 5496
of coverage that provides for the coverage of beneficiaries under 5497
any other federal health care program regulated by a federal 5498
regulatory body, or an evidence of coverage that provides for the 5499
coverage of beneficiaries under any contract covering officers or 5500
employees of the state that has been entered into by the 5501
department of administrative services, if both of the following 5502
apply: 5503

(1) The evidence of coverage has been approved by the United 5504
States department of health and human services, the United States 5505
office of personnel management, the ~~Ohio~~ department of ~~job and~~ 5506
~~family services~~ health care administration, or the department of 5507

administrative services. 5508

(2) The evidence of coverage is filed with the superintendent of insurance prior to use and is accompanied by documentation of approval from the United States department of health and human services, the United States office of personnel management, the ~~Ohio~~ department of ~~job and family services~~ health care administration, or the department of administrative services. 5509 5510 5511 5512 5513 5514

Sec. 1751.12. (A)(1) No contractual periodic prepayment and no premium rate for nongroup and conversion policies for health care services, or any amendment to them, may be used by any health insuring corporation at any time until the contractual periodic prepayment and premium rate, or amendment, have been filed with the superintendent of insurance, and shall not be effective until the expiration of sixty days after their filing unless the superintendent sooner gives approval. The filing shall be accompanied by an actuarial certification in the form prescribed by the superintendent. The superintendent shall disapprove the filing, if the superintendent determines within the sixty-day period that the contractual periodic prepayment or premium rate, or amendment, is not in accordance with sound actuarial principles or is not reasonably related to the applicable coverage and characteristics of the applicable class of enrollees. The superintendent shall notify the health insuring corporation of the disapproval, and it shall thereafter be unlawful for the health insuring corporation to use the contractual periodic prepayment or premium rate, or amendment. 5515 5516 5517 5518 5519 5520 5521 5522 5523 5524 5525 5526 5527 5528 5529 5530 5531 5532 5533

(2) No contractual periodic prepayment for group policies for health care services shall be used until the contractual periodic prepayment has been filed with the superintendent. The filing shall be accompanied by an actuarial certification in the form prescribed by the superintendent. The superintendent may reject a 5534 5535 5536 5537 5538

filing made under division (A)(2) of this section at any time, with at least thirty days' written notice to a health insuring corporation, if the contractual periodic prepayment is not in accordance with sound actuarial principles or is not reasonably related to the applicable coverage and characteristics of the applicable class of enrollees. 5539 5540 5541 5542 5543 5544

(3) At any time, the superintendent, upon at least thirty days' written notice to a health insuring corporation, may withdraw the approval given under division (A)(1) of this section, deemed or actual, of any contractual periodic prepayment or premium rate, or amendment, based on information that either of the following applies: 5545 5546 5547 5548 5549 5550

(a) The contractual periodic prepayment or premium rate, or amendment, is not in accordance with sound actuarial principles. 5551 5552

(b) The contractual periodic prepayment or premium rate, or amendment, is not reasonably related to the applicable coverage and characteristics of the applicable class of enrollees. 5553 5554 5555

(4) Any disapproval under division (A)(1) of this section, any rejection of a filing made under division (A)(2) of this section, or any withdrawal of approval under division (A)(3) of this section, shall be effected by a written notice, which shall state the specific basis for the disapproval, rejection, or withdrawal and shall be issued in accordance with Chapter 119. of the Revised Code. 5556 5557 5558 5559 5560 5561 5562

(B) Notwithstanding division (A) of this section, a health insuring corporation may use a contractual periodic prepayment or premium rate for policies used for the coverage of beneficiaries enrolled in medicare pursuant to a medicare risk contract or medicare cost contract, or for policies used for the coverage of beneficiaries enrolled in the federal employees health benefits program pursuant to 5 U.S.C.A. 8905, or for policies used for the 5563 5564 5565 5566 5567 5568 5569

coverage of medicaid recipients, or for policies used for coverage of participants of the children's buy-in program, or for policies used for the coverage of beneficiaries under any other federal health care program regulated by a federal regulatory body, or for policies used for the coverage of beneficiaries under any contract covering officers or employees of the state that has been entered into by the department of administrative services, if both of the following apply: 5570 5571 5572 5573 5574 5575 5576 5577

(1) The contractual periodic prepayment or premium rate has been approved by the United States department of health and human services, the United States office of personnel management, the department of ~~job and family services~~ health care administration, or the department of administrative services. 5578 5579 5580 5581 5582

(2) The contractual periodic prepayment or premium rate is filed with the superintendent prior to use and is accompanied by documentation of approval from the United States department of health and human services, the United States office of personnel management, the department of ~~job and family services~~ health care administration, or the department of administrative services. 5583 5584 5585 5586 5587 5588

(C) The administrative expense portion of all contractual periodic prepayment or premium rate filings submitted to the superintendent for review must reflect the actual cost of administering the product. The superintendent may require that the administrative expense portion of the filings be itemized and supported. 5589 5590 5591 5592 5593 5594

(D)(1) Copayments must be reasonable and must not be a barrier to the necessary utilization of services by enrollees. 5595 5596

(2) A health insuring corporation, in order to ensure that copayments are reasonable and not a barrier to the necessary utilization of basic health care services by enrollees, may do one of the following: 5597 5598 5599 5600

(a) Impose copayment charges on any single covered basic health care service that does not exceed forty per cent of the average cost to the health insuring corporation of providing the service; 5601 5602 5603 5604

(b) Impose copayment charges that annually do not exceed twenty per cent of the total annual cost to the health insuring corporation of providing all covered basic health care services, including physician office visits, urgent care services, and emergency health services, when aggregated as to all persons covered under the filed product in question. In addition, annual copayment charges as to each enrollee shall not exceed twenty per cent of the total annual cost to the health insuring corporation of providing all covered basic health care services, including physician office visits, urgent care services, and emergency health services, as to such enrollee. The total annual cost of providing a health care service is the cost to the health insuring corporation of providing the health care service to its enrollees as reduced by any applicable provider discount. 5605 5606 5607 5608 5609 5610 5611 5612 5613 5614 5615 5616 5617 5618

(3) To ensure that copayments are reasonable and not a barrier to the utilization of basic health care services, a health insuring corporation may not impose, in any contract year, on any subscriber or enrollee, copayments that exceed two hundred per cent of the average annual premium rate to subscribers or enrollees. 5619 5620 5621 5622 5623 5624

(4) For purposes of division (D) of this section, both of the following apply: 5625 5626

(a) Copayments imposed by health insuring corporations in connection with a high deductible health plan that is linked to a health savings account are reasonable and are not a barrier to the necessary utilization of services by enrollees. 5627 5628 5629 5630

(b) Divisions (D)(2) and (3) of this section do not apply to 5631

a high deductible health plan that is linked to a health savings account. 5632 5633

(E) A health insuring corporation shall not impose lifetime maximums on basic health care services. However, a health insuring corporation may establish a benefit limit for inpatient hospital services that are provided pursuant to a policy, contract, certificate, or agreement for supplemental health care services. 5634 5635 5636 5637 5638

(F) A health insuring corporation may require that an enrollee pay an annual deductible that does not exceed one thousand dollars per enrollee or two thousand dollars per family, except that: 5639 5640 5641 5642

(1) A health insuring corporation may impose higher deductibles for high deductible health plans that are linked to health savings accounts; 5643 5644 5645

(2) The superintendent may adopt rules allowing different annual deductible amounts for plans with a medical savings account, health reimbursement arrangement, flexible spending account, or similar account; 5646 5647 5648 5649

(3) A health insuring corporation may impose higher deductibles under health plans if requested by the group contract, policy, certificate, or agreement holder, or an individual seeking coverage under an individual health plan. This shall not be construed as requiring the health insuring corporation to create customized health plans for group contract holders or individuals. 5650 5651 5652 5653 5654 5655

(G) As used in this section, "health savings account" and "high deductible health plan" have the same meanings as in the "Internal Revenue Code of 1986," 100 Stat. 2085, 26 U.S.C. 223, as amended. 5656 5657 5658 5659

Sec. 1751.18. (A)(1) No health insuring corporation shall cancel or fail to renew the coverage of a subscriber or enrollee 5660 5661

because of any health status-related factor in relation to the subscriber or enrollee, the subscriber's or enrollee's requirements for health care services, or for any other reason designated under rules adopted by the superintendent of insurance. 5662 5663 5664 5665

(2) Unless otherwise required by state or federal law, no health insuring corporation, or health care facility or provider through which the health insuring corporation has made arrangements to provide health care services, shall discriminate against any individual with regard to enrollment, disenrollment, or the quality of health care services rendered, on the basis of the individual's race, color, sex, age, religion, military status as defined in section 4112.01 of the Revised Code, or status as a recipient of medicare or medicaid, or any health status-related factor in relation to the individual. However, a health insuring corporation shall not be required to accept a recipient of medicare or ~~medical assistance~~ medicaid, if an agreement has not been reached on appropriate payment mechanisms between the health insuring corporation and the governmental agency administering these programs. Further, except during a period of open enrollment under section 1751.15 of the Revised Code, a health insuring corporation may reject an applicant for nongroup enrollment on the basis of any health status-related factor in relation to the applicant. 5666 5667 5668 5669 5670 5671 5672 5673 5674 5675 5676 5677 5678 5679 5680 5681 5682 5683 5684

(B) A health insuring corporation may cancel or decide not to renew the coverage of an enrollee if the enrollee has performed an act or practice that constitutes fraud or intentional misrepresentation of material fact under the terms of the coverage and if the cancellation or nonrenewal is not based, either directly or indirectly, on any health status-related factor in relation to the enrollee. 5685 5686 5687 5688 5689 5690 5691

(C) An enrollee may appeal any action or decision of a health insuring corporation taken pursuant to section 2742(b) to (e) of 5692 5693

the "Health Insurance Portability and Accountability Act of 1996," Pub. L. No. 104-191, 110 Stat. 1955, 42 U.S.C.A. 300gg-42, as amended. To appeal, the enrollee may submit a written complaint to the health insuring corporation pursuant to section 1751.19 of the Revised Code. The enrollee may, within thirty days after receiving a written response from the health insuring corporation, appeal the health insuring corporation's action or decision to the superintendent. 5694 5695 5696 5697 5698 5699 5700 5701

(D) As used in this section, "health status-related factor" means any of the following: 5702 5703

(1) Health status; 5704

(2) Medical condition, including both physical and mental illnesses; 5705 5706

(3) Claims experience; 5707

(4) Receipt of health care; 5708

(5) Medical history; 5709

(6) Genetic information; 5710

(7) Evidence of insurability, including conditions arising out of acts of domestic violence; 5711 5712

(8) Disability. 5713

Sec. 1751.271. (A) Each health insuring corporation that provides coverage to medicaid recipients shall post a performance bond in the amount of three million dollars as security to fulfill the obligations of the health insuring corporation to pay claims of contracted providers for covered health care services provided to medicaid recipients. The bond shall be payable to the department of insurance in the event that the health insuring corporation is placed in rehabilitation or liquidation proceedings under Chapter 3903. of the Revised Code, and shall become a 5714 5715 5716 5717 5718 5719 5720 5721 5722

special deposit subject to section 3903.14 or 3903.421 of the Revised Code, as applicable. In lieu of the performance bond, a medicaid health insuring corporation may deposit securities with the superintendent of insurance, acceptable to the superintendent, in the amount of three million dollars, to satisfy the bonding requirements of this section. Upon rehabilitation or liquidation, the securities shall become a special deposit subject to sections 3903.14 and 3903.421 of the Revised Code, as applicable. The health insuring corporation shall receive the interest on the deposited securities as long as the health insuring corporation remains solvent. 5723 5724 5725 5726 5727 5728 5729 5730 5731 5732 5733

(B) The bond shall be issued by a surety company licensed with the department of insurance. The bond or deposit, or any replacement bond or deposit, shall be in a form acceptable to the superintendent, and shall remain in effect during the duration of the medicaid health insuring corporation's license and thereafter until all claims against the medicaid health insuring corporation have been paid in full. 5734 5735 5736 5737 5738 5739 5740

(C) Documentation of the bond acceptable to the superintendent of insurance shall be filed with the superintendent prior to the issuance of a certificate of authority. Annually, thirty days prior to the renewal of its certificate of authority, every medicaid health insuring corporation shall furnish the superintendent of insurance with evidence that the required bond is still in effect. 5741 5742 5743 5744 5745 5746 5747

(D) As used in this section: 5748

(1) "Contracted provider" means a provider that has a contract with a medicaid health insuring corporation to provide covered health care services to medicaid recipients. 5749 5750 5751

(2) "Medicaid health insuring corporation" means a health insuring corporation that provides health insurance coverage or 5752 5753

otherwise assumes claims liabilities for medicaid recipients. 5754

(3) "Medicaid recipient" means a person eligible for medical assistance under the medicaid program ~~operated pursuant to Chapter 5111. of the Revised Code~~. 5755 5756 5757

Sec. 1751.31. (A) Any changes in a health insuring corporation's solicitation document shall be filed with the superintendent of insurance. The superintendent, within sixty days of filing, may disapprove any solicitation document or amendment to it on any of the grounds stated in this section. Such disapproval shall be effected by written notice to the health insuring corporation. The notice shall state the grounds for disapproval and shall be issued in accordance with Chapter 119. of the Revised Code. 5758 5759 5760 5761 5762 5763 5764 5765 5766

(B) The solicitation document shall contain all information necessary to enable a consumer to make an informed choice as to whether or not to enroll in the health insuring corporation. The information shall include a specific description of the health care services to be available and the approximate number and type of full-time equivalent medical practitioners. The information shall be presented in the solicitation document in a manner that is clear, concise, and intelligible to prospective applicants in the proposed service area. 5767 5768 5769 5770 5771 5772 5773 5774 5775

(C) Every potential applicant whose subscription to a health care plan is solicited shall receive, at or before the time of solicitation, a solicitation document approved by the superintendent. 5776 5777 5778 5779

(D) Notwithstanding division (A) of this section, a health insuring corporation may use a solicitation document that the corporation uses in connection with policies for medicare beneficiaries pursuant to a medicare risk contract or medicare cost contract, or for policies for beneficiaries of the federal 5780 5781 5782 5783 5784

employees health benefits program pursuant to 5 U.S.C.A. 8905, or 5785
for policies for medicaid recipients, or for policies for 5786
beneficiaries of any other federal health care program regulated 5787
by a federal regulatory body, or for policies for participants of 5788
the children's buy-in program, or for policies for beneficiaries 5789
of contracts covering officers or employees of the state entered 5790
into by the department of administrative services, if both of the 5791
following apply: 5792

(1) The solicitation document has been approved by the United 5793
States department of health and human services, the United States 5794
office of personnel management, the department of ~~job and family~~ 5795
~~services~~ health care administration, or the department of 5796
administrative services. 5797

(2) The solicitation document is filed with the 5798
superintendent of insurance prior to use and is accompanied by 5799
documentation of approval from the United States department of 5800
health and human services, the United States office of personnel 5801
management, the department of ~~job and family services~~ health care 5802
administration, or the department of administrative services. 5803

(E) No health insuring corporation, or its agents or 5804
representatives, shall use monetary or other valuable 5805
consideration, engage in misleading or deceptive practices, or 5806
make untrue, misleading, or deceptive representations to induce 5807
enrollment. Nothing in this division shall prohibit incentive 5808
forms of remuneration such as commission sales programs for the 5809
health insuring corporation's employees and agents. 5810

(F) Any person obligated for any part of a premium rate in 5811
connection with an enrollment agreement, in addition to any right 5812
otherwise available to revoke an offer, may cancel such agreement 5813
within seventy-two hours after having signed the agreement or 5814
offer to enroll. Cancellation occurs when written notice of the 5815
cancellation is given to the health insuring corporation or its 5816

agents or other representatives. A notice of cancellation mailed to the health insuring corporation shall be considered to have been filed on its postmark date. 5817 5818 5819

(G) Nothing in this section shall prohibit healthy lifestyle programs. 5820 5821

Sec. 1751.60. (A) Except as provided for in divisions (E) and (F) of this section, every provider or health care facility that contracts with a health insuring corporation to provide health care services to the health insuring corporation's enrollees or subscribers shall seek compensation for covered services solely from the health insuring corporation and not, under any circumstances, from the enrollees or subscribers, except for approved copayments and deductibles. 5822 5823 5824 5825 5826 5827 5828 5829

(B) No subscriber or enrollee of a health insuring corporation is liable to any contracting provider or health care facility for the cost of any covered health care services, if the subscriber or enrollee has acted in accordance with the evidence of coverage. 5830 5831 5832 5833 5834

(C) Except as provided for in divisions (E) and (F) of this section, every contract between a health insuring corporation and provider or health care facility shall contain a provision approved by the superintendent of insurance requiring the provider or health care facility to seek compensation solely from the health insuring corporation and not, under any circumstances, from the subscriber or enrollee, except for approved copayments and deductibles. 5835 5836 5837 5838 5839 5840 5841 5842

(D) Nothing in this section shall be construed as preventing a provider or health care facility from billing the enrollee or subscriber of a health insuring corporation for noncovered services. 5843 5844 5845 5846

(E) Upon application by a health insuring corporation and a provider or health care facility, the superintendent may waive the requirements of divisions (A) and (C) of this section when, in addition to the reserve requirements contained in section 1751.28 of the Revised Code, the health insuring corporation provides sufficient assurances to the superintendent that the provider or health care facility has been provided with financial guarantees. No waiver of the requirements of divisions (A) and (C) of this section is effective as to enrollees or subscribers for whom the health insuring corporation is compensated under a provider agreement or risk contract entered into pursuant to Chapter ~~5111. or~~ 5115. <u>or 5168.</u> of the Revised Code or under the children's buy-in program. 5847 5848 5849 5850 5851 5852 5853 5854 5855 5856 5857 5858 5859

(F) The requirements of divisions (A) to (C) of this section apply only to health care services provided to an enrollee or subscriber prior to the effective date of a termination of a contract between the health insuring corporation and the provider or health care facility. 5860 5861 5862 5863 5864

Sec. 1751.88. Consistent with the Rules of Evidence, a written decision or opinion prepared by or for an independent review organization under section 1751.84 or 1751.85 of the Revised Code shall be admissible in any civil action related to the coverage decision that was the subject of the decision or opinion. The independent review organization's decision or opinion shall be presumed to be a scientifically valid and accurate description of the state of medical knowledge at the time it was written. 5865 5866 5867 5868 5869 5870 5871 5872 5873

Consistent with the Rules of Evidence, any party to a civil action related to a health insuring corporation's coverage decision involving an investigational or experimental drug, device, or treatment may introduce into evidence any applicable 5874 5875 5876 5877

medicare reimbursement standards established under ~~Title XVIII of~~ the ~~"Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended~~ medicare program. 5878 5879 5880

Sec. 1751.89. Sections 1751.77 to 1751.85 of the Revised Code do not apply to either of the following: 5881 5882

(A) Coverage provided to beneficiaries enrolled in the medicare+choice program operated under ~~Title XVIII of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended~~ the medicare program; 5883 5884 5885 5886

(B) Coverage provided to medicaid recipients; 5887

(C) Coverage provided to participants of the children's buy-in program. 5888 5889

Sec. 1923.14. (A) Except as otherwise provided in this section, within ten days after receiving a writ of execution described in division (A) or (B) of section 1923.13 of the Revised Code, the sheriff, police officer, constable, or bailiff shall execute it by restoring the plaintiff to the possession of the premises, and shall levy and collect the costs and make return, as upon other executions. If an appeal from the judgment of restitution is filed and if, following the filing of the appeal, a stay of execution is obtained and any required bond is filed with the court of common pleas, municipal court, or county court, the judge of that court immediately shall issue an order to the sheriff, police officer, constable, or bailiff commanding the delay of all further proceedings upon the execution. If the premises have been restored to the plaintiff, the sheriff, police officer, constable, or bailiff shall forthwith place the defendant in possession of them, and return the writ with the sheriff's, police officer's, constable's, or bailiff's proceedings and the costs taxed on it. 5890 5891 5892 5893 5894 5895 5896 5897 5898 5899 5900 5901 5902 5903 5904 5905 5906 5907

(B)(1) After a court of common pleas, municipal court, or county court issues a writ of execution described in division (B) of section 1923.13 of the Revised Code, the clerk of the court shall send by regular mail, to the last known address of the titled owner of the manufactured home, mobile home, or recreational vehicle that is the subject of the writ and to the last known address of each other person who is listed on the writ as having any outstanding right, title, or interest in the home, vehicle, or personal property and to the auditor and treasurer of the county in which the court is located, a written notice that the home or vehicle potentially may be sold, destroyed, or have its title transferred under the circumstances described in division (B)(3) or (4) of this section. 5908 5909 5910 5911 5912 5913 5914 5915 5916 5917 5918 5919 5920

(2) Except as otherwise provided in this division, after receiving a writ of execution described in division (B) of section 1923.13 of the Revised Code, and after causing the defendant to be removed from the residential premises of the manufactured home park, if necessary, in accordance with the writ, the sheriff, police officer, constable, or bailiff may cause the manufactured home, mobile home, or recreational vehicle that is the subject of the writ, and all personal property on the residential premises, at the sheriff's, police officer's, constable's, or bailiff's option, either to be removed from the manufactured home park and, if necessary, moved to a storage facility of the sheriff's, police officer's, constable's, or bailiff's choice, or to be retained at their current location on the residential premises, until they are claimed by the defendant or they are disposed of in a manner authorized by division (B)(3), (4), or (6) of this section or by another section of the Revised Code. The sheriff, police officer, constable, or bailiff shall not cause the manufactured home, mobile home, or recreational vehicle that is the subject of the writ, or the personal property, to be removed from the manufactured home park or moved to a storage facility if the 5921 5922 5923 5924 5925 5926 5927 5928 5929 5930 5931 5932 5933 5934 5935 5936 5937 5938 5939 5940

holder of any outstanding lien, right, title, or interest in the home or vehicle, other than the titled owner of the home or vehicle, meets the conditions set forth in division (B)(6) or (7) of this section. 5941 5942 5943 5944

The sheriff, police officer, constable, or bailiff who removes the manufactured home, mobile home, or recreational vehicle, or the abandoned personal property, from the residential premises shall be immune from civil liability pursuant to section 2744.03 of the Revised Code for any damage caused to the home, vehicle, or any personal property during the removal. The park operator shall not be liable for any damage caused by the park operator's removal of the manufactured home, mobile home, or recreational vehicle or the removal of the personal property from the residential premises, or for any damage to the home, vehicle, or personal property during the time the home, vehicle, or property remains abandoned or stored in the manufactured home park, unless the damage is the result of acts that the park operator or the park operator's agents or employees performed with malicious purpose, in bad faith, or in a wanton or reckless manner. The reasonable costs for a removal of the manufactured home, mobile home, or recreational vehicle and personal property and, as applicable, the reasonable costs for its storage shall constitute a lien upon the home or vehicle payable by the titled owner of the home or vehicle or payable pursuant to division (B)(3) of this section. 5945 5946 5947 5948 5949 5950 5951 5952 5953 5954 5955 5956 5957 5958 5959 5960 5961 5962 5963 5964 5965

(3) Except as provided in divisions (B)(4), (5), and (6) of this section and division (D) of section 1923.12 of the Revised Code, within sixty days after receiving a writ of execution described in division (B) of section 1923.13 of the Revised Code, the sheriff, police officer, constable, or bailiff shall commence proceedings for the sale of the manufactured home, mobile home, or recreational vehicle that is the subject of the writ, and the 5966 5967 5968 5969 5970 5971 5972

abandoned personal property on the residential premises, if the 5973
home or vehicle is determined to be abandoned in accordance with 5974
the procedures for the sale of goods on execution under Chapter 5975
2329. of the Revised Code. In addition to all notices required to 5976
be given under section 2329.13 of the Revised Code, the sheriff, 5977
police officer, constable, or bailiff shall serve at their 5978
respective last known addresses a written notice of the date, 5979
time, and place of the sale upon all persons who are listed on the 5980
writ of execution as having any outstanding right, title, or 5981
interest in the abandoned manufactured home, mobile home, or 5982
recreational vehicle and the personal property and shall provide 5983
written notice to the auditor and the treasurer of the county in 5984
which the court issuing the writ is located. 5985

Unless the proceedings are governed by division (D) of 5986
section 1923.12 of the Revised Code, notwithstanding any statutory 5987
provision to the contrary, including, but not limited to, section 5988
2329.66 of the Revised Code, there shall be no stay of execution 5989
or exemption from levy or sale on execution available to the 5990
titled owner of the abandoned manufactured home, mobile home, or 5991
recreational vehicle in relation to a sale under this division. 5992
Except as otherwise provided in sections 2113.031, 2117.25, and 5993
~~5111.11~~ 5162.40 of the Revised Code in a case involving a deceased 5994
resident or resident's estate, the sheriff, police officer, 5995
constable, or bailiff shall distribute the proceeds from the sale 5996
of an abandoned manufactured home, mobile home, or recreational 5997
vehicle and any personal property under this division in the 5998
following manner: 5999

(a) The sheriff, police officer, constable, or bailiff shall 6000
first pay the costs for any moving of and any storage outside the 6001
manufactured home park of the home or vehicle and any personal 6002
property pursuant to division (B)(2) of this section, the costs of 6003
the sale, including reimbursing the park operator for the deposit 6004

that the park operator paid to the clerk of court under division (C) of section 1923.12 of the Revised Code, and any unpaid court costs assessed against the defendant in the underlying action. 6005 6006 6007

(b) Following the payment required by division (B)(3)(a) of this section, the sheriff, police officer, constable, or bailiff shall pay all outstanding tax liens on the home or vehicle. 6008 6009 6010

(c) Following the payment required by division (B)(3)(b) of this section, the sheriff, police officer, constable, or bailiff shall pay all other outstanding security interests, liens, or encumbrances on the home or vehicle by priority of filing or other priority. 6011 6012 6013 6014 6015

(d) Following the payment required by division (B)(3)(c) of this section, the sheriff, police officer, constable, or bailiff shall pay any outstanding monetary judgment rendered under section 1923.09 or 1923.11 of the Revised Code in favor of the plaintiff and any costs associated with retaining the home or vehicle prior to the sale at its location on the residential premises within the manufactured home park pursuant to division (B)(2) of this section. 6016 6017 6018 6019 6020 6021 6022 6023

(e) After complying with divisions (B)(3)(a) to (d) of this section, the sheriff, police officer, constable, or bailiff shall report any remaining money as unclaimed funds pursuant to Chapter 169. of the Revised Code. 6024 6025 6026 6027

Upon the return of any writ of execution for the satisfaction of which an abandoned manufactured home, mobile home, or recreational vehicle has been sold under this division, on careful examination of the proceedings of the sheriff, police officer, constable, or bailiff conducting the sale, if the court that issued the writ finds that the sale was made, in all respects, in conformity with the relevant provisions of Chapter 2329. of the Revised Code and with this division, it shall direct the clerk of 6028 6029 6030 6031 6032 6033 6034 6035

the court to make an entry on the journal that the court is satisfied with the legality of the sale and the court shall direct the clerk of the court of common pleas of the county in which the writ was issued to issue a certificate of title, free and clear of all security interests, liens, and encumbrances, to the purchaser of the home or vehicle. The clerk of the court of common pleas shall issue the new certificate of title to the purchaser of the home or vehicle regardless of whether the writ was issued by the court of common pleas or another court duly authorized to issue the writ. If the manufactured home, mobile home, or recreational vehicle sold under this division is located in a manufactured home park, the purchaser of the home or vehicle shall have no right to maintain the home or vehicle in the manufactured home park without the park operator's consent and the sheriff, police officer, constable, or bailiff conducting the sale shall notify all prospective purchasers of this fact prior to the commencement of the sale. 6036 6037 6038 6039 6040 6041 6042 6043 6044 6045 6046 6047 6048 6049 6050 6051 6052

If, after it is offered for sale on two occasions under this division, the abandoned manufactured home, mobile home, or recreational vehicle cannot be sold due to a want of bidders, the sheriff, police officer, constable, or bailiff shall present the writ of execution unsatisfied to the clerk of the court of common pleas of the county in which the writ was issued for the issuance by the clerk in the manner prescribed in section 4505.10 of the Revised Code of a certificate of title transferring the title of the home or vehicle to the plaintiff, free and clear of all security interests, liens, and encumbrances. The clerk of the court of common pleas shall issue the new certificate of title transferring the title of the manufactured home, mobile home, or recreational vehicle to the plaintiff regardless of whether the writ was issued by the court of common pleas or another court duly authorized to issue the writ. If any taxes are owed on the home or vehicle at this time, the county auditor shall remove the 6053 6054 6055 6056 6057 6058 6059 6060 6061 6062 6063 6064 6065 6066 6067 6068

delinquent taxes from the manufactured home tax list and the delinquent manufactured home tax list and remit any penalties for late payment of manufactured home taxes. Acceptance of the certificate of title by the plaintiff terminates all further proceedings under this section. 6069 6070 6071 6072 6073

(4) Except as provided in division (B)(5) or (6) of this section and division (D) of section 1923.12 of the Revised Code, within sixty days after receiving a writ of execution described in division (B) of section 1923.13 of the Revised Code, if the manufactured home, mobile home, or recreational vehicle is determined to be abandoned and to have a value of less than three thousand dollars, the sheriff, police officer, constable, or bailiff shall serve at their respective last known addresses a written notice of potential action as described in this division upon all persons who are listed on the writ as having any outstanding right, title, or interest in the home or vehicle. This notice shall be in addition to all notices required to be given under section 2329.13 of the Revised Code. Subject to the fulfillment of these notice requirements, the sheriff, police officer, constable, or bailiff shall take one of the following actions with respect to the abandoned manufactured home, mobile home, or recreational vehicle: 6074 6075 6076 6077 6078 6079 6080 6081 6082 6083 6084 6085 6086 6087 6088 6089 6090

(a) Cause its destruction if there is no person having an outstanding right, title, or interest in the home or vehicle, other than the titled owner of the home or vehicle; 6091 6092 6093

(b) Proceed with its sale under division (B)(3) of this section; 6094 6095

(c) If there is no person having an outstanding right, title, or interest in the home or vehicle other than the titled owner of the home or vehicle, or if there is an outstanding right, title, or interest in the home or vehicle and the lienholder consents in writing, present the writ of execution to the clerk of the court 6096 6097 6098 6099 6100

of common pleas of the county in which the writ was issued for the issuance by the clerk in the manner prescribed in section 4505.10 of the Revised Code of a certificate of title transferring the title of the home or vehicle to the plaintiff, free and clear of all security interests, liens, and encumbrances. The clerk of the court of common pleas shall issue the new certificate of title transferring the title of the home or vehicle regardless of whether the writ was issued by the court of common pleas or another court duly authorized to issue the writ. If any taxes are owed on the home or vehicle at this time, the county auditor shall remove the delinquent taxes from the manufactured home tax list and the delinquent manufactured home tax list and remit any penalties for late payment of manufactured home taxes. Acceptance of the certificate of title by the plaintiff terminates all further proceedings under this section. 6101 6102 6103 6104 6105 6106 6107 6108 6109 6110 6111 6112 6113 6114 6115

(5) At any time prior to the issuance of the writ of execution described in division (B) of section 1923.13 of the Revised Code, the titled owner of the manufactured home, mobile home, or recreational vehicle that would be the subject of the writ may remove the abandoned home or vehicle from the manufactured home park or other place of storage upon payment to the county auditor of all outstanding tax liens on the home or vehicle and, unless the owner is indigent, payment to the clerk of court of all unpaid court costs assessed against the defendant in the underlying action. After the issuance of the writ of execution, the titled owner of the home or vehicle may remove the abandoned home or vehicle from the manufactured home park or other place of storage at any time up to the day before the scheduled sale, destruction, or transfer of the home or vehicle pursuant to division (B)(3) or (4) of this section upon payment of all of the following: 6116 6117 6118 6119 6120 6121 6122 6123 6124 6125 6126 6127 6128 6129 6130 6131

(a) All costs for moving and storage of the home or vehicle 6132

pursuant to division (B)(2) of this section and all costs incurred by the sheriff, police officer, constable, or bailiff up to and including the date of the removal of the home or vehicle; 6133 6134 6135

(b) All outstanding tax liens on the home or vehicle; 6136

(c) Unless the owner is indigent, all unpaid court costs assessed against the defendant in the underlying action. 6137 6138

(6) At any time after the issuance of the writ of execution described in division (B) of section 1923.13 of the Revised Code, the holder of any outstanding lien, right, title, or interest in the manufactured home, mobile home, or recreational vehicle, other than the titled owner of the home or vehicle, may stop the sheriff, police officer, constable, or bailiff from proceeding with the sale under this division by doing both of the following: 6139 6140 6141 6142 6143 6144 6145

(a) Commencing a proceeding to repossess the home or vehicle pursuant to Chapters 1309. and 1317. of the Revised Code; 6146 6147

(b) Paying to the park operator all monthly rental payments for the lot on which the home or vehicle is located from the time of the issuance of the writ of execution until the time that the home or vehicle is sold pursuant to Chapters 1309. and 1317. of the Revised Code. 6148 6149 6150 6151 6152

(7)(a) At any time prior to the day before the scheduled sale of the property pursuant to division (B)(3) of this section, the defendant may remove any personal property of the defendant from the abandoned home or vehicle or other place of storage. 6153 6154 6155 6156

(b) If personal property owned by a person other than the defendant is abandoned on the residential premises and has not previously been removed, the owner of the personal property may remove the personal property from the abandoned home or vehicle or other place of storage up to the day before the scheduled sale of the property pursuant to division (B)(3) of this section upon presentation of proof of ownership of the property that is 6157 6158 6159 6160 6161 6162 6163

satisfactory to the sheriff, police officer, constable, or bailiff 6164
conducting the sale. 6165

Sec. 2113.041. (A) The administrator of the medicaid estate 6166
recovery program established pursuant to section ~~5111.11~~ 5162.40 6167
of the Revised Code may present an affidavit to a financial 6168
institution requesting that the financial institution release 6169
account proceeds to recover the cost of services correctly 6170
provided to a medicaid recipient who is subject to the medicaid 6171
estate recovery program. The affidavit shall include all of the 6172
following information: 6173

(1) The name of the decedent; 6174

(2) The name of any person who gave notice that the decedent 6175
was a medicaid recipient and that person's relationship to the 6176
decedent; 6177

(3) The name of the financial institution; 6178

(4) The account number; 6179

(5) A description of the claim for estate recovery; 6180

(6) The amount of funds to be recovered. 6181

(B) A financial institution may release account proceeds to 6182
the administrator of the medicaid estate recovery program if all 6183
of the following apply: 6184

(1) The decedent held an account at the financial institution 6185
that was in the decedent's name only. 6186

(2) No estate has been, and it is reasonable to assume that 6187
no estate will be, opened for the decedent. 6188

(3) The decedent has no outstanding debts known to the 6189
administrator of the medicaid estate recovery program. 6190

(4) The financial institution has received no objections or 6191
has determined that no valid objections to release of proceeds 6192

have been received.

(C) If proceeds have been released pursuant to division (B) of this section and the department of ~~job and family services~~ health care administration receives notice of a valid claim to the proceeds that has a higher priority under section 2117.25 of the Revised Code than the claim of the medicaid estate recovery program, the department may refund the proceeds to the financial institution or pay them to the person or government entity with the claim.

Sec. 2113.06. Administration of the estate of an intestate shall be granted to persons mentioned in this section, in the following order:

(A) To the surviving spouse of the deceased, if resident of the state;

(B) To one of the next of kin of the deceased, resident of the state.

If the persons entitled to administer the estate fail to take or renounce administration voluntarily, they shall be cited by the probate court for that purpose.

If there are no persons entitled to administration, or if they are for any reason unsuitable for the discharge of the trust, or if without sufficient cause they neglect to apply within a reasonable time for the administration of the estate, their right to priority shall be lost, and the court shall commit the administration to some suitable person who is a resident of the state, or to the attorney general or the attorney general's designee, if the department of ~~job and family services~~ health care administration is seeking to recover ~~medical assistance~~ medicaid costs from the deceased pursuant to section ~~5111.11~~ 5162.40 or ~~5111.111~~ 5162.41 of the Revised Code. Such person may be a

creditor of the estate. 6223

This section applies to the appointment of an administrator 6224
de bonis non. 6225

Sec. 2117.061. (A) As used in this section: 6226

(1) "Medicaid estate recovery program" means the program 6227
instituted under section ~~5111.11~~ 5162.40 of the Revised Code. 6228

(2) "Permanently institutionalized individual" has the same 6229
meaning as in section ~~5111.11~~ 5162.40 of the Revised Code. 6230

(3) "Person responsible for the estate" means the executor, 6231
administrator, commissioner, or person who filed pursuant to 6232
section 2113.03 of the Revised Code for release from 6233
administration of an estate. 6234

(B) The person responsible for the estate of a decedent 6235
subject to the medicaid estate recovery program or the estate of a 6236
decedent who was the spouse of a decedent subject to the medicaid 6237
estate recovery program shall submit a properly completed medicaid 6238
estate recovery reporting form prescribed under division (D) of 6239
this section to the administrator of the medicaid estate recovery 6240
program not later than thirty days after the occurrence of any of 6241
the following: 6242

(1) The granting of letters testamentary; 6243

(2) The administration of the estate; 6244

(3) The filing of an application for release from 6245
administration or summary release from administration. 6246

(C) The person responsible for the estate shall mark the 6247
appropriate box on the appropriate probate form to indicate 6248
compliance with the requirements of division (B) of this section. 6249

The probate court shall send a copy of the completed probate 6250
form to the administrator of the medicaid estate recovery program. 6251

(D) The administrator of the medicaid estate recovery program 6252
shall prescribe a medicaid estate recovery reporting form for the 6253
purpose of division (B) of this section. In the case of a decedent 6254
subject to the medicaid estate recovery program, the form shall 6255
require, at a minimum, that the person responsible for the estate 6256
list all of the decedent's real and personal property and other 6257
assets that are part of the decedent's estate as defined in 6258
section ~~5111.11~~ 5162.40 of the Revised Code. In the case of a 6259
decedent who was the spouse of a decedent subject to the medicaid 6260
estate recovery program, the form shall require, at a minimum, 6261
that the person responsible for the estate list all of the 6262
decedent's real and personal property and other assets that are 6263
part of the decedent's estate as defined in section ~~5111.11~~ 6264
5162.40 of the Revised Code and were also part of the estate, as 6265
so defined, of the decedent subject to the medicaid estate 6266
recovery program. The administrator shall include on the form a 6267
statement printed in bold letters informing the person responsible 6268
for the estate that knowingly making a false statement on the form 6269
is falsification under section 2921.13 of the Revised Code, a 6270
misdemeanor of the first degree. 6271

(E) The administrator of the medicaid estate recovery program 6272
shall present a claim for estate recovery to the person 6273
responsible for the estate of the decedent or the person's legal 6274
representative not later than ninety days after the date on which 6275
the medicaid estate recovery reporting form is received under 6276
division (B) of this section or one year after the decedent's 6277
death, whichever is later. 6278

Sec. 2117.25. (A) Every executor or administrator shall 6279
proceed with diligence to pay the debts of the decedent and shall 6280
apply the assets in the following order: 6281

(1) Costs and expenses of administration; 6282

(2) An amount, not exceeding four thousand dollars, for 6283
funeral expenses that are included in the bill of a funeral 6284
director, funeral expenses other than those in the bill of a 6285
funeral director that are approved by the probate court, and an 6286
amount, not exceeding three thousand dollars, for burial and 6287
cemetery expenses, including that portion of the funeral 6288
director's bill allocated to cemetery expenses that have been paid 6289
to the cemetery by the funeral director. 6290

For purposes of this division, burial and cemetery expenses 6291
shall be limited to the following: 6292

(a) The purchase of a right of interment; 6293

(b) Monuments or other markers; 6294

(c) The outer burial container; 6295

(d) The cost of opening and closing the place of interment; 6296

(e) The urn. 6297

(3) The allowance for support made to the surviving spouse, 6298
minor children, or both under section 2106.13 of the Revised Code; 6299

(4) Debts entitled to a preference under the laws of the 6300
United States; 6301

(5) Expenses of the last sickness of the decedent; 6302

(6) If the total bill of a funeral director for funeral 6303
expenses exceeds four thousand dollars, then, in addition to the 6304
amount described in division (A)(2) of this section, an amount, 6305
not exceeding two thousand dollars, for funeral expenses that are 6306
included in the bill and that exceed four thousand dollars; 6307

(7) Personal property taxes, claims made under the medicaid 6308
estate recovery program instituted pursuant to section ~~5111.11~~ 6309
5162.40 of the Revised Code, and obligations for which the 6310
decedent was personally liable to the state or any of its 6311
subdivisions; 6312

(8) Debts for manual labor performed for the decedent within twelve months preceding the decedent's death, not exceeding three hundred dollars to any one person; 6313 6314 6315

(9) Other debts for which claims have been presented and finally allowed. 6316 6317

(B) The part of the bill of a funeral director that exceeds the total of six thousand dollars as described in divisions (A)(2) and (6) of this section, and the part of a claim included in division (A)(8) of this section that exceeds three hundred dollars shall be included as a debt under division (A)(9) of this section, depending upon the time when the claim for the additional amount is presented. 6318 6319 6320 6321 6322 6323 6324

(C) Any natural person or fiduciary who pays a claim of any creditor described in division (A) of this section shall be subrogated to the rights of that creditor proportionate to the amount of the payment and shall be entitled to reimbursement for that amount in accordance with the priority of payments set forth in that division. 6325 6326 6327 6328 6329 6330

(D)(1) Chapters 2113. to 2125. of the Revised Code, relating to the manner in which and the time within which claims shall be presented, shall apply to claims set forth in divisions (A)(2), (6), and (8) of this section. Claims for an expense of administration or for the allowance for support need not be presented. The executor or administrator shall pay debts included in divisions (A)(4) and (7) of this section, of which the executor or administrator has knowledge, regardless of presentation. 6331 6332 6333 6334 6335 6336 6337 6338

(2) The giving of written notice to an executor or administrator of a motion or application to revive an action pending against the decedent at the date of death shall be equivalent to the presentation of a claim to the executor or administrator for the purpose of determining the order of payment 6339 6340 6341 6342 6343

of any judgment rendered or decree entered in such an action. 6344

(E) No payments shall be made to creditors of one class until all those of the preceding class are fully paid or provided for. If the assets are insufficient to pay all the claims of one class, the creditors of that class shall be paid ratably. 6345 6346 6347 6348

(F) If it appears at any time that the assets have been exhausted in paying prior or preferred charges, allowances, or claims, those payments shall be a bar to an action on any claim not entitled to that priority or preference. 6349 6350 6351 6352

Sec. 2133.01. Unless the context otherwise requires, as used in sections 2133.01 to 2133.15 of the Revised Code: 6353 6354

(A) "Adult" means an individual who is eighteen years of age or older. 6355 6356

(B) "Attending physician" means the physician to whom a declarant or other patient, or the family of a declarant or other patient, has assigned primary responsibility for the treatment or care of the declarant or other patient, or, if the responsibility has not been assigned, the physician who has accepted that responsibility. 6357 6358 6359 6360 6361 6362

(C) "Comfort care" means any of the following: 6363

(1) Nutrition when administered to diminish the pain or discomfort of a declarant or other patient, but not to postpone the declarant's or other patient's death; 6364 6365 6366

(2) Hydration when administered to diminish the pain or discomfort of a declarant or other patient, but not to postpone the declarant's or other patient's death; 6367 6368 6369

(3) Any other medical or nursing procedure, treatment, intervention, or other measure that is taken to diminish the pain or discomfort of a declarant or other patient, but not to postpone the declarant's or other patient's death. 6370 6371 6372 6373

(D) "Consulting physician" means a physician who, in conjunction with the attending physician of a declarant or other patient, makes one or more determinations that are required to be made by the attending physician, or to be made by the attending physician and one other physician, by an applicable provision of this chapter, to a reasonable degree of medical certainty and in accordance with reasonable medical standards. 6374 6375 6376 6377 6378 6379 6380

(E) "Declarant" means any adult who has executed a declaration in accordance with section 2133.02 of the Revised Code. 6381 6382 6383

(F) "Declaration" means a written document executed in accordance with section 2133.02 of the Revised Code. 6384 6385

(G) "Durable power of attorney for health care" means a document created pursuant to sections 1337.11 to 1337.17 of the Revised Code. 6386 6387 6388

(H) "Guardian" means a person appointed by a probate court pursuant to Chapter 2111. of the Revised Code to have the care and management of the person of an incompetent. 6389 6390 6391

(I) "Health care facility" means any of the following: 6392

(1) A hospital; 6393

(2) A hospice care program or other institution that specializes in comfort care of patients in a terminal condition or in a permanently unconscious state; 6394 6395 6396

(3) A nursing home or residential care facility, as defined in section 3721.01 of the Revised Code; 6397 6398

(4) A home health agency and any residential facility where a person is receiving care under the direction of a home health agency; 6399 6400 6401

(5) An intermediate care facility for the mentally retarded. 6402

(J) "Health care personnel" means physicians, nurses, 6403

physician assistants, emergency medical technicians-basic, emergency medical technicians-intermediate, emergency medical technicians-paramedic, medical technicians, dietitians, other authorized persons acting under the direction of an attending physician, and administrators of health care facilities. 6404 6405 6406 6407 6408

(K) "Home health agency" has the same meaning as in section 3701.881 of the Revised Code. 6409 6410

(L) "Hospice care program" has the same meaning as in section 3712.01 of the Revised Code. 6411 6412

(M) "Hospital" has the same meanings as in sections 3701.01, 3727.01, and 5122.01 of the Revised Code. 6413 6414

(N) "Hydration" means fluids that are artificially or technologically administered. 6415 6416

(O) "Incompetent" has the same meaning as in section 2111.01 of the Revised Code. 6417 6418

(P) "Intermediate care facility for the mentally retarded" has the same meaning as in section ~~5111.20~~ 5164.01 of the Revised Code. 6419 6420 6421

(Q) "Life-sustaining treatment" means any medical procedure, treatment, intervention, or other measure that, when administered to a qualified patient or other patient, will serve principally to prolong the process of dying. 6422 6423 6424 6425

(R) "Nurse" means a person who is licensed to practice nursing as a registered nurse or to practice practical nursing as a licensed practical nurse pursuant to Chapter 4723. of the Revised Code. 6426 6427 6428 6429

(S) "Nursing home" has the same meaning as in section 3721.01 of the Revised Code. 6430 6431

(T) "Nutrition" means sustenance that is artificially or technologically administered. 6432 6433

(U) "Permanently unconscious state" means a state of permanent unconsciousness in a declarant or other patient that, to a reasonable degree of medical certainty as determined in accordance with reasonable medical standards by the declarant's or other patient's attending physician and one other physician who has examined the declarant or other patient, is characterized by both of the following: 6434 6435 6436 6437 6438 6439 6440

(1) Irreversible unawareness of one's being and environment. 6441

(2) Total loss of cerebral cortical functioning, resulting in the declarant or other patient having no capacity to experience pain or suffering. 6442 6443 6444

(V) "Person" has the same meaning as in section 1.59 of the Revised Code and additionally includes political subdivisions and governmental agencies, boards, commissions, departments, institutions, offices, and other instrumentalities. 6445 6446 6447 6448

(W) "Physician" means a person who is authorized under Chapter 4731. of the Revised Code to practice medicine and surgery or osteopathic medicine and surgery. 6449 6450 6451

(X) "Political subdivision" and "state" have the same meanings as in section 2744.01 of the Revised Code. 6452 6453

(Y) "Professional disciplinary action" means action taken by the board or other entity that regulates the professional conduct of health care personnel, including the state medical board and the board of nursing. 6454 6455 6456 6457

(Z) "Qualified patient" means an adult who has executed a declaration and has been determined to be in a terminal condition or in a permanently unconscious state. 6458 6459 6460

(AA) "Terminal condition" means an irreversible, incurable, and untreatable condition caused by disease, illness, or injury from which, to a reasonable degree of medical certainty as 6461 6462 6463

determined in accordance with reasonable medical standards by a 6464
declarant's or other patient's attending physician and one other 6465
physician who has examined the declarant or other patient, both of 6466
the following apply: 6467

(1) There can be no recovery. 6468

(2) Death is likely to occur within a relatively short time 6469
if life-sustaining treatment is not administered. 6470

(BB) "Tort action" means a civil action for damages for 6471
injury, death, or loss to person or property, other than a civil 6472
action for damages for breach of a contract or another agreement 6473
between persons. 6474

Sec. 2151.3514. (A) As used in this section: 6475

(1) "Alcohol and drug addiction program" has the same meaning 6476
as in section 3793.01 of the Revised Code; 6477

(2) "Chemical dependency" means either of the following: 6478

(a) The chronic and habitual use of alcoholic beverages to 6479
the extent that the user no longer can control the use of alcohol 6480
or endangers the user's health, safety, or welfare or that of 6481
others; 6482

(b) The use of a drug of abuse to the extent that the user 6483
becomes physically or psychologically dependent on the drug or 6484
endangers the user's health, safety, or welfare or that of others. 6485

(3) "Drug of abuse" has the same meaning as in section 6486
3719.011 of the Revised Code. 6487

~~(4) "Medicaid" means the program established under Chapter~~ 6488
~~5111. of the Revised Code.~~ 6489

(B) If the juvenile court issues an order of temporary 6490
custody or protective supervision under division (A) of section 6491
2151.353 of the Revised Code with respect to a child adjudicated 6492

to be an abused, neglected, or dependent child and the alcohol or other drug addiction of a parent or other caregiver of the child was the basis for the adjudication of abuse, neglect, or dependency, the court shall issue an order requiring the parent or other caregiver to submit to an assessment and, if needed, treatment from an alcohol and drug addiction program certified by the department of alcohol and drug addiction services. The court may order the parent or other caregiver to submit to alcohol or other drug testing during, after, or both during and after, the treatment. The court shall send any order issued pursuant to this division to the public children services agency that serves the county in which the court is located for use as described in section 340.15 of the Revised Code. 6493 6494 6495 6496 6497 6498 6499 6500 6501 6502 6503 6504 6505

(C) Any order requiring alcohol or other drug testing that is issued pursuant to division (B) of this section shall require one alcohol or other drug test to be conducted each month during a period of twelve consecutive months beginning the month immediately following the month in which the order for alcohol or other drug testing is issued. Arrangements for administering the alcohol or other drug tests, as well as funding the costs of the tests, shall be locally determined in accordance with sections 340.033 and 340.15 of the Revised Code. If a parent or other caregiver required to submit to alcohol or other drug tests under this section is not a recipient of medicaid, the agency that refers the parent or caregiver for the tests may require the parent or caregiver to reimburse the agency for the cost of conducting the tests. 6506 6507 6508 6509 6510 6511 6512 6513 6514 6515 6516 6517 6518 6519

(D) The certified alcohol and drug addiction program that conducts any alcohol or other drug tests ordered in accordance with divisions (B) and (C) of this section shall send the results of the tests, along with the program's recommendations as to the benefits of continued treatment, to the court and to the public 6520 6521 6522 6523 6524

children services agency providing services to the involved family, according to federal regulations set forth in 42 C.F.R. Part 2, and division (B) of section 340.15 of the Revised Code. The court shall consider the results and the recommendations sent to it under this division in any adjudication or review by the court, according to section 2151.353, 2151.414, or 2151.419 of the Revised Code. 6525 6526 6527 6528 6529 6530 6531

Sec. 2305.234. (A) As used in this section: 6532

(1) "Chiropractic claim," "medical claim," and "optometric claim" have the same meanings as in section 2305.113 of the Revised Code. 6533 6534 6535

(2) "Dental claim" has the same meaning as in section 2305.113 of the Revised Code, except that it does not include any claim arising out of a dental operation or any derivative claim for relief that arises out of a dental operation. 6536 6537 6538 6539

(3) "Governmental health care program" has the same meaning as in section 4731.65 of the Revised Code. 6540 6541

(4) "Health care facility or location" means a hospital, clinic, ambulatory surgical facility, office of a health care professional or associated group of health care professionals, training institution for health care professionals, or any other place where medical, dental, or other health-related diagnosis, care, or treatment is provided to a person. 6542 6543 6544 6545 6546 6547

(5) "Health care professional" means any of the following who provide medical, dental, or other health-related diagnosis, care, or treatment: 6548 6549 6550

(a) Physicians authorized under Chapter 4731. of the Revised Code to practice medicine and surgery or osteopathic medicine and surgery; 6551 6552 6553

(b) Registered nurses and licensed practical nurses licensed 6554

under Chapter 4723. of the Revised Code and individuals who hold a certificate of authority issued under that chapter that authorizes the practice of nursing as a certified registered nurse anesthetist, clinical nurse specialist, certified nurse-midwife, or certified nurse practitioner; 6555 6556 6557 6558 6559

(c) Physician assistants authorized to practice under Chapter 4730. of the Revised Code; 6560 6561

(d) Dentists and dental hygienists licensed under Chapter 4715. of the Revised Code; 6562 6563

(e) Physical therapists, physical therapist assistants, occupational therapists, and occupational therapy assistants licensed under Chapter 4755. of the Revised Code; 6564 6565 6566

(f) Chiropractors licensed under Chapter 4734. of the Revised Code; 6567 6568

(g) Optometrists licensed under Chapter 4725. of the Revised Code; 6569 6570

(h) Podiatrists authorized under Chapter 4731. of the Revised Code to practice podiatry; 6571 6572

(i) Dietitians licensed under Chapter 4759. of the Revised Code; 6573 6574

(j) Pharmacists licensed under Chapter 4729. of the Revised Code; 6575 6576

(k) Emergency medical technicians-basic, emergency medical technicians-intermediate, and emergency medical technicians-paramedic, certified under Chapter 4765. of the Revised Code; 6577 6578 6579 6580

(l) Respiratory care professionals licensed under Chapter 4761. of the Revised Code; 6581 6582

(m) Speech-language pathologists and audiologists licensed under Chapter 4753. of the Revised Code. 6583 6584

(6) "Health care worker" means a person other than a health 6585
care professional who provides medical, dental, or other 6586
health-related care or treatment under the direction of a health 6587
care professional with the authority to direct that individual's 6588
activities, including medical technicians, medical assistants, 6589
dental assistants, orderlies, aides, and individuals acting in 6590
similar capacities. 6591

(7) "Indigent and uninsured person" means a person who meets 6592
all of the following requirements: 6593

(a) The person's income is not greater than two hundred per 6594
cent of the current poverty line as defined by the United States 6595
office of management and budget and revised in accordance with 6596
section 673(2) of the "Omnibus Budget Reconciliation Act of 1981," 6597
95 Stat. 511, 42 U.S.C. 9902, as amended. 6598

(b) The person is ~~not eligible to receive medical assistance~~ 6599
~~under Chapter 5111.~~ ineligible for the medicaid program, the 6600
disability medical assistance ~~under Chapter 5115. of the Revised~~ 6601
~~Code or~~ program, and assistance under any other governmental 6602
health care program. 6603

(c) Either of the following applies: 6604

(i) The person is not a policyholder, certificate holder, 6605
insured, contract holder, subscriber, enrollee, member, 6606
beneficiary, or other covered individual under a health insurance 6607
or health care policy, contract, or plan. 6608

(ii) The person is a policyholder, certificate holder, 6609
insured, contract holder, subscriber, enrollee, member, 6610
beneficiary, or other covered individual under a health insurance 6611
or health care policy, contract, or plan, but the insurer, policy, 6612
contract, or plan denies coverage or is the subject of insolvency 6613
or bankruptcy proceedings in any jurisdiction. 6614

(8) "Nonprofit health care referral organization" means an 6615

entity that is not operated for profit and refers patients to, or arranges for the provision of, health-related diagnosis, care, or treatment by a health care professional or health care worker. 6616 6617 6618

(9) "Operation" means any procedure that involves cutting or otherwise infiltrating human tissue by mechanical means, including surgery, laser surgery, ionizing radiation, therapeutic ultrasound, or the removal of intraocular foreign bodies. "Operation" does not include the administration of medication by injection, unless the injection is administered in conjunction with a procedure infiltrating human tissue by mechanical means other than the administration of medicine by injection. "Operation" does not include routine dental restorative procedures, the scaling of teeth, or extractions of teeth that are not impacted. 6619 6620 6621 6622 6623 6624 6625 6626 6627 6628 6629

(10) "Tort action" means a civil action for damages for injury, death, or loss to person or property other than a civil action for damages for a breach of contract or another agreement between persons or government entities. 6630 6631 6632 6633

(11) "Volunteer" means an individual who provides any medical, dental, or other health-care related diagnosis, care, or treatment without the expectation of receiving and without receipt of any compensation or other form of remuneration from an indigent and uninsured person, another person on behalf of an indigent and uninsured person, any health care facility or location, any nonprofit health care referral organization, or any other person or government entity. 6634 6635 6636 6637 6638 6639 6640 6641

(12) "Community control sanction" has the same meaning as in section 2929.01 of the Revised Code. 6642 6643

(13) "Deep sedation" means a drug-induced depression of consciousness during which a patient cannot be easily aroused but responds purposefully following repeated or painful stimulation, a 6644 6645 6646

patient's ability to independently maintain ventilatory function may be impaired, a patient may require assistance in maintaining a patent airway and spontaneous ventilation may be inadequate, and cardiovascular function is usually maintained. 6647 6648 6649 6650

(14) "General anesthesia" means a drug-induced loss of consciousness during which a patient is not arousable, even by painful stimulation, the ability to independently maintain ventilatory function is often impaired, a patient often requires assistance in maintaining a patent airway, positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function, and cardiovascular function may be impaired. 6651 6652 6653 6654 6655 6656 6657 6658

(B)(1) Subject to divisions (F) and (G)(3) of this section, a health care professional who is a volunteer and complies with division (B)(2) of this section is not liable in damages to any person or government entity in a tort or other civil action, including an action on a medical, dental, chiropractic, optometric, or other health-related claim, for injury, death, or loss to person or property that allegedly arises from an action or omission of the volunteer in the provision to an indigent and uninsured person of medical, dental, or other health-related diagnosis, care, or treatment, including the provision of samples of medicine and other medical products, unless the action or omission constitutes willful or wanton misconduct. 6659 6660 6661 6662 6663 6664 6665 6666 6667 6668 6669 6670

(2) To qualify for the immunity described in division (B)(1) of this section, a health care professional shall do all of the following prior to providing diagnosis, care, or treatment: 6671 6672 6673

(a) Determine, in good faith, that the indigent and uninsured person is mentally capable of giving informed consent to the provision of the diagnosis, care, or treatment and is not subject to duress or under undue influence; 6674 6675 6676 6677

(b) Inform the person of the provisions of this section, including notifying the person that, by giving informed consent to the provision of the diagnosis, care, or treatment, the person cannot hold the health care professional liable for damages in a tort or other civil action, including an action on a medical, dental, chiropractic, optometric, or other health-related claim, unless the action or omission of the health care professional constitutes willful or wanton misconduct; 6678 6679 6680 6681 6682 6683 6684 6685

(c) Obtain the informed consent of the person and a written waiver, signed by the person or by another individual on behalf of and in the presence of the person, that states that the person is mentally competent to give informed consent and, without being subject to duress or under undue influence, gives informed consent to the provision of the diagnosis, care, or treatment subject to the provisions of this section. A written waiver under division (B)(2)(c) of this section shall state clearly and in conspicuous type that the person or other individual who signs the waiver is signing it with full knowledge that, by giving informed consent to the provision of the diagnosis, care, or treatment, the person cannot bring a tort or other civil action, including an action on a medical, dental, chiropractic, optometric, or other health-related claim, against the health care professional unless the action or omission of the health care professional constitutes willful or wanton misconduct. 6686 6687 6688 6689 6690 6691 6692 6693 6694 6695 6696 6697 6698 6699 6700 6701

(3) A physician or podiatrist who is not covered by medical malpractice insurance, but complies with division (B)(2) of this section, is not required to comply with division (A) of section 4731.143 of the Revised Code. 6702 6703 6704 6705

(C) Subject to divisions (F) and (G)(3) of this section, health care workers who are volunteers are not liable in damages to any person or government entity in a tort or other civil action, including an action upon a medical, dental, chiropractic, 6706 6707 6708 6709

optometric, or other health-related claim, for injury, death, or loss to person or property that allegedly arises from an action or omission of the health care worker in the provision to an indigent and uninsured person of medical, dental, or other health-related diagnosis, care, or treatment, unless the action or omission constitutes willful or wanton misconduct. 6710 6711 6712 6713 6714 6715

(D) Subject to divisions (F) and (G)(3) of this section, a nonprofit health care referral organization is not liable in damages to any person or government entity in a tort or other civil action, including an action on a medical, dental, chiropractic, optometric, or other health-related claim, for injury, death, or loss to person or property that allegedly arises from an action or omission of the nonprofit health care referral organization in referring indigent and uninsured persons to, or arranging for the provision of, medical, dental, or other health-related diagnosis, care, or treatment by a health care professional described in division (B)(1) of this section or a health care worker described in division (C) of this section, unless the action or omission constitutes willful or wanton misconduct. 6716 6717 6718 6719 6720 6721 6722 6723 6724 6725 6726 6727 6728 6729

(E) Subject to divisions (F) and (G)(3) of this section and to the extent that the registration requirements of section 3701.071 of the Revised Code apply, a health care facility or location associated with a health care professional described in division (B)(1) of this section, a health care worker described in division (C) of this section, or a nonprofit health care referral organization described in division (D) of this section is not liable in damages to any person or government entity in a tort or other civil action, including an action on a medical, dental, chiropractic, optometric, or other health-related claim, for injury, death, or loss to person or property that allegedly arises from an action or omission of the health care professional or 6730 6731 6732 6733 6734 6735 6736 6737 6738 6739 6740 6741

worker or nonprofit health care referral organization relative to the medical, dental, or other health-related diagnosis, care, or treatment provided to an indigent and uninsured person on behalf of or at the health care facility or location, unless the action or omission constitutes willful or wanton misconduct. 6742 6743 6744 6745 6746

(F)(1) Except as provided in division (F)(2) of this section, the immunities provided by divisions (B), (C), (D), and (E) of this section are not available to a health care professional, health care worker, nonprofit health care referral organization, or health care facility or location if, at the time of an alleged injury, death, or loss to person or property, the health care professionals or health care workers involved are providing one of the following: 6747 6748 6749 6750 6751 6752 6753 6754

(a) Any medical, dental, or other health-related diagnosis, care, or treatment pursuant to a community service work order entered by a court under division (B) of section 2951.02 of the Revised Code or imposed by a court as a community control sanction; 6755 6756 6757 6758 6759

(b) Performance of an operation to which any one of the following applies: 6760 6761

(i) The operation requires the administration of deep sedation or general anesthesia. 6762 6763

(ii) The operation is a procedure that is not typically performed in an office. 6764 6765

(iii) The individual involved is a health care professional, and the operation is beyond the scope of practice or the education, training, and competence, as applicable, of the health care professional. 6766 6767 6768 6769

(c) Delivery of a baby or any other purposeful termination of a human pregnancy. 6770 6771

(2) Division (F)(1) of this section does not apply when a health care professional or health care worker provides medical, dental, or other health-related diagnosis, care, or treatment that is necessary to preserve the life of a person in a medical emergency. 6772 6773 6774 6775 6776

(G)(1) This section does not create a new cause of action or substantive legal right against a health care professional, health care worker, nonprofit health care referral organization, or health care facility or location. 6777 6778 6779 6780

(2) This section does not affect any immunities from civil liability or defenses established by another section of the Revised Code or available at common law to which a health care professional, health care worker, nonprofit health care referral organization, or health care facility or location may be entitled in connection with the provision of emergency or other medical, dental, or other health-related diagnosis, care, or treatment. 6781 6782 6783 6784 6785 6786 6787

(3) This section does not grant an immunity from tort or other civil liability to a health care professional, health care worker, nonprofit health care referral organization, or health care facility or location for actions that are outside the scope of authority of health care professionals or health care workers. 6788 6789 6790 6791 6792

(4) This section does not affect any legal responsibility of a health care professional, health care worker, or nonprofit health care referral organization to comply with any applicable law of this state or rule of an agency of this state. 6793 6794 6795 6796

(5) This section does not affect any legal responsibility of a health care facility or location to comply with any applicable law of this state, rule of an agency of this state, or local code, ordinance, or regulation that pertains to or regulates building, housing, air pollution, water pollution, sanitation, health, fire, zoning, or safety. 6797 6798 6799 6800 6801 6802

Sec. 2307.65. (A) The attorney general may bring a civil action in the Franklin county court of common pleas on behalf of the department of ~~job and family services~~ health care administration, and the prosecuting attorney of the county in which a violation of division (B) of section 2913.401 of the Revised Code occurs may bring a civil action in the court of common pleas of that county on behalf of the county department of job and family services, against a person who violates division (B) of section 2913.401 of the Revised Code for the recovery of the amount of benefits paid on behalf of a person that either department would not have paid but for the violation minus any amounts paid in restitution under division (C)(2) of section 2913.401 of the Revised Code and for reasonable attorney's fees and all other fees and costs of litigation. 6803 6804 6805 6806 6807 6808 6809 6810 6811 6812 6813 6814 6815 6816

(B) In a civil action brought under division (A) of this section, if the defendant failed to disclose a transfer of property in violation of division (B)(3) of section 2913.401 of the Revised Code, the court may also grant any of the following relief to the extent permitted by 42 U.S.C. 1396p: 6817 6818 6819 6820 6821

(1) Avoidance of the transfer of property that was not disclosed in violation of division (B)(3) of section 2913.401 of the Revised Code to the extent of the amount of benefits the department would not have paid but for the violation; 6822 6823 6824 6825

(2) An order of attachment or garnishment against the property in accordance with Chapter 2715. or 2716. of the Revised Code; 6826 6827 6828

(3) An injunction against any further disposition by the transferor or transferee, or both, of the property the transfer of which was not disclosed in violation of division (B)(3) of section 2913.401 of the Revised Code or against the disposition of other property by the transferor or transferee; 6829 6830 6831 6832 6833

(4) Appointment of a receiver to take charge of the property transferred or of other property of the transferee; 6834 6835

(5) Any other relief that the court considers just and equitable. 6836 6837

(C) To the extent permitted by 42 U.S.C. 1396p, the department of ~~job and family services~~ health care administration or the county department of job and family services may enforce a judgment obtained under this section by levying on property the transfer of which was not disclosed in violation of division (B)(3) of section 2913.401 of the Revised Code or on the proceeds of the transfer of that property in accordance with Chapter 2329. of the Revised Code. 6838 6839 6840 6841 6842 6843 6844 6845

(D) The remedies provided in divisions (B) and (C) of this section do not apply if the transferee of the property the transfer of which was not disclosed in violation of division (B)(3) of section 2913.401 of the Revised Code acquired the property in good faith and for fair market value. 6846 6847 6848 6849 6850

(E) The remedies provided in this section are not exclusive and do not preclude the use of any other criminal or civil remedy for any act that is in violation of section 2913.401 of the Revised Code. 6851 6852 6853 6854

(F) Amounts of medicaid benefits paid and recovered in an action brought under this section shall be credited to the general revenue fund, and any applicable federal share shall be returned to the appropriate agency or department of the United States. 6855 6856 6857 6858

Sec. 2317.02. The following persons shall not testify in certain respects: 6859 6860

(A)(1) An attorney, concerning a communication made to the attorney by a client in that relation or the attorney's advice to a client, except that the attorney may testify by express consent 6861 6862 6863

of the client or, if the client is deceased, by the express consent of the surviving spouse or the executor or administrator of the estate of the deceased client. However, if the client voluntarily testifies or is deemed by section 2151.421 of the Revised Code to have waived any testimonial privilege under this division, the attorney may be compelled to testify on the same subject. 6864 6865 6866 6867 6868 6869 6870

The testimonial privilege established under this division does not apply concerning a communication between a client who has since died and the deceased client's attorney if the communication is relevant to a dispute between parties who claim through that deceased client, regardless of whether the claims are by testate or intestate succession or by inter vivos transaction, and the dispute addresses the competency of the deceased client when the deceased client executed a document that is the basis of the dispute or whether the deceased client was a victim of fraud, undue influence, or duress when the deceased client executed a document that is the basis of the dispute. 6871 6872 6873 6874 6875 6876 6877 6878 6879 6880 6881

(2) An attorney, concerning a communication made to the attorney by a client in that relationship or the attorney's advice to a client, except that if the client is an insurance company, the attorney may be compelled to testify, subject to an in camera inspection by a court, about communications made by the client to the attorney or by the attorney to the client that are related to the attorney's aiding or furthering an ongoing or future commission of bad faith by the client, if the party seeking disclosure of the communications has made a prima facie showing of bad faith, fraud, or criminal misconduct by the client. 6882 6883 6884 6885 6886 6887 6888 6889 6890 6891

(B)(1) A physician or a dentist concerning a communication made to the physician or dentist by a patient in that relation or the physician's or dentist's advice to a patient, except as otherwise provided in this division, division (B)(2), and division 6892 6893 6894 6895

(B)(3) of this section, and except that, if the patient is deemed by section 2151.421 of the Revised Code to have waived any testimonial privilege under this division, the physician may be compelled to testify on the same subject. 6896 6897 6898 6899

The testimonial privilege established under this division does not apply, and a physician or dentist may testify or may be compelled to testify, in any of the following circumstances: 6900 6901 6902

(a) In any civil action, in accordance with the discovery provisions of the Rules of Civil Procedure in connection with a civil action, or in connection with a claim under Chapter 4123. of the Revised Code, under any of the following circumstances: 6903 6904 6905 6906

(i) If the patient or the guardian or other legal representative of the patient gives express consent; 6907 6908

(ii) If the patient is deceased, the spouse of the patient or the executor or administrator of the patient's estate gives express consent; 6909 6910 6911

(iii) If a medical claim, dental claim, chiropractic claim, or optometric claim, as defined in section 2305.113 of the Revised Code, an action for wrongful death, any other type of civil action, or a claim under Chapter 4123. of the Revised Code is filed by the patient, the personal representative of the estate of the patient if deceased, or the patient's guardian or other legal representative. 6912 6913 6914 6915 6916 6917 6918

(b) In any civil action concerning court-ordered treatment or services received by a patient, if the court-ordered treatment or services were ordered as part of a case plan journalized under section 2151.412 of the Revised Code or the court-ordered treatment or services are necessary or relevant to dependency, neglect, or abuse or temporary or permanent custody proceedings under Chapter 2151. of the Revised Code. 6919 6920 6921 6922 6923 6924 6925

(c) In any criminal action concerning any test or the results 6926

of any test that determines the presence or concentration of alcohol, a drug of abuse, a combination of them, a controlled substance, or a metabolite of a controlled substance in the patient's whole blood, blood serum or plasma, breath, urine, or other bodily substance at any time relevant to the criminal offense in question. 6927 6928 6929 6930 6931 6932

(d) In any criminal action against a physician or dentist. In such an action, the testimonial privilege established under this division does not prohibit the admission into evidence, in accordance with the Rules of Evidence, of a patient's medical or dental records or other communications between a patient and the physician or dentist that are related to the action and obtained by subpoena, search warrant, or other lawful means. A court that permits or compels a physician or dentist to testify in such an action or permits the introduction into evidence of patient records or other communications in such an action shall require that appropriate measures be taken to ensure that the confidentiality of any patient named or otherwise identified in the records is maintained. Measures to ensure confidentiality that may be taken by the court include sealing its records or deleting specific information from its records. 6933 6934 6935 6936 6937 6938 6939 6940 6941 6942 6943 6944 6945 6946 6947

(e)(i) If the communication was between a patient who has since died and the deceased patient's physician or dentist, the communication is relevant to a dispute between parties who claim through that deceased patient, regardless of whether the claims are by testate or intestate succession or by inter vivos transaction, and the dispute addresses the competency of the deceased patient when the deceased patient executed a document that is the basis of the dispute or whether the deceased patient was a victim of fraud, undue influence, or duress when the deceased patient executed a document that is the basis of the dispute. 6948 6949 6950 6951 6952 6953 6954 6955 6956 6957 6958

(ii) If neither the spouse of a patient nor the executor or administrator of that patient's estate gives consent under division (B)(1)(a)(ii) of this section, testimony or the disclosure of the patient's medical records by a physician, dentist, or other health care provider under division (B)(1)(e)(i) of this section is a permitted use or disclosure of protected health information, as defined in 45 C.F.R. 160.103, and an authorization or opportunity to be heard shall not be required. 6959 6960 6961 6962 6963 6964 6965 6966

(iii) Division (B)(1)(e)(i) of this section does not require a mental health professional to disclose psychotherapy notes, as defined in 45 C.F.R. 164.501. 6967 6968 6969

(iv) An interested person who objects to testimony or disclosure under division (B)(1)(e)(i) of this section may seek a protective order pursuant to Civil Rule 26. 6970 6971 6972

(v) A person to whom protected health information is disclosed under division (B)(1)(e)(i) of this section shall not use or disclose the protected health information for any purpose other than the litigation or proceeding for which the information was requested and shall return the protected health information to the covered entity or destroy the protected health information, including all copies made, at the conclusion of the litigation or proceeding. 6973 6974 6975 6976 6977 6978 6979 6980

(2)(a) If any law enforcement officer submits a written statement to a health care provider that states that an official criminal investigation has begun regarding a specified person or that a criminal action or proceeding has been commenced against a specified person, that requests the provider to supply to the officer copies of any records the provider possesses that pertain to any test or the results of any test administered to the specified person to determine the presence or concentration of alcohol, a drug of abuse, a combination of them, a controlled substance, or a metabolite of a controlled substance in the 6981 6982 6983 6984 6985 6986 6987 6988 6989 6990

person's whole blood, blood serum or plasma, breath, or urine at any time relevant to the criminal offense in question, and that conforms to section 2317.022 of the Revised Code, the provider, except to the extent specifically prohibited by any law of this state or of the United States, shall supply to the officer a copy of any of the requested records the provider possesses. If the health care provider does not possess any of the requested records, the provider shall give the officer a written statement that indicates that the provider does not possess any of the requested records. 6991 6992 6993 6994 6995 6996 6997 6998 6999 7000

(b) If a health care provider possesses any records of the type described in division (B)(2)(a) of this section regarding the person in question at any time relevant to the criminal offense in question, in lieu of personally testifying as to the results of the test in question, the custodian of the records may submit a certified copy of the records, and, upon its submission, the certified copy is qualified as authentic evidence and may be admitted as evidence in accordance with the Rules of Evidence. Division (A) of section 2317.422 of the Revised Code does not apply to any certified copy of records submitted in accordance with this division. Nothing in this division shall be construed to limit the right of any party to call as a witness the person who administered the test to which the records pertain, the person under whose supervision the test was administered, the custodian of the records, the person who made the records, or the person under whose supervision the records were made. 7001 7002 7003 7004 7005 7006 7007 7008 7009 7010 7011 7012 7013 7014 7015 7016

(3)(a) If the testimonial privilege described in division (B)(1) of this section does not apply as provided in division (B)(1)(a)(iii) of this section, a physician or dentist may be compelled to testify or to submit to discovery under the Rules of Civil Procedure only as to a communication made to the physician or dentist by the patient in question in that relation, or the 7017 7018 7019 7020 7021 7022

physician's or dentist's advice to the patient in question, that related causally or historically to physical or mental injuries that are relevant to issues in the medical claim, dental claim, chiropractic claim, or optometric claim, action for wrongful death, other civil action, or claim under Chapter 4123. of the Revised Code. 7023 7024 7025 7026 7027 7028

(b) If the testimonial privilege described in division (B)(1) of this section does not apply to a physician or dentist as provided in division (B)(1)(c) of this section, the physician or dentist, in lieu of personally testifying as to the results of the test in question, may submit a certified copy of those results, and, upon its submission, the certified copy is qualified as authentic evidence and may be admitted as evidence in accordance with the Rules of Evidence. Division (A) of section 2317.422 of the Revised Code does not apply to any certified copy of results submitted in accordance with this division. Nothing in this division shall be construed to limit the right of any party to call as a witness the person who administered the test in question, the person under whose supervision the test was administered, the custodian of the results of the test, the person who compiled the results, or the person under whose supervision the results were compiled. 7029 7030 7031 7032 7033 7034 7035 7036 7037 7038 7039 7040 7041 7042 7043 7044

(4) The testimonial privilege described in division (B)(1) of this section is not waived when a communication is made by a physician to a pharmacist or when there is communication between a patient and a pharmacist in furtherance of the physician-patient relation. 7045 7046 7047 7048 7049

(5)(a) As used in divisions (B)(1) to (4) of this section, "communication" means acquiring, recording, or transmitting any information, in any manner, concerning any facts, opinions, or statements necessary to enable a physician or dentist to diagnose, treat, prescribe, or act for a patient. A "communication" may 7050 7051 7052 7053 7054

include, but is not limited to, any medical or dental, office, or hospital communication such as a record, chart, letter, memorandum, laboratory test and results, x-ray, photograph, financial statement, diagnosis, or prognosis. 7055 7056 7057 7058

(b) As used in division (B)(2) of this section, "health care provider" means a hospital, ambulatory care facility, long-term care facility, pharmacy, emergency facility, or health care practitioner. 7059 7060 7061 7062

(c) As used in division (B)(5)(b) of this section: 7063

(i) "Ambulatory care facility" means a facility that provides medical, diagnostic, or surgical treatment to patients who do not require hospitalization, including a dialysis center, ambulatory surgical facility, cardiac catheterization facility, diagnostic imaging center, extracorporeal shock wave lithotripsy center, home health agency, inpatient hospice, birthing center, radiation therapy center, emergency facility, and an urgent care center. "Ambulatory health care facility" does not include the private office of a physician or dentist, whether the office is for an individual or group practice. 7064 7065 7066 7067 7068 7069 7070 7071 7072 7073

(ii) "Emergency facility" means a hospital emergency department or any other facility that provides emergency medical services. 7074 7075 7076

(iii) "Health care practitioner" has the same meaning as in section 4769.01 of the Revised Code. 7077 7078

(iv) "Hospital" has the same meaning as in section 3727.01 of the Revised Code. 7079 7080

(v) "Long-term care facility" means a nursing home, residential care facility, or home for the aging, as those terms are defined in section 3721.01 of the Revised Code; an adult care facility, as defined in section 3722.01 of the Revised Code; a nursing facility or intermediate care facility for the mentally 7081 7082 7083 7084 7085

retarded, as those terms are defined in section ~~5111.20~~ 5164.01 of the Revised Code; a facility or portion of a facility certified as a skilled nursing facility under Title XVIII of the "Social Security Act," 49 Stat. 286 (1965), 42 U.S.C.A. 1395, as amended. 7086 7087 7088 7089

(vi) "Pharmacy" has the same meaning as in section 4729.01 of the Revised Code. 7090 7091

(d) As used in divisions (B)(1) and (2) of this section, "drug of abuse" has the same meaning as in section 4506.01 of the Revised Code. 7092 7093 7094

(6) Divisions (B)(1), (2), (3), (4), and (5) of this section apply to doctors of medicine, doctors of osteopathic medicine, doctors of podiatry, and dentists. 7095 7096 7097

(7) Nothing in divisions (B)(1) to (6) of this section affects, or shall be construed as affecting, the immunity from civil liability conferred by section 307.628 of the Revised Code or the immunity from civil liability conferred by section 2305.33 of the Revised Code upon physicians who report an employee's use of a drug of abuse, or a condition of an employee other than one involving the use of a drug of abuse, to the employer of the employee in accordance with division (B) of that section. As used in division (B)(7) of this section, "employee," "employer," and "physician" have the same meanings as in section 2305.33 of the Revised Code. 7098 7099 7100 7101 7102 7103 7104 7105 7106 7107 7108

(C)(1) A cleric, when the cleric remains accountable to the authority of that cleric's church, denomination, or sect, concerning a confession made, or any information confidentially communicated, to the cleric for a religious counseling purpose in the cleric's professional character. The cleric may testify by express consent of the person making the communication, except when the disclosure of the information is in violation of a sacred trust and except that, if the person voluntarily testifies or is 7109 7110 7111 7112 7113 7114 7115 7116

deemed by division (A)(4)(c) of section 2151.421 of the Revised Code to have waived any testimonial privilege under this division, the cleric may be compelled to testify on the same subject except when disclosure of the information is in violation of a sacred trust. 7117 7118 7119 7120 7121

(2) As used in division (C) of this section: 7122

(a) "Cleric" means a member of the clergy, rabbi, priest, Christian Science practitioner, or regularly ordained, accredited, or licensed minister of an established and legally cognizable church, denomination, or sect. 7123 7124 7125 7126

(b) "Sacred trust" means a confession or confidential communication made to a cleric in the cleric's ecclesiastical capacity in the course of discipline enjoined by the church to which the cleric belongs, including, but not limited to, the Catholic Church, if both of the following apply: 7127 7128 7129 7130 7131

(i) The confession or confidential communication was made directly to the cleric. 7132 7133

(ii) The confession or confidential communication was made in the manner and context that places the cleric specifically and strictly under a level of confidentiality that is considered inviolate by canon law or church doctrine. 7134 7135 7136 7137

(D) Husband or wife, concerning any communication made by one to the other, or an act done by either in the presence of the other, during coverture, unless the communication was made, or act done, in the known presence or hearing of a third person competent to be a witness; and such rule is the same if the marital relation has ceased to exist; 7138 7139 7140 7141 7142 7143

(E) A person who assigns a claim or interest, concerning any matter in respect to which the person would not, if a party, be permitted to testify; 7144 7145 7146

(F) A person who, if a party, would be restricted under section 2317.03 of the Revised Code, when the property or thing is sold or transferred by an executor, administrator, guardian, trustee, heir, devisee, or legatee, shall be restricted in the same manner in any action or proceeding concerning the property or thing. 7147 7148 7149 7150 7151 7152

(G)(1) A school guidance counselor who holds a valid educator license from the state board of education as provided for in section 3319.22 of the Revised Code, a person licensed under Chapter 4757. of the Revised Code as a professional clinical counselor, professional counselor, social worker, independent social worker, marriage and family therapist or independent marriage and family therapist, or registered under Chapter 4757. of the Revised Code as a social work assistant concerning a confidential communication received from a client in that relation or the person's advice to a client unless any of the following applies: 7153 7154 7155 7156 7157 7158 7159 7160 7161 7162 7163

(a) The communication or advice indicates clear and present danger to the client or other persons. For the purposes of this division, cases in which there are indications of present or past child abuse or neglect of the client constitute a clear and present danger. 7164 7165 7166 7167 7168

(b) The client gives express consent to the testimony. 7169

(c) If the client is deceased, the surviving spouse or the executor or administrator of the estate of the deceased client gives express consent. 7170 7171 7172

(d) The client voluntarily testifies, in which case the school guidance counselor or person licensed or registered under Chapter 4757. of the Revised Code may be compelled to testify on the same subject. 7173 7174 7175 7176

(e) The court in camera determines that the information 7177

communicated by the client is not germane to the counselor-client, marriage and family therapist-client, or social worker-client relationship. 7178 7179 7180

(f) A court, in an action brought against a school, its administration, or any of its personnel by the client, rules after an in-camera inspection that the testimony of the school guidance counselor is relevant to that action. 7181 7182 7183 7184

(g) The testimony is sought in a civil action and concerns court-ordered treatment or services received by a patient as part of a case plan journalized under section 2151.412 of the Revised Code or the court-ordered treatment or services are necessary or relevant to dependency, neglect, or abuse or temporary or permanent custody proceedings under Chapter 2151. of the Revised Code. 7185 7186 7187 7188 7189 7190 7191

(2) Nothing in division (G)(1) of this section shall relieve a school guidance counselor or a person licensed or registered under Chapter 4757. of the Revised Code from the requirement to report information concerning child abuse or neglect under section 2151.421 of the Revised Code. 7192 7193 7194 7195 7196

(H) A mediator acting under a mediation order issued under division (A) of section 3109.052 of the Revised Code or otherwise issued in any proceeding for divorce, dissolution, legal separation, annulment, or the allocation of parental rights and responsibilities for the care of children, in any action or proceeding, other than a criminal, delinquency, child abuse, child neglect, or dependent child action or proceeding, that is brought by or against either parent who takes part in mediation in accordance with the order and that pertains to the mediation process, to any information discussed or presented in the mediation process, to the allocation of parental rights and responsibilities for the care of the parents' children, or to the awarding of parenting time rights in relation to their children; 7197 7198 7199 7200 7201 7202 7203 7204 7205 7206 7207 7208 7209

(I) A communications assistant, acting within the scope of the communication assistant's authority, when providing telecommunications relay service pursuant to section 4931.35 of the Revised Code or Title II of the "Communications Act of 1934," 104 Stat. 366 (1990), 47 U.S.C. 225, concerning a communication made through a telecommunications relay service. Nothing in this section shall limit the obligation of a communications assistant to divulge information or testify when mandated by federal law or regulation or pursuant to subpoena in a criminal proceeding. 7210 7211 7212 7213 7214 7215 7216 7217 7218

Nothing in this section shall limit any immunity or privilege granted under federal law or regulation. 7219 7220

(J)(1) A chiropractor in a civil proceeding concerning a communication made to the chiropractor by a patient in that relation or the chiropractor's advice to a patient, except as otherwise provided in this division. The testimonial privilege established under this division does not apply, and a chiropractor may testify or may be compelled to testify, in any civil action, in accordance with the discovery provisions of the Rules of Civil Procedure in connection with a civil action, or in connection with a claim under Chapter 4123. of the Revised Code, under any of the following circumstances: 7221 7222 7223 7224 7225 7226 7227 7228 7229 7230

(a) If the patient or the guardian or other legal representative of the patient gives express consent. 7231 7232

(b) If the patient is deceased, the spouse of the patient or the executor or administrator of the patient's estate gives express consent. 7233 7234 7235

(c) If a medical claim, dental claim, chiropractic claim, or optometric claim, as defined in section 2305.113 of the Revised Code, an action for wrongful death, any other type of civil action, or a claim under Chapter 4123. of the Revised Code is filed by the patient, the personal representative of the estate of 7236 7237 7238 7239 7240

the patient if deceased, or the patient's guardian or other legal representative. 7241 7242

(2) If the testimonial privilege described in division (J)(1) of this section does not apply as provided in division (J)(1)(c) of this section, a chiropractor may be compelled to testify or to submit to discovery under the Rules of Civil Procedure only as to a communication made to the chiropractor by the patient in question in that relation, or the chiropractor's advice to the patient in question, that related causally or historically to physical or mental injuries that are relevant to issues in the medical claim, dental claim, chiropractic claim, or optometric claim, action for wrongful death, other civil action, or claim under Chapter 4123. of the Revised Code. 7243 7244 7245 7246 7247 7248 7249 7250 7251 7252 7253

(3) The testimonial privilege established under this division does not apply, and a chiropractor may testify or be compelled to testify, in any criminal action or administrative proceeding. 7254 7255 7256

(4) As used in this division, "communication" means acquiring, recording, or transmitting any information, in any manner, concerning any facts, opinions, or statements necessary to enable a chiropractor to diagnose, treat, or act for a patient. A communication may include, but is not limited to, any chiropractic, office, or hospital communication such as a record, chart, letter, memorandum, laboratory test and results, x-ray, photograph, financial statement, diagnosis, or prognosis. 7257 7258 7259 7260 7261 7262 7263 7264

(K)(1) Except as provided under division (K)(2) of this section, a critical incident stress management team member concerning a communication received from an individual who receives crisis response services from the team member, or the team member's advice to the individual, during a debriefing session. 7265 7266 7267 7268 7269 7270

(2) The testimonial privilege established under division 7271

(K)(1) of this section does not apply if any of the following are true: 7272 7273

(a) The communication or advice indicates clear and present danger to the individual who receives crisis response services or to other persons. For purposes of this division, cases in which there are indications of present or past child abuse or neglect of the individual constitute a clear and present danger. 7274 7275 7276 7277 7278

(b) The individual who received crisis response services gives express consent to the testimony. 7279 7280

(c) If the individual who received crisis response services is deceased, the surviving spouse or the executor or administrator of the estate of the deceased individual gives express consent. 7281 7282 7283

(d) The individual who received crisis response services voluntarily testifies, in which case the team member may be compelled to testify on the same subject. 7284 7285 7286

(e) The court in camera determines that the information communicated by the individual who received crisis response services is not germane to the relationship between the individual and the team member. 7287 7288 7289 7290

(f) The communication or advice pertains or is related to any criminal act. 7291 7292

(3) As used in division (K) of this section: 7293

(a) "Crisis response services" means consultation, risk assessment, referral, and on-site crisis intervention services provided by a critical incident stress management team to individuals affected by crisis or disaster. 7294 7295 7296 7297

(b) "Critical incident stress management team member" or "team member" means an individual specially trained to provide crisis response services as a member of an organized community or local crisis response team that holds membership in the Ohio 7298 7299 7300 7301

critical incident stress management network. 7302

(c) "Debriefing session" means a session at which crisis response services are rendered by a critical incident stress management team member during or after a crisis or disaster. 7303 7304 7305

(L)(1) Subject to division (L)(2) of this section and except as provided in division (L)(3) of this section, an employee assistance professional, concerning a communication made to the employee assistance professional by a client in the employee assistance professional's official capacity as an employee assistance professional. 7306 7307 7308 7309 7310 7311

(2) Division (L)(1) of this section applies to an employee assistance professional who meets either or both of the following requirements: 7312 7313 7314

(a) Is certified by the employee assistance certification commission to engage in the employee assistance profession; 7315 7316

(b) Has education, training, and experience in all of the following: 7317 7318

(i) Providing workplace-based services designed to address employer and employee productivity issues; 7319 7320

(ii) Providing assistance to employees and employees' dependents in identifying and finding the means to resolve personal problems that affect the employees or the employees' performance; 7321 7322 7323 7324

(iii) Identifying and resolving productivity problems associated with an employee's concerns about any of the following matters: health, marriage, family, finances, substance abuse or other addiction, workplace, law, and emotional issues; 7325 7326 7327 7328

(iv) Selecting and evaluating available community resources; 7329

(v) Making appropriate referrals; 7330

(vi) Local and national employee assistance agreements; 7331

(vii) Client confidentiality. 7332

(3) Division (L)(1) of this section does not apply to any of the following: 7333 7334

(a) A criminal action or proceeding involving an offense under sections 2903.01 to 2903.06 of the Revised Code if the employee assistance professional's disclosure or testimony relates directly to the facts or immediate circumstances of the offense; 7335 7336 7337 7338

(b) A communication made by a client to an employee assistance professional that reveals the contemplation or commission of a crime or serious, harmful act; 7339 7340 7341

(c) A communication that is made by a client who is an unemancipated minor or an adult adjudicated to be incompetent and indicates that the client was the victim of a crime or abuse; 7342 7343 7344

(d) A civil proceeding to determine an individual's mental competency or a criminal action in which a plea of not guilty by reason of insanity is entered; 7345 7346 7347

(e) A civil or criminal malpractice action brought against the employee assistance professional; 7348 7349

(f) When the employee assistance professional has the express consent of the client or, if the client is deceased or disabled, the client's legal representative; 7350 7351 7352

(g) When the testimonial privilege otherwise provided by division (L)(1) of this section is abrogated under law. 7353 7354

Sec. 2335.39. (A) As used in this section: 7355

(1) "Court" means any court of record. 7356

(2) "Eligible party" means a party to an action or appeal involving the state, other than the following: 7357 7358

(a) The state; 7359

(b) An individual whose net worth exceeded one million dollars at the time the action or appeal was filed; 7360 7361

(c) A sole owner of an unincorporated business that had, or a partnership, corporation, association, or organization that had, a net worth exceeding five million dollars at the time the action or appeal was filed, except that an organization that is described in subsection 501(c)(3) and is tax exempt under subsection 501(a) of the Internal Revenue Code shall not be excluded as an eligible party under this division because of its net worth; 7362 7363 7364 7365 7366 7367 7368

(d) A sole owner of an unincorporated business that employed, or a partnership, corporation, association, or organization that employed, more than five hundred persons at the time the action or appeal was filed. 7369 7370 7371 7372

(3) "Fees" means reasonable attorney's fees, in an amount not to exceed seventy-five dollars per hour or a higher hourly fee approved by the court. 7373 7374 7375

(4) "Internal Revenue Code" means the "Internal Revenue Code of 1954," 68A Stat. 3, 26 U.S.C. 1, as amended. 7376 7377

(5) "Prevailing eligible party" means an eligible party that prevails in an action or appeal involving the state. 7378 7379

(6) "State" has the same meaning as in section 2743.01 of the Revised Code. 7380 7381

(B)(1) Except as provided in divisions (B)(2) and (F) of this section, in a civil action, or appeal of a judgment in a civil action, to which the state is a party, or in an appeal of an adjudication order of an agency pursuant to section 119.12 of the Revised Code, the prevailing eligible party is entitled, upon filing a motion in accordance with this division, to compensation for fees incurred by that party in connection with the action or appeal. Compensation, when payable to a prevailing eligible party under this section, is in addition to any other costs and expenses 7382 7383 7384 7385 7386 7387 7388 7389 7390

that may be awarded to that party by the court pursuant to law or rule. 7391 7392

A prevailing eligible party that desires an award of compensation for fees shall file a motion requesting the award with the court within thirty days after the court enters final judgment in the action or appeal. The motion shall do all of the following: 7393 7394 7395 7396 7397

(a) Identify the party; 7398

(b) Indicate that the party is the prevailing eligible party and is entitled to receive an award of compensation for fees; 7399 7400

(c) Include a statement that the state's position in initiating the matter in controversy was not substantially justified; 7401 7402 7403

(d) Indicate the amount sought as an award; 7404

(e) Itemize all fees sought in the requested award. The itemization shall include a statement from any attorney who represented the prevailing eligible party, that indicates the fees charged, the actual time expended, and the rate at which the fees were calculated. 7405 7406 7407 7408 7409

(2) Upon the filing of a motion under this section, the court shall review the request for the award of compensation for fees and determine whether the position of the state in initiating the matter in controversy was substantially justified, whether special circumstances make an award unjust, and whether the prevailing eligible party engaged in conduct during the course of the action or appeal that unduly and unreasonably protracted the final resolution of the matter in controversy. The court shall issue an order, in writing, on the motion of the prevailing eligible party, which order shall include a statement indicating whether an award has been granted, the findings and conclusions underlying it, the reasons or bases for the findings and conclusions, and, if an 7410 7411 7412 7413 7414 7415 7416 7417 7418 7419 7420 7421

award has been granted, its amount. The order shall be included in the record of the action or appeal, and the clerk of the court shall mail a certified copy of it to the state and the prevailing eligible party. 7422 7423 7424 7425

With respect to a motion under this section, the state has the burden of proving that its position in initiating the matter in controversy was substantially justified, that special circumstances make an award unjust, or that the prevailing eligible party engaged in conduct during the course of the action or appeal that unduly and unreasonably protracted the final resolution of the matter in controversy. 7426 7427 7428 7429 7430 7431 7432

A court considering a motion under this section may deny an award entirely, or reduce the amount of an award that otherwise would be payable, to a prevailing eligible party only as follows: 7433 7434 7435

(a) If the court determines that the state has sustained its burden of proof that its position in initiating the matter in controversy was substantially justified or that special circumstances make an award unjust, the motion shall be denied; 7436 7437 7438 7439

(b) If the court determines that the state has sustained its burden of proof that the prevailing eligible party engaged in conduct during the course of the action or appeal that unduly and unreasonably protracted the final resolution of the matter in controversy, the court may reduce the amount of an award, or deny an award, to that party to the extent of that conduct. 7440 7441 7442 7443 7444 7445

An order of a court considering a motion under this section is appealable as in other cases, by a prevailing eligible party that is denied an award or receives a reduced award. If the case is an appeal of the adjudication order of an agency pursuant to section 119.12 of the Revised Code, the agency may appeal an order granting an award. The order of the court may be modified by the appellate court only if it finds that the grant or the failure to 7446 7447 7448 7449 7450 7451 7452

grant an award, or the calculation of the amount of an award, involved an abuse of discretion. 7453 7454

(C) Compensation for fees awarded to a prevailing eligible party under this section may be paid by the specific branch of the state government or the state department, board, office, commission, agency, institution, or other instrumentality over which the party prevailed in the action or appeal from any funds available to it for payment of such compensation. If compensation is not paid from such funds or such funds are not available, upon the filing of the court's order in favor of the prevailing eligible party with the clerk of the court of claims, the order shall be treated as if it were a judgment under Chapter 2743. of the Revised Code and be payable in accordance with the procedures specified in section 2743.19 of the Revised Code, except that interest shall not be paid in relation to the award. 7455 7456 7457 7458 7459 7460 7461 7462 7463 7464 7465 7466 7467

(D) If compensation for fees is awarded under this section to a prevailing eligible party that is appealing an agency adjudication order pursuant to section 119.12 of the Revised Code, it shall include the fees incurred in the appeal and, if requested in the motion, the fees incurred by the party in the adjudication hearing conducted under Chapter 119. of the Revised Code. A motion containing such a request shall itemize, in the manner described in division (B)(1)(e) of section 119.092 of the Revised Code, the fees, as defined in that section, that are sought in an award. 7468 7469 7470 7471 7472 7473 7474 7475 7476

(E) Each court that orders during any fiscal year compensation for fees to be paid to a prevailing eligible party pursuant to this section shall prepare a report for that year. The report shall be completed no later than the first day of October of the fiscal year following the fiscal year covered by the report, and copies of it shall be filed with the general assembly. It shall contain the following information: 7477 7478 7479 7480 7481 7482 7483

(1) The total amount and total number of awards of 7484

compensation for fees required to be paid to prevailing eligible parties; 7485 7486

(2) The amount and nature of each individual award ordered; 7487

(3) Any other information that may aid the general assembly in evaluating the scope and impact of awards of compensation for fees. 7488 7489 7490

(F) The provisions of this section do not apply in any of the following: 7491 7492

(1) Appropriation proceedings under Chapter 163. of the Revised Code; 7493 7494

(2) Civil actions or appeals of civil actions that involve torts; 7495 7496

(3) An appeal pursuant to section 119.12 of the Revised Code that involves any of the following: 7497 7498

(a) An adjudication order entered after a hearing described in division (F) of section 119.092 of the Revised Code; 7499 7500

(b) A prevailing eligible party represented in the appeal by an attorney who was paid pursuant to an appropriation by the federal or state government or a local government; 7501 7502 7503

(c) An administrative appeal decision made under section 5101.35 <u>or 5160.34</u> of the Revised Code. 7504 7505

Sec. 2505.02. (A) As used in this section: 7506

(1) "Substantial right" means a right that the United States Constitution, the Ohio Constitution, a statute, the common law, or a rule of procedure entitles a person to enforce or protect. 7507 7508 7509

(2) "Special proceeding" means an action or proceeding that is specially created by statute and that prior to 1853 was not denoted as an action at law or a suit in equity. 7510 7511 7512

(3) "Provisional remedy" means a proceeding ancillary to an action, including, but not limited to, a proceeding for a preliminary injunction, attachment, discovery of privileged matter, suppression of evidence, a prima-facie showing pursuant to section 2307.85 or 2307.86 of the Revised Code, a prima-facie showing pursuant to section 2307.92 of the Revised Code, or a finding made pursuant to division (A)(3) of section 2307.93 of the Revised Code. 7513 7514 7515 7516 7517 7518 7519 7520

(B) An order is a final order that may be reviewed, affirmed, modified, or reversed, with or without retrial, when it is one of the following: 7521 7522 7523

(1) An order that affects a substantial right in an action that in effect determines the action and prevents a judgment; 7524 7525

(2) An order that affects a substantial right made in a special proceeding or upon a summary application in an action after judgment; 7526 7527 7528

(3) An order that vacates or sets aside a judgment or grants a new trial; 7529 7530

(4) An order that grants or denies a provisional remedy and to which both of the following apply: 7531 7532

(a) The order in effect determines the action with respect to the provisional remedy and prevents a judgment in the action in favor of the appealing party with respect to the provisional remedy. 7533 7534 7535 7536

(b) The appealing party would not be afforded a meaningful or effective remedy by an appeal following final judgment as to all proceedings, issues, claims, and parties in the action. 7537 7538 7539

(5) An order that determines that an action may or may not be maintained as a class action; 7540 7541

(6) An order determining the constitutionality of any changes 7542

to the Revised Code made by Am. Sub. S.B. 281 of the 124th general 7543
assembly, including the amendment of sections 1751.67, 2117.06, 7544
2305.11, 2305.15, 2305.234, 2317.02, 2317.54, 2323.56, 2711.21, 7545
2711.22, 2711.23, 2711.24, 2743.02, 2743.43, 2919.16, 3923.63, 7546
3923.64, 4705.15, and ~~5111.018~~ 5163.17, and the enactment of 7547
sections 2305.113, 2323.41, 2323.43, and 2323.55 of the Revised 7548
Code or any changes made by Sub. S.B. 80 of the 125th general 7549
assembly, including the amendment of sections 2125.02, 2305.10, 7550
2305.131, 2315.18, 2315.19, and 2315.21 of the Revised Code; 7551

(7) An order in an appropriation proceeding that may be 7552
appealed pursuant to division (B)(3) of section 163.09 of the 7553
Revised Code. 7554

(C) When a court issues an order that vacates or sets aside a 7555
judgment or grants a new trial, the court, upon the request of 7556
either party, shall state in the order the grounds upon which the 7557
new trial is granted or the judgment vacated or set aside. 7558

(D) This section applies to and governs any action, including 7559
an appeal, that is pending in any court on July 22, 1998, and all 7560
claims filed or actions commenced on or after July 22, 1998, 7561
notwithstanding any provision of any prior statute or rule of law 7562
of this state. 7563

Sec. 2705.02. A person guilty of any of the following acts 7564
may be punished as for a contempt: 7565

(A) Disobedience of, or resistance to, a lawful writ, 7566
process, order, rule, judgment, or command of a court or officer; 7567

(B) Misbehavior of an officer of the court in the performance 7568
of official duties, or in official transactions; 7569

(C) A failure to obey a subpoena duly served, or a refusal to 7570
be sworn or to answer as a witness, when lawfully required; 7571

(D) The rescue, or attempted rescue, of a person or of 7572

property in the custody of an officer by virtue of an order or process of court held by the officer; 7573 7574

(E) A failure upon the part of a person recognized to appear as a witness in a court to appear in compliance with the terms of the person's recognizance; 7575 7576 7577

(F) A failure to comply with an order issued pursuant to section 3109.19 or 3111.81 of the Revised Code; 7578 7579

(G) A failure to obey a subpoena issued by the department of job and family services or a child support enforcement agency pursuant to section 5101.37 of the Revised Code; 7580 7581 7582

(H) A failure to obey a subpoena issued by the department of health care administration pursuant to section 5160.28 of the Revised Code; 7583 7584 7585

(I) A willful failure to submit to genetic testing, or a willful failure to submit a child to genetic testing, as required by an order for genetic testing issued under section 3111.41 of the Revised Code. 7586 7587 7588 7589

Sec. 2744.05. Notwithstanding any other provisions of the Revised Code or rules of a court to the contrary, in an action against a political subdivision to recover damages for injury, death, or loss to person or property caused by an act or omission in connection with a governmental or proprietary function: 7590 7591 7592 7593 7594

(A) Punitive or exemplary damages shall not be awarded. 7595

(B)(1) If a claimant receives or is entitled to receive benefits for injuries or loss allegedly incurred from a policy or policies of insurance or any other source, the benefits shall be disclosed to the court, and the amount of the benefits shall be deducted from any award against a political subdivision recovered by that claimant. No insurer or other person is entitled to bring an action under a subrogation provision in an insurance or other 7596 7597 7598 7599 7600 7601 7602

contract against a political subdivision with respect to those benefits.

The amount of the benefits shall be deducted from an award against a political subdivision under division (B)(1) of this section regardless of whether the claimant may be under an obligation to pay back the benefits upon recovery, in whole or in part, for the claim. A claimant whose benefits have been deducted from an award under division (B)(1) of this section is not considered fully compensated and shall not be required to reimburse a subrogated claim for benefits deducted from an award pursuant to division (B)(1) of this section.

(2) Nothing in division (B)(1) of this section shall be construed to do either of the following:

(a) Limit the rights of a beneficiary under a life insurance policy or the rights of sureties under fidelity or surety bonds;

(b) Prohibit the department of ~~job and family services~~ health care administration from recovering from the political subdivision, pursuant to section ~~5101.58~~ 5160.38 of the Revised Code, the cost of medical assistance benefits provided under ~~sections 5101.5211 to 5101.5216 or Chapter 5107., 5111., or 5115. of the Revised Code~~ the medicaid program, disability medical assistance program, or children's buy-in program.

(C)(1) There shall not be any limitation on compensatory damages that represent the actual loss of the person who is awarded the damages. However, except in wrongful death actions brought pursuant to Chapter 2125. of the Revised Code, damages that arise from the same cause of action, transaction or occurrence, or series of transactions or occurrences and that do not represent the actual loss of the person who is awarded the damages shall not exceed two hundred fifty thousand dollars in favor of any one person. The limitation on damages that do not

represent the actual loss of the person who is awarded the damages provided in this division does not apply to court costs that are awarded to a plaintiff, or to interest on a judgment rendered in favor of a plaintiff, in an action against a political subdivision. 7634 7635 7636 7637 7638

(2) As used in this division, "the actual loss of the person who is awarded the damages" includes all of the following: 7639 7640

(a) All wages, salaries, or other compensation lost by the person injured as a result of the injury, including wages, salaries, or other compensation lost as of the date of a judgment and future expected lost earnings of the person injured; 7641 7642 7643 7644

(b) All expenditures of the person injured or another person on behalf of the person injured for medical care or treatment, for rehabilitation services, or for other care, treatment, services, products, or accommodations that were necessary because of the injury; 7645 7646 7647 7648 7649

(c) All expenditures to be incurred in the future, as determined by the court, by the person injured or another person on behalf of the person injured for medical care or treatment, for rehabilitation services, or for other care, treatment, services, products, or accommodations that will be necessary because of the injury; 7650 7651 7652 7653 7654 7655

(d) All expenditures of a person whose property was injured or destroyed or of another person on behalf of the person whose property was injured or destroyed in order to repair or replace the property that was injured or destroyed; 7656 7657 7658 7659

(e) All expenditures of the person injured or of the person whose property was injured or destroyed or of another person on behalf of the person injured or of the person whose property was injured or destroyed in relation to the actual preparation or presentation of the claim involved; 7660 7661 7662 7663 7664

(f) Any other expenditures of the person injured or of the person whose property was injured or destroyed or of another person on behalf of the person injured or of the person whose property was injured or destroyed that the court determines represent an actual loss experienced because of the personal or property injury or property loss. 7665 7666 7667 7668 7669 7670

"The actual loss of the person who is awarded the damages" does not include any fees paid or owed to an attorney for any services rendered in relation to a personal or property injury or property loss, and does not include any damages awarded for pain and suffering, for the loss of society, consortium, companionship, care, assistance, attention, protection, advice, guidance, counsel, instruction, training, or education of the person injured, for mental anguish, or for any other intangible loss. 7671 7672 7673 7674 7675 7676 7677 7678

Sec. 2903.33. As used in sections 2903.33 to 2903.36 of the Revised Code: 7679 7680

(A) "Care facility" means any of the following: 7681

(1) Any "home" as defined in section 3721.10 or ~~5111.20~~ 5164.01 of the Revised Code; 7682 7683

(2) Any "residential facility" as defined in section 5123.19 of the Revised Code; 7684 7685

(3) Any institution or facility operated or provided by the department of mental health or by the department of mental retardation and developmental disabilities pursuant to sections 5119.02 and 5123.03 of the Revised Code; 7686 7687 7688 7689

(4) Any "residential facility" as defined in section 5119.22 of the Revised Code; 7690 7691

(5) Any unit of any hospital, as defined in section 3701.01 of the Revised Code, that provides the same services as a nursing home, as defined in section 3721.01 of the Revised Code; 7692 7693 7694

(6) Any institution, residence, or facility that provides, for a period of more than twenty-four hours, whether for a consideration or not, accommodations to one individual or two unrelated individuals who are dependent upon the services of others; 7695 7696 7697 7698 7699

(7) Any "adult care facility" as defined in section 3722.01 of the Revised Code; 7700 7701

(8) Any adult foster home certified by the department of aging or its designee under section 173.36 of the Revised Code; 7702 7703

(9) Any "community alternative home" as defined in section 3724.01 of the Revised Code. 7704 7705

(B) "Abuse" means knowingly causing physical harm or recklessly causing serious physical harm to a person by physical contact with the person or by the inappropriate use of a physical or chemical restraint, medication, or isolation on the person. 7706 7707 7708 7709

(C)(1) "Gross neglect" means knowingly failing to provide a person with any treatment, care, goods, or service that is necessary to maintain the health or safety of the person when the failure results in physical harm or serious physical harm to the person. 7710 7711 7712 7713 7714

(2) "Neglect" means recklessly failing to provide a person with any treatment, care, goods, or service that is necessary to maintain the health or safety of the person when the failure results in serious physical harm to the person. 7715 7716 7717 7718

(D) "Inappropriate use of a physical or chemical restraint, medication, or isolation" means the use of physical or chemical restraint, medication, or isolation as punishment, for staff convenience, excessively, as a substitute for treatment, or in quantities that preclude habilitation and treatment. 7719 7720 7721 7722 7723

Sec. 2913.40. (A) As used in this section: 7724

(1) "Statement or representation" means any oral, written, electronic, electronic impulse, or magnetic communication that is used to identify an item of goods or a service for which reimbursement may be made under the ~~medical assistance~~ medicaid program or that states income and expense and is or may be used to determine a rate of reimbursement under the ~~medical assistance~~ medicaid program.

(2) ~~"Medical assistance program" means the program established by the department of job and family services to provide medical assistance under section 5111.01 of the Revised Code and the medicaid program of Title XIX of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C. 301, as amended.~~

~~(3)~~ "Provider" means any person who has signed a provider agreement with the department of ~~job and family services~~ health care administration to provide goods or services pursuant to the ~~medical assistance~~ medicaid program or any person who has signed an agreement with a party to such a provider agreement under which the person agrees to provide goods or services that are reimbursable under the ~~medical assistance~~ medicaid program.

(4) "Provider agreement" means an oral or written agreement between the department of ~~job and family services~~ health care administration and a person in which the person agrees to provide goods or services under the ~~medical assistance~~ medicaid program.

(5) "Recipient" means any individual who receives goods or services from a provider under the ~~medical assistance~~ medicaid program.

(6) "Records" means any medical, professional, financial, or business records relating to the treatment or care of any recipient, to goods or services provided to any recipient, or to rates paid for goods or services provided to any recipient and any records that are required by the rules of the director of ~~job and~~

~~family services~~ health care administration to be kept for the 7756
~~medical assistance~~ medicaid program. 7757

(B) No person shall knowingly make or cause to be made a 7758
false or misleading statement or representation for use in 7759
obtaining reimbursement from the ~~medical assistance~~ medicaid 7760
program. 7761

(C) No person, with purpose to commit fraud or knowing that 7762
the person is facilitating a fraud, shall do either of the 7763
following: 7764

(1) Contrary to the terms of the person's provider agreement, 7765
charge, solicit, accept, or receive for goods or services that the 7766
person provides under the ~~medical assistance~~ medicaid program any 7767
property, money, or other consideration in addition to the amount 7768
of reimbursement under the ~~medical assistance~~ medicaid program and 7769
the person's provider agreement for the goods or services and any 7770
cost-sharing expenses authorized by section ~~5111.0112~~ 5162.35 of 7771
the Revised Code or rules adopted pursuant to section ~~5111.01,~~ 7772
~~5111.011,~~ 5162.20 or ~~5111.02~~ 5163.15 of the Revised Code. 7773

(2) Solicit, offer, or receive any remuneration, other than 7774
any cost-sharing expenses authorized by section ~~5111.0112~~ 5162.35 7775
of the Revised Code or rules adopted under section ~~5111.01,~~ 7776
~~5111.011,~~ 5162.20 or ~~5111.02~~ 5163.15 of the Revised Code, in cash 7777
or in kind, including, but not limited to, a kickback or rebate, 7778
in connection with the furnishing of goods or services for which 7779
whole or partial reimbursement is or may be made under the ~~medical~~ 7780
~~assistance~~ medicaid program. 7781

(D) No person, having submitted a claim for or provided goods 7782
or services under the ~~medical assistance~~ medicaid program, shall 7783
do either of the following for a period of at least six years 7784
after a reimbursement pursuant to that claim, or a reimbursement 7785
for those goods or services, is received under the ~~medical~~ 7786

~~assistance~~ medicaid program: 7787

(1) Knowingly alter, falsify, destroy, conceal, or remove any records that are necessary to fully disclose the nature of all goods or services for which the claim was submitted, or for which reimbursement was received, by the person; 7788 7789 7790 7791

(2) Knowingly alter, falsify, destroy, conceal, or remove any records that are necessary to disclose fully all income and expenditures upon which rates of reimbursements were based for the person. 7792 7793 7794 7795

(E) Whoever violates this section is guilty of medicaid fraud. Except as otherwise provided in this division, medicaid fraud is a misdemeanor of the first degree. If the value of property, services, or funds obtained in violation of this section is five hundred dollars or more and is less than five thousand dollars, medicaid fraud is a felony of the fifth degree. If the value of property, services, or funds obtained in violation of this section is five thousand dollars or more and is less than one hundred thousand dollars, medicaid fraud is a felony of the fourth degree. If the value of the property, services, or funds obtained in violation of this section is one hundred thousand dollars or more, medicaid fraud is a felony of the third degree. 7796 7797 7798 7799 7800 7801 7802 7803 7804 7805 7806 7807

(F) Upon application of the governmental agency, office, or other entity that conducted the investigation and prosecution in a case under this section, the court shall order any person who is convicted of a violation of this section for receiving any reimbursement for furnishing goods or services under the ~~medical assistance~~ medicaid program to which the person is not entitled to pay to the applicant its cost of investigating and prosecuting the case. The costs of investigation and prosecution that a defendant is ordered to pay pursuant to this division shall be in addition to any other penalties for the receipt of that reimbursement that are provided in this section, section ~~5111.03~~ 5163.03 of the 7808 7809 7810 7811 7812 7813 7814 7815 7816 7817 7818

Revised Code, or any other provision of law.

(G) The provisions of this section are not intended to be exclusive remedies and do not preclude the use of any other criminal or civil remedy for any act that is in violation of this section.

Sec. 2913.401. (A) As used in this section:

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

(2) "Property" means any real or personal property or other asset in which a person has any legal title or interest.

(B) No person shall knowingly do any of the following in an application for medicaid benefits or in a document that requires a disclosure of assets for the purpose of determining eligibility to receive medicaid benefits:

(1) Make or cause to be made a false or misleading statement;

(2) Conceal an interest in property;

(3)(a) Except as provided in division (B)(3)(b) of this section, fail to disclose a transfer of property that occurred during the period beginning thirty-six months before submission of the application or document and ending on the date the application or document was submitted;

(b) Fail to disclose a transfer of property that occurred during the period beginning sixty months before submission of the application or document and ending on the date the application or document was submitted and that was made to an irrevocable trust a portion of which is not distributable to the applicant for medicaid benefits or the recipient of medicaid benefits or to a revocable trust.

(C)(1) Whoever violates this section is guilty of medicaid eligibility fraud. Except as otherwise provided in this division, a violation of this section is a misdemeanor of the first degree. If the value of the medicaid benefits paid as a result of the violation is five hundred dollars or more and is less than five thousand dollars, a violation of this section is a felony of the fifth degree. If the value of the medicaid benefits paid as a result of the violation is five thousand dollars or more and is less than one hundred thousand dollars, a violation of this section is a felony of the fourth degree. If the value of the medicaid benefits paid as a result of the violation is one hundred thousand dollars or more, a violation of this section is a felony of the third degree. 7848 7849 7850 7851 7852 7853 7854 7855 7856 7857 7858 7859 7860

(2) In addition to imposing a sentence under division (C)(1) of this section, the court shall order that a person who is guilty of medicaid eligibility fraud make restitution in the full amount of any medicaid benefits paid on behalf of an applicant for or recipient of medicaid benefits for which the applicant or recipient was not eligible, plus interest at the rate applicable to judgments on unreimbursed amounts from the date on which the benefits were paid to the date on which restitution is made. 7861 7862 7863 7864 7865 7866 7867 7868

(3) The remedies and penalties provided in this section are not exclusive and do not preclude the use of any other criminal or civil remedy for any act that is in violation of this section. 7869 7870 7871

(D) This section does not apply to a person who fully disclosed in an application for medicaid benefits or in a document that requires a disclosure of assets for the purpose of determining eligibility to receive medicaid benefits all of the interests in property of the applicant for or recipient of medicaid benefits, all transfers of property by the applicant for or recipient of medicaid benefits, and the circumstances of all those transfers. 7872 7873 7874 7875 7876 7877 7878 7879

(E) Any amounts of medicaid benefits recovered as restitution under this section and any interest on those amounts shall be credited to the general revenue fund, and any applicable federal share shall be returned to the appropriate agency or department of the United States. 7880 7881 7882 7883 7884

Sec. 2921.01. As used in sections 2921.01 to 2921.45 of the Revised Code: 7885 7886

(A) "Public official" means any elected or appointed officer, or employee, or agent of the state or any political subdivision, whether in a temporary or permanent capacity, and includes, but is not limited to, legislators, judges, and law enforcement officers. 7887 7888 7889 7890

(B) "Public servant" means any of the following: 7891

(1) Any public official; 7892

(2) Any person performing ad hoc a governmental function, including, but not limited to, a juror, member of a temporary commission, master, arbitrator, advisor, or consultant; 7893 7894 7895

(3) A person who is a candidate for public office, whether or not the person is elected or appointed to the office for which the person is a candidate. A person is a candidate for purposes of this division if the person has been nominated according to law for election or appointment to public office, or if the person has filed a petition or petitions as required by law to have the person's name placed on the ballot in a primary, general, or special election, or if the person campaigns as a write-in candidate in any primary, general, or special election. 7896 7897 7898 7899 7900 7901 7902 7903 7904

(C) "Party official" means any person who holds an elective or appointive post in a political party in the United States or this state, by virtue of which the person directs, conducts, or participates in directing or conducting party affairs at any level of responsibility. 7905 7906 7907 7908 7909

(D) "Official proceeding" means any proceeding before a legislative, judicial, administrative, or other governmental agency or official authorized to take evidence under oath, and includes any proceeding before a referee, hearing examiner, commissioner, notary, or other person taking testimony or a deposition in connection with an official proceeding. 7910 7911 7912 7913 7914 7915

(E) "Detention" means arrest; confinement in any vehicle subsequent to an arrest; confinement in any public or private facility for custody of persons charged with or convicted of crime in this state or another state or under the laws of the United States or alleged or found to be a delinquent child or unruly child in this state or another state or under the laws of the United States; hospitalization, institutionalization, or confinement in any public or private facility that is ordered pursuant to or under the authority of section 2945.37, 2945.371, 2945.38, 2945.39, 2945.40, 2945.401, or 2945.402 of the Revised Code; confinement in any vehicle for transportation to or from any facility of any of those natures; detention for extradition or deportation; except as provided in this division, supervision by any employee of any facility of any of those natures that is incidental to hospitalization, institutionalization, or confinement in the facility but that occurs outside the facility; supervision by an employee of the department of rehabilitation and correction of a person on any type of release from a state correctional institution; or confinement in any vehicle, airplane, or place while being returned from outside of this state into this state by a private person or entity pursuant to a contract entered into under division (E) of section 311.29 of the Revised Code or division (B) of section 5149.03 of the Revised Code. For a person confined in a county jail who participates in a county jail industry program pursuant to section 5147.30 of the Revised Code, "detention" includes time spent at an assigned work site and going to and from the work site. 7916 7917 7918 7919 7920 7921 7922 7923 7924 7925 7926 7927 7928 7929 7930 7931 7932 7933 7934 7935 7936 7937 7938 7939 7940 7941 7942

(F) "Detention facility" means any public or private place 7943
used for the confinement of a person charged with or convicted of 7944
any crime in this state or another state or under the laws of the 7945
United States or alleged or found to be a delinquent child or 7946
unruly child in this state or another state or under the laws of 7947
the United States. 7948

(G) "Valuable thing or valuable benefit" includes, but is not 7949
limited to, a contribution. This inclusion does not indicate or 7950
imply that a contribution was not included in those terms before 7951
September 17, 1986. 7952

(H) "Campaign committee," "contribution," "political action 7953
committee," "legislative campaign fund," "political party," and 7954
"political contributing entity" have the same meanings as in 7955
section 3517.01 of the Revised Code. 7956

(I) "Provider agreement" ~~and "medical assistance program"~~ 7957
~~have~~ has the same ~~meanings~~ meaning as in section 2913.40 of the 7958
Revised Code. 7959

Sec. 2921.13. (A) No person shall knowingly make a false 7960
statement, or knowingly swear or affirm the truth of a false 7961
statement previously made, when any of the following applies: 7962

(1) The statement is made in any official proceeding. 7963

(2) The statement is made with purpose to incriminate 7964
another. 7965

(3) The statement is made with purpose to mislead a public 7966
official in performing the public official's official function. 7967

(4) The statement is made with purpose to secure the payment 7968
of unemployment compensation; Ohio works first; prevention, 7969
retention, and contingency benefits and services; disability 7970
financial assistance; retirement benefits; economic development 7971
assistance, as defined in section 9.66 of the Revised Code; or 7972

other benefits administered by a governmental agency or paid out of a public treasury. 7973 7974

(5) The statement is made with purpose to secure the issuance by a governmental agency of a license, permit, authorization, certificate, registration, release, or provider agreement. 7975 7976 7977

(6) The statement is sworn or affirmed before a notary public or another person empowered to administer oaths. 7978 7979

(7) The statement is in writing on or in connection with a report or return that is required or authorized by law. 7980 7981

(8) The statement is in writing and is made with purpose to induce another to extend credit to or employ the offender, to confer any degree, diploma, certificate of attainment, award of excellence, or honor on the offender, or to extend to or bestow upon the offender any other valuable benefit or distinction, when the person to whom the statement is directed relies upon it to that person's detriment. 7982 7983 7984 7985 7986 7987 7988

(9) The statement is made with purpose to commit or facilitate the commission of a theft offense. 7989 7990

(10) The statement is knowingly made to a probate court in connection with any action, proceeding, or other matter within its jurisdiction, either orally or in a written document, including, but not limited to, an application, petition, complaint, or other pleading, or an inventory, account, or report. 7991 7992 7993 7994 7995

(11) The statement is made on an account, form, record, stamp, label, or other writing that is required by law. 7996 7997

(12) The statement is made in connection with the purchase of a firearm, as defined in section 2923.11 of the Revised Code, and in conjunction with the furnishing to the seller of the firearm of a fictitious or altered driver's or commercial driver's license or permit, a fictitious or altered identification card, or any other 7998 7999 8000 8001 8002

document that contains false information about the purchaser's 8003
identity. 8004

(13) The statement is made in a document or instrument of 8005
writing that purports to be a judgment, lien, or claim of 8006
indebtedness and is filed or recorded with the secretary of state, 8007
a county recorder, or the clerk of a court of record. 8008

(14) The statement is made with purpose to obtain an Ohio's 8009
best Rx program enrollment card under section ~~173.773~~ 5169.073 of 8010
the Revised Code or a payment under section ~~173.801~~ 5169.101 of 8011
the Revised Code. 8012

(15) The statement is made in an application filed with a 8013
county sheriff pursuant to section 2923.125 of the Revised Code in 8014
order to obtain or renew a license to carry a concealed handgun or 8015
is made in an affidavit submitted to a county sheriff to obtain a 8016
temporary emergency license to carry a concealed handgun under 8017
section 2923.1213 of the Revised Code. 8018

(16) The statement is required under section 5743.71 of the 8019
Revised Code in connection with the person's purchase of 8020
cigarettes or tobacco products in a delivery sale. 8021

(B) No person, in connection with the purchase of a firearm, 8022
as defined in section 2923.11 of the Revised Code, shall knowingly 8023
furnish to the seller of the firearm a fictitious or altered 8024
driver's or commercial driver's license or permit, a fictitious or 8025
altered identification card, or any other document that contains 8026
false information about the purchaser's identity. 8027

(C) No person, in an attempt to obtain a license to carry a 8028
concealed handgun under section 2923.125 of the Revised Code, 8029
shall knowingly present to a sheriff a fictitious or altered 8030
document that purports to be certification of the person's 8031
competence in handling a handgun as described in division (B)(3) 8032
of section 2923.125 of the Revised Code. 8033

(D) It is no defense to a charge under division (A)(6) of this section that the oath or affirmation was administered or taken in an irregular manner. 8034 8035 8036

(E) If contradictory statements relating to the same fact are made by the offender within the period of the statute of limitations for falsification, it is not necessary for the prosecution to prove which statement was false but only that one or the other was false. 8037 8038 8039 8040 8041

(F)(1) Whoever violates division (A)(1), (2), (3), (4), (5), (6), (7), (8), (10), (11), (13), (14), or (16) of this section is guilty of falsification, a misdemeanor of the first degree. 8042 8043 8044

(2) Whoever violates division (A)(9) of this section is guilty of falsification in a theft offense. Except as otherwise provided in this division, falsification in a theft offense is a misdemeanor of the first degree. If the value of the property or services stolen is five hundred dollars or more and is less than five thousand dollars, falsification in a theft offense is a felony of the fifth degree. If the value of the property or services stolen is five thousand dollars or more and is less than one hundred thousand dollars, falsification in a theft offense is a felony of the fourth degree. If the value of the property or services stolen is one hundred thousand dollars or more, falsification in a theft offense is a felony of the third degree. 8045 8046 8047 8048 8049 8050 8051 8052 8053 8054 8055 8056

(3) Whoever violates division (A)(12) or (B) of this section is guilty of falsification to purchase a firearm, a felony of the fifth degree. 8057 8058 8059

(4) Whoever violates division (A)(15) or (C) of this section is guilty of falsification to obtain a concealed handgun license, a felony of the fourth degree. 8060 8061 8062

(G) A person who violates this section is liable in a civil action to any person harmed by the violation for injury, death, or 8063 8064

loss to person or property incurred as a result of the commission of the offense and for reasonable attorney's fees, court costs, and other expenses incurred as a result of prosecuting the civil action commenced under this division. A civil action under this division is not the exclusive remedy of a person who incurs injury, death, or loss to person or property as a result of a violation of this section. 8065 8066 8067 8068 8069 8070 8071

Sec. 2945.401. (A) A defendant found incompetent to stand trial and committed pursuant to section 2945.39 of the Revised Code or a person found not guilty by reason of insanity and committed pursuant to section 2945.40 of the Revised Code shall remain subject to the jurisdiction of the trial court pursuant to that commitment, and to the provisions of this section, until the final termination of the commitment as described in division (J)(1) of this section. If the jurisdiction is terminated under this division because of the final termination of the commitment resulting from the expiration of the maximum prison term or term of imprisonment described in division (J)(1)(b) of this section, the court or prosecutor may file an affidavit for the civil commitment of the defendant or person pursuant to Chapter 5122. or 5123. of the Revised Code. 8072 8073 8074 8075 8076 8077 8078 8079 8080 8081 8082 8083 8084 8085

(B) A hearing conducted under any provision of sections 2945.37 to 2945.402 of the Revised Code shall not be conducted in accordance with Chapters 5122. and 5123. of the Revised Code. Any person who is committed pursuant to section 2945.39 or 2945.40 of the Revised Code shall not voluntarily admit the person or be voluntarily admitted to a hospital or institution pursuant to section 5122.02, 5122.15, 5123.69, or 5123.76 of the Revised Code. All other provisions of Chapters 5122. and 5123. of the Revised Code regarding hospitalization or institutionalization shall apply to the extent they are not in conflict with this chapter. A commitment under section 2945.39 or 2945.40 of the Revised Code 8086 8087 8088 8089 8090 8091 8092 8093 8094 8095 8096

shall not be terminated and the conditions of the commitment shall not be changed except as otherwise provided in division (D)(2) of this section with respect to a mentally retarded person subject to institutionalization by court order or except by order of the trial court. 8097 8098 8099 8100 8101

(C) The hospital, facility, or program to which a defendant or person has been committed under section 2945.39 or 2945.40 of the Revised Code shall report in writing to the trial court, at the times specified in this division, as to whether the defendant or person remains a mentally ill person subject to hospitalization by court order or a mentally retarded person subject to institutionalization by court order and, in the case of a defendant committed under section 2945.39 of the Revised Code, as to whether the defendant remains incompetent to stand trial. The hospital, facility, or program shall make the reports after the initial six months of treatment and every two years after the initial report is made. The trial court shall provide copies of the reports to the prosecutor and to the counsel for the defendant or person. Within thirty days after its receipt pursuant to this division of a report from a hospital, facility, or program, the trial court shall hold a hearing on the continued commitment of the defendant or person or on any changes in the conditions of the commitment of the defendant or person. The defendant or person may request a change in the conditions of confinement, and the trial court shall conduct a hearing on that request if six months or more have elapsed since the most recent hearing was conducted under this section. 8102 8103 8104 8105 8106 8107 8108 8109 8110 8111 8112 8113 8114 8115 8116 8117 8118 8119 8120 8121 8122 8123

(D)(1) Except as otherwise provided in division (D)(2) of this section, when a defendant or person has been committed under section 2945.39 or 2945.40 of the Revised Code, at any time after evaluating the risks to public safety and the welfare of the defendant or person, the chief clinical officer of the hospital, 8124 8125 8126 8127 8128

facility, or program to which the defendant or person is committed may recommend a termination of the defendant's or person's commitment or a change in the conditions of the defendant's or person's commitment. 8129 8130 8131 8132

Except as otherwise provided in division (D)(2) of this section, if the chief clinical officer recommends on-grounds unsupervised movement, off-grounds supervised movement, or nonsecured status for the defendant or person or termination of the defendant's or person's commitment, the following provisions apply: 8133 8134 8135 8136 8137 8138

(a) If the chief clinical officer recommends on-grounds unsupervised movement or off-grounds supervised movement, the chief clinical officer shall file with the trial court an application for approval of the movement and shall send a copy of the application to the prosecutor. Within fifteen days after receiving the application, the prosecutor may request a hearing on the application and, if a hearing is requested, shall so inform the chief clinical officer. If the prosecutor does not request a hearing within the fifteen-day period, the trial court shall approve the application by entering its order approving the requested movement or, within five days after the expiration of the fifteen-day period, shall set a date for a hearing on the application. If the prosecutor requests a hearing on the application within the fifteen-day period, the trial court shall hold a hearing on the application within thirty days after the hearing is requested. If the trial court, within five days after the expiration of the fifteen-day period, sets a date for a hearing on the application, the trial court shall hold the hearing within thirty days after setting the hearing date. At least fifteen days before any hearing is held under this division, the trial court shall give the prosecutor written notice of the date, time, and place of the hearing. At the conclusion of each hearing 8139 8140 8141 8142 8143 8144 8145 8146 8147 8148 8149 8150 8151 8152 8153 8154 8155 8156 8157 8158 8159 8160

conducted under this division, the trial court either shall approve or disapprove the application and shall enter its order accordingly. 8161 8162 8163

(b) If the chief clinical officer recommends termination of the defendant's or person's commitment at any time or if the chief clinical officer recommends the first of any nonsecured status for the defendant or person, the chief clinical officer shall send written notice of this recommendation to the trial court and to the local forensic center. The local forensic center shall evaluate the committed defendant or person and, within thirty days after its receipt of the written notice, shall submit to the trial court and the chief clinical officer a written report of the evaluation. The trial court shall provide a copy of the chief clinical officer's written notice and of the local forensic center's written report to the prosecutor and to the counsel for the defendant or person. Upon the local forensic center's submission of the report to the trial court and the chief clinical officer, all of the following apply: 8164 8165 8166 8167 8168 8169 8170 8171 8172 8173 8174 8175 8176 8177 8178

(i) If the forensic center disagrees with the recommendation of the chief clinical officer, it shall inform the chief clinical officer and the trial court of its decision and the reasons for the decision. The chief clinical officer, after consideration of the forensic center's decision, shall either withdraw, proceed with, or modify and proceed with the recommendation. If the chief clinical officer proceeds with, or modifies and proceeds with, the recommendation, the chief clinical officer shall proceed in accordance with division (D)(1)(b)(iii) of this section. 8179 8180 8181 8182 8183 8184 8185 8186 8187

(ii) If the forensic center agrees with the recommendation of the chief clinical officer, it shall inform the chief clinical officer and the trial court of its decision and the reasons for the decision, and the chief clinical officer shall proceed in accordance with division (D)(1)(b)(iii) of this section. 8188 8189 8190 8191 8192

(iii) If the forensic center disagrees with the recommendation of the chief clinical officer and the chief clinical officer proceeds with, or modifies and proceeds with, the recommendation or if the forensic center agrees with the recommendation of the chief clinical officer, the chief clinical officer shall work with the board of alcohol, drug addiction, and mental health services or community mental health board serving the area, as appropriate, to develop a plan to implement the recommendation. If the defendant or person is on medication, the plan shall include, but shall not be limited to, a system to monitor the defendant's or person's compliance with the prescribed medication treatment plan. The system shall include a schedule that clearly states when the defendant or person shall report for a medication compliance check. The medication compliance checks shall be based upon the effective duration of the prescribed medication, taking into account the route by which it is taken, and shall be scheduled at intervals sufficiently close together to detect a potential increase in mental illness symptoms that the medication is intended to prevent. 8193 8194 8195 8196 8197 8198 8199 8200 8201 8202 8203 8204 8205 8206 8207 8208 8209 8210 8211

The chief clinical officer, after consultation with the board of alcohol, drug addiction, and mental health services or the community mental health board serving the area, shall send the recommendation and plan developed under division (D)(1)(b)(iii) of this section, in writing, to the trial court, the prosecutor and the counsel for the committed defendant or person. The trial court shall conduct a hearing on the recommendation and plan developed under division (D)(1)(b)(iii) of this section. Divisions (D)(1)(c) and (d) and (E) to (J) of this section apply regarding the hearing. 8212 8213 8214 8215 8216 8217 8218 8219 8220 8221

(c) If the chief clinical officer's recommendation is for nonsecured status or termination of commitment, the prosecutor may obtain an independent expert evaluation of the defendant's or 8222 8223 8224

person's mental condition, and the trial court may continue the 8225
hearing on the recommendation for a period of not more than thirty 8226
days to permit time for the evaluation. 8227

The prosecutor may introduce the evaluation report or present 8228
other evidence at the hearing in accordance with the Rules of 8229
Evidence. 8230

(d) The trial court shall schedule the hearing on a chief 8231
clinical officer's recommendation for nonsecured status or 8232
termination of commitment and shall give reasonable notice to the 8233
prosecutor and the counsel for the defendant or person. Unless 8234
continued for independent evaluation at the prosecutor's request 8235
or for other good cause, the hearing shall be held within thirty 8236
days after the trial court's receipt of the recommendation and 8237
plan. 8238

(2)(a) Division (D)(1) of this section does not apply to 8239
on-grounds unsupervised movement of a defendant or person who has 8240
been committed under section 2945.39 or 2945.40 of the Revised 8241
Code, who is a mentally retarded person subject to 8242
institutionalization by court order, and who is being provided 8243
residential habilitation, care, and treatment in a facility 8244
operated by the department of mental retardation and developmental 8245
disabilities. 8246

(b) If, pursuant to section 2945.39 of the Revised Code, the 8247
trial court commits a defendant who is found incompetent to stand 8248
trial and who is a mentally retarded person subject to 8249
institutionalization by court order, if the defendant is being 8250
provided residential habilitation, care, and treatment in a 8251
facility operated by the department of mental retardation and 8252
developmental disabilities, if an individual who is conducting a 8253
survey for the department of health to determine the facility's 8254
compliance with the certification requirements of the medicaid 8255
program ~~under chapter 5111. of the Revised Code and Title XIX of~~ 8256

~~the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301,~~ 8257
~~as amended,~~ cites the defendant's receipt of the residential 8258
habilitation, care, and treatment in the facility as being 8259
inappropriate under the certification requirements, if the 8260
defendant's receipt of the residential habilitation, care, and 8261
treatment in the facility potentially jeopardizes the facility's 8262
continued receipt of federal medicaid moneys, and if as a result 8263
of the citation the chief clinical officer of the facility 8264
determines that the conditions of the defendant's commitment 8265
should be changed, the department of mental retardation and 8266
developmental disabilities may cause the defendant to be removed 8267
from the particular facility and, after evaluating the risks to 8268
public safety and the welfare of the defendant and after 8269
determining whether another type of placement is consistent with 8270
the certification requirements, may place the defendant in another 8271
facility that the department selects as an appropriate facility 8272
for the defendant's continued receipt of residential habilitation, 8273
care, and treatment and that is a no less secure setting than the 8274
facility in which the defendant had been placed at the time of the 8275
citation. Within three days after the defendant's removal and 8276
alternative placement under the circumstances described in 8277
division (D)(2)(b) of this section, the department of mental 8278
retardation and developmental disabilities shall notify the trial 8279
court and the prosecutor in writing of the removal and alternative 8280
placement. 8281

The trial court shall set a date for a hearing on the removal 8282
and alternative placement, and the hearing shall be held within 8283
twenty-one days after the trial court's receipt of the notice from 8284
the department of mental retardation and developmental 8285
disabilities. At least ~~ten-days~~ <u>ten days</u> before the hearing is 8286
held, the trial court shall give the prosecutor, the department of 8287
mental retardation and developmental disabilities, and the counsel 8288
for the defendant written notice of the date, time, and place of 8289

the hearing. At the hearing, the trial court shall consider the citation issued by the individual who conducted the survey for the department of health to be prima-facie evidence of the fact that the defendant's commitment to the particular facility was inappropriate under the certification requirements of the medicaid program ~~under Chapter 5111. of the Revised Code and Title XIX of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended,~~ and potentially jeopardizes the particular facility's continued receipt of federal medicaid moneys. At the conclusion of the hearing, the trial court may approve or disapprove the defendant's removal and alternative placement. If the trial court approves the defendant's removal and alternative placement, the department of mental retardation and developmental disabilities may continue the defendant's alternative placement. If the trial court disapproves the defendant's removal and alternative placement, it shall enter an order modifying the defendant's removal and alternative placement, but that order shall not require the department of mental retardation and developmental disabilities to replace the defendant for purposes of continued residential habilitation, care, and treatment in the facility associated with the citation issued by the individual who conducted the survey for the department of health. 8290 8291 8292 8293 8294 8295 8296 8297 8298 8299 8300 8301 8302 8303 8304 8305 8306 8307 8308 8309 8310 8311

(E) In making a determination under this section regarding nonsecured status or termination of commitment, the trial court shall consider all relevant factors, including, but not limited to, all of the following: 8312 8313 8314 8315

(1) Whether, in the trial court's view, the defendant or person currently represents a substantial risk of physical harm to the defendant or person or others; 8316 8317 8318

(2) Psychiatric and medical testimony as to the current mental and physical condition of the defendant or person; 8319 8320

(3) Whether the defendant or person has insight into the 8321

dependant's or person's condition so that the defendant or person will continue treatment as prescribed or seek professional assistance as needed; 8322 8323 8324

(4) The grounds upon which the state relies for the proposed commitment; 8325 8326

(5) Any past history that is relevant to establish the defendant's or person's degree of conformity to the laws, rules, regulations, and values of society; 8327 8328 8329

(6) If there is evidence that the defendant's or person's mental illness is in a state of remission, the medically suggested cause and degree of the remission and the probability that the defendant or person will continue treatment to maintain the remissive state of the defendant's or person's illness should the defendant's or person's commitment conditions be altered. 8330 8331 8332 8333 8334 8335

(F) At any hearing held pursuant to division (C) or (D)(1) or (2) of this section, the defendant or the person shall have all the rights of a defendant or person at a commitment hearing as described in section 2945.40 of the Revised Code. 8336 8337 8338 8339

(G) In a hearing held pursuant to division (C) or (D)(1) of this section, the prosecutor has the burden of proof as follows: 8340 8341

(1) For a recommendation of termination of commitment, to show by clear and convincing evidence that the defendant or person remains a mentally ill person subject to hospitalization by court order or a mentally retarded person subject to institutionalization by court order; 8342 8343 8344 8345 8346

(2) For a recommendation for a change in the conditions of the commitment to a less restrictive status, to show by clear and convincing evidence that the proposed change represents a threat to public safety or a threat to the safety of any person. 8347 8348 8349 8350

(H) In a hearing held pursuant to division (C) or (D)(1) or 8351

(2) of this section, the prosecutor shall represent the state or the public interest. 8352 8353

(I) At the conclusion of a hearing conducted under division (D)(1) of this section regarding a recommendation from the chief clinical officer of a hospital, program, or facility, the trial court may approve, disapprove, or modify the recommendation and shall enter an order accordingly. 8354 8355 8356 8357 8358

(J)(1) A defendant or person who has been committed pursuant to section 2945.39 or 2945.40 of the Revised Code continues to be under the jurisdiction of the trial court until the final termination of the commitment. For purposes of division (J) of this section, the final termination of a commitment occurs upon the earlier of one of the following: 8359 8360 8361 8362 8363 8364

(a) The defendant or person no longer is a mentally ill person subject to hospitalization by court order or a mentally retarded person subject to institutionalization by court order, as determined by the trial court; 8365 8366 8367 8368

(b) The expiration of the maximum prison term or term of imprisonment that the defendant or person could have received if the defendant or person had been convicted of the most serious offense with which the defendant or person is charged or in relation to which the defendant or person was found not guilty by reason of insanity; 8369 8370 8371 8372 8373 8374

(c) The trial court enters an order terminating the commitment under the circumstances described in division (J)(2)(a)(ii) of this section. 8375 8376 8377

(2)(a) If a defendant is found incompetent to stand trial and committed pursuant to section 2945.39 of the Revised Code, if neither of the circumstances described in divisions (J)(1)(a) and (b) of this section applies to that defendant, and if a report filed with the trial court pursuant to division (C) of this 8378 8379 8380 8381 8382

section indicates that the defendant presently is competent to stand trial or if, at any other time during the period of the defendant's commitment, the prosecutor, the counsel for the defendant, or the chief clinical officer of the hospital, facility, or program to which the defendant is committed files an application with the trial court alleging that the defendant presently is competent to stand trial and requesting a hearing on the competency issue or the trial court otherwise has reasonable cause to believe that the defendant presently is competent to stand trial and determines on its own motion to hold a hearing on the competency issue, the trial court shall schedule a hearing on the competency of the defendant to stand trial, shall give the prosecutor, the counsel for the defendant, and the chief clinical officer notice of the date, time, and place of the hearing at least fifteen days before the hearing, and shall conduct the hearing within thirty days of the filing of the application or of its own motion. If, at the conclusion of the hearing, the trial court determines that the defendant presently is capable of understanding the nature and objective of the proceedings against the defendant and of assisting in the defendant's defense, the trial court shall order that the defendant is competent to stand trial and shall be proceeded against as provided by law with respect to the applicable offenses described in division (C)(1) of section 2945.38 of the Revised Code and shall enter whichever of the following additional orders is appropriate: 8383 8384 8385 8386 8387 8388 8389 8390 8391 8392 8393 8394 8395 8396 8397 8398 8399 8400 8401 8402 8403 8404 8405 8406 8407

(i) If the trial court determines that the defendant remains a mentally ill person subject to hospitalization by court order or a mentally retarded person subject to institutionalization by court order, the trial court shall order that the defendant's commitment to the hospital, facility, or program be continued during the pendency of the trial on the applicable offenses described in division (C)(1) of section 2945.38 of the Revised Code. 8408 8409 8410 8411 8412 8413 8414 8415

(ii) If the trial court determines that the defendant no longer is a mentally ill person subject to hospitalization by court order or a mentally retarded person subject to institutionalization by court order, the trial court shall order that the defendant's commitment to the hospital, facility, or program shall not be continued during the pendency of the trial on the applicable offenses described in division (C)(1) of section 2945.38 of the Revised Code. This order shall be a final termination of the commitment for purposes of division (J)(1)(c) of this section. 8416 8417 8418 8419 8420 8421 8422 8423 8424 8425

(b) If, at the conclusion of the hearing described in division (J)(2)(a) of this section, the trial court determines that the defendant remains incapable of understanding the nature and objective of the proceedings against the defendant or of assisting in the defendant's defense, the trial court shall order that the defendant continues to be incompetent to stand trial, that the defendant's commitment to the hospital, facility, or program shall be continued, and that the defendant remains subject to the jurisdiction of the trial court pursuant to that commitment, and to the provisions of this section, until the final termination of the commitment as described in division (J)(1) of this section. 8426 8427 8428 8429 8430 8431 8432 8433 8434 8435 8436 8437

Sec. 3101.051. (A) Except as provided in division (B) of this section, a probate court shall make available to any person for inspection the records pertaining to the issuance of marriage licenses as provided under section 149.43 of the Revised Code. 8438 8439 8440 8441

(B) Before it makes available to a person any records pertaining to the issuance of a marriage license as described in division (A) of this section, subject to division (C) of this section, a probate court shall delete or otherwise remove any social security numbers of the parties to a marriage so that they 8442 8443 8444 8445 8446

are not available to the person inspecting the records.

(C) Division (B) of this section does not apply in any of the following circumstances:

(1) If the records in question are inspected by authorized personnel of the division of child support in the department of job and family services under section ~~5101.31~~ 3125.41 of the Revised Code;

(2) If the records in question are inspected by law enforcement personnel for purposes of a criminal investigation;

(3) If the records in question with the social security numbers are necessary for use in a civil or criminal trial and the release of the records with the social security numbers is ordered by a court with jurisdiction over the trial;

(4) If the records in question are inspected by either party to the marriage to which the records pertain;

(5) If the court possessed the records in question prior to ~~the effective date of this section~~ February 12, 2001.

Sec. 3107.083. Not later than ninety days after June 20, 1996, the director of job and family services shall do all of the following:

(A)(1) For a parent of a child who, if adopted, will be an adopted person as defined in section 3107.45 of the Revised Code, prescribe a form that has the following six components:

(a) A component the parent signs under section 3107.071, 3107.081, or 5103.151 of the Revised Code to indicate the requirements of section 3107.082 or 5103.152 of the Revised Code have been met. The component shall be as follows:

"Statement Concerning Ohio Law and Adoption Materials

By signing this component of this form, I acknowledge that it

has been explained to me, and I understand, that, if I check the space on the next component of this form that indicates that I authorize the release, the adoption file maintained by the Ohio Department of Health, which contains identifying information about me at the time of my child's birth, will be released, on request, to the adoptive parent when the adoptee is at least age eighteen but younger than age twenty-one and to the adoptee when he or she is age twenty-one or older. It has also been explained to me, and I understand, that I may prohibit the release of identifying information about me contained in the adoption file by checking the space on the next component of this form that indicates that I do not authorize the release of the identifying information. It has additionally been explained to me, and I understand, that I may change my mind regarding the decision I make on the next component of this form at any time and as many times as I desire by signing, dating, and having filed with the Ohio Department of Health a denial of release form or authorization of release form prescribed and provided by the Department of Health and providing the Department two items of identification. 8476 8477 8478 8479 8480 8481 8482 8483 8484 8485 8486 8487 8488 8489 8490 8491 8492 8493 8494

By signing this component of this form, I also acknowledge that I have been provided a copy of written materials about adoption prepared by the Ohio Department of Job and Family Services, the adoption process and ramifications of consenting to adoption or entering into a voluntary permanent custody surrender agreement have been discussed with me, and I have been provided the opportunity to review the materials and ask questions about the materials and discussion. 8495 8496 8497 8498 8499 8500 8501 8502

Signature of biological parent: 8503

Signature of witness: 8504

Date: ...." 8505

(b) A component the parent signs under section 3107.071, 3107.081, or 5103.151 of the Revised Code regarding the parent's 8506 8507

decision whether to allow identifying information about the parent 8508
contained in an adoption file maintained by the department of 8509
health to be released to the parent's child and adoptive parent 8510
pursuant to section 3107.47 of the Revised Code. The component 8511
shall be as follows: 8512

"Statement Regarding Release of Identifying Information 8513

The purpose of this component of this form is to allow a 8514
biological parent to decide whether to allow the Ohio Department 8515
of Health to provide an adoptee and adoptive parent identifying 8516
information about the adoptee's biological parent contained in an 8517
adoption file maintained by the Department. Please check one of 8518
the following spaces: 8519

...... YES, I authorize the Ohio Department of Health to release identifying information about me, on request, to the adoptive parent when the adoptee is at least age eighteen but younger than age twenty-one and to the adoptee when he or she is age twenty-one or older. 8520

...... NO, I do not authorize the release of identifying information about me to the adoptive parent or adoptee. 8521

Signature of biological parent: 8522
Signature of witness: 8523
Date: ...." 8524

(c) A component the parent, if the mother of the child, 8525
completes and signs under section 3107.071, 3107.081, or 5103.151 8526
of the Revised Code to indicate, to the extent of the mother's 8527
knowledge, all of the following: 8528

(i) Whether the mother, during her pregnancy, was a recipient 8529
of the ~~medical assistance~~ medicaid program ~~established under~~ 8530
~~Chapter 5111. of the Revised Code~~ or other public health insurance 8531
program and, if so, the dates her eligibility began and ended; 8532

(ii) Whether the mother, during her pregnancy, was covered by private health insurance and, if so, the dates the coverage began and ended, the name of the insurance provider, the type of coverage, and the identification number of the coverage; 8533 8534 8535 8536

(iii) The name and location of the hospital, freestanding birth center, or other place where the mother gave birth and, if different, received medical care immediately after giving birth; 8537 8538 8539

(iv) The expenses of the obstetrical and neonatal care; 8540

(v) Whether the mother has been informed that the adoptive parent or the agency or attorney arranging the adoption are to pay expenses involved in the adoption, including expenses the mother has paid and expects to receive or has received reimbursement, and, if so, what expenses are to be or have been paid and an estimate of the expenses; 8541 8542 8543 8544 8545 8546

(vi) Any other information related to expenses the department determines appropriate to be included in this component. 8547 8548

(d) A component the parent may sign to authorize the agency or attorney arranging the adoption to provide to the child or adoptive parent materials, other than photographs of the parent, that the parent requests be given to the child or adoptive parent pursuant to section 3107.68 of the Revised Code. 8549 8550 8551 8552 8553

(e) A component the parent may sign to authorize the agency or attorney arranging the adoption to provide to the child or adoptive parent photographs of the parent pursuant to section 3107.68 of the Revised Code. 8554 8555 8556 8557

(f) A component the parent may sign to authorize the agency or attorney arranging the adoption to provide to the child or adoptive parent the first name of the parent pursuant to section 3107.68 of the Revised Code. 8558 8559 8560 8561

(2) State at the bottom of the form that the parent is to 8562

receive a copy of the form the parent signed. 8563

(3) Provide copies of the form prescribed under this division to probate and juvenile courts, public children services agencies, private child placing agencies, private noncustodial agencies, attorneys, and persons authorized to take acknowledgments. 8564 8565 8566 8567

(B)(1) For a parent of a child who, if adopted, will become an adopted person as defined in section 3107.39 of the Revised Code, prescribe a form that has the following five components: 8568 8569 8570

(a) A component the parent signs under section 3107.071, 3107.081, or 5103.151 of the Revised Code to attest that the requirement of division (A) of section 3107.082 or division (A) of section 5103.152 of the Revised Code has been met; 8571 8572 8573 8574

(b) A component the parent, if the mother of the child, completes and signs under section 3107.071, 3107.081, or 5103.151 of the Revised Code to indicate, to the extent of the mother's knowledge, all of the following: 8575 8576 8577 8578

(i) Whether the mother, during her pregnancy, was a recipient of the ~~medical assistance~~ medicaid program ~~established under Chapter 5111. of the Revised Code~~ or other public health insurance program and, if so, the dates her eligibility began and ended; 8579 8580 8581 8582

(ii) Whether the mother, during her pregnancy, was covered by private health insurance and, if so, the dates the coverage began and ended, the name of the insurance provider, the type of coverage, and the identification number of the coverage; 8583 8584 8585 8586

(iii) The name and location of the hospital, freestanding birth center, or other place where the mother gave birth and, if different, received medical care immediately after giving birth; 8587 8588 8589

(iv) The expenses of the obstetrical and neonatal care; 8590

(v) Whether the mother has been informed that the adoptive parent or the agency or attorney arranging the adoption are to pay 8591 8592

expenses involved in the adoption, including expenses the mother has paid and expects to receive or has received reimbursement for, and, if so, what expenses are to be or have been paid and an estimate of the expenses; 8593 8594 8595 8596

(vi) Any other information related to expenses the department determines appropriate to be included in the component. 8597 8598

(c) A component the parent may sign to authorize the agency or attorney arranging the adoption to provide to the child or adoptive parent materials, other than photographs of the parent, that the parent requests be given to the child or adoptive parent pursuant to section 3107.68 of the Revised Code. 8599 8600 8601 8602 8603

(d) A component the parent may sign to authorize the agency or attorney arranging the adoption to provide to the child or adoptive parent photographs of the parent pursuant to section 3107.68 of the Revised Code. 8604 8605 8606 8607

(e) A component the parent may sign to authorize the agency or attorney arranging the adoption to provide to the child or adoptive parent the first name of the parent pursuant to section 3107.68 of the Revised Code. 8608 8609 8610 8611

(2) State at the bottom of the form that the parent is to receive a copy of the form the parent signed. 8612 8613

(3) Provide copies of the form prescribed under this division to probate and juvenile courts, public children services agencies, private child placing agencies, private noncustodial agencies, and attorneys. 8614 8615 8616 8617

(C) Prepare the written materials about adoption that are required to be given to parents under division (A) of section 3107.082 and division (A) of section 5103.152 of the Revised Code. The materials shall provide information about the adoption process, including ramifications of a parent consenting to a child's adoption or entering into a voluntary permanent custody 8618 8619 8620 8621 8622 8623

surrender agreement. The materials also shall include referral information for professional counseling and adoption support organizations. The director shall provide the materials to assessors. 8624 8625 8626 8627

(D) Adopt rules in accordance with Chapter 119. of the Revised Code specifying the documents that must be filed with a probate court under divisions (B) and (D) of section 3107.081 of the Revised Code and a juvenile court under divisions (C) and (E) of section 5103.151 of the Revised Code. 8628 8629 8630 8631 8632

Sec. 3111.04. (A) An action to determine the existence or nonexistence of the father and child relationship may be brought by the child or the child's personal representative, the child's mother or her personal representative, a man alleged or alleging himself to be the child's father, the child support enforcement agency of the county in which the child resides if the child's mother, father, or alleged father is a recipient of public assistance or of services under Title IV-D of the "Social Security Act," 88 Stat. 2351 (1975), 42 U.S.C.A. 651, as amended, or the alleged father's personal representative. 8633 8634 8635 8636 8637 8638 8639 8640 8641 8642

(B) An agreement does not bar an action under this section. 8643

(C) If an action under this section is brought before the birth of the child and if the action is contested, all proceedings, except service of process and the taking of depositions to perpetuate testimony, may be stayed until after the birth. 8644 8645 8646 8647 8648

(D) A recipient of public assistance or of services under Title IV-D of the "Social Security Act," 88 Stat. 2351 (1975), 42 U.S.C.A. 651, as amended, shall cooperate with the child support enforcement agency of the county in which a child resides to obtain an administrative determination pursuant to sections 3111.38 to 3111.54 of the Revised Code, or, if necessary, a court 8649 8650 8651 8652 8653 8654

determination pursuant to sections 3111.01 to 3111.18 of the Revised Code, of the existence or nonexistence of a parent and child relationship between the father and the child. If the recipient fails to cooperate, the agency may commence an action to determine the existence or nonexistence of a parent and child relationship between the father and the child pursuant to sections 3111.01 to 3111.18 of the Revised Code. 8655 8656 8657 8658 8659 8660 8661

(E) As used in this section, "public assistance" means all of the following: 8662 8663

(1) Medicaid ~~under Chapter 5111. of the Revised Code~~; 8664

(2) Ohio works first under Chapter 5107. of the Revised Code; 8665

(3) Disability financial assistance under Chapter 5115. of the Revised Code; 8666 8667

(4) Disability medical assistance ~~under Chapter 5115. of the Revised Code~~; 8668 8669

(5) Children's buy-in program ~~under sections 5101.5211 to 5101.5216 of the Revised Code~~. 8670 8671

Sec. 3111.72. The contract between the department of job and family services and a local hospital shall require all of the following: 8672 8673 8674

(A) That the hospital provide a staff person to meet with each unmarried mother who gave birth in or en route to the hospital within twenty-four hours of the birth or before the mother is released from the hospital; 8675 8676 8677 8678

(B) That the staff person attempt to meet with the father of the unmarried mother's child if possible; 8679 8680

(C) That the staff person explain to the unmarried mother and the father, if he is present, the benefit to the child of establishing a parent and child relationship between the father 8681 8682 8683

and the child and the various proper procedures for establishing a parent and child relationship; 8684 8685

(D) That the staff person present to the unmarried mother and, if possible, the father, the pamphlet or statement regarding the rights and responsibilities of a natural parent that is prepared and provided by the department of job and family services pursuant to section 3111.32 of the Revised Code; 8686 8687 8688 8689 8690

(E) That the staff person provide the mother and, if possible, the father, all forms and statements necessary to voluntarily establish a parent and child relationship, including, but not limited to, the acknowledgment of paternity affidavit prepared by the department of job and family services pursuant to section 3111.31 of the Revised Code; 8691 8692 8693 8694 8695 8696

(F) That the staff person, at the request of both the mother and father, help the mother and father complete any form or statement necessary to establish a parent and child relationship; 8697 8698 8699

(G) That the hospital provide a notary public to notarize an acknowledgment of paternity affidavit signed by the mother and father; 8700 8701 8702

(H) That the staff person present to an unmarried mother who is not participating in the Ohio works first program established under Chapter 5107. or receiving ~~medical assistance under Chapter 5111. of the Revised Code~~ medicaid an application for Title IV-D services; 8703 8704 8705 8706 8707

(I) That the staff person forward any completed acknowledgment of paternity, no later than ten days after it is completed, to the office of child support in the department of job and family services; 8708 8709 8710 8711

(J) That the department of job and family services pay the hospital twenty dollars for every correctly signed and notarized acknowledgment of paternity affidavit from the hospital. 8712 8713 8714

Sec. 3113.06. No father, or mother when she is charged with the maintenance, of a child under eighteen years of age, or a mentally or physically handicapped child under age twenty-one, who is legally a ward of a public children services agency or is the recipient of aid pursuant to sections ~~5101.5211~~ 5167.35 to ~~5101.5216~~ 5167.40 or Chapter 5107. ~~or~~, 5115., or 5168. of the Revised Code, shall neglect or refuse to pay such agency the reasonable cost of maintaining such child when such father or mother is able to do so by reason of property, labor, or earnings.

An offense under this section shall be held committed in the county in which the agency is located. The agency shall file charges against any parent who violates this section, unless the agency files charges under section 2919.21 of the Revised Code, or unless charges of nonsupport are filed by a relative or guardian of the child, or unless an action to enforce support is brought under Chapter 3115. of the Revised Code.

Sec. 3119.29. (A) As used in this section and sections 3119.30 to 3119.56 of the Revised Code:

(1) "Cash medical support" means an amount ordered to be paid in a child support order toward the cost of health insurance provided by a public entity, another parent, or person with whom the child resides, through employment or otherwise, or for other medical cost not covered by insurance.

(2) "Federal poverty line" has the same meaning as defined in section 5104.01 of the Revised Code.

(3) "Health care" means such medical support that includes coverage under a health insurance plan, payment of costs of premiums, ~~co-payments~~ copayments, and deductibles, or payment for medical expenses incurred on behalf of the child.

(4) "Health insurance coverage" means accessible private health insurance that provides primary care services within thirty miles from the residence of the child subject to the child support order. 8745 8746 8747 8748

(5) "Health plan administrator" means any entity authorized under Title XXXIX of the Revised Code to engage in the business of insurance in this state, any health insuring corporation, any legal entity that is self-insured and provides benefits to its employees or members, and the administrator of any such entity or corporation. 8749 8750 8751 8752 8753 8754

(6) "National medical support notice" means a form required by the "Child Support Performance and Incentive Act of 1998," P.L. 105-200, 112 Stat. 659, 42 U.S.C. 666(a)(19), as amended, and jointly developed and promulgated by the secretary of health and human services and the secretary of labor in federal regulations adopted under that act as modified by the department of job and family services under section 3119.291 of the Revised Code. 8755 8756 8757 8758 8759 8760 8761 8762

(7) "Person required to provide health insurance coverage" means the obligor, obligee, or both, required by the court under a court child support order or by the child support enforcement agency under an administrative child support order to provide health insurance coverage pursuant to section 3119.30 of the Revised Code. 8763 8764 8765 8766 8767 8768

(8) Subject to division (B) of this section, "reasonable cost" means the contributing cost of private family health insurance to the person responsible for the health care of the children subject to the child support order that does not exceed an amount equal to five per cent of the annual gross income of that person. 8769 8770 8771 8772 8773 8774

(9) "Title XIX" has the same meaning as defined in section 8775

~~5111.20~~ 5164.01 of the Revised Code. 8776

(B) If the United States secretary of health and human services issues a regulation defining "reasonable cost" or a similar term or phrase relevant to the provisions in child support orders relating to the provision of health care for children subject to the orders, and if that definition is substantively different from the meaning of "reasonable cost" as defined in division (A) of this section, "reasonable cost" as used in this section shall have the meaning as defined by the United States secretary of health and human services. 8777 8778 8779 8780 8781 8782 8783 8784 8785

Sec. 3119.54. A party to a child support order issued in accordance with section 3119.30 of the Revised Code shall notify any physician, hospital, or other provider of medical services that provides medical services to the child who is the subject of the child support order of the number of any health insurance or health care policy, contract, or plan that covers the child if the child is eligible for medical assistance under ~~sections 5101.5211 to 5101.5216 or Chapter 5111. or 5115. of the Revised Code~~ the medicaid program, the disability medical assistance program, or the children's buy-in program. The party shall include in the notice the name and address of the insurer. Any physician, hospital, or other provider of medical services for which medical assistance is available under ~~sections 5101.5211 to 5101.5216 or Chapter 5111. or 5115. of the Revised Code~~ the medicaid program, the disability medical assistance program, or the children's buy-in program who is notified under this section of the existence of a health insurance or health care policy, contract, or plan with coverage for children who are eligible for medical assistance shall first bill the insurer for any services provided for those children. If the insurer fails to pay all or any part of a claim filed under this section and the services for which the claim is filed are covered by ~~sections 5101.5211 to 5101.5216 or Chapter~~ 8786 8787 8788 8789 8790 8791 8792 8793 8794 8795 8796 8797 8798 8799 8800 8801 8802 8803 8804 8805 8806 8807

~~5111. or 5115. of the Revised Code~~ the medicaid program, the 8808
disability medical assistance program, or the children's buy-in 8809
program, the physician, hospital, or other medical services 8810
provider shall bill the remaining unpaid costs of the services in 8811
accordance with ~~sections 5101.5211 to 5101.5216 or Chapter 5111.~~ 8812
~~or 5115. of the Revised Code~~ the law governing the medicaid 8813
program, disability medical assistance program, or children's 8814
buy-in program. 8815

Sec. 3121.441. (A) Notwithstanding the provisions of this 8816
chapter, Chapters 3119., 3123., and 3125., and sections 3770.071 8817
and 5107.20 of the Revised Code providing for the office of child 8818
support in the department of job and family services to collect, 8819
withhold, or deduct spousal support, when a court pursuant to 8820
section 3105.18 or 3105.65 of the Revised Code issues or modifies 8821
an order requiring an obligor to pay spousal support or grants or 8822
modifies a decree of dissolution of marriage incorporating a 8823
separation agreement that provides for spousal support, or at any 8824
time after the issuance, granting, or modification of an order or 8825
decree of that type, the court may permit the obligor to make the 8826
spousal support payments directly to the obligee instead of to the 8827
office if the obligee and the obligor have no minor children born 8828
as a result of their marriage and the obligee has not assigned the 8829
spousal support amounts to the department pursuant to section 8830
~~5101.59 or~~ 5107.20 or 5160.37 of the Revised Code. 8831

(B) A court that permits an obligor to make spousal support 8832
payments directly to the obligee pursuant to division (A) of this 8833
section shall order the obligor to make the spousal support 8834
payments as a check, as a money order, or in any other form that 8835
establishes a clear record of payment. 8836

(C) If a court permits an obligor to make spousal support 8837
payments directly to an obligee pursuant to division (A) of this 8838

section and the obligor is in default in making any spousal 8839
support payment to the obligee, the court, upon motion of the 8840
obligee or on its own motion, may rescind the permission granted 8841
under that division. After the rescission, the court shall 8842
determine the amount of arrearages in the spousal support payments 8843
and order the obligor to make to the office of child support in 8844
the department of job and family services any spousal support 8845
payments that are in arrears and any future spousal support 8846
payments. Upon the issuance of the order of the court under this 8847
division, the provisions of this chapter, Chapters 3119., 3123., 8848
and 3125., and sections 3770.071 and 5107.20 of the Revised Code 8849
apply with respect to the collection, withholding, or deduction of 8850
the obligor's spousal support payments that are the subject of 8851
that order of the court. 8852

Sec. 3121.898. ~~The~~ As used in this section, "state agency" 8853
means every department, bureau, board, commission, office, or 8854
other organized body established by the constitution or laws of 8855
this state for the exercise of state government; every entity of 8856
county government that is subject to the rules of a state agency; 8857
and every contractual agent of a state agency. 8858

The department of job and family services shall use the new 8859
hire reports it receives for any of the following purposes set 8860
forth in 42 U.S.C. 653a, as amended, including: 8861

(A) To locate individuals for the purposes of establishing 8862
paternity and for establishing, modifying, and enforcing child 8863
support orders. 8864

(B) ~~As used in this division, "state agency" means every~~ 8865
~~department, bureau, board, commission, office, or other organized~~ 8866
~~body established by the constitution or laws of this state for the~~ 8867
~~exercise of state government; every entity of county government~~ 8868
~~that is subject to the rules of a state agency; and every~~ 8869

~~contractual agent of a state agency.~~ 8870

To make available to any state agency responsible for administering any of the following programs for purposes of verifying program eligibility: 8871 8872 8873

(1) Any Title IV-A program as defined in section 5101.80 of the Revised Code; 8874 8875

(2) The medicaid program ~~authorized by Chapter 5111. of the Revised Code~~; 8876 8877

(3) The unemployment compensation program authorized by Chapter 4141. of the Revised Code; 8878 8879

(4) The food stamp program authorized by section 5101.54 of the Revised Code; 8880 8881

(5) Any other program authorized in 42 U.S.C. 1320b-7(b), as amended. 8882 8883

(C) The administration of the employment security program under the director of job and family services. 8884 8885

Sec. 3125.36. (A) Subject to division (B) of this section, all support orders that are administered by a child support enforcement agency designated under section 307.981 of the Revised Code or former section 2301.35 of the Revised Code and are eligible for Title IV-D services shall be Title IV-D cases under Title IV-D of the "Social Security Act." Subject to division (B) of this section, all obligees of support orders administered by the agency shall be considered to have filed a signed application for Title IV-D services. 8886 8887 8888 8889 8890 8891 8892 8893 8894

(B) Except as provided in division (D) of this section, a court that issues or modifies a support order shall require the obligee under the order to sign, at the time of the issuance or modification of the order, an application for Title IV-D services and to file, as soon as possible, the signed application with the 8895 8896 8897 8898 8899

child support enforcement agency that will administer the order. The application shall be on a form prescribed by the department of job and family services. Except as provided in division (D) of this section, a support order that is administered by a child support enforcement agency, and that is eligible for Title IV-D services shall be a Title IV-D case under Title IV-D of the "Social Security Act" only upon the filing of the signed application for Title IV-D services. 8900 8901 8902 8903 8904 8905 8906 8907

(C) A child support enforcement agency shall make available an application for Title IV-D services to all persons requesting a child support enforcement agency's assistance in an action under sections 3111.01 to 3111.18 of the Revised Code or in an administrative proceeding brought to establish a parent and child relationship, to establish or modify an administrative support order, or to establish or modify an order to provide health insurance coverage for the children subject to a support order. 8908 8909 8910 8911 8912 8913 8914 8915

(D) An obligee under a support order who has assigned the right to the support pursuant to section ~~5101.59 or~~ 5107.20 or 5160.37 of the Revised Code shall not be required to sign an application for Title IV-D services. The support order shall be considered a Title IV-D case. 8916 8917 8918 8919 8920

Sec. 3307.20. (A) As used in this section: 8921

(1) "Personal history record" means information maintained by the state teachers retirement board on an individual who is a member, former member, contributor, former contributor, retirant, or beneficiary that includes the address, telephone number, social security number, record of contributions, correspondence with the state teachers retirement system, or other information the board determines to be confidential. 8922 8923 8924 8925 8926 8927 8928

(2) "Retirant" has the same meaning as in section 3307.50 of the Revised Code. 8929 8930

(B) The records of the board shall be open to public inspection, except for the following, which shall be excluded, except with the written authorization of the individual concerned: 8931 8932 8933

(1) The individual's personal records provided for in section 3307.23 of the Revised Code; 8934 8935

(2) The individual's personal history record; 8936

(3) Any information identifying, by name and address, the amount of a monthly allowance or benefit paid to the individual. 8937 8938

(C) All medical reports and recommendations under sections 3307.62, 3307.64, and 3307.66 of the Revised Code are privileged, except that copies of such medical reports or recommendations shall be made available to the personal physician, attorney, or authorized agent of the individual concerned upon written release received from the individual or the individual's agent, or, when necessary for the proper administration of the fund, to the board assigned physician. 8939 8940 8941 8942 8943 8944 8945 8946

(D) Any person who is a member or contributor of the system shall be furnished, on written request, with a statement of the amount to the credit of the person's account. The board need not answer more than one request of a person in any one year. 8947 8948 8949 8950

(E) Notwithstanding the exceptions to public inspection in division (B) of this section, the board may furnish the following information: 8951 8952 8953

(1) If a member, former member, retirant, contributor, or former contributor is subject to an order issued under section 2907.15 of the Revised Code or an order issued under division (A) or (B) of section 2929.192 of the Revised Code or is convicted of or pleads guilty to a violation of section 2921.41 of the Revised Code, on written request of a prosecutor as defined in section 2935.01 of the Revised Code, the board shall furnish to the prosecutor the information requested from the individual's 8954 8955 8956 8957 8958 8959 8960 8961

personal history record.

(2) Pursuant to a court or administrative order issued under section 3119.80, 3119.81, 3121.02, 3121.03, or 3123.06 of the Revised Code, the board shall furnish to a court or child support enforcement agency the information required under that section.

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

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

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

On the written request of an alternate payee, as defined in section 3105.80 of the Revised Code, the system shall furnish to

the alternate payee information on the amount and status of any amounts payable to the alternate payee under an order issued under section 3105.171 or 3105.65 of the Revised Code. 8993 8994 8995

(6) At the request of any person, the board shall make available to the person copies of all documents, including resumes, in the board's possession regarding filling a vacancy of a contributing member or retired teacher member of the board. The person who made the request shall pay the cost of compiling, copying, and mailing the documents. The information described in this division is a public record. 8996 8997 8998 8999 9000 9001 9002

(F) A statement that contains information obtained from the system's records that is signed by an officer of the retirement system and to which the system's official seal is affixed, or copies of the system's records to which the signature and seal are attached, shall be received as true copies of the system's records in any court or before any officer of this state. 9003 9004 9005 9006 9007 9008

Sec. 3309.22. (A)(1) As used in this division, "personal history record" means information maintained by the board on an individual who is a member, former member, contributor, former contributor, retirant, or beneficiary that includes the address, telephone number, social security number, record of contributions, correspondence with the system, and other information the board determines to be confidential. 9009 9010 9011 9012 9013 9014 9015

(2) The records of the board shall be open to public inspection, except for the following, which shall be excluded, except with the written authorization of the individual concerned: 9016 9017 9018

(a) The individual's statement of previous service and other information as provided for in section 3309.28 of the Revised Code; 9019 9020 9021

(b) Any information identifying by name and address the 9022

amount of a monthly allowance or benefit paid to the individual; 9023

(c) The individual's personal history record. 9024

(B) All medical reports and recommendations required by the system are privileged except that copies of such medical reports or recommendations shall be made available to the personal physician, attorney, or authorized agent of the individual concerned upon written release received from the individual or the individual's agent, or when necessary for the proper administration of the fund, to the board assigned physician. 9025 9026 9027 9028 9029 9030 9031

(C) Any person who is a contributor of the system shall be furnished, on written request, with a statement of the amount to the credit of the person's account. The board need not answer more than one such request of a person in any one year. 9032 9033 9034 9035

(D) Notwithstanding the exceptions to public inspection in division (A)(2) of this section, the board may furnish the following information: 9036 9037 9038

(1) If a member, former member, contributor, former contributor, or retirant is subject to an order issued under section 2907.15 of the Revised Code or an order issued under division (A) or (B) of section 2929.192 of the Revised Code or is convicted of or pleads guilty to a violation of section 2921.41 of the Revised Code, on written request of a prosecutor as defined in section 2935.01 of the Revised Code, the board shall furnish to the prosecutor the information requested from the individual's personal history record. 9039 9040 9041 9042 9043 9044 9045 9046 9047

(2) Pursuant to a court or administrative order issued under section 3119.80, 3119.81, 3121.02, 3121.03, or 3123.06 of the Revised Code, the board shall furnish to a court or child support enforcement agency the information required under that section. 9048 9049 9050 9051

(3) At the written request of any person, the board shall provide to the person a list of the names and addresses of 9052 9053

members, former members, retirants, contributors, former contributors, or beneficiaries. The costs of compiling, copying, and mailing the list shall be paid by such person.

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

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

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

(6) At the request of any person, the board shall make available to the person copies of all documents, including resumes, in the board's possession regarding filling a vacancy of an employee member or retirant member of the board. The person who made the request shall pay the cost of compiling, copying, and

mailing the documents. The information described in this division 9086
is a public record. 9087

(E) A statement that contains information obtained from the 9088
system's records that is signed by an officer of the retirement 9089
system and to which the system's official seal is affixed, or 9090
copies of the system's records to which the signature and seal are 9091
attached, shall be received as true copies of the system's records 9092
in any court or before any officer of this state. 9093

Sec. 3313.714. (A) As used in this section: 9094

(1) "Board of education" means the board of education of a 9095
city, local, exempted village, or joint vocational school 9096
district. 9097

(2) "Healthcheck" means the early and periodic screening, 9098
diagnosis, and treatment program, a component of the ~~medical~~ 9099
~~assistance~~ medicaid program ~~established under Title XIX of the~~ 9100
~~"Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 302, as~~ 9101
~~amended, and Chapter 5111. of the Revised Code~~. 9102

(3) "Pupil" means a person under age twenty-two enrolled in 9103
the schools of a city, local, exempted village, or joint 9104
vocational school district. 9105

(4) "Parent" means either parent with the following 9106
exceptions: 9107

(a) If one parent has custody by court order, "parent" means 9108
the parent with custody. 9109

(b) If neither parent has legal custody, "parent" means the 9110
person or government entity with legal custody. 9111

(c) The child's legal guardian or a person who has accepted 9112
responsibility for the health, safety, and welfare of the child. 9113

(B) At the request of the department of ~~job and family~~ 9114

~~services~~ health care administration, a board of education shall establish and conduct a healthcheck program for pupils enrolled in the schools of the district who are medicaid recipients ~~of medical assistance under Chapter 5111. of the Revised Code~~. At the request of a board of education, the department may authorize the board to establish a healthcheck program. A board that establishes a healthcheck program shall enter into a ~~medical assistance~~ medicaid provider agreement with the department. 9115–9122

A healthcheck program established by a board of education shall be conducted in accordance with rules adopted by the director of ~~job and family services~~ health care administration under division (F) of this section. The healthcheck program shall include all of the following components: 9123–9127

(1) A comprehensive health and development history; 9128

(2) A comprehensive physical examination; 9129

(3) A developmental assessment; 9130

(4) A nutritional assessment; 9131

(5) A vision assessment; 9132

(6) A hearing assessment; 9133

(7) An immunization assessment; 9134

(8) Lead screening and laboratory tests ordered by a doctor of medicine or osteopathic medicine as part of one of the other components; 9135–9137

(9) Such other assessment as may be required by the department of ~~job and family services~~ health care administration in accordance with the requirements of the healthcheck program. 9138–9140

All services included in a board of education's healthcheck program that the board provided under sections 3313.67, 3313.673, 3313.68, 3313.69, and 3313.71 of the Revised Code during the 1990-1991 school year shall continue to be provided to ~~medical~~ 9141–9144

~~assistance~~ medicaid recipients by the board pursuant to those sections. The services shall be considered part of the healthcheck program for medicaid recipients ~~of medical assistance~~, and the board shall be eligible for reimbursement from the ~~state~~ department in accordance with this division for providing the services.

The department shall reimburse boards of education for healthcheck program services provided under this division at the rates paid under the ~~medical assistance~~ medicaid program to physicians, dentists, nurses, and other providers of healthcheck services.

(C) Each board of education that conducts a healthcheck program shall determine for each pupil enrolled in the schools of the district whether the pupil is a ~~medical assistance~~ medicaid recipient. The department of ~~job and family services~~ health care administration and county departments of ~~human~~ job and family services shall assist the board in making these determinations. Except as necessary to carry out the purposes of this section, all information received by a board under this division shall be confidential.

Before the first day of October of each year, each board that conducts a healthcheck program shall send the parent of each pupil who is under age eighteen and a medicaid recipient ~~of medical assistance~~ notice that the pupil will be examined under the district's healthcheck program unless the parent notifies the board that the parent denies consent for the examination. The notice shall include a form to be used by the parent to indicate that the parent denies consent. The denial shall be effective only if the form is signed by the parent and returned to the board or the school in which the pupil is enrolled. If the parent does not return a signed form indicating denial of consent within two weeks after the date the notice is sent, the school district and the

department of ~~job and family services~~ health care administration 9177
shall deem the parent to have consented to examination of the 9178
parent's child under the healthcheck program. In the case of a 9179
pupil age eighteen or older, the notice shall be given to the 9180
pupil, and the school district and the department ~~of job and~~ 9181
~~family services~~ shall deem the pupil to have consented to 9182
examination unless the pupil returns the signed form indicating 9183
the pupil's denial of consent. 9184

(D)(1) As used in this division: 9185

(a) "Nonfederal share" means the portion of expenditures for 9186
services that is required under the ~~medical assistance~~ medicaid 9187
program to be paid for with state or local government funds. 9188

(b) "Federal financial participation" means the portion of 9189
expenditures for services that is reimbursed under the ~~medical~~ 9190
~~assistance~~ medicaid program with federal funds. 9191

(2) At the request of a board of education, the ~~state~~ 9192
department may enter into an agreement with board under which the 9193
board provides medical services to a medicaid recipient ~~of medical~~ 9194
~~assistance~~ that are reimbursable under the ~~medical assistance~~ 9195
medicaid program but not under the healthcheck program. The 9196
agreement may be for a term specified in the agreement and 9197
renewable by mutual consent of the board and the department, or 9198
may continue in force as long as agreeable to the board and the 9199
department. 9200

The board shall use state or local funds of the district to 9201
pay the nonfederal share of expenditures for services provided 9202
under this division. Prior to entering into or renewing an 9203
agreement and at any other time requested by the department while 9204
the agreement is in force, the board shall certify to the 9205
department in accordance with the rules adopted under division (F) 9206
of this section that it will have sufficient state or local funds 9207

to pay the nonfederal share of expenditures under this division. If the board fails to make the certification, the department shall not enter into or renew the agreement. If an agreement has been entered into, it shall be void unless the board makes the certification not later than fifteen days after receiving notice from the department that the certification is due. The board shall report to the department, in accordance with the rules, the amount of state or local funds it spends to provide services under this division.

The department shall reimburse the board the federal financial participation allowed for the board's expenditures for services under this division. The total of the nonfederal share spent by the board and the federal financial participation reimbursed by the department for a service rendered under this division shall be an amount agreed to by the board and the department, but shall not exceed the maximum reimbursable for that service under rules adopted by the director of ~~job and family services~~ health care administration under ~~Chapter 5111.~~ section 5163.15 of the Revised Code. The rules adopted under division (F) of this section shall include procedures under which the department will recover from a board overpayments and subsequent federal audit disallowances of federal financial participation reimbursed by the department.

(E) A board of education shall provide services under division (D) of this section and under its healthcheck program as provided in division (E)(1), (2), or (3) of this section:

(1) By having the services performed by physicians, dentists, and nurses employed by the board;

(2) By contracting with physicians, dentists, nurses, and other providers of services who have ~~medical assistance~~ medicaid provider agreements with the department of ~~job and family services~~ health care administration;

(3) By having some of the services performed by persons described in division (E)(1) of this section and others performed by persons described in division (E)(2) of this section.

(F) The director of ~~job and family services~~ health care administration shall adopt rules in accordance with Chapter 119. of the Revised Code governing healthcheck programs conducted under this section and services provided under division (D) of this section.

Sec. 3313.715. The board of education of a school district may request from the director of mental retardation and developmental disabilities the appropriate identification numbers for all students residing in the district who are ~~medical assistance~~ medicaid recipients ~~under Chapter 5111. of the Revised Code~~. The director shall furnish such numbers upon receipt of lists of student names furnished by the district board, in such form as the director may require.

The director of ~~job and family services~~ health care administration shall provide the director of mental retardation and developmental disabilities with the data necessary for compliance with this section.

Section 3319.321 of the Revised Code does not apply to the release of student names or other data to the director of mental retardation and developmental disabilities for the purposes of this section. Chapter 1347. of the Revised Code does not apply to information required to be kept by a school board or the departments of ~~job and family services~~ health care administration or mental retardation and developmental disabilities to the extent necessary to comply with this section and section 3313.714 of the Revised Code. However, any such information or data shall be used only for the specific legal purposes of such boards and departments and shall not be released to any unauthorized person.

Sec. 3323.021. As used in this section, "participating county MR/DD board" means a county board of mental retardation and developmental disabilities electing to participate in the provision of or contracting for educational services for children under division (D) of section 5126.05 of the Revised Code. 9271 9272 9273 9274 9275

(A) When a school district, educational service center, or participating county MR/DD board enters into an agreement or contract with another school district, educational service center, or participating county MR/DD board to provide educational services to a disabled child during a school year, both of the following shall apply: 9276 9277 9278 9279 9280 9281

(1) Beginning with fiscal year 1999, if the provider of the services intends to increase the amount it charges for some or all of those services during the next school year or if the provider intends to cease offering all or part of those services during the next school year, the provider shall notify the entity for which the services are provided of these intended changes no later ~~that~~ <u>than</u> the first day of March of the current fiscal year. 9282 9283 9284 9285 9286 9287 9288

(2) Beginning with fiscal year 1999, if the entity for which services are provided intends to cease obtaining those services from the provider for the next school year or intends to change the type or amount of services it obtains from the provider for the next school year, the entity shall notify the service provider of these intended changes no later than the first day of March of the current fiscal year. 9289 9290 9291 9292 9293 9294 9295

(B) School districts, educational service centers, participating county MR/DD boards, and other applicable governmental entities shall collaborate where possible to maximize federal sources of revenue to provide additional funds for special education related services for disabled children. Annually, each school district shall report to the department of education any 9296 9297 9298 9299 9300 9301

amounts of money the district received through ~~such medical~~ 9302
~~assistance~~ the medicaid program. 9303

(C) The state board of education, the department of mental 9304
retardation and developmental disabilities, and the department of 9305
~~job and family services~~ health care administration shall develop 9306
working agreements for pursuing additional funds for services for 9307
disabled children. 9308

Sec. 3599.45. (A) No candidate for the office of attorney 9309
general or county prosecutor or such a candidate's campaign 9310
committee shall knowingly accept any contribution from a provider 9311
of services or goods under contract with the department of ~~job and~~ 9312
~~family services~~ health care administration pursuant to the 9313
medicaid program ~~of Title XIX of the "Social Security Act," 49~~ 9314
~~Stat. 620 (1935), 42 U.S.C. 301, as amended,~~ or from any person 9315
having an ownership interest in the provider. 9316

As used in this section "candidate," "campaign committee," 9317
and "contribution" have the same meaning as in section 3517.01 of 9318
the Revised Code. 9319

(B) Whoever violates this section is guilty of a misdemeanor 9320
of the first degree. 9321

Sec. 3701.023. (A) The department of health shall review 9322
applications for eligibility for the program for medically 9323
handicapped children that are submitted to the department by city 9324
and general health districts and physician providers approved in 9325
accordance with division (C) of this section. The department shall 9326
determine whether the applicants meet the medical and financial 9327
eligibility requirements established by the public health council 9328
pursuant to division (A)(1) of section 3701.021 of the Revised 9329
Code, and by the department in the manual of operational 9330
procedures and guidelines for the program for medically 9331

handicapped children developed pursuant to division (B) of that 9332
section. Referrals of potentially eligible children for the 9333
program may be submitted to the department on behalf of the child 9334
by parents, guardians, public health nurses, or any other 9335
interested person. The department of health may designate other 9336
agencies to refer applicants to the department of health. 9337

(B) In accordance with the procedures established in rules 9338
adopted under division (A)(4) of section 3701.021 of the Revised 9339
Code, the department of health shall authorize a provider or 9340
providers to provide to any Ohio resident under twenty-one years 9341
of age, without charge to the resident or the resident's family 9342
and without restriction as to the economic status of the resident 9343
or the resident's family, diagnostic services necessary to 9344
determine whether the resident has a medically handicapping or 9345
potentially medically handicapping condition. 9346

(C) The department of health shall review the applications of 9347
health professionals, hospitals, medical equipment suppliers, and 9348
other individuals, groups, or agencies that apply to become 9349
providers. The department shall enter into a written agreement 9350
with each applicant who is determined, pursuant to the 9351
requirements set forth in rules adopted under division (A)(2) of 9352
section 3701.021 of the Revised Code, to be eligible to be a 9353
provider in accordance with the provider agreement required by the 9354
~~medical assistance~~ medicaid program ~~established under section~~ 9355
~~5111.01 of the Revised Code~~. No provider shall charge a medically 9356
handicapped child or the child's parent or guardian for services 9357
authorized by the department under division (B) or (D) of this 9358
section. 9359

The department, in accordance with rules adopted under 9360
division (A)(3) of section 3701.021 of the Revised Code, may 9361
disqualify any provider from further participation in the program 9362
for violating any requirement set forth in rules adopted under 9363

division (A)(2) of that section. The disqualification shall not take effect until a written notice, specifying the requirement violated and describing the nature of the violation, has been delivered to the provider and the department has afforded the provider an opportunity to appeal the disqualification under division (H) of this section. 9364 9365 9366 9367 9368 9369

(D) The department of health shall evaluate applications from city and general health districts and approved physician providers for authorization to provide treatment services, service coordination, and related goods to children determined to be eligible for the program for medically handicapped children pursuant to division (A) of this section. The department shall authorize necessary treatment services, service coordination, and related goods for each eligible child in accordance with an individual plan of treatment for the child. As an alternative, the department may authorize payment of health insurance premiums on behalf of eligible children when the department determines, in accordance with criteria set forth in rules adopted under division (A)(9) of section 3701.021 of the Revised Code, that payment of the premiums is cost-effective. 9370 9371 9372 9373 9374 9375 9376 9377 9378 9379 9380 9381 9382 9383

(E) The department of health shall pay, from appropriations to the department, any necessary expenses, including but not limited to, expenses for diagnosis, treatment, service coordination, supportive services, transportation, and accessories and their upkeep, provided to medically handicapped children, provided that the provision of the goods or services is authorized by the department under division (B) or (D) of this section. Money appropriated to the department of health may also be expended for reasonable administrative costs incurred by the program. The department of health also may purchase liability insurance covering the provision of services under the program for medically handicapped children by physicians and other health care 9384 9385 9386 9387 9388 9389 9390 9391 9392 9393 9394 9395

professionals. 9396

Payments made to providers by the department of health 9397
pursuant to this division for inpatient hospital care, outpatient 9398
care, and all other medical assistance furnished to eligible 9399
recipients shall be made in accordance with rules adopted by the 9400
public health council pursuant to division (A) of section 3701.021 9401
of the Revised Code. 9402

The departments of health and ~~job and family services~~ health 9403
care administration shall jointly implement procedures to ensure 9404
that duplicate payments are not made under the program for 9405
medically handicapped children and the ~~medical assistance~~ medicaid 9406
program ~~established under section 5111.01 of the Revised Code~~ and 9407
to identify and recover duplicate payments. 9408

(F) At the time of applying for participation in the program 9409
for medically handicapped children, a medically handicapped child 9410
or the child's parent or guardian shall disclose the identity of 9411
any third party against whom the child or the child's parent or 9412
guardian has or may have a right of recovery for goods and 9413
services provided under division (B) or (D) of this section. The 9414
department of health shall require a medically handicapped child 9415
who receives services from the program or the child's parent or 9416
guardian to apply for all third-party benefits for which the child 9417
may be eligible and require the child, parent, or guardian to 9418
apply all third-party benefits received to the amount determined 9419
under division (E) of this section as the amount payable for goods 9420
and services authorized under division (B) or (D) of this section. 9421
The department is the payer of last resort and shall pay for 9422
authorized goods or services, up to the amount determined under 9423
division (E) of this section for the authorized goods or services, 9424
only to the extent that payment for the authorized goods or 9425
services is not made through third-party benefits. When a third 9426
party fails to act on an application or claim for benefits by a 9427

medically handicapped child or the child's parent or guardian, the department shall pay for the goods or services only after ninety days have elapsed since the date the child, parents, or guardians made an application or claim for all third-party benefits. Third-party benefits received shall be applied to the amount determined under division (E) of this section. Third-party payments for goods and services not authorized under division (B) or (D) of this section shall not be applied to payment amounts determined under division (E) of this section. Payment made by the department shall be considered payment in full of the amount determined under division (E) of this section. Medicaid payments for persons eligible for the ~~medical assistance~~ <u>medicaid</u> program ~~established under section 5111.01 of the Revised Code~~ shall be considered payment in full of the amount determined under division (E) of this section. 9428 9429 9430 9431 9432 9433 9434 9435 9436 9437 9438 9439 9440 9441 9442

(G) The department of health shall administer a program to provide services to Ohio residents who are twenty-one or more years of age who have cystic fibrosis and who meet the eligibility requirements established by the rules of the public health council pursuant to division (A)(7) of section 3701.021 of the Revised Code, subject to all provisions of this section, but not subject to section 3701.024 of the Revised Code. 9443 9444 9445 9446 9447 9448 9449

(H) The department of health shall provide for appeals, in accordance with rules adopted under section 3701.021 of the Revised Code, of denials of applications for the program for medically handicapped children under division (A) or (D) of this section, disqualification of providers, or amounts paid under division (E) of this section. Appeals under this division are not subject to Chapter 119. of the Revised Code. 9450 9451 9452 9453 9454 9455 9456

The department may designate ombudspersons to assist medically handicapped children or their parents or guardians, upon the request of the children, parents, or guardians, in filing 9457 9458 9459

appeals under this division and to serve as children's, parents', or guardians' advocates in matters pertaining to the administration of the program for medically handicapped children and eligibility for program services. The ombudspersons shall receive no compensation but shall be reimbursed by the department, in accordance with rules of the office of budget and management, for their actual and necessary travel expenses incurred in the performance of their duties. 9460 9461 9462 9463 9464 9465 9466 9467

(I) The department of health, and city and general health districts providing service coordination pursuant to division (A)(2) of section 3701.024 of the Revised Code, shall provide service coordination in accordance with the standards set forth in the rules adopted under section 3701.021 of the Revised Code, without charge, and without restriction as to economic status. 9468 9469 9470 9471 9472 9473

Sec. 3701.024. (A)(1) Under a procedure established in rules adopted under section 3701.021 of the Revised Code, the department of health shall determine the amount each county shall provide annually for the program for medically handicapped children, based on a proportion of the county's total general property tax duplicate, not to exceed one-tenth of a mill, and charge the county for any part of expenses incurred under the program for treatment services on behalf of medically handicapped children having legal settlement in the county that is not paid from federal funds or through the ~~medical assistance~~ medicaid program ~~established under section 5111.01 of the Revised Code~~. The department shall not charge the county for expenses exceeding the difference between the amount determined under division (A)(1) of this section and any amounts retained under divisions (A)(2) and (3) of this section. 9474 9475 9476 9477 9478 9479 9480 9481 9482 9483 9484 9485 9486 9487 9488

All amounts collected by the department under division (A)(1) of this section shall be deposited into the state treasury to the 9489 9490

credit of the medically handicapped children-county assessment fund, which is hereby created. The fund shall be used by the department to comply with sections 3701.021 to 3701.028 of the Revised Code. 9491 9492 9493 9494

(2) The department, in accordance with rules adopted under section 3701.021 of the Revised Code, may allow each county to retain up to ten per cent of the amount determined under division (A)(1) of this section to provide funds to city or general health districts of the county with which the districts shall provide service coordination, public health nursing, or transportation services for medically handicapped children. 9495 9496 9497 9498 9499 9500 9501

(3) In addition to any amount retained under division (A)(2) of this section, the department, in accordance with rules adopted under section 3701.021 of the Revised Code, may allow counties that it determines have significant numbers of potentially eligible medically handicapped children to retain an amount equal to the difference between: 9502 9503 9504 9505 9506 9507

(a) Twenty-five per cent of the amount determined under division (A)(1) of this section; 9508 9509

(b) Any amount retained under division (A)(2) of this section. 9510 9511

Counties shall use amounts retained under division (A)(3) of this section to provide funds to city or general health districts of the county with which the districts shall conduct outreach activities to increase participation in the program for medically handicapped children. 9512 9513 9514 9515 9516

(4) Prior to any increase in the millage charged to a county, the public health council shall hold a public hearing on the proposed increase and shall give notice of the hearing to each board of county commissioners that would be affected by the increase at least thirty days prior to the date set for the 9517 9518 9519 9520 9521

hearing. Any county commissioner may appear and give testimony at the hearing. Any increase in the millage any county is required to provide for the program for medically handicapped children shall be determined, and notice of the amount of the increase shall be provided to each affected board of county commissioners, no later than the first day of June of the fiscal year next preceding the fiscal year in which the increase will take effect. 9522 9523 9524 9525 9526 9527 9528

(B) Each board of county commissioners shall establish a medically handicapped children's fund and shall appropriate thereto an amount, determined in accordance with division (A)(1) of this section, for the county's share in providing medical, surgical, and other aid to medically handicapped children residing in such county and for the purposes specified in divisions (A)(2) and (3) of this section. Each county shall use money retained under divisions (A)(2) and (3) of this section only for the purposes specified in those divisions. 9529 9530 9531 9532 9533 9534 9535 9536 9537

Sec. 3701.027. The department of health shall administer funds received from the "Maternal and Child Health Block Grant," Title V of the "Social Security Act," 95 Stat. 818 (1981), 42 U.S.C.A. 701, as amended, for programs including the program for medically handicapped children, and to provide technical assistance and consultation to city and general health districts and local health planning organizations in implementing local, community-based, family-centered, coordinated systems of care for medically handicapped children. The department may make grants to persons and other entities for the provision of services with the funds. In addition, the department may use the funds to purchase liability insurance covering the provision of services under the programs by physicians and other health care professionals, and to pay health insurance premiums on behalf of medically handicapped children participating in the program for medically handicapped children when the department determines, in accordance with 9538 9539 9540 9541 9542 9543 9544 9545 9546 9547 9548 9549 9550 9551 9552 9553

criteria set forth in rules adopted under division (A)(9) of section 3701.021 of the Revised Code, that payment of the premiums is cost effective. 9554 9555 9556

In determining eligibility for services provided with funds received from the "Maternal and Child Health Block Grant," the department may use the application form established under section ~~5111.013~~ 5162.15 of the Revised Code. The department may require applicants to furnish their social security numbers. 9557 9558 9559 9560 9561

Sec. 3701.043. If authorized by federal statute or regulation, the director of health may establish and collect fees for conducting the initial certification of any person or entity as a provider of health services for purposes of the medicare program ~~established under Title XVIII of the Social Security Act, 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended~~. The fee established for conducting an initial medicare certification shall not exceed the actual and necessary costs incurred by the department of health in conducting the certification. 9562 9563 9564 9565 9566 9567 9568 9569 9570

All fees collected under this section shall be deposited into the state treasury to the credit of the medicare initial certification fund, which is hereby created. Money credited to the fund shall be used solely to pay the costs of conducting initial medicare certifications. 9571 9572 9573 9574 9575

Sec. 3701.132. The department of health is hereby designated as the state agency to administer the "special supplemental nutrition program for women, infants, and children" established under the "Child Nutrition Act of 1966," 80 Stat. 885, 42 U.S.C. 1786, as amended. The public health council may adopt rules pursuant to Chapter 119. of the Revised Code as necessary for administering the program. The rules may include civil money penalties for violations of the rules. 9576 9577 9578 9579 9580 9581 9582 9583

In determining eligibility for services provided under the program, the department may use the application form established under section ~~5111.013~~ 5162.15 of the Revised Code for the healthy start program. The department may require applicants to furnish their social security numbers. 9584 9585 9586 9587 9588

If the department determines that a vendor has committed an act with respect to the program that federal statutes or regulations or state statutes or rules prohibit, the department shall take action against the vendor in the manner required by 7 C.F.R. part 246, including imposition of a civil money penalty in accordance with 7 C.F.R. 246.12, or rules adopted under this section. 9589 9590 9591 9592 9593 9594 9595

Sec. 3701.243. (A) Except as provided in this section or section 3701.248 of the Revised Code, no person or agency of state or local government that acquires the information while providing any health care service or while in the employ of a health care facility or health care provider shall disclose or compel another to disclose any of the following: 9596 9597 9598 9599 9600 9601

(1) The identity of any individual on whom an HIV test is performed; 9602 9603

(2) The results of an HIV test in a form that identifies the individual tested; 9604 9605

(3) The identity of any individual diagnosed as having AIDS or an AIDS-related condition. 9606 9607

(B)(1) Except as provided in divisions (B)(2), (C), (D), and (F) of this section, the results of an HIV test or the identity of an individual on whom an HIV test is performed or who is diagnosed as having AIDS or an AIDS-related condition may be disclosed only to the following: 9608 9609 9610 9611 9612

(a) The individual who was tested or the individual's legal 9613

guardian, and the individual's spouse or any sexual partner; 9614

(b) A person to whom disclosure is authorized by a written release, executed by the individual tested or by the individual's legal guardian and specifying to whom disclosure of the test results or diagnosis is authorized and the time period during which the release is to be effective; 9615 9616 9617 9618 9619

(c) The individual's physician; 9620

(d) The department of health or a health commissioner to which reports are made under section 3701.24 of the Revised Code; 9621 9622

(e) A health care facility or provider that procures, processes, distributes, or uses a human body part from a deceased individual, donated for a purpose specified in Chapter 2108. of the Revised Code, and that needs medical information about the deceased individual to ensure that the body part is medically acceptable for its intended purpose; 9623 9624 9625 9626 9627 9628

(f) Health care facility staff committees or accreditation or oversight review organizations conducting program monitoring, program evaluation, or service reviews; 9629 9630 9631

(g) A health care provider, emergency medical services worker, or peace officer who sustained a significant exposure to the body fluids of another individual, if that individual was tested pursuant to division (E)(6) of section 3701.242 of the Revised Code, except that the identity of the individual tested shall not be revealed; 9632 9633 9634 9635 9636 9637

(h) To law enforcement authorities pursuant to a search warrant or a subpoena issued by or at the request of a grand jury, a prosecuting attorney, a city director of law or similar chief legal officer of a municipal corporation, or a village solicitor, in connection with a criminal investigation or prosecution. 9638 9639 9640 9641 9642

(2) The results of an HIV test or a diagnosis of AIDS or an 9643

AIDS-related condition may be disclosed to a health care provider, or an authorized agent or employee of a health care facility or a health care provider, if the provider, agent, or employee has a medical need to know the information and is participating in the diagnosis, care, or treatment of the individual on whom the test was performed or who has been diagnosed as having AIDS or an AIDS-related condition. 9644 9645 9646 9647 9648 9649 9650

This division does not impose a standard of disclosure different from the standard for disclosure of all other specific information about a patient to health care providers and facilities. Disclosure may not be requested or made solely for the purpose of identifying an individual who has a positive HIV test result or has been diagnosed as having AIDS or an AIDS-related condition in order to refuse to treat the individual. Referral of an individual to another health care provider or facility based on reasonable professional judgment does not constitute refusal to treat the individual. 9651 9652 9653 9654 9655 9656 9657 9658 9659 9660

(3) Not later than ninety days after November 1, 1989, each health care facility in this state shall establish a protocol to be followed by employees and individuals affiliated with the facility in making disclosures authorized by division (B)(2) of this section. A person employed by or affiliated with a health care facility who determines in accordance with the protocol established by the facility that a disclosure is authorized by division (B)(2) of this section is immune from liability to any person in a civil action for damages for injury, death, or loss to person or property resulting from the disclosure. 9661 9662 9663 9664 9665 9666 9667 9668 9669 9670

(C)(1) Any person or government agency may seek access to or authority to disclose the HIV test records of an individual in accordance with the following provisions: 9671 9672 9673

(a) The person or government agency shall bring an action in a court of common pleas requesting disclosure of or authority to 9674 9675

disclose the results of an HIV test of a specific individual, who shall be identified in the complaint by a pseudonym but whose name shall be communicated to the court confidentially, pursuant to a court order restricting the use of the name. The court shall provide the individual with notice and an opportunity to participate in the proceedings if the individual is not named as a party. Proceedings shall be conducted in chambers unless the individual agrees to a hearing in open court. 9676 9677 9678 9679 9680 9681 9682 9683

(b) The court may issue an order granting the plaintiff access to or authority to disclose the test results only if the court finds by clear and convincing evidence that the plaintiff has demonstrated a compelling need for disclosure of the information that cannot be accommodated by other means. In assessing compelling need, the court shall weigh the need for disclosure against the privacy right of the individual tested and against any disservice to the public interest that might result from the disclosure, such as discrimination against the individual or the deterrence of others from being tested. 9684 9685 9686 9687 9688 9689 9690 9691 9692 9693

(c) If the court issues an order, it shall guard against unauthorized disclosure by specifying the persons who may have access to the information, the purposes for which the information shall be used, and prohibitions against future disclosure. 9694 9695 9696 9697

(2) A person or government agency that considers it necessary to disclose the results of an HIV test of a specific individual in an action in which it is a party may seek authority for the disclosure by filing an in camera motion with the court in which the action is being heard. In hearing the motion, the court shall employ procedures for confidentiality similar to those specified in division (C)(1) of this section. The court shall grant the motion only if it finds by clear and convincing evidence that a compelling need for the disclosure has been demonstrated. 9698 9699 9700 9701 9702 9703 9704 9705 9706

(3) Except for an order issued in a criminal prosecution or 9707

an order under division (C)(1) or (2) of this section granting 9708
disclosure of the result of an HIV test of a specific individual, 9709
a court shall not compel a blood bank, hospital blood center, or 9710
blood collection facility to disclose the result of HIV tests 9711
performed on the blood of voluntary donors in a way that reveals 9712
the identity of any donor. 9713

(4) In a civil action in which the plaintiff seeks to recover 9714
damages from an individual defendant based on an allegation that 9715
the plaintiff contracted the HIV virus as a result of actions of 9716
the defendant, the prohibitions against disclosure in this section 9717
do not bar discovery of the results of any HIV test given to the 9718
defendant or any diagnosis that the defendant suffers from AIDS or 9719
an AIDS-related condition. 9720

(D) The results of an HIV test or the identity of an 9721
individual on whom an HIV test is performed or who is diagnosed as 9722
having AIDS or an AIDS-related condition may be disclosed to a 9723
federal, state, or local government agency, or the official 9724
representative of such an agency, for purposes of the ~~medical~~ 9725
~~assistance~~ <u>medicaid</u> program ~~established under section 5111.01 of~~ 9726
~~the Revised Code~~, the medicare program ~~established under Title~~ 9727
~~XVIII of the "Social Security Act," 49 Stat. 620 (1935) 42~~ 9728
~~U.S.C.A. 301, as amended~~, or any other public assistance program. 9729

(E) Any disclosure pursuant to this section shall be in 9730
writing and accompanied by a written statement that includes the 9731
following or substantially similar language: "This information has 9732
been disclosed to you from confidential records protected from 9733
disclosure by state law. You shall make no further disclosure of 9734
this information without the specific, written, and informed 9735
release of the individual to whom it pertains, or as otherwise 9736
permitted by state law. A general authorization for the release of 9737
medical or other information is not sufficient for the purpose of 9738
the release of HIV test results or diagnoses." 9739

(F) An individual who knows that the individual has received a positive result on an HIV test or has been diagnosed as having AIDS or an AIDS-related condition shall disclose this information to any other person with whom the individual intends to make common use of a hypodermic needle or engage in sexual conduct as defined in section 2907.01 of the Revised Code. An individual's compliance with this division does not prohibit a prosecution of the individual for a violation of division (B) of section 2903.11 of the Revised Code. 9740 9741 9742 9743 9744 9745 9746 9747 9748

(G) Nothing in this section prohibits the introduction of evidence concerning an HIV test of a specific individual in a criminal proceeding. 9749 9750 9751

Sec. 3701.507. (A) To assist in implementing sections 3701.503 to 3701.509 of the Revised Code, the medically handicapped children's medical advisory council created in section 3701.025 of the Revised Code shall appoint a permanent infant hearing screening subcommittee. The subcommittee shall consist of the following members: 9752 9753 9754 9755 9756 9757

(1) One otolaryngologist; 9758

(2) One neonatologist; 9759

(3) One pediatrician; 9760

(4) One neurologist; 9761

(5) One hospital administrator; 9762

(6) Two or more audiologists who are experienced in infant hearing screening and evaluation; 9763 9764

(7) One speech-language pathologist licensed under section 4753.07 of the Revised Code; 9765 9766

(8) Two persons who are each a parent of a hearing-impaired child; 9767 9768

(9) One geneticist; 9769

(10) One epidemiologist; 9770

(11) One adult who is deaf or hearing impaired; 9771

(12) One representative from an organization for the deaf or 9772
hearing impaired; 9773

(13) One family advocate; 9774

(14) One nurse from a well-baby neonatal nursery; 9775

(15) One nurse from a special care neonatal nursery; 9776

(16) One teacher of the deaf who works with infants and 9777
toddlers; 9778

(17) One representative of the health insurance industry; 9779

(18) One representative of the bureau for children with 9780
medical handicaps; 9781

(19) One representative of the department of education; 9782

(20) One representative of the ~~Ohio~~ department of ~~job and~~ 9783
~~family services who has responsibilities regarding medicaid~~ health 9784
care administration; 9785

(21) Any other person the advisory council appoints. 9786

(B) The infant hearing subcommittee shall: 9787

(1) Consult with the director of health regarding the 9788
administration of sections 3701.503 to 3701.509 of the Revised 9789
Code; 9790

(2) Advise and make recommendations regarding proposed rules 9791
prior to their adoption by the public health council under section 9792
3701.508 of the Revised Code; 9793

(3) Consult with the director of health and advise and make 9794
recommendations regarding program development and implementation 9795
under sections 3701.503 to 3701.509 of the Revised Code, including 9796

all of the following: 9797

(a) Establishment under section 3701.504 of the Revised Code of the statewide hearing screening, tracking, and early intervention program to identify newborn and infant hearing impairment; 9798 9799 9800 9801

(b) Identification of locations where hearing evaluations may be conducted; 9802 9803

(c) Recommendations for methods and techniques of hearing screening and hearing evaluation; 9804 9805

(d) Referral, data recording and compilation, and procedures to encourage follow-up hearing care; 9806 9807

(e) Maintenance of a register of newborns and infants who do not pass the hearing screening; 9808 9809

(f) Preparation of the information required by section 3701.506 of the Revised Code and any other information the public health council requires the department of health to provide. 9810 9811 9812

Sec. 3701.74. (A) As used in this section and section 3701.741 of the Revised Code: 9813 9814

(1) "Ambulatory care facility" means a facility that provides medical, diagnostic, or surgical treatment to patients who do not require hospitalization, including a dialysis center, ambulatory surgical facility, cardiac catheterization facility, diagnostic imaging center, extracorporeal shock wave lithotripsy center, home health agency, inpatient hospice, birthing center, radiation therapy center, emergency facility, and an urgent care center. "Ambulatory care facility" does not include the private office of a physician or dentist, whether the office is for an individual or group practice. 9815 9816 9817 9818 9819 9820 9821 9822 9823 9824

(2) "Chiropractor" means an individual licensed under Chapter 4734. of the Revised Code to practice chiropractic. 9825 9826

(3) "Emergency facility" means a hospital emergency department or any other facility that provides emergency medical services. 9827 9828 9829

(4) "Health care practitioner" means all of the following: 9830

(a) A dentist or dental hygienist licensed under Chapter 4715. of the Revised Code; 9831 9832

(b) A registered or licensed practical nurse licensed under Chapter 4723. of the Revised Code; 9833 9834

(c) An optometrist licensed under Chapter 4725. of the Revised Code; 9835 9836

(d) A dispensing optician, spectacle dispensing optician, contact lens dispensing optician, or spectacle-contact lens dispensing optician licensed under Chapter 4725. of the Revised Code; 9837 9838 9839 9840

(e) A pharmacist licensed under Chapter 4729. of the Revised Code; 9841 9842

(f) A physician; 9843

(g) A physician assistant authorized under Chapter 4730. of the Revised Code to practice as a physician assistant; 9844 9845

(h) A practitioner of a limited branch of medicine issued a certificate under Chapter 4731. of the Revised Code; 9846 9847

(i) A psychologist licensed under Chapter 4732. of the Revised Code; 9848 9849

(j) A chiropractor; 9850

(k) A hearing aid dealer or fitter licensed under Chapter 4747. of the Revised Code; 9851 9852

(l) A speech-language pathologist or audiologist licensed under Chapter 4753. of the Revised Code; 9853 9854

(m) An occupational therapist or occupational therapy 9855

assistant licensed under Chapter 4755. of the Revised Code; 9856

(n) A physical therapist or physical therapy assistant 9857
licensed under Chapter 4755. of the Revised Code; 9858

(o) A professional clinical counselor, professional 9859
counselor, social worker, or independent social worker licensed, 9860
or a social work assistant registered, under Chapter 4757. of the 9861
Revised Code; 9862

(p) A dietitian licensed under Chapter 4759. of the Revised 9863
Code; 9864

(q) A respiratory care professional licensed under Chapter 9865
4761. of the Revised Code; 9866

(r) An emergency medical technician-basic, emergency medical 9867
technician-intermediate, or emergency medical technician-paramedic 9868
certified under Chapter 4765. of the Revised Code. 9869

(5) "Health care provider" means a hospital, ambulatory care 9870
facility, long-term care facility, pharmacy, emergency facility, 9871
or health care practitioner. 9872

(6) "Hospital" has the same meaning as in section 3727.01 of 9873
the Revised Code. 9874

(7) "Long-term care facility" means a nursing home, 9875
residential care facility, or home for the aging, as those terms 9876
are defined in section 3721.01 of the Revised Code; an adult care 9877
facility, as defined in section 3722.01 of the Revised Code; a 9878
nursing facility or intermediate care facility for the mentally 9879
retarded, as those terms are defined in section ~~5111.20~~ 5164.01 of 9880
the Revised Code; a facility or portion of a facility certified as 9881
a skilled nursing facility under ~~Title XVIII of~~ the ~~"Social~~ 9882
~~Security Act," 49 Stat. 286 (1965), 42 U.S.C.A. 1395, as amended~~ 9883
medicare program. 9884

(8) "Medical record" means data in any form that pertains to 9885

a patient's medical history, diagnosis, prognosis, or medical condition and that is generated and maintained by a health care provider in the process of the patient's health care treatment. 9886 9887 9888

(9) "Medical records company" means a person who stores, locates, or copies medical records for a health care provider, or is compensated for doing so by a health care provider, and charges a fee for providing medical records to a patient or patient's representative. 9889 9890 9891 9892 9893

(10) "Patient" means either of the following: 9894

(a) An individual who received health care treatment from a health care provider; 9895 9896

(b) A guardian, as defined in section 1337.11 of the Revised Code, of an individual described in division (A)(10)(a) of this section. 9897 9898 9899

(11) "Patient's personal representative" means a minor patient's parent or other person acting in loco parentis, a court-appointed guardian, or a person with durable power of attorney for health care for a patient, the executor or administrator of the patient's estate, or the person responsible for the patient's estate if it is not to be probated. "Patient's personal representative" does not include an insurer authorized under Title XXXIX of the Revised Code to do the business of sickness and accident insurance in this state, a health insuring corporation holding a certificate of authority under Chapter 1751. of the Revised Code, or any other person not named in this division. 9900 9901 9902 9903 9904 9905 9906 9907 9908 9909 9910 9911

(12) "Pharmacy" has the same meaning as in section 4729.01 of the Revised Code. 9912 9913

(13) "Physician" means a person authorized under Chapter 4731. of the Revised Code to practice medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and 9914 9915 9916

surgery. 9917

(14) "Authorized person" means a person to whom a patient has given written authorization to act on the patient's behalf regarding the patient's medical record. 9918 9919 9920

(B) A patient, a patient's personal representative or an authorized person who wishes to examine or obtain a copy of part or all of a medical record shall submit to the health care provider a written request signed by the patient, personal representative, or authorized person dated not more than one year before the date on which it is submitted. The request shall indicate whether the copy is to be sent to the requestor, physician or chiropractor, or held for the requestor at the office of the health care provider. Within a reasonable time after receiving a request that meets the requirements of this division and includes sufficient information to identify the record requested, a health care provider that has the patient's medical records shall permit the patient to examine the record during regular business hours without charge or, on request, shall provide a copy of the record in accordance with section 3701.741 of the Revised Code, except that if a physician or chiropractor who has treated the patient determines for clearly stated treatment reasons that disclosure of the requested record is likely to have an adverse effect on the patient, the health care provider shall provide the record to a physician or chiropractor designated by the patient. The health care provider shall take reasonable steps to establish the identity of the person making the request to examine or obtain a copy of the patient's record. 9921 9922 9923 9924 9925 9926 9927 9928 9929 9930 9931 9932 9933 9934 9935 9936 9937 9938 9939 9940 9941 9942 9943

(C) If a health care provider fails to furnish a medical record as required by division (B) of this section, the patient, personal representative, or authorized person who requested the record may bring a civil action to enforce the patient's right of access to the record. 9944 9945 9946 9947 9948

(D)(1) This section does not apply to medical records whose release is covered by section 173.20 or 3721.13 of the Revised Code, by Chapter 1347. or 5122. of the Revised Code, by 42 C.F.R. part 2, "Confidentiality of Alcohol and Drug Abuse Patient Records," or by 42 C.F.R. 483.10. 9949 9950 9951 9952 9953

(2) Nothing in this section is intended to supersede the confidentiality provisions of sections 2305.24, 2305.25, 2305.251, and 2305.252 of the Revised Code. 9954 9955 9956

Sec. 3701.741. (A) Each health care provider and medical records company shall provide copies of medical records in accordance with this section. 9957 9958 9959

(B) Except as provided in divisions (C) and (E) of this section, a health care provider or medical records company that receives a request for a copy of a patient's medical record shall charge not more than the amounts set forth in this section. 9960 9961 9962 9963

(1) If the request is made by the patient or the patient's personal representative, total costs for copies and all services related to those copies shall not exceed the sum of the following: 9964 9965 9966

(a) Except as provided in division (B)(1)(b) of this section, with respect to data recorded on paper or electronically, the following amounts: 9967 9968 9969

(i) Two dollars and seventy-four cents per page for the first ten pages; 9970 9971

(ii) Fifty-seven cents per page for pages eleven through fifty; 9972 9973

(iii) Twenty-three cents per page for pages fifty-one and higher; 9974 9975

(b) With respect to data resulting from an x-ray, magnetic resonance imaging (MRI), or computed axial tomography (CAT) scan and recorded on paper or film, one dollar and eighty-seven cents 9976 9977 9978

per page; 9979

(c) The actual cost of any related postage incurred by the health care provider or medical records company. 9980 9981

(2) If the request is made other than by the patient or the patient's personal representative, total costs for copies and all services related to those copies shall not exceed the sum of the following: 9982 9983 9984 9985

(a) An initial fee of sixteen dollars and eighty-four cents, which shall compensate for the records search; 9986 9987

(b) Except as provided in division (B)(2)(c) of this section, with respect to data recorded on paper or electronically, the following amounts: 9988 9989 9990

(i) One dollar and eleven cents per page for the first ten pages; 9991 9992

(ii) Fifty-seven cents per page for pages eleven through fifty; 9993 9994

(iii) Twenty-three cents per page for pages fifty-one and higher. 9995 9996

(c) With respect to data resulting from an x-ray, magnetic resonance imaging (MRI), or computed axial tomography (CAT) scan and recorded on paper or film, one dollar and eighty-seven cents per page; 9997 9998 9999 10000

(d) The actual cost of any related postage incurred by the health care provider or medical records company. 10001 10002

(C)(1) On request, a health care provider or medical records company shall provide one copy of the patient's medical record and one copy of any records regarding treatment performed subsequent to the original request, not including copies of records already provided, without charge to the following: 10003 10004 10005 10006 10007

(a) The bureau of workers' compensation, in accordance with 10008

Chapters 4121. and 4123. of the Revised Code and the rules adopted 10009
under those chapters; 10010

(b) The industrial commission, in accordance with Chapters 10011
4121. and 4123. of the Revised Code and the rules adopted under 10012
those chapters; 10013

(c) The department of job and family services or a county 10014
department of job and family services, in accordance with Chapters 10015
5101. and 5111. of the Revised Code and the rules adopted under 10016
those chapters; 10017

(d) The attorney general, in accordance with sections 2743.51 10018
to 2743.72 of the Revised Code and any rules that may be adopted 10019
under those sections; 10020

(e) A patient, patient's personal representative, or 10021
authorized person if the medical record is necessary to support a 10022
claim under Title II ~~or Title XVI~~ of the "Social Security Act," 49 10023
Stat. 620 (1935), 42 U.S.C.~~A.~~ 401 ~~and 1381~~, as amended, or the 10024
supplemental security income program and the request is 10025
accompanied by documentation that a claim has been filed. 10026

(2) Nothing in division (C)(1) of this section requires a 10027
health care provider or medical records company to provide a copy 10028
without charge to any person or entity not listed in division 10029
(C)(1) of this section. 10030

(D) Division (C) of this section shall not be construed to 10031
supersede any rule of the bureau of workers' compensation, the 10032
industrial commission, or the department of job and family 10033
services. 10034

(E) A health care provider or medical records company may 10035
enter into a contract with either of the following for the copying 10036
of medical records at a fee other than as provided in division (B) 10037
of this section: 10038

(1) A patient, a patient's personal representative, or an authorized person; 10039 10040

(2) An insurer authorized under Title XXXIX of the Revised Code to do the business of sickness and accident insurance in this state or health insuring corporations holding a certificate of authority under Chapter 1751. of the Revised Code. 10041 10042 10043 10044

(F) This section does not apply to medical records the copying of which is covered by section 173.20 of the Revised Code or by 42 C.F.R. 483.10. 10045 10046 10047

Sec. 3701.881. (A) As used in this section: 10048

(1) "Applicant" means both of the following: 10049

(a) A person who is under final consideration for appointment to or employment with a home health agency in a position as a person responsible for the care, custody, or control of a child; 10050 10051 10052

(b) A person who is under final consideration for employment with a home health agency in a full-time, part-time, or temporary position that involves providing direct care to an older adult. With regard to persons providing direct care to older adults, "applicant" does not include a person who provides direct care as a volunteer without receiving or expecting to receive any form of remuneration other than reimbursement for actual expenses. 10053 10054 10055 10056 10057 10058 10059

(2) "Criminal records check" and "older adult" have the same meanings as in section 109.572 of the Revised Code. 10060 10061

(3) "Home health agency" means a person or government entity, other than a nursing home, residential care facility, or hospice care program, that has the primary function of providing any of the following services to a patient at a place of residence used as the patient's home: 10062 10063 10064 10065 10066

(a) Skilled nursing care; 10067

(b) Physical therapy; 10068

(c) Speech-language pathology; 10069

(d) Occupational therapy; 10070

(e) Medical social services; 10071

(f) Home health aide services. 10072

(4) "Home health aide services" means any of the following services provided by an individual employed with or contracted for by a home health agency: 10073 10074 10075

(a) Hands-on bathing or assistance with a tub bath or shower; 10076

(b) Assistance with dressing, ambulation, and toileting; 10077

(c) Catheter care but not insertion; 10078

(d) Meal preparation and feeding. 10079

(5) "Hospice care program" has the same meaning as in section 3712.01 of the Revised Code. 10080 10081

(6) "Medical social services" means services provided by a social worker under the direction of a patient's attending physician. 10082 10083 10084

(7) "Minor drug possession offense" has the same meaning as in section 2925.01 of the Revised Code. 10085 10086

(8) "Nursing home," "residential care facility," and "skilled nursing care" have the same meanings as in section 3721.01 of the Revised Code. 10087 10088 10089

(9) "Occupational therapy" has the same meaning as in section 4755.04 of the Revised Code. 10090 10091

(10) "Physical therapy" has the same meaning as in section 4755.40 of the Revised Code. 10092 10093

(11) "Social worker" means a person licensed under Chapter 4757. of the Revised Code to practice as a social worker or 10094 10095

independent social worker. 10096

(12) "Speech-language pathology" has the same meaning as in section 4753.01 of the Revised Code. 10097 10098

(B)(1) Except as provided in division (I) of this section, the chief administrator of a home health agency shall request the superintendent of the bureau of criminal identification and investigation to conduct a criminal records check with respect to each applicant. If the position may involve both responsibility for the care, custody, or control of a child and provision of direct care to an older adult, the chief administrator shall request that the superintendent conduct a single criminal records check for the applicant. If an applicant for whom a criminal records check request is required under this division does not present proof of having been a resident of this state for the five-year period immediately prior to the date upon which the criminal records check is requested or does not provide evidence that within that five-year period the superintendent has requested information about the applicant from the federal bureau of investigation in a criminal records check, the chief administrator shall request that the superintendent obtain information from the federal bureau of investigation as a part of the criminal records check for the applicant. Even if an applicant for whom a criminal records check request is required under this division presents proof that the applicant has been a resident of this state for that five-year period, the chief administrator may request that the superintendent include information from the federal bureau of investigation in the criminal records check. 10099 10100 10101 10102 10103 10104 10105 10106 10107 10108 10109 10110 10111 10112 10113 10114 10115 10116 10117 10118 10119 10120 10121 10122

(2) Any person required by division (B)(1) of this section to request a criminal records check shall provide to each applicant for whom a criminal records check request is required under that division a copy of the form prescribed pursuant to division (C)(1) of section 109.572 of the Revised Code and a standard impression 10123 10124 10125 10126 10127

sheet prescribed pursuant to division (C)(2) of section 109.572 of the Revised Code, obtain the completed form and impression sheet from each applicant, and forward the completed form and impression sheet to the superintendent of the bureau of criminal identification and investigation at the time the chief administrator requests a criminal records check pursuant to division (B)(1) of this section. 10128 10129 10130 10131 10132 10133 10134

(3) An applicant who receives pursuant to division (B)(2) of this section a copy of the form prescribed pursuant to division (C)(1) of section 109.572 of the Revised Code and a copy of an impression sheet prescribed pursuant to division (C)(2) of that section and who is requested to complete the form and provide a set of fingerprint impressions shall complete the form or provide all the information necessary to complete the form and shall provide the impression sheets with the impressions of the applicant's fingerprints. If an applicant, upon request, fails to provide the information necessary to complete the form or fails to provide fingerprint impressions, the home health agency shall not employ that applicant for any position for which a criminal records check is required by division (B)(1) of this section. 10135 10136 10137 10138 10139 10140 10141 10142 10143 10144 10145 10146 10147

(C)(1) Except as provided in rules adopted by the department of health in accordance with division (F) of this section and subject to division (C)(3) of this section, no home health agency shall employ a person as a person responsible for the care, custody, or control of a child if the person previously has been convicted of or pleaded guilty to any of the following: 10148 10149 10150 10151 10152 10153

(a) A violation of section 2903.01, 2903.02, 2903.03, 2903.04, 2903.11, 2903.12, 2903.13, 2903.16, 2903.21, 2903.34, 2905.01, 2905.02, 2905.05, 2907.02, 2907.03, 2907.04, 2907.05, 2907.06, 2907.07, 2907.08, 2907.09, 2907.21, 2907.22, 2907.23, 2907.25, 2907.31, 2907.32, 2907.321, 2907.322, 2907.323, 2911.01, 2911.02, 2911.11, 2911.12, 2919.12, 2919.22, 2919.24, 2919.25, 10154 10155 10156 10157 10158 10159

2923.12, 2923.13, 2923.161, 2925.02, 2925.03, 2925.04, 2925.05, 2925.06, or 3716.11 of the Revised Code, a violation of section 2905.04 of the Revised Code as it existed prior to July 1, 1996, a violation of section 2919.23 of the Revised Code that would have been a violation of section 2905.04 of the Revised Code as it existed prior to July 1, 1996, had the violation been committed prior to that date, a violation of section 2925.11 of the Revised Code that is not a minor drug possession offense, or felonious sexual penetration in violation of former section 2907.12 of the Revised Code; 10160 10161 10162 10163 10164 10165 10166 10167 10168 10169

(b) A violation of an existing or former law of this state, any other state, or the United States that is substantially equivalent to any of the offenses listed in division (C)(1)(a) of this section. 10170 10171 10172 10173

(2) Except as provided in rules adopted by the department of health in accordance with division (F) of this section and subject to division (C)(3) of this section, no home health agency shall employ a person in a position that involves providing direct care to an older adult if the person previously has been convicted of or pleaded guilty to any of the following: 10174 10175 10176 10177 10178 10179

(a) A violation of section 2903.01, 2903.02, 2903.03, 2903.04, 2903.11, 2903.12, 2903.13, 2903.16, 2903.21, 2903.34, 2905.01, 2905.02, 2905.11, 2905.12, 2907.02, 2907.03, 2907.05, 2907.06, 2907.07, 2907.08, 2907.09, 2907.12, 2907.25, 2907.31, 2907.32, 2907.321, 2907.322, 2907.323, 2911.01, 2911.02, 2911.11, 2911.12, 2911.13, 2913.02, 2913.03, 2913.04, 2913.11, 2913.21, 2913.31, 2913.40, 2913.43, 2913.47, 2913.51, 2919.25, 2921.36, 2923.12, 2923.13, 2923.161, 2925.02, 2925.03, 2925.11, 2925.13, 2925.22, 2925.23, or 3716.11 of the Revised Code. 10180 10181 10182 10183 10184 10185 10186 10187 10188

(b) A violation of an existing or former law of this state, any other state, or the United States that is substantially equivalent to any of the offenses listed in division (C)(2)(a) of 10189 10190 10191

this section. 10192

(3)(a) A home health agency may employ conditionally an applicant for whom a criminal records check request is required under division (B) of this section as a person responsible for the care, custody, or control of a child until the criminal records check regarding the applicant required by this section is completed and the agency receives the results of the criminal records check. If the results of the criminal records check indicate that, pursuant to division (C)(1) of this section, the applicant does not qualify for employment, the agency shall release the applicant from employment unless the agency chooses to employ the applicant pursuant to division (F) of this section. 10193 10194 10195 10196 10197 10198 10199 10200 10201 10202 10203

(b)(i) A home health agency may employ conditionally an applicant for whom a criminal records check request is required under division (B) of this section in a position that involves providing direct care to an older adult or in a position that involves both responsibility for the care, custody, and control of a child and the provision of direct care to older adults prior to obtaining the results of a criminal records check regarding the individual, provided that the agency shall request a criminal records check regarding the individual in accordance with division (B)(1) of this section not later than five business days after the individual begins conditional employment. In the circumstances described in division (I)(2) of this section, a home health agency may employ conditionally in a position that involves providing direct care to an older adult an applicant who has been referred to the home health agency by an employment service that supplies full-time, part-time, or temporary staff for positions involving the direct care of older adults and for whom, pursuant to that division, a criminal records check is not required under division (B) of this section. In the circumstances described in division (I)(4) of this section, a home health agency may employ 10204 10205 10206 10207 10208 10209 10210 10211 10212 10213 10214 10215 10216 10217 10218 10219 10220 10221 10222 10223

conditionally in a position that involves both responsibility for the care, custody, and control of a child and the provision of direct care to older adults an applicant who has been referred to the home health agency by an employment service that supplies full-time, part-time, or temporary staff for positions involving both responsibility for the care, custody, and control of a child and the provision of direct care to older adults and for whom, pursuant to that division, a criminal records check is not required under division (B) of this section. 10224 10225 10226 10227 10228 10229 10230 10231 10232

(ii) A home health agency that employs an individual conditionally under authority of division (C)(3)(b)(i) of this section shall terminate the individual's employment if the results of the criminal records check requested under division (B)(1) of this section or described in division (I)(2) or (4) of this section, other than the results of any request for information from the federal bureau of investigation, are not obtained within the period ending thirty days after the date the request is made. Regardless of when the results of the criminal records check are obtained, if the individual was employed conditionally in a position that involves the provision of direct care to older adults and the results indicate that the individual has been convicted of or pleaded guilty to any of the offenses listed or described in division (C)(2) of this section, or if the individual was employed conditionally in a position that involves both responsibility for the care, custody, and control of a child and the provision of direct care to older adults and the results indicate that the individual has been convicted of or pleaded guilty to any of the offenses listed or described in division (C)(1) or (2) of this section, the agency shall terminate the individual's employment unless the agency chooses to employ the individual pursuant to division (F) of this section. Termination of employment under this division shall be considered just cause for discharge for purposes of division (D)(2) of section 4141.29 10233 10234 10235 10236 10237 10238 10239 10240 10241 10242 10243 10244 10245 10246 10247 10248 10249 10250 10251 10252 10253 10254 10255 10256

of the Revised Code if the individual makes any attempt to deceive the agency about the individual's criminal record. 10257 10258

(D)(1) Each home health agency shall pay to the bureau of criminal identification and investigation the fee prescribed pursuant to division (C)(3) of section 109.572 of the Revised Code for each criminal records check conducted in accordance with that section upon the request pursuant to division (B)(1) of this section of the chief administrator of the home health agency. 10259 10260 10261 10262 10263 10264

(2) A home health agency may charge an applicant a fee for the costs it incurs in obtaining a criminal records check under this section, unless the ~~medical assistance~~ medicaid program ~~established under Chapter 5111. of the Revised Code~~ reimburses the agency for the costs. A fee charged under division (D)(2) of this section shall not exceed the amount of fees the agency pays under division (D)(1) of this section. If a fee is charged under division (D)(2) of this section, the agency shall notify the applicant at the time of the applicant's initial application for employment of the amount of the fee and that, unless the fee is paid, the agency will not consider the applicant for employment. 10265 10266 10267 10268 10269 10270 10271 10272 10273 10274 10275

(E) The report of any criminal records check conducted by the bureau of criminal identification and investigation in accordance with section 109.572 of the Revised Code and pursuant to a request made under division (B)(1) of this section is not a public record for the purposes of section 149.43 of the Revised Code and shall not be made available to any person other than the following: 10276 10277 10278 10279 10280 10281

(1) The individual who is the subject of the criminal records check or the individual's representative; 10282 10283

(2) The home health agency requesting the criminal records check or its representative; 10284 10285

(3) The administrator of any other facility, agency, or program that provides direct care to older adults that is owned or 10286 10287

operated by the same entity that owns or operates the home health agency; 10288 10289

(4) Any court, hearing officer, or other necessary individual involved in a case dealing with a denial of employment of the applicant or dealing with employment or unemployment benefits of the applicant; 10290 10291 10292 10293

(5) Any person to whom the report is provided pursuant to, and in accordance with, division (I)(1), (2), (3), or (4) of this section. 10294 10295 10296

(F) The department of health shall adopt rules in accordance with Chapter 119. of the Revised Code to implement this section. The rules shall specify circumstances under which the home health agency may employ a person who has been convicted of or pleaded guilty to an offense listed or described in division (C)(1) of this section but who meets standards in regard to rehabilitation set by the department or employ a person who has been convicted of or pleaded guilty to an offense listed or described in division (C)(2) of this section but meets personal character standards set by the department. 10297 10298 10299 10300 10301 10302 10303 10304 10305 10306

(G) Any person required by division (B)(1) of this section to request a criminal records check shall inform each person, at the time of initial application for employment that the person is required to provide a set of fingerprint impressions and that a criminal records check is required to be conducted and satisfactorily completed in accordance with section 109.572 of the Revised Code if the person comes under final consideration for appointment or employment as a precondition to employment for that position. 10307 10308 10309 10310 10311 10312 10313 10314 10315

(H) In a tort or other civil action for damages that is brought as the result of an injury, death, or loss to person or property caused by an individual who a home health agency employs 10316 10317 10318

in a position that involves providing direct care to older adults, all of the following shall apply: 10319 10320

(1) If the agency employed the individual in good faith and reasonable reliance on the report of a criminal records check requested under this section, the agency shall not be found negligent solely because of its reliance on the report, even if the information in the report is determined later to have been incomplete or inaccurate; 10321 10322 10323 10324 10325 10326

(2) If the agency employed the individual in good faith on a conditional basis pursuant to division (C)(3)(b) of this section, the agency shall not be found negligent solely because it employed the individual prior to receiving the report of a criminal records check requested under this section; 10327 10328 10329 10330 10331

(3) If the agency in good faith employed the individual according to the personal character standards established in rules adopted under division (F) of this section, the agency shall not be found negligent solely because the individual prior to being employed had been convicted of or pleaded guilty to an offense listed or described in division (C)(1) or (2) of this section. 10332 10333 10334 10335 10336 10337

(I)(1) The chief administrator of a home health agency is not required to request that the superintendent of the bureau of criminal identification and investigation conduct a criminal records check of an applicant for a position that involves the provision of direct care to older adults if the applicant has been referred to the agency by an employment service that supplies full-time, part-time, or temporary staff for positions involving the direct care of older adults and both of the following apply: 10338 10339 10340 10341 10342 10343 10344 10345

(a) The chief administrator receives from the employment service or the applicant a report of the results of a criminal records check regarding the applicant that has been conducted by the superintendent within the one-year period immediately 10346 10347 10348 10349

preceding the applicant's referral; 10350

(b) The report of the criminal records check demonstrates that the person has not been convicted of or pleaded guilty to an offense listed or described in division (C)(2) of this section, or the report demonstrates that the person has been convicted of or pleaded guilty to one or more of those offenses, but the home health agency chooses to employ the individual pursuant to division (F) of this section. 10351 10352 10353 10354 10355 10356 10357

(2) The chief administrator of a home health agency is not required to request that the superintendent of the bureau of criminal identification and investigation conduct a criminal records check of an applicant for a position that involves providing direct care to older adults and may employ the applicant conditionally in a position of that nature as described in this division, if the applicant has been referred to the agency by an employment service that supplies full-time, part-time, or temporary staff for positions involving the direct care of older adults and if the chief administrator receives from the employment service or the applicant a letter from the employment service that is on the letterhead of the employment service, dated, and signed by a supervisor or another designated official of the employment service and that states that the employment service has requested the superintendent to conduct a criminal records check regarding the applicant, that the requested criminal records check will include a determination of whether the applicant has been convicted of or pleaded guilty to any offense listed or described in division (C)(2) of this section, that, as of the date set forth on the letter, the employment service had not received the results of the criminal records check, and that, when the employment service receives the results of the criminal records check, it promptly will send a copy of the results to the home health agency. If a home health agency employs an applicant conditionally 10358 10359 10360 10361 10362 10363 10364 10365 10366 10367 10368 10369 10370 10371 10372 10373 10374 10375 10376 10377 10378 10379 10380 10381

in accordance with this division, the employment service, upon its receipt of the results of the criminal records check, promptly shall send a copy of the results to the home health agency, and division (C)(3)(b) of this section applies regarding the conditional employment. 10382 10383 10384 10385 10386

(3) The chief administrator of a home health agency is not required to request that the superintendent of the bureau of criminal identification and investigation conduct a criminal records check of an applicant for a position that involves both responsibility for the care, custody, and control of a child and the provision of direct care to older adults if the applicant has been referred to the agency by an employment service that supplies full-time, part-time, or temporary staff for positions involving both responsibility for the care, custody, and control of a child and the provision of direct care to older adults and both of the following apply: 10387 10388 10389 10390 10391 10392 10393 10394 10395 10396 10397

(a) The chief administrator receives from the employment service or applicant a report of a criminal records check of the type described in division (I)(1)(a) of this section; 10398 10399 10400

(b) The report of the criminal records check demonstrates that the person has not been convicted of or pleaded guilty to an offense listed or described in division (C)(1) or (2) of this section, or the report demonstrates that the person has been convicted of or pleaded guilty to one or more of those offenses, but the home health agency chooses to employ the individual pursuant to division (F) of this section. 10401 10402 10403 10404 10405 10406 10407

(4) The chief administrator of a home health agency is not required to request that the superintendent of the bureau of criminal identification and investigation conduct a criminal records check of an applicant for a position that involves both responsibility for the care, custody, and control of a child and the provision of direct care to older adults and may employ the 10408 10409 10410 10411 10412 10413

applicant conditionally in a position of that nature as described in this division, if the applicant has been referred to the agency by an employment service that supplies full-time, part-time, or temporary staff for positions involving both responsibility for the care, custody, and control of a child and the direct care of older adults and if the chief administrator receives from the employment service or the applicant a letter from the employment service that is on the letterhead of the employment service, dated, and signed by a supervisor or another designated official of the employment service and that states that the employment service has requested the superintendent to conduct a criminal records check regarding the applicant, that the requested criminal records check will include a determination of whether the applicant has been convicted of or pleaded guilty to any offense listed or described in division (C)(1) or (2) of this section, that, as of the date set forth on the letter, the employment service had not received the results of the criminal records check, and that, when the employment service receives the results of the criminal records check, it promptly will send a copy of the results to the home health agency. If a home health agency employs an applicant conditionally in accordance with this division, the employment service, upon its receipt of the results of the criminal records check, promptly shall send a copy of the results to the home health agency, and division (C)(3)(b) of this section applies regarding the conditional employment. 10414 10415 10416 10417 10418 10419 10420 10421 10422 10423 10424 10425 10426 10427 10428 10429 10430 10431 10432 10433 10434 10435 10436 10437 10438

Sec. 3702.30. (A) As used in this section: 10439

(1) "Ambulatory surgical facility" means a facility, whether or not part of the same organization as a hospital, that is located in a building distinct from another in which inpatient care is provided, and to which any of the following apply: 10440 10441 10442 10443

(a) Outpatient surgery is routinely performed in the 10444

facility, and the facility functions separately from a hospital's inpatient surgical service and from the offices of private physicians, podiatrists, and dentists. 10445 10446 10447

(b) Anesthesia is administered in the facility by an anesthesiologist or certified registered nurse anesthetist, and the facility functions separately from a hospital's inpatient surgical service and from the offices of private physicians, podiatrists, and dentists. 10448 10449 10450 10451 10452

(c) The facility applies to be certified by the United States centers for medicare and medicaid services as an ambulatory surgical center for purposes of reimbursement under Part B of the medicare program~~, Part B of Title XVIII of the "Social Security Act," 79 Stat. 286 (1965), 42 U.S.C.A. 1395, as amended~~. 10453 10454 10455 10456 10457

(d) The facility applies to be certified by a national accrediting body approved by the centers for medicare and medicaid services for purposes of deemed compliance with the conditions for participating in the medicare program as an ambulatory surgical center. 10458 10459 10460 10461 10462

(e) The facility bills or receives from any third-party payer, governmental health care program, or other person or government entity any ambulatory surgical facility fee that is billed or paid in addition to any fee for professional services. 10463 10464 10465 10466

(f) The facility is held out to any person or government entity as an ambulatory surgical facility or similar facility by means of signage, advertising, or other promotional efforts. 10467 10468 10469

"Ambulatory surgical facility" does not include a hospital emergency department. 10470 10471

(2) "Ambulatory surgical facility fee" means a fee for certain overhead costs associated with providing surgical services in an outpatient setting. A fee is an ambulatory surgical facility fee only if it directly or indirectly pays for costs associated 10472 10473 10474 10475

with any of the following: 10476

(a) Use of operating and recovery rooms, preparation areas, and waiting rooms and lounges for patients and relatives; 10477 10478

(b) Administrative functions, record keeping, housekeeping, utilities, and rent; 10479 10480

(c) Services provided by nurses, orderlies, technical personnel, and others involved in patient care related to providing surgery. 10481 10482 10483

"Ambulatory surgical facility fee" does not include any additional payment in excess of a professional fee that is provided to encourage physicians, podiatrists, and dentists to perform certain surgical procedures in their office or their group practice's office rather than a health care facility, if the purpose of the additional fee is to compensate for additional cost incurred in performing office-based surgery. 10484 10485 10486 10487 10488 10489 10490

(3) "Governmental health care program" has the same meaning as in section 4731.65 of the Revised Code. 10491 10492

(4) "Health care facility" means any of the following: 10493

(a) An ambulatory surgical facility; 10494

(b) A freestanding dialysis center; 10495

(c) A freestanding inpatient rehabilitation facility; 10496

(d) A freestanding birthing center; 10497

(e) A freestanding radiation therapy center; 10498

(f) A freestanding or mobile diagnostic imaging center. 10499

(5) "Third-party payer" has the same meaning as in section 3901.38 of the Revised Code. 10500 10501

(B) By rule adopted in accordance with sections 3702.12 and 3702.13 of the Revised Code, the director of health shall establish quality standards for health care facilities. The 10502 10503 10504

standards may incorporate accreditation standards or other quality standards established by any entity recognized by the director. 10505 10506

(C) Every ambulatory surgical facility shall require that each physician who practices at the facility comply with all relevant provisions in the Revised Code that relate to the obtaining of informed consent from a patient. 10507 10508 10509 10510

(D) The director shall issue a license to each health care facility that makes application for a license and demonstrates to the director that it meets the quality standards established by the rules adopted under division (B) of this section and satisfies the informed consent compliance requirements specified in division (C) of this section. 10511 10512 10513 10514 10515 10516

(E)(1) Except as provided in section 3702.301 of the Revised Code, no health care facility shall operate without a license issued under this section. 10517 10518 10519

(2) If the department of health finds that a physician who practices at a health care facility is not complying with any provision of the Revised Code related to the obtaining of informed consent from a patient, the department shall report its finding to the state medical board, the physician, and the health care facility. 10520 10521 10522 10523 10524 10525

(3) This division does not create, and shall not be construed as creating, a new cause of action or substantive legal right against a health care facility and in favor of a patient who allegedly sustains harm as a result of the failure of the patient's physician to obtain informed consent from the patient prior to performing a procedure on or otherwise caring for the patient in the health care facility. 10526 10527 10528 10529 10530 10531 10532

(F) The rules adopted under division (B) of this section shall include all of the following: 10533 10534

(1) Provisions governing application for, renewal, 10535

suspension, and revocation of a license under this section; 10536

(2) Provisions governing orders issued pursuant to section 3702.32 of the Revised Code for a health care facility to cease its operations or to prohibit certain types of services provided by a health care facility; 10537 10538 10539 10540

(3) Provisions governing the imposition under section 3702.32 of the Revised Code of civil penalties for violations of this section or the rules adopted under this section, including a scale for determining the amount of the penalties. 10541 10542 10543 10544

(G) An ambulatory surgical facility that performs or induces abortions shall comply with section 3701.791 of the Revised Code. 10545 10546

Sec. 3702.31. (A) The quality monitoring and inspection fund is hereby created in the state treasury. The director of health shall use the fund to administer and enforce this section and sections 3702.11 to 3702.20, 3702.30, 3702.301, and 3702.32 of the Revised Code and rules adopted pursuant to those sections. The director shall deposit in the fund any moneys collected pursuant to this section or section 3702.32 of the Revised Code. All investment earnings of the fund shall be credited to the fund. 10547 10548 10549 10550 10551 10552 10553 10554

(B) The director of health shall adopt rules pursuant to Chapter 119. of the Revised Code establishing fees for both of the following: 10555 10556 10557

(1) Initial and renewal license applications submitted under section 3702.30 of the Revised Code. The fees established under division (B)(1) of this section shall not exceed the actual and necessary costs of performing the activities described in division (A) of this section. 10558 10559 10560 10561 10562

(2) Inspections conducted under section 3702.15 or 3702.30 of the Revised Code. The fees established under division (B)(2) of this section shall not exceed the actual and necessary costs 10563 10564 10565

incurred during an inspection, including any indirect costs incurred by the department for staff, salary, or other administrative costs. The director of health shall provide to each health care facility or provider inspected pursuant to section 3702.15 or 3702.30 of the Revised Code a written statement of the fee. The statement shall itemize and total the costs incurred. Within fifteen days after receiving a statement from the director, the facility or provider shall forward the total amount of the fee to the director. 10566 10567 10568 10569 10570 10571 10572 10573 10574

(3) The fees described in divisions (B)(1) and (2) of this section shall meet both of the following requirements: 10575 10576

(a) For each service described in section 3702.11 of the Revised Code, the fee shall not exceed one thousand seven hundred fifty dollars annually, except that the total fees charged to a health care provider under this section shall not exceed five thousand dollars annually. 10577 10578 10579 10580 10581

(b) The fee shall exclude any costs reimbursable by the United States centers for medicare and medicaid services as part of the certification process for the medicare program ~~established under Title XVIII of the "Social Security Act," 79 Stat. 286 (1935), 42 U.S.C.A. 1395, as amended~~, and the medicaid program ~~established under Title XIX of the "Social Security Act," 79 Stat. 286 (1965), 42 U.S.C. 1396~~. 10582 10583 10584 10585 10586 10587 10588

(4) The director shall not establish a fee for any service for which a licensure or inspection fee is paid by the health care provider to a state agency for the same or similar licensure or inspection. 10589 10590 10591 10592

Sec. 3702.51. As used in sections 3702.51 to 3702.62 of the Revised Code: 10593 10594

(A) "Applicant" means any person that submits an application 10595

for a certificate of need and who is designated in the application 10596
as the applicant. 10597

(B) "Person" means any individual, corporation, business 10598
trust, estate, firm, partnership, association, joint stock 10599
company, insurance company, government unit, or other entity. 10600

(C) "Certificate of need" means a written approval granted by 10601
the director of health to an applicant to authorize conducting a 10602
reviewable activity. 10603

(D) "Health service area" means a geographic region 10604
designated by the director of health under section 3702.58 of the 10605
Revised Code. 10606

(E) "Health service" means a clinically related service, such 10607
as a diagnostic, treatment, rehabilitative, or preventive service. 10608

(F) "Health service agency" means an agency designated to 10609
serve a health service area in accordance with section 3702.58 of 10610
the Revised Code. 10611

(G) "Health care facility" means: 10612

(1) A hospital registered under section 3701.07 of the 10613
Revised Code; 10614

(2) A nursing home licensed under section 3721.02 of the 10615
Revised Code, or by a political subdivision certified under 10616
section 3721.09 of the Revised Code; 10617

(3) A county home or a county nursing home as defined in 10618
section 5155.31 of the Revised Code that is certified under ~~Title~~ 10619
~~XVIII or XIX of~~ the ~~"Social Security Act," 49 Stat. 620 (1935), 42~~ 10620
~~U.S.C.A. 301, as amended~~ medicare program; 10621

(4) A freestanding dialysis center; 10622

(5) A freestanding inpatient rehabilitation facility; 10623

(6) An ambulatory surgical facility; 10624

(7) A freestanding cardiac catheterization facility; 10625

(8) A freestanding birthing center; 10626

(9) A freestanding or mobile diagnostic imaging center; 10627

(10) A freestanding radiation therapy center. 10628

A health care facility does not include the offices of 10629
private physicians and dentists whether for individual or group 10630
practice, residential facilities licensed under section 5123.19 of 10631
the Revised Code, or an institution for the sick that is operated 10632
exclusively for patients who use spiritual means for healing and 10633
for whom the acceptance of medical care is inconsistent with their 10634
religious beliefs, accredited by a national accrediting 10635
organization, exempt from federal income taxation under section 10636
501 of the Internal Revenue Code of 1986, 100 Stat. 2085, 26 10637
U.S.C.A. 1, as amended, and providing twenty-four hour nursing 10638
care pursuant to the exemption in division (E) of section 4723.32 10639
of the Revised Code from the licensing requirements of Chapter 10640
4723. of the Revised Code. 10641

(H) "Medical equipment" means a single unit of medical 10642
equipment or a single system of components with related functions 10643
that is used to provide health services. 10644

(I) "Third-party payer" means a health insuring corporation 10645
licensed under Chapter 1751. of the Revised Code, a health 10646
maintenance organization as defined in division (K) of this 10647
section, an insurance company that issues sickness and accident 10648
insurance in conformity with Chapter 3923. of the Revised Code, a 10649
state-financed health insurance program under Chapter 3701.~~,~~ or 10650
4123.~~, or 5111.~~ of the Revised Code, the medicaid program, or any 10651
self-insurance plan. 10652

(J) "Government unit" means the state and any county, 10653
municipal corporation, township, or other political subdivision of 10654
the state, or any department, division, board, or other agency of 10655

the state or a political subdivision. 10656

(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. 10657 10658 10659 10660

(L) "Existing health care facility" means either of the following: 10661 10662

(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; 10663 10664 10665 10666 10667 10668 10669

(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. 10670 10671 10672 10673 10674 10675 10676 10677 10678 10679 10680

(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. 10681 10682 10683 10684 10685 10686

(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. 10687 10688 10689 10690 10691

(O) "Affected person" means: 10692

(1) An applicant for a certificate of need, including an applicant whose application was reviewed comparatively with the application in question; 10693 10694 10695

(2) The person that requested the reviewability ruling in question; 10696 10697

(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; 10698 10699 10700 10701

(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; 10702 10703 10704

(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; 10705 10706 10707 10708

(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. 10709 10710 10711 10712

(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: 10713 10714 10715 10716

(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; 10717 10718 10719 10720

(2) Maintaining an active medical staff, the majority of which is comprised of osteopathic physicians; 10721 10722

(3) Maintaining a medical staff executive committee that has osteopathic physicians as a majority of its members. 10723 10724

(Q) "Ambulatory surgical facility" has the same meaning as in section 3702.30 of the Revised Code. 10725 10726

(R) Except as otherwise provided in division (T) of this section, and until the termination date specified in section 3702.511 of the Revised Code, "reviewable activity" means any of the following: 10727 10728 10729 10730

(1) The addition by any person of any of the following health services, regardless of the amount of operating costs or capital expenditures: 10731 10732 10733

(a) A heart, heart-lung, lung, liver, kidney, bowel, pancreas, or bone marrow transplantation service, a stem cell harvesting and reinfusion service, or a service for transplantation of any other organ unless transplantation of the organ is designated by public health council rule not to be a reviewable activity; 10734 10735 10736 10737 10738 10739

(b) A cardiac catheterization service; 10740

(c) An open-heart surgery service; 10741

(d) Any new, experimental medical technology that is designated by rule of the public health council. 10742 10743

(2) The acceptance of high-risk patients, as defined in rules adopted under section 3702.57 of the Revised Code, by any cardiac catheterization service that was initiated without a certificate 10744 10745 10746

of need pursuant to division (R)(3)(b) of the version of this section in effect immediately prior to April 20, 1995; 10747 10748

(3)(a) The establishment, development, or construction of a new health care facility other than a new long-term care facility or a new hospital; 10749 10750 10751

(b) The establishment, development, or construction of a new hospital or the relocation of an existing hospital; 10752 10753

(c) The relocation of hospital beds, other than long-term care, perinatal, or pediatric intensive care beds, into or out of a rural area. 10754 10755 10756

(4)(a) The replacement of an existing hospital; 10757

(b) The replacement of an existing hospital obstetric or newborn care unit or freestanding birthing center. 10758 10759

(5)(a) The renovation of a hospital that involves a capital expenditure, obligated on or after June 30, 1995, of five million dollars or more, not including expenditures for equipment, staffing, or operational costs. For purposes of division (R)(5)(a) of this section, a capital expenditure is obligated: 10760 10761 10762 10763 10764

(i) When a contract enforceable under Ohio law is entered into for the construction, acquisition, lease, or financing of a capital asset; 10765 10766 10767

(ii) When the governing body of a hospital takes formal action to commit its own funds for a construction project undertaken by the hospital as its own contractor; 10768 10769 10770

(iii) In the case of donated property, on the date the gift is completed under applicable Ohio law. 10771 10772

(b) The renovation of a hospital obstetric or newborn care unit or freestanding birthing center that involves a capital expenditure of five million dollars or more, not including expenditures for equipment, staffing, or operational costs. 10773 10774 10775 10776

(6) Any change in the health care services, bed capacity, or site, or any other failure to conduct the reviewable activity in substantial accordance with the approved application for which a certificate of need was granted, if the change is made prior to the date the activity for which the certificate was issued ceases to be a reviewable activity; 10777 10778 10779 10780 10781 10782

(7) Any of the following changes in perinatal bed capacity or pediatric intensive care bed capacity: 10783 10784

(a) An increase in bed capacity; 10785

(b) A change in service or service-level designation of newborn care beds or obstetric beds in a hospital or freestanding birthing center, other than a change of service that is provided within the service-level designation of newborn care or obstetric beds as registered by the department of health; 10786 10787 10788 10789 10790

(c) A relocation of perinatal or pediatric intensive care beds from one physical facility or site to another, excluding the relocation of beds within a hospital or freestanding birthing center or the relocation of beds among buildings of a hospital or freestanding birthing center at the same site. 10791 10792 10793 10794 10795

(8) The expenditure of more than one hundred ten per cent of the maximum expenditure specified in a certificate of need; 10796 10797

(9) Any transfer of a certificate of need issued prior to April 20, 1995, from the person to whom it was issued to another person before the project that constitutes a reviewable activity is completed, any agreement that contemplates the transfer of a certificate of need issued prior to that date upon completion of the project, and any transfer of the controlling interest in an entity that holds a certificate of need issued prior to that date. However, the transfer of a certificate of need issued prior to that date or agreement to transfer such a certificate of need from the person to whom the certificate of need was issued to an 10798 10799 10800 10801 10802 10803 10804 10805 10806 10807

affiliated or related person does not constitute a reviewable transfer of a certificate of need for the purposes of this division, unless the transfer results in a change in the person that holds the ultimate controlling interest in the certificate of need. 10808 10809 10810 10811 10812

(10)(a) The acquisition by any person of any of the following medical equipment, regardless of the amount of operating costs or capital expenditure: 10813 10814 10815

(i) A cobalt radiation therapy unit; 10816

(ii) A linear accelerator; 10817

(iii) A gamma knife unit. 10818

(b) The acquisition by any person of medical equipment with a cost of two million dollars or more. The cost of acquiring medical equipment includes the sum of the following: 10819 10820 10821

(i) The greater of its fair market value or the cost of its lease or purchase; 10822 10823

(ii) The cost of installation and any other activities essential to the acquisition of the equipment and its placement into service. 10824 10825 10826

(11) The addition of another cardiac catheterization laboratory to an existing cardiac catheterization service. 10827 10828

(S) Except as provided in division (T) of this section, "reviewable activity" also means any of the following activities, none of which are subject to a termination date: 10829 10830 10831

(1) The establishment, development, or construction of a new long-term care facility; 10832 10833

(2) The replacement of an existing long-term care facility; 10834

(3) The renovation of a long-term care facility that involves a capital expenditure of two million dollars or more, not 10835 10836

including expenditures for equipment, staffing, or operational costs; 10837 10838

(4) Any of the following changes in long-term care bed capacity: 10839 10840

(a) An increase in bed capacity; 10841

(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; 10842 10843 10844 10845

(c) A recategorization of hospital beds registered under section 3701.07 of the Revised Code from another registration category to skilled nursing beds or long-term care beds. 10846 10847 10848

(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; 10849 10850 10851 10852 10853 10854

(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; 10855 10856 10857

(7) Any transfer of a certificate of need that concerns long-term care beds and was issued prior to April 20, 1995, from the person to whom it was issued to another person before the project that constitutes a reviewable activity is completed, any agreement that contemplates the transfer of such a certificate of need upon completion of the project, and any transfer of the controlling interest in an entity that holds such a certificate of need. However, the transfer of a certificate of need that concerns long-term care beds and was issued prior to April 20, 1995, or agreement to transfer such a certificate of need from the person 10858 10859 10860 10861 10862 10863 10864 10865 10866 10867

to whom the certificate was issued to an affiliated or related person does not constitute a reviewable transfer of a certificate of need for purposes of this division, unless the transfer results in a change in the person that holds the ultimate controlling interest in the certificate of need. 10868 10869 10870 10871 10872

(T) "Reviewable activity" does not include any of the following activities: 10873 10874

(1) Acquisition of computer hardware or software; 10875

(2) Acquisition of a telephone system; 10876

(3) Construction or acquisition of parking facilities; 10877

(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; 10878 10879 10880

(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; 10881 10882 10883

(6) Correction of cited deficiencies identified by accreditation surveys of the joint commission on accreditation of healthcare organizations or of the American osteopathic association; 10884 10885 10886 10887

(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; 10888 10889 10890

(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; 10891 10892 10893 10894

(9) Construction, repair, or renovation of bathroom facilities; 10895 10896

(10) Construction of laundry facilities, waste disposal 10897

facilities, dietary department projects, heating and air conditioning projects, administrative offices, and portions of medical office buildings used exclusively for physician services; 10898 10899 10900

(11) Acquisition of medical equipment to conduct research required by the United States food and drug administration or clinical trials sponsored by the national institute of health. Use of medical equipment that was acquired without a certificate of need under division (T)(11) of this section and for which premarket approval has been granted by the United States food and drug administration to provide services for which patients or reimbursement entities will be charged shall be a reviewable activity. 10901 10902 10903 10904 10905 10906 10907 10908 10909

(12) Removal of asbestos from a health care facility. 10910

Only that portion of a project that meets the requirements of division (T) of this section is not a reviewable activity. 10911 10912

(U) "Small rural hospital" means a hospital that is located within a rural area, has fewer than one hundred beds, and to which fewer than four thousand persons were admitted during the most recent calendar year. 10913 10914 10915 10916

(V) "Children's hospital" means any of the following: 10917

(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; 10918 10919 10920 10921 10922

(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 10923 10924 10925 10926 10927 10928

individuals less than eighteen years of age; 10929

(3) A distinct portion of a hospital, if the hospital is registered under section 3701.07 of the Revised Code as a children's hospital and the children's hospital meets all the requirements of division (V)(1) of this section. 10930 10931 10932 10933

(W) "Long-term care facility" means any of the following: 10934

(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; 10935 10936 10937

(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"; 10938 10939 10940 10941

(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. 10942 10943 10944

(X) "Long-term care bed" means a bed in a long-term care facility. 10945 10946

(Y) "Perinatal bed" means a bed in a hospital that is registered under section 3701.07 of the Revised Code as a newborn care bed or obstetric bed, or a bed in a freestanding birthing center. 10947 10948 10949 10950

(Z) "Freestanding birthing center" means any facility in which deliveries routinely occur, regardless of whether the facility is located on the campus of another health care facility, and which is not licensed under Chapter 3711. of the Revised Code as a level one, two, or three maternity unit or a limited maternity unit. 10951 10952 10953 10954 10955 10956

(AA)(1) "Reviewability ruling" means a ruling issued by the director of health under division (A) of section 3702.52 of the 10957 10958

Revised Code as to whether a particular proposed project is or is not a reviewable activity. 10959 10960

(2) "Nonreviewability ruling" means a ruling issued under that division that a particular proposed project is not a reviewable activity. 10961 10962 10963

(BB)(1) "Metropolitan statistical area" means an area of this state designated a metropolitan statistical area or primary metropolitan statistical area in United States office of management and budget bulletin no. 93-17, June 30, 1993, and its attachments. 10964 10965 10966 10967 10968

(2) "Rural area" means any area of this state not located within a metropolitan statistical area. 10969 10970

(CC) "County nursing home" has the same meaning as in section 5155.31 of the Revised Code. 10971 10972

Sec. 3702.522. (A) Reviews of applications for certificates of need to recategorize hospital beds to skilled nursing beds shall be conducted in accordance with this division and rules adopted by the public health council. 10973 10974 10975 10976

(1) No hospital recategorizing beds shall apply for a certificate of need for more than twenty skilled nursing beds. 10977 10978

(2) No beds for which a certificate of need is requested under this division shall be reviewed under or counted in any formula developed under public health council rules for the purpose of determining the number of long-term care beds that may be needed within the state. 10979 10980 10981 10982 10983

(3) No beds shall be approved under this division unless the hospital certifies and demonstrates in the application that the beds will be dedicated to patients with a length of stay of no more than thirty days. 10984 10985 10986 10987

(4) No beds shall be approved under this division unless the 10988

hospital can satisfactorily demonstrate in the application that it 10989
is routinely unable to place the patients planned for the beds in 10990
accessible skilled nursing facilities. 10991

(5) In developing rules to implement this division, the 10992
public health council shall give special attention to the required 10993
documentation of the need for such beds, including the efforts 10994
made by the hospital to place patients in suitable skilled nursing 10995
facilities, and special attention to the appropriate size of units 10996
with such beds given the historical pattern of the applicant 10997
hospital's documented difficulty in placing skilled nursing 10998
patients. 10999

(B) To assist the director of health in monitoring the use of 11000
hospital beds recategorized as skilled nursing beds after August 11001
5, 1989, the public health council shall adopt rules specifying 11002
appropriate quarterly procedures for reporting to the department 11003
of health. 11004

(C) A patient may stay in a hospital bed that, after August 11005
5, 1989, has been recategorized as a skilled nursing bed for more 11006
than thirty days if the hospital is able to demonstrate that it 11007
made a good faith effort to place the patient in an accessible 11008
skilled nursing facility acceptable to the patient within the 11009
thirty-day period, but was unable to do so. 11010

(D) No hospital bed recategorized after August 5, 1989, as a 11011
skilled nursing bed shall be covered by a provider agreement under 11012
the ~~medical assistance~~ medicaid program ~~established under Chapter~~ 11013
~~5111. of the Revised Code~~. 11014

(E) Nothing in this section requires a hospital to place a 11015
patient in any nursing home if the patient does not wish to be 11016
placed in the nursing home. Nothing in this section limits the 11017
ability of a hospital to file a certificate of need application 11018
for the addition of long-term care beds that meet the definition 11019

of "home" in section 3721.01 of the Revised Code. Nothing in this 11020
section limits the ability of the director to grant certificates 11021
of need necessary for hospitals to engage in demonstration 11022
projects authorized by the federal government for the purpose of 11023
enhancing long-term quality of care and cost containment. Nothing 11024
in this section limits the ability of hospitals to develop swing 11025
bed programs in accordance with federal regulations. 11026

No hospital that is granted a certificate of need after 11027
August 5, 1989, to recategorize hospital beds as skilled nursing 11028
beds is subject to sections 3721.01 to 3721.09 of the Revised 11029
Code. If the portion of the hospital in which the recategorized 11030
beds are located is certified as a skilled nursing facility under 11031
~~Title XVIII of~~ the ~~"Social Security Act," 49 Stat. 620 (1935), 42~~ 11032
~~U.S.C.A. 301, as amended~~ medicare program, that portion of the 11033
hospital is subject to sections 3721.10 to 3721.17 and sections 11034
3721.21 to 3721.34 of the Revised Code. If the beds are registered 11035
pursuant to section 3701.07 of the Revised Code as long-term care 11036
beds, the beds are subject to sections ~~3721.50~~ 5166.20 to ~~3721.58~~ 11037
5166.30 of the Revised Code. 11038

(F) The public health council shall adopt rules authorizing 11039
the creation of one or more nursing home placement clearinghouses. 11040
Any public or private agency or facility may apply to the 11041
department of health to serve as a nursing home placement 11042
clearinghouse, and the rules shall provide the procedure for 11043
application and process for designation of clearinghouses. 11044

The department may approve one or more clearinghouses, but in 11045
no event shall there be more than one nursing home placement 11046
clearinghouse in each county. Any nursing home may list with a 11047
nursing home placement clearinghouse the services it provides and 11048
the types of patients it is approved for and equipped to serve. 11049
The clearinghouse shall make reasonable efforts to update its 11050
information at least every six months. 11051

If an appropriate clearinghouse has been designated, each hospital granted a certificate of need after August 5, 1989, to recategorize hospital beds as skilled nursing beds shall, and any other hospital may, utilize the nursing home placement clearinghouse prior to admitting a patient to a skilled nursing bed within the hospital and prior to keeping a patient in a skilled nursing bed within a hospital in excess of thirty days. 11052 11053 11054 11055 11056 11057 11058

The department shall provide at least annually to all hospitals a list of the designated nursing home placement clearinghouses. 11059 11060 11061

Sec. 3702.591. As specified in former Section 11 of Am. Sub. S.B. 50 of the 121st general assembly, as amended by Am. Sub. H.B. 405 of the 124th general assembly, all of the following apply: 11062 11063 11064 11065

(A) The removal of former divisions (E) and (F) of section 3702.52 of the Revised Code by Sections 1 and 2 of Am. Sub. S.B. 50 of the 121st general assembly does not release the holders of certificates of need issued under those divisions from complying with any conditions on which the granting of the certificates of need was based, including the requirement of former division (E)(6) of that section that the holders not enter into medicaid provider agreements ~~under Chapter 5111. of the Revised Code and Title XIX of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C. 301, as amended,~~ for at least ten years following initial licensure of the long-term care facilities for which the certificates were granted. 11066 11067 11068 11069 11070 11071 11072 11073 11074 11075 11076 11077

(B) The repeal of section 3702.55 of the Revised Code by Section 2 of Am. Sub. S.B. 50 of the 121st general assembly does not release the holders of certificates of need issued under that section from complying with any conditions on which the granting of the certificates of need was based, other than the requirement 11078 11079 11080 11081 11082

of division (A)(6) of that section that the holders not seek certification under ~~Title XVIII of~~ the ~~"Social Security Act"~~ medicare program for beds recategorized under the certificates. That repeal also does not eliminate the requirement that the director of health revoke the licensure of the beds under Chapter 3721. of the Revised Code if a person to which their ownership is transferred fails, as required by division (A)(6) of the repealed section, to file within ten days after the transfer a sworn statement not to seek certification under ~~Title XIX of~~ the ~~"Social Security Act"~~ medicaid program for beds recategorized under the certificates of need. 11083–11093

(C) The repeal of section 3702.56 of the Revised Code by Section 2 of Am. Sub. S.B. 50 of the 121st general assembly does not release the holders of certificates of need issued under that section from complying with any conditions on which the granting of the certificates of need was based. 11094–11098

Sec. 3702.62. (A) Any action pursuant to section 140.03, 140.04, 140.05, 307.091, 313.21, 339.01, 339.021, 339.03, 339.06, 339.08, 339.09, 339.12, 339.14, 513.05, 513.07, 513.08, 513.081, 513.12, 513.15, 513.17, 513.171, 749.02, 749.03, 749.14, 749.16, 749.20, 749.25, 749.28, 749.35, 1751.06, or 3707.29 of the Revised Code shall be taken in accordance with sections 3702.51 to 3702.61 of the Revised Code. 11099–11105

(B) A nursing home certified as an intermediate care facility for the mentally retarded under ~~Title XIX of~~ the ~~"Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended~~ medicaid program, that is required to apply for licensure as a residential facility under section 5123.19 of the Revised Code is not, with respect to the portion of the home certified as an intermediate care facility for the mentally retarded, subject to sections 3702.51 to 3702.61 of the Revised Code. 11106–11113

Sec. 3702.74. (A) A primary care physician who has signed a letter of intent under section 3702.73 of the Revised Code and the director of health may enter into a contract for the physician's participation in the physician loan repayment program. The physician's employer or other funding source may also be a party to the contract. 11114 11115 11116 11117 11118 11119

(B) The contract shall include all of the following obligations: 11120 11121

(1) The primary care physician agrees to provide primary care services in the health resource shortage area identified in the letter of intent for at least two years; 11122 11123 11124

(2) When providing primary care services in the health resource shortage area, the primary care physician agrees to do all of the following: 11125 11126 11127

(a) Provide primary care services for a minimum of forty hours per week, of which at least twenty-one hours will be spent providing patient care in an outpatient or ambulatory setting; 11128 11129 11130

(b) Provide primary care services without regard to a patient's ability to pay; 11131 11132

(c) Meet the conditions ~~prescribed by the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended, and the department of job and family services~~ for participation in the medicaid program ~~established under Chapter 5111. of the Revised Code~~ and enter into a contract with the department of health care administration to provide primary care services to medicaid recipients ~~of the medical assistance program~~; 11133 11134 11135 11136 11137 11138 11139

(d) Meet the conditions established by the department of job and family services for participation in the disability medical assistance program ~~established under Chapter 5115. of the Revised Code~~ and enter into a contract with the department to provide 11140 11141 11142 11143

primary care services to recipients of disability medical assistance. 11144 11145

(3) The department of health agrees, as provided in section 3702.75 of the Revised Code, to repay, so long as the primary care physician performs the service obligation agreed to under division (B)(1) of this section, all or part of the principal and interest of a government or other educational loan taken by the primary care physician for expenses described in section 3702.75 of the Revised Code; 11146 11147 11148 11149 11150 11151 11152

(4) The primary care physician agrees to pay the department of health an amount established by rules adopted under section 3702.79 of the Revised Code if the physician fails to complete the service obligation agreed to under division (B)(1) of this section. 11153 11154 11155 11156 11157

(C) The contract may include any other terms agreed upon by the parties. 11158 11159

Sec. 3702.91. (A) An individual who has signed a letter of intent under section 3702.90 of the Revised Code may enter into a contract with the director of health for participation in the dentist loan repayment program. A lending institution may also be a party to the contract. 11160 11161 11162 11163 11164

(B) The contract shall include all of the following obligations: 11165 11166

(1) The individual agrees to provide dental services in the dental health resource shortage area identified in the letter of intent for at least one year. 11167 11168 11169

(2) When providing dental services in the dental health resource shortage area, the individual agrees to do all of the following: 11170 11171 11172

(a) Provide dental services for a minimum of forty hours per 11173

week; 11174

(b) Provide dental services without regard to a patient's 11175
ability to pay; 11176

(c) Meet the conditions ~~prescribed by the "Social Security~~ 11177
~~Act," 49 Stat. 620 (1935), 42 U.S.C. 301, as amended, and the~~ 11178
~~department of job and family services~~ for participation in the 11179
medicaid program ~~established under Chapter 5111. of the Revised~~ 11180
~~Code~~ and enter into a contract with the department of health care 11181
administration to provide dental services to medicaid recipients. 11182

(3) The department of health agrees, as provided in section 11183
3702.85 of the Revised Code, to repay, so long as the individual 11184
performs the service obligation agreed to under division (B)(1) of 11185
this section, all or part of the principal and interest of a 11186
government or other educational loan taken by the individual for 11187
expenses described in section 3702.85 of the Revised Code up to 11188
but not exceeding twenty thousand dollars per year of service. 11189

(4) The individual agrees to pay the department of health the 11190
following as damages if the individual fails to complete the 11191
service obligation agreed to under division (B)(1) of this 11192
section: 11193

(a) If the failure occurs during the first two years of the 11194
service obligation, three times the total amount the department 11195
has agreed to repay under division (B)(3) of this section; 11196

(b) If the failure occurs after the first two years of the 11197
service obligation, three times the amount the department is still 11198
obligated to repay under division (B)(3) of this section. 11199

(C) The contract may include any other terms agreed upon by 11200
the parties, including an assignment to the department of health 11201
of the individual's duty to pay the principal and interest of a 11202
government or other educational loan taken by the individual for 11203
expenses described in section 3702.85 of the Revised Code. If the 11204

department assumes the individual's duty to pay a loan, the 11205
contract shall set forth the total amount of principal and 11206
interest to be paid, an amortization schedule, and the amount of 11207
each payment to be made under the schedule. 11208

(D) Not later than the thirty-first day of January of each 11209
year, the department of health shall mail to each individual to 11210
whom or on whose behalf repayment is made under the dentist loan 11211
repayment program a statement showing the amount of principal and 11212
interest repaid by the department pursuant to the contract in the 11213
preceding year. The statement shall be sent by ordinary mail with 11214
address correction and forwarding requested in the manner 11215
prescribed by the United States postal service. 11216

Sec. 3712.07. (A) As used in this section, "terminal care 11217
facility for the homeless" means a facility that provides 11218
accommodations to homeless individuals who are terminally ill. 11219

(B) A person or public agency licensed under this chapter to 11220
provide a hospice care program may enter into an agreement with a 11221
terminal care facility for the homeless under which hospice care 11222
program services may be provided to individuals residing at the 11223
facility, if all of the following apply: 11224

(1) Each resident of the facility has been diagnosed by a 11225
physician as having a terminal condition and an anticipated life 11226
expectancy of six months or less; 11227

(2) No resident of the facility has a relative or other 11228
person willing or capable of providing the care necessary to cope 11229
with ~~his~~ the resident's terminal illness or is financially capable 11230
of hiring a person to provide such care; 11231

(3) Each resident of the facility is under the direct care of 11232
a physician; 11233

(4) No resident of the facility requires the staff of the 11234

facility to administer medication by injection; 11235

(5) The facility does not receive any remuneration, directly or indirectly, from the residents; 11236 11237

(6) The facility does not receive any remuneration, directly or indirectly, from the ~~medical assistance~~ medicaid program ~~established under section 5111.01 of the Revised Code~~ or the medicare program ~~established under Title XVIII of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended~~; 11238 11239 11240 11241 11242

(7) The facility meets all applicable state and federal health and safety standards, including standards for fire prevention, maintenance of safe and sanitary conditions, and proper preparation and storage of foods. 11243 11244 11245 11246

(C) Hospice care program services may be provided at a terminal care facility for the homeless only by the personnel of the person or public agency that has entered into an agreement with the facility under this section. 11247 11248 11249 11250

(D) A terminal care facility for the homeless that has entered into an agreement under this section may assist its residents with the self-administration of medication if the medication has been prescribed by a physician and is not administered by injection. In the event that a resident has entered the final stages of dying and is no longer mentally alert, the facility may administer medication to that resident if the medication has been prescribed by a physician and is not administered by injection. Determinations of whether an individual has entered the final stages of dying and is no longer mentally alert shall be based on directions from the personnel who provide hospice care program services at the facility. 11251 11252 11253 11254 11255 11256 11257 11258 11259 11260 11261 11262

Sec. 3712.09. (A) As used in this section: 11263

(1) "Applicant" means a person who is under final 11264

consideration for employment with a hospice care program in a full-time, part-time, or temporary position that involves providing direct care to an older adult. "Applicant" does not include a person who provides direct care as a volunteer without receiving or expecting to receive any form of remuneration other than reimbursement for actual expenses. 11265 11266 11267 11268 11269 11270

(2) "Criminal records check" and "older adult" have the same meanings as in section 109.572 of the Revised Code. 11271 11272

(B)(1) Except as provided in division (I) of this section, the chief administrator of a hospice care program shall request that the superintendent of the bureau of criminal identification and investigation conduct a criminal records check with respect to each applicant. If an applicant for whom a criminal records check request is required under this division does not present proof of having been a resident of this state for the five-year period immediately prior to the date the criminal records check is requested or provide evidence that within that five-year period the superintendent has requested information about the applicant from the federal bureau of investigation in a criminal records check, the chief administrator shall request that the superintendent obtain information from the federal bureau of investigation as part of the criminal records check of the applicant. Even if an applicant for whom a criminal records check request is required under this division presents proof of having been a resident of this state for the five-year period, the chief administrator may request that the superintendent include information from the federal bureau of investigation in the criminal records check. 11273 11274 11275 11276 11277 11278 11279 11280 11281 11282 11283 11284 11285 11286 11287 11288 11289 11290 11291 11292

(2) A person required by division (B)(1) of this section to request a criminal records check shall do both of the following: 11293 11294

(a) Provide to each applicant for whom a criminal records check request is required under that division a copy of the form 11295 11296

prescribed pursuant to division (C)(1) of section 109.572 of the Revised Code and a standard fingerprint impression sheet prescribed pursuant to division (C)(2) of that section, and obtain the completed form and impression sheet from the applicant; 11297 11298 11299 11300

(b) Forward the completed form and impression sheet to the superintendent of the bureau of criminal identification and investigation. 11301 11302 11303

(3) An applicant provided the form and fingerprint impression sheet under division (B)(2)(a) of this section who fails to complete the form or provide fingerprint impressions shall not be employed in any position for which a criminal records check is required by this section. 11304 11305 11306 11307 11308

(C)(1) Except as provided in rules adopted by the public health council in accordance with division (F) of this section and subject to division (C)(2) of this section, no hospice care program shall employ a person in a position that involves providing direct care to an older adult if the person has been convicted of or pleaded guilty to any of the following: 11309 11310 11311 11312 11313 11314

(a) A violation of section 2903.01, 2903.02, 2903.03, 2903.04, 2903.11, 2903.12, 2903.13, 2903.16, 2903.21, 2903.34, 2905.01, 2905.02, 2905.11, 2905.12, 2907.02, 2907.03, 2907.05, 2907.06, 2907.07, 2907.08, 2907.09, 2907.12, 2907.25, 2907.31, 2907.32, 2907.321, 2907.322, 2907.323, 2911.01, 2911.02, 2911.11, 2911.12, 2911.13, 2913.02, 2913.03, 2913.04, 2913.11, 2913.21, 2913.31, 2913.40, 2913.43, 2913.47, 2913.51, 2919.25, 2921.36, 2923.12, 2923.13, 2923.161, 2925.02, 2925.03, 2925.11, 2925.13, 2925.22, 2925.23, or 3716.11 of the Revised Code. 11315 11316 11317 11318 11319 11320 11321 11322 11323

(b) A violation of an existing or former law of this state, any other state, or the United States that is substantially equivalent to any of the offenses listed in division (C)(1)(a) of this section. 11324 11325 11326 11327

(2)(a) A hospice care program may employ conditionally an applicant for whom a criminal records check request is required under division (B) of this section prior to obtaining the results of a criminal records check regarding the individual, provided that the program shall request a criminal records check regarding the individual in accordance with division (B)(1) of this section not later than five business days after the individual begins conditional employment. In the circumstances described in division (I)(2) of this section, a hospice care program may employ conditionally an applicant who has been referred to the hospice care program by an employment service that supplies full-time, part-time, or temporary staff for positions involving the direct care of older adults and for whom, pursuant to that division, a criminal records check is not required under division (B) of this section. 11328 11329 11330 11331 11332 11333 11334 11335 11336 11337 11338 11339 11340 11341 11342

(b) A hospice care program that employs an individual conditionally under authority of division (C)(2)(a) of this section shall terminate the individual's employment if the results of the criminal records check requested under division (B) of this section or described in division (I)(2) of this section, other than the results of any request for information from the federal bureau of investigation, are not obtained within the period ending thirty days after the date the request is made. Regardless of when the results of the criminal records check are obtained, if the results indicate that the individual has been convicted of or pleaded guilty to any of the offenses listed or described in division (C)(1) of this section, the program shall terminate the individual's employment unless the program chooses to employ the individual pursuant to division (F) of this section. Termination of employment under this division shall be considered just cause for discharge for purposes of division (D)(2) of section 4141.29 of the Revised Code if the individual makes any attempt to deceive the program about the individual's criminal record. 11343 11344 11345 11346 11347 11348 11349 11350 11351 11352 11353 11354 11355 11356 11357 11358 11359 11360

(D)(1) Each hospice care program shall pay to the bureau of 11361
criminal identification and investigation the fee prescribed 11362
pursuant to division (C)(3) of section 109.572 of the Revised Code 11363
for each criminal records check conducted pursuant to a request 11364
made under division (B) of this section. 11365

(2) A hospice care program may charge an applicant a fee not 11366
exceeding the amount the program pays under division (D)(1) of 11367
this section. A program may collect a fee only if both of the 11368
following apply: 11369

(a) The program notifies the person at the time of initial 11370
application for employment of the amount of the fee and that, 11371
unless the fee is paid, the person will not be considered for 11372
employment; 11373

(b) The ~~medical assistance~~ <u>medicaid</u> program ~~established under~~ 11374
~~Chapter 5111. of the Revised Code~~ does not reimburse the program 11375
the fee it pays under division (D)(1) of this section. 11376

(E) The report of a criminal records check conducted pursuant 11377
to a request made under this section is not a public record for 11378
the purposes of section 149.43 of the Revised Code and shall not 11379
be made available to any person other than the following: 11380

(1) The individual who is the subject of the criminal records 11381
check or the individual's representative; 11382

(2) The chief administrator of the program requesting the 11383
criminal records check or the administrator's representative; 11384

(3) The administrator of any other facility, agency, or 11385
program that provides direct care to older adults that is owned or 11386
operated by the same entity that owns or operates the hospice care 11387
program; 11388

(4) A court, hearing officer, or other necessary individual 11389
involved in a case dealing with a denial of employment of the 11390

applicant or dealing with employment or unemployment benefits of the applicant; 11391 11392

(5) Any person to whom the report is provided pursuant to, and in accordance with, division (I)(1) or (2) of this section. 11393 11394

(F) The public health council shall adopt rules in accordance with Chapter 119. of the Revised Code to implement this section. The rules shall specify circumstances under which a hospice care program may employ a person who has been convicted of or pleaded guilty to an offense listed or described in division (C)(1) of this section but meets personal character standards set by the council. 11395 11396 11397 11398 11399 11400 11401

(G) The chief administrator of a hospice care program shall inform each individual, at the time of initial application for a position that involves providing direct care to an older adult, that the individual is required to provide a set of fingerprint impressions and that a criminal records check is required to be conducted if the individual comes under final consideration for employment. 11402 11403 11404 11405 11406 11407 11408

(H) In a tort or other civil action for damages that is brought as the result of an injury, death, or loss to person or property caused by an individual who a hospice care program employs in a position that involves providing direct care to older adults, all of the following shall apply: 11409 11410 11411 11412 11413

(1) If the program employed the individual in good faith and reasonable reliance on the report of a criminal records check requested under this section, the program shall not be found negligent solely because of its reliance on the report, even if the information in the report is determined later to have been incomplete or inaccurate; 11414 11415 11416 11417 11418 11419

(2) If the program employed the individual in good faith on a conditional basis pursuant to division (C)(2) of this section, the 11420 11421

program shall not be found negligent solely because it employed the individual prior to receiving the report of a criminal records check requested under this section; 11422 11423 11424

(3) If the program in good faith employed the individual according to the personal character standards established in rules adopted under division (F) of this section, the program shall not be found negligent solely because the individual prior to being employed had been convicted of or pleaded guilty to an offense listed or described in division (C)(1) of this section. 11425 11426 11427 11428 11429 11430

(I)(1) The chief administrator of a hospice care program is not required to request that the superintendent of the bureau of criminal identification and investigation conduct a criminal records check of an applicant if the applicant has been referred to the program by an employment service that supplies full-time, part-time, or temporary staff for positions involving the direct care of older adults and both of the following apply: 11431 11432 11433 11434 11435 11436 11437

(a) The chief administrator receives from the employment service or the applicant a report of the results of a criminal records check regarding the applicant that has been conducted by the superintendent within the one-year period immediately preceding the applicant's referral; 11438 11439 11440 11441 11442

(b) The report of the criminal records check demonstrates that the person has not been convicted of or pleaded guilty to an offense listed or described in division (C)(1) of this section, or the report demonstrates that the person has been convicted of or pleaded guilty to one or more of those offenses, but the hospice care program chooses to employ the individual pursuant to division (F) of this section. 11443 11444 11445 11446 11447 11448 11449

(2) The chief administrator of a hospice care program is not required to request that the superintendent of the bureau of criminal identification and investigation conduct a criminal 11450 11451 11452

records check of an applicant and may employ the applicant conditionally as described in this division, if the applicant has been referred to the program by an employment service that supplies full-time, part-time, or temporary staff for positions involving the direct care of older adults and if the chief administrator receives from the employment service or the applicant a letter from the employment service that is on the letterhead of the employment service, dated, and signed by a supervisor or another designated official of the employment service and that states that the employment service has requested the superintendent to conduct a criminal records check regarding the applicant, that the requested criminal records check will include a determination of whether the applicant has been convicted of or pleaded guilty to any offense listed or described in division (C)(1) of this section, that, as of the date set forth on the letter, the employment service had not received the results of the criminal records check, and that, when the employment service receives the results of the criminal records check, it promptly will send a copy of the results to the hospice care program. If a hospice care program employs an applicant conditionally in accordance with this division, the employment service, upon its receipt of the results of the criminal records check, promptly shall send a copy of the results to the hospice care program, and division (C)(2)(b) of this section applies regarding the conditional employment. 11453 11454 11455 11456 11457 11458 11459 11460 11461 11462 11463 11464 11465 11466 11467 11468 11469 11470 11471 11472 11473 11474 11475 11476 11477

Sec. 3721.01. (A) As used in sections 3721.01 to 3721.09 and 3721.99 of the Revised Code: 11478 11479

(1)(a) "Home" means an institution, residence, or facility that provides, for a period of more than twenty-four hours, whether for a consideration or not, accommodations to three or more unrelated individuals who are dependent upon the services of others, including a nursing home, residential care facility, home 11480 11481 11482 11483 11484

for the aging, and a veterans' home operated under Chapter 5907. 11485
of the Revised Code. 11486

(b) "Home" also means both of the following: 11487

(i) Any facility that a person, as defined in section 3702.51 11488
of the Revised Code, proposes for certification as a skilled 11489
nursing facility ~~or nursing facility~~ under ~~Title XVIII or XIX of~~ 11490
the ~~"Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301,~~ 11491
~~as amended~~ medicare program, or as a nursing facility under the 11492
medicaid program and for which a certificate of need, other than a 11493
certificate to recategorize hospital beds as described in section 11494
3702.522 of the Revised Code or division (R)(7)(d) of the version 11495
of section 3702.51 of the Revised Code in effect immediately prior 11496
to April 20, 1995, has been granted to the person under sections 11497
3702.51 to 3702.62 of the Revised Code after August 5, 1989; 11498

(ii) A county home or district home that is or has been 11499
licensed as a residential care facility. 11500

(c) "Home" does not mean any of the following: 11501

(i) Except as provided in division (A)(1)(b) of this section, 11502
a public hospital or hospital as defined in section 3701.01 or 11503
5122.01 of the Revised Code; 11504

(ii) A residential facility for mentally ill persons as 11505
defined under section 5119.22 of the Revised Code; 11506

(iii) A residential facility as defined in section 5123.19 of 11507
the Revised Code; 11508

(iv) A community alternative home as defined in section 11509
3724.01 of the Revised Code; 11510

(v) An adult care facility as defined in section 3722.01 of 11511
the Revised Code; 11512

(vi) An alcohol or drug addiction program as defined in 11513
section 3793.01 of the Revised Code; 11514

(vii) A facility licensed to provide methadone treatment under section 3793.11 of the Revised Code; 11515 11516

(viii) A facility providing services under contract with the department of mental retardation and developmental disabilities under section 5123.18 of the Revised Code; 11517 11518 11519

(ix) A facility operated by a hospice care program licensed under section 3712.04 of the Revised Code that is used exclusively for care of hospice patients; 11520 11521 11522

(x) A facility, infirmary, or other entity that is operated by a religious order, provides care exclusively to members of religious orders who take vows of celibacy and live by virtue of their vows within the orders as if related, and does not participate in the medicare program ~~established under Title XVIII of the "Social Security Act"~~ or the ~~medical assistance~~ medicaid program ~~established under Chapter 5111. of the Revised Code and Title XIX of the "Social Security Act,"~~ if on January 1, 1994, the facility, infirmary, or entity was providing care exclusively to members of the religious order; 11523 11524 11525 11526 11527 11528 11529 11530 11531 11532

(xi) A county home or district home that has never been licensed as a residential care facility. 11533 11534

(2) "Unrelated individual" means one who is not related to the owner or operator of a home or to the spouse of the owner or operator as a parent, grandparent, child, grandchild, brother, sister, niece, nephew, aunt, uncle, or as the child of an aunt or uncle. 11535 11536 11537 11538 11539

(3) "Mental impairment" does not mean mental illness as defined in section 5122.01 of the Revised Code or mental retardation as defined in section 5123.01 of the Revised Code. 11540 11541 11542

(4) "Skilled nursing care" means procedures that require technical skills and knowledge beyond those the untrained person possesses and that are commonly employed in providing for the 11543 11544 11545

physical, mental, and emotional needs of the ill or otherwise incapacitated. "Skilled nursing care" includes, but is not limited to, the following: 11546 11547 11548

(a) Irrigations, catheterizations, application of dressings, and supervision of special diets; 11549 11550

(b) Objective observation of changes in the patient's condition as a means of analyzing and determining the nursing care required and the need for further medical diagnosis and treatment; 11551 11552 11553

(c) Special procedures contributing to rehabilitation; 11554

(d) Administration of medication by any method ordered by a physician, such as hypodermically, rectally, or orally, including observation of the patient after receipt of the medication; 11555 11556 11557

(e) Carrying out other treatments prescribed by the physician that involve a similar level of complexity and skill in administration. 11558 11559 11560

(5)(a) "Personal care services" means services including, but not limited to, the following: 11561 11562

(i) Assisting residents with activities of daily living; 11563

(ii) Assisting residents with self-administration of medication, in accordance with rules adopted under section 3721.04 of the Revised Code; 11564 11565 11566

(iii) Preparing special diets, other than complex therapeutic diets, for residents pursuant to the instructions of a physician or a licensed dietitian, in accordance with rules adopted under section 3721.04 of the Revised Code. 11567 11568 11569 11570

(b) "Personal care services" does not include "skilled nursing care" as defined in division (A)(4) of this section. A facility need not provide more than one of the services listed in division (A)(5)(a) of this section to be considered to be providing personal care services. 11571 11572 11573 11574 11575

(6) "Nursing home" means a home used for the reception and care of individuals who by reason of illness or physical or mental impairment require skilled nursing care and of individuals who require personal care services but not skilled nursing care. A nursing home is licensed to provide personal care services and skilled nursing care. 11576 11577 11578 11579 11580 11581

(7) "Residential care facility" means a home that provides either of the following: 11582 11583

(a) Accommodations for seventeen or more unrelated individuals and supervision and personal care services for three or more of those individuals who are dependent on the services of others by reason of age or physical or mental impairment; 11584 11585 11586 11587

(b) Accommodations for three or more unrelated individuals, supervision and personal care services for at least three of those individuals who are dependent on the services of others by reason of age or physical or mental impairment, and, to at least one of those individuals, any of the skilled nursing care authorized by section 3721.011 of the Revised Code. 11588 11589 11590 11591 11592 11593

(8) "Home for the aging" means a home that provides services as a residential care facility and a nursing home, except that the home provides its services only to individuals who are dependent on the services of others by reason of both age and physical or mental impairment. 11594 11595 11596 11597 11598

The part or unit of a home for the aging that provides services only as a residential care facility is licensed as a residential care facility. The part or unit that may provide skilled nursing care beyond the extent authorized by section 3721.011 of the Revised Code is licensed as a nursing home. 11599 11600 11601 11602 11603

(9) "County home" and "district home" mean a county home or district home operated under Chapter 5155. of the Revised Code. 11604 11605

(B) The public health council may further classify homes. For 11606

the purposes of this chapter, any residence, institution, hotel, congregate housing project, or similar facility that meets the definition of a home under this section is such a home regardless of how the facility holds itself out to the public. 11607 11608 11609 11610

(C) For purposes of this chapter, personal care services or skilled nursing care shall be considered to be provided by a facility if they are provided by a person employed by or associated with the facility or by another person pursuant to an agreement to which neither the resident who receives the services nor the resident's sponsor is a party. 11611 11612 11613 11614 11615 11616

(D) Nothing in division (A)(4) of this section shall be construed to permit skilled nursing care to be imposed on an individual who does not require skilled nursing care. 11617 11618 11619

Nothing in division (A)(5) of this section shall be construed to permit personal care services to be imposed on an individual who is capable of performing the activity in question without assistance. 11620 11621 11622 11623

(E) Division (A)(1)(c)(x) of this section does not prohibit a facility, infirmary, or other entity described in that division from seeking licensure under sections 3721.01 to 3721.09 of the Revised Code or certification under Title XVIII or XIX of the "Social Security Act." However, such a facility, infirmary, or entity that applies for licensure or certification must meet the requirements of those sections or titles and the rules adopted under them and obtain a certificate of need from the director of health under section 3702.52 of the Revised Code. 11624 11625 11626 11627 11628 11629 11630 11631 11632

(F) Nothing in this chapter, or rules adopted pursuant to it, shall be construed as authorizing the supervision, regulation, or control of the spiritual care or treatment of residents or patients in any home who rely upon treatment by prayer or spiritual means in accordance with the creed or tenets of any 11633 11634 11635 11636 11637

recognized church or religious denomination. 11638

Sec. 3721.011. (A) In addition to providing accommodations, 11639
supervision, and personal care services to its residents, a 11640
residential care facility may provide skilled nursing care to its 11641
residents as follows: 11642

(1) Supervision of special diets; 11643

(2) Application of dressings, in accordance with rules 11644
adopted under section 3721.04 of the Revised Code; 11645

(3) Subject to division (B)(1) of this section, 11646
administration of medication; 11647

(4) Subject to division (C) of this section, other skilled 11648
nursing care provided on a part-time, intermittent basis for not 11649
more than a total of one hundred twenty days in a twelve-month 11650
period; 11651

(5) Subject to division (D) of this section, skilled nursing 11652
care provided for more than one hundred twenty days in a 11653
twelve-month period to a hospice patient, as defined in section 11654
3712.01 of the Revised Code. 11655

A residential care facility may not admit or retain an 11656
individual requiring skilled nursing care that is not authorized 11657
by this section. A residential care facility may not provide 11658
skilled nursing care beyond the limits established by this 11659
section. 11660

(B)(1) A residential care facility may admit or retain an 11661
individual requiring medication, including biologicals, only if 11662
the individual's personal physician has determined in writing that 11663
the individual is capable of self-administering the medication or 11664
the facility provides for the medication to be administered to the 11665
individual by a home health agency certified under ~~Title XVIII of~~ 11666
the ~~"Social Security Act," 79 Stat. 620 (1965), 42 U.S.C.A. 1395,~~ 11667

~~as amended~~ medicare program; a hospice care program licensed under Chapter 3712. of the Revised Code; or a member of the staff of the residential care facility who is qualified to perform medication administration. Medication may be administered in a residential care facility only by the following persons authorized by law to administer medication: 11668 11669 11670 11671 11672 11673

(a) A registered nurse licensed under Chapter 4723. of the Revised Code; 11674 11675

(b) A licensed practical nurse licensed under Chapter 4723. of the Revised Code who holds proof of successful completion of a course in medication administration approved by the board of nursing and who administers the medication only at the direction of a registered nurse or a physician authorized under Chapter 4731. of the Revised Code to practice medicine and surgery or osteopathic medicine and surgery; 11676 11677 11678 11679 11680 11681 11682

(c) A medication aide certified under Chapter 4723. of the Revised Code; 11683 11684

(d) A physician authorized under Chapter 4731. of the Revised Code to practice medicine and surgery or osteopathic medicine and surgery. 11685 11686 11687

(2) In assisting a resident with self-administration of medication, any member of the staff of a residential care facility may do the following: 11688 11689 11690

(a) Remind a resident when to take medication and watch to ensure that the resident follows the directions on the container; 11691 11692

(b) Assist a resident by taking the medication from the locked area where it is stored, in accordance with rules adopted pursuant to section 3721.04 of the Revised Code, and handing it to the resident. If the resident is physically unable to open the container, a staff member may open the container for the resident. 11693 11694 11695 11696 11697

(c) Assist a physically impaired but mentally alert resident, such as a resident with arthritis, cerebral palsy, or Parkinson's disease, in removing oral or topical medication from containers and in consuming or applying the medication, upon request by or with the consent of the resident. If a resident is physically unable to place a dose of medicine to the resident's mouth without spilling it, a staff member may place the dose in a container and place the container to the mouth of the resident.

(C) A residential care facility may admit or retain individuals who require skilled nursing care beyond the supervision of special diets, application of dressings, or administration of medication, only if the care will be provided on a part-time, intermittent basis for not more than a total of one hundred twenty days in any twelve-month period. In accordance with Chapter 119. of the Revised Code, the public health council shall adopt rules specifying what constitutes the need for skilled nursing care on a part-time, intermittent basis. The council shall adopt rules that are consistent with rules pertaining to home health care adopted by the director of ~~job and family services~~ health care administration for the ~~medical assistance~~ medicaid program ~~established under Chapter 5111. of the Revised Code~~. Skilled nursing care provided pursuant to this division may be provided by a home health agency certified under ~~Title XVIII of~~ the ~~"Social Security Act,"~~ medicare program, a hospice care program licensed under Chapter 3712. of the Revised Code, or a member of the staff of a residential care facility who is qualified to perform skilled nursing care.

A residential care facility that provides skilled nursing care pursuant to this division shall do both of the following:

(1) Evaluate each resident receiving the skilled nursing care at least once every seven days to determine whether the resident should be transferred to a nursing home;

(2) Meet the skilled nursing care needs of each resident receiving the care. 11730 11731

(D) A residential care facility may admit or retain a hospice patient who requires skilled nursing care for more than one hundred twenty days in any twelve-month period only if the facility has entered into a written agreement with a hospice care program licensed under Chapter 3712. of the Revised Code. The agreement between the residential care facility and hospice program shall include all of the following provisions: 11732 11733 11734 11735 11736 11737 11738

(1) That the hospice patient will be provided skilled nursing care in the facility only if a determination has been made that the patient's needs can be met at the facility; 11739 11740 11741

(2) That the hospice patient will be retained in the facility only if periodic redeterminations are made that the patient's needs are being met at the facility; 11742 11743 11744

(3) That the redeterminations will be made according to a schedule specified in the agreement; 11745 11746

(4) That the hospice patient has been given an opportunity to choose the hospice care program that best meets the patient's needs. 11747 11748 11749

(E) Notwithstanding any other provision of this chapter, a residential care facility in which residents receive skilled nursing care pursuant to this section is not a nursing home. 11750 11751 11752

Sec. 3721.021. Every person who operates a home, as defined in section 3721.01 of the Revised Code, and each county home and district home licensed as a residential care facility shall have available in the home for review by prospective patients and residents, their guardians, or other persons assisting in their placement, each inspection report completed pursuant to section 3721.02 of the Revised Code and each statement of deficiencies and 11753 11754 11755 11756 11757 11758 11759

plan of correction completed and made available to the public 11760
under ~~Titles XVIII and XIX of~~ the ~~"Social Security Act," 49 Stat.~~ 11761
~~620 (1935), 42 U.S.C. 301, as amended~~ medicare program and 11762
medicaid program, and any rules promulgated under ~~Titles XVIII and~~ 11763
~~XIX~~ those programs, including such reports that result from life 11764
safety code and health inspections during the preceding three 11765
years, and shall post prominently within the home a notice of this 11766
requirement. 11767

Sec. 3721.022. (A) As used in this section: 11768

(1) "Nursing facility" has the same meaning as in section 11769
~~5111.20~~ 5164.01 of the Revised Code. 11770

(2) "Deficiency" and "survey" have the same meanings as in 11771
section ~~5111.35~~ 5164.50 of the Revised Code. 11772

(B) The department of health is hereby designated the state 11773
agency responsible for establishing and maintaining health 11774
standards and serving as the state survey agency for the purposes 11775
of ~~Titles XVIII and XIX of the "Social Security Act," 49 Stat. 620~~ 11776
~~(1935), 42 U.S.C.A. 301, as amended~~ the medicare and medicaid 11777
programs. The department shall carry out these functions in 11778
accordance with the regulations, guidelines, and procedures issued 11779
~~under Titles XVIII and XIX~~ for the medicare and medicaid programs 11780
by the United States secretary of health and human services and 11781
with sections ~~5111.35~~ 5164.50 to ~~5111.62~~ 5164.78 of the Revised 11782
Code. The director of health shall enter into agreements with 11783
regard to these functions with the department of ~~job and family~~ 11784
~~services~~ health care administration and the United States 11785
department of health and human services. The director may also 11786
enter into agreements with the department of ~~job and family~~ 11787
~~services~~ health care administration under which the department of 11788
health is designated to perform functions under sections ~~5111.35~~ 11789
5164.50 to ~~5111.62~~ 5164.78 of the Revised Code. 11790

The director, in accordance with Chapter 119. of the Revised Code, shall adopt rules necessary to implement the survey and certification requirements for skilled nursing facilities and nursing facilities established by the United States secretary of health and human services ~~under Titles XVIII and XIX of the "Social Security Act,"~~ for the medicare and medicaid programs and the survey requirements established under sections ~~5111.35~~ 5164.50 to ~~5111.62~~ 5164.78 of the Revised Code. The rules shall include an informal process by which a facility may obtain a review of deficiencies that have been cited on a statement of deficiencies made by the department of health under section ~~5111.42~~ 5164.58 of the Revised Code. The review shall be conducted by an employee of the department who did not participate in and was not otherwise involved in any way with the survey. If the employee conducting the review determines that any deficiency citation is unjustified, that determination shall be reflected clearly in all records relating to the survey.

The director need not adopt as rules any of the regulations, guidelines, or procedures issued ~~under Titles XVIII and XIX of the "Social Security Act"~~ for the medicare or medicaid programs by the United States secretary of health and human services.

Sec. 3721.024. As used in this section, "nursing facility" has the same meaning as in section ~~5111.20~~ 5164.01 of the Revised Code.

The department of health may establish a program of recognition of nursing facilities that provide the highest quality care to residents who are medicaid recipients ~~of medical assistance under Chapter 5111. of the Revised Code~~. The program may be funded with public funds appropriated by the general assembly for the purpose of the program or any funds appropriated for nursing home licensure.

Sec. 3721.026. (A) As used in this section and section 3721.027 of the Revised Code, "nursing facility" and "survey" have the same meanings as in section ~~5111.35~~ 5164.50 of the Revised Code.

(B) The director of health shall establish a unit within the department of health to provide advice and technical assistance and to conduct on-site visits to nursing facilities for the purpose of improving resident outcomes. The director shall assign to the unit employees who have training or experience in conducting or supervising surveys, but employees assigned to the unit shall not conduct surveys. The director shall adopt rules in accordance with Chapter 119. of the Revised Code to implement this section and shall consult with interested parties in developing the rules. Technical assistance reports are not public records under section 149.43 of the Revised Code and shall not be distributed to any person outside the unit except:

(1) The nursing facility that is provided with the technical assistance;

(2) Persons charged with inspecting nursing facilities under section 3721.02 of the Revised Code or with conducting surveys or reviews of nursing facilities under section 3721.022 of the Revised Code whenever any such person finds that there is serious harm to resident health or safety that is more than isolated at the nursing facility.

The provisions of this section and rules adopted under this section do not affect the department's authority to administer and enforce other sections of this chapter.

(C) On or before the last day of December each year, the director shall submit a report to the governor and the general assembly describing the unit's activities that year and its effectiveness in improving resident outcomes.

Sec. 3721.042. The director of health may not deny a nursing home license to a facility seeking a license under this chapter as a nursing home on the grounds that the facility does not satisfy a requirement established in rules adopted under section 3721.04 of the Revised Code regarding the toilet rooms and dining and recreational areas of nursing homes if all of the following requirements are met:

(A) The facility seeks a license under this chapter because it is a county home or district home being sold under section 5155.31 of the Revised Code to a person who may not operate the facility without a nursing home license under this chapter.

(B) The requirement would not have applied to the facility had the facility been a nursing home first licensed under this chapter before October 20, 2001.

(C) The facility was a nursing facility, as defined in section ~~5111.20~~ 5164.01 of the Revised Code, on the date immediately preceding the date the facility is sold to the person seeking the license.

Sec. 3721.071. The buildings in which a home is housed shall be equipped with both an automatic fire extinguishing system and fire alarm system. Such systems shall conform to standards set forth in the regulations of the board of building standards and the state fire marshal.

The time for compliance with the requirements imposed by this section shall be January 1, 1975, except that the date for compliance with the automatic fire extinguishing requirements is extended to January 1, 1976, provided the buildings of the home are otherwise in compliance with fire safety laws and regulations and:

(A) The home within thirty days after August 4, 1975, files a

written plan with the state fire marshal's office that: 11883

(1) Outlines the interim safety procedures which shall be 11884
carried out to reduce the possibility of a fire; 11885

(2) Provides evidence that the home has entered into an 11886
agreement for a fire safety inspection to be conducted not less 11887
than monthly by a qualified independent safety engineer consultant 11888
or a township, municipal, or other legally constituted fire 11889
department, or by a township or municipal fire prevention officer; 11890

(3) Provides verification that the home has entered into a 11891
valid contract for the installation of an automatic fire 11892
extinguishing system or fire alarm system, or both, as required to 11893
comply with this section; 11894

(4) Includes a statement regarding the expected date for the 11895
completion of the fire extinguishing system or fire alarm system, 11896
or both. 11897

(B) Inspections by a qualified independent safety engineer 11898
consultant or a township, municipal, or other legally constituted 11899
fire department, or by a township or municipal fire prevention 11900
officer are initiated no later than sixty days after August 4, 11901
1975, and are conducted no less than monthly thereafter, and 11902
reports of the consultant, fire department, or fire prevention 11903
officer identifying existing hazards and recommended corrective 11904
actions are submitted to the state fire marshal, the division of 11905
industrial compliance in the department of commerce, and the 11906
department of health. 11907

It is the express intent of the general assembly that the 11908
department of ~~job and family services~~ <u>health care administration</u> 11909
shall terminate <u>medicaid</u> payments ~~under Title XIX of the "Social~~ 11910
~~Security Act," 49 Stat. 620 (1935), 42 U.S.C. 301, as amended,~~ to 11911
those homes which do not comply with the requirements of this 11912
section for the submission of a written fire safety plan and the 11913

deadline for entering into contracts for the installation of 11914
systems. 11915

Sec. 3721.08. (A) As used in this section, "real and present 11916
danger" means imminent danger of serious physical or 11917
life-threatening harm to one or more occupants of a home. 11918

(B) The director of health may petition the court of common 11919
pleas of the county in which the home is located for an order 11920
enjoining any person from operating a home without a license or 11921
enjoining a county home or district home that has had its license 11922
revoked from continuing to operate. The court shall have 11923
jurisdiction to grant such injunctive relief upon a showing that 11924
the respondent named in the petition is operating a home without a 11925
license or that the county home or district home named in the 11926
petition is operating despite the revocation of its license. The 11927
court shall have jurisdiction to grant such injunctive relief 11928
against the operation of a home without a valid license regardless 11929
of whether the home meets essential licensing requirements. 11930

(C) Unless the department of ~~job and family services~~ health 11931
care administration or contracting agency has taken action under 11932
section ~~5111.51~~ 5164.67 of the Revised Code to appoint a temporary 11933
manager or seek injunctive relief, if, in the judgment of the 11934
director of health, real and present danger exists at any home, 11935
the director may petition the court of common pleas of the county 11936
in which the home is located for such injunctive relief as is 11937
necessary to close the home, transfer one or more occupants to 11938
other homes or other appropriate care settings, or otherwise 11939
eliminate the real and present danger. The court shall have the 11940
jurisdiction to grant such injunctive relief upon a showing that 11941
there is real and present danger. 11942

(D)(1) If the director determines that real and present 11943
danger exists at a home and elects not to immediately seek 11944

injunctive relief under division (C) of this section, the director may give written notice of proposed action to the home. The notice shall specify all of the following: 11945 11946 11947

(a) The nature of the conditions giving rise to the real and present danger; 11948 11949

(b) The measures that the director determines the home must take to respond to the conditions; 11950 11951

(c) The date on which the director intends to seek injunctive relief under division (C) of this section if the director determines that real and present danger exists at the home. 11952 11953 11954

(2) If the home notifies the director, within the time specified pursuant to division (D)(1)(c) of this section, that it believes the conditions giving rise to the real and present danger have been substantially corrected, the director shall conduct an inspection to determine whether real and present danger exists. If the director determines on the basis of the inspection that real and present danger exists, the director may petition under division (C) of this section for injunctive relief. 11955 11956 11957 11958 11959 11960 11961 11962

(E)(1) If in the judgment of the director of health conditions exist at a home that will give rise to real and present danger if not corrected, the director shall give written notice of proposed action to the home. The notice shall specify all of the following: 11963 11964 11965 11966 11967

(a) The nature of the conditions giving rise to the director's judgment; 11968 11969

(b) The measures that the director determines the home must take to respond to the conditions; 11970 11971

(c) The date, which shall be no less than ten days after the notice is delivered, on which the director intends to seek injunctive relief under division (C) of this section if the 11972 11973 11974

conditions are not substantially corrected and the director determines that a real and present danger exists. 11975 11976

(2) If the home notifies the director, within the period of time specified pursuant to division (E)(1)(c) of this section, that the conditions giving rise to the director's determination have been substantially corrected, the director shall conduct an inspection. If the director determines on the basis of the inspection that the conditions have not been corrected and a real and present danger exists, the director may petition under division (C) of this section for injunctive relief. 11977 11978 11979 11980 11981 11982 11983 11984

(F)(1) A court that grants injunctive relief under division (C) of this section may also appoint a special master who, subject to division (F)(2) of this section, shall have such powers and authority over the home and length of appointment as the court considers necessary. Subject to division (F)(2) of this section, the salary of a special master and any costs incurred by a special master shall be the obligation of the home. 11985 11986 11987 11988 11989 11990 11991

(2) No special master shall enter into any employment contract on behalf of a home, or purchase with the home's funds any capital goods totaling more than ten thousand dollars, unless the special master has obtained approval for the contract or purchase from the home's operator or the court. 11992 11993 11994 11995 11996

(G) If the director takes action under division (C), (D), or (E) of this section, the director may also appoint employees of the department of health to conduct on-site monitoring of the home. Appointment of monitors is not subject to appeal under Chapter 119. or any other section of the Revised Code. No employee of a home for which monitors are appointed, no person employed by the home within the previous two years, and no person who currently has a consulting contract with the department or a home, shall be appointed under this division. Every monitor shall have the professional qualifications necessary to monitor correction of 11997 11998 11999 12000 12001 12002 12003 12004 12005 12006

the conditions that give rise to or, in the director's judgment, will give rise to real and present danger. The number of monitors present at a home at any given time shall not exceed one for every fifty residents, or fraction thereof. 12007 12008 12009 12010

(H) On finding that the real and present danger for which injunctive relief was granted under division (C) of this section has been eliminated and that the home's operator has demonstrated the capacity to prevent the real and present danger from recurring, the court shall terminate its jurisdiction over the home and return control and management of the home to the operator. If the real and present danger cannot be eliminated practicably within a reasonable time following appointment of a special master, the court may order the special master to close the home and transfer all residents to other homes or other appropriate care settings. 12011 12012 12013 12014 12015 12016 12017 12018 12019 12020 12021

(I) The director of health shall give notice of proposed action under divisions (D) and (E) of this section to both of the following: 12022 12023 12024

(1) The home's administrator; 12025

(2) If the home is operated by an organization described in subsection 501(c)(3) and tax exempt under subsection 501(a) of the "Internal Revenue Code of 1986," 100 Stat. 2085, 26 U.S.C.A. 1, as amended, the board of trustees of the organization; or, if the home is not operated by such an organization, the owner of the home. 12026 12027 12028 12029 12030 12031

Notices shall be delivered by certified mail or hand delivery. If notices are mailed, they shall be addressed to the persons specified in divisions (I)(1) and (2) of this section, as indicated in the department of health's records. If they are hand delivered, they shall be delivered to persons who would reasonably appear to the average prudent person to have authority to accept 12032 12033 12034 12035 12036 12037

them. 12038

(J) If ownership of a home is assigned or transferred to a 12039
different person, the new owner is responsible and liable for 12040
compliance with any notice of proposed action or order issued 12041
under this section prior to the effective date of the assignment 12042
or transfer. 12043

Sec. 3721.10. As used in sections 3721.10 to 3721.18 of the 12044
Revised Code: 12045

(A) "Home" means all of the following: 12046

(1) A home as defined in section 3721.01 of the Revised Code; 12047

(2) Any facility or part of a facility not defined as a home 12048
under section 3721.01 of the Revised Code that is certified as a 12049
skilled nursing facility ~~under Title XVIII of the "Social Security~~ 12050
~~Act," 79 Stat. 286 (1965), 42 U.S.C.A. 1395 and 1396, as amended,~~ 12051
for the medicare program or as a nursing facility ~~as defined in~~ 12052
~~section 5111.20 of the Revised Code~~ for the medicaid program; 12053

(3) A county home or district home operated pursuant to 12054
Chapter 5155. of the Revised Code. 12055

(B) "Resident" means a resident or a patient of a home. 12056

(C) "Administrator" means all of the following: 12057

(1) With respect to a home as defined in section 3721.01 of 12058
the Revised Code, a nursing home administrator as defined in 12059
section 4751.01 of the Revised Code; 12060

(2) With respect to a facility or part of a facility not 12061
defined as a home in section 3721.01 of the Revised Code that is 12062
authorized to provide skilled nursing facility or nursing facility 12063
services, the administrator of the facility or part of a facility; 12064

(3) With respect to a county home or district home, the 12065
superintendent appointed under Chapter 5155. of the Revised Code. 12066

(D) "Sponsor" means an adult relative, friend, or guardian of a resident who has an interest or responsibility in the resident's welfare. 12067 12068 12069

(E) "Residents' rights advocate" means: 12070

(1) An employee or representative of any state or local government entity that has a responsibility regarding residents and that has registered with the department of health under division (B) of section 3701.07 of the Revised Code; 12071 12072 12073 12074

(2) An employee or representative of any private nonprofit corporation or association that qualifies for tax-exempt status under section 501(a) of the "Internal Revenue Code of 1986," 100 Stat. 2085, 26 U.S.C.~~A.~~ 1, as amended, and that has registered with the department of health under division (B) of section 3701.07 of the Revised Code and whose purposes include educating and counseling residents, assisting residents in resolving problems and complaints concerning their care and treatment, and assisting them in securing adequate services to meet their needs; 12075 12076 12077 12078 12079 12080 12081 12082 12083

(3) A member of the general assembly. 12084

(F) "Physical restraint" means, but is not limited to, any article, device, or garment that interferes with the free movement of the resident and that the resident is unable to remove easily, a geriatric chair, or a locked room door. 12085 12086 12087 12088

(G) "Chemical restraint" means any medication bearing the American hospital formulary service therapeutic class 4.00, 28:16:08, 28:24:08, or 28:24:92 that alters the functioning of the central nervous system in a manner that limits physical and cognitive functioning to the degree that the resident cannot attain the resident's highest practicable physical, mental, and psychosocial well-being. 12089 12090 12091 12092 12093 12094 12095

(H) "Ancillary service" means, but is not limited to, podiatry, dental, hearing, vision, physical therapy, occupational 12096 12097

therapy, speech therapy, and psychological and social services. 12098

(I) "Facility" means a facility, or part of a facility, 12099
certified as a nursing facility or skilled nursing facility under 12100
~~Title XVIII or Title XIX of~~ the ~~"Social Security Act."~~ medicare or 12101
medicaid programs. "Facility" does not include an intermediate 12102
care facility for the mentally retarded, as defined in section 12103
~~5111.20~~ 5164.01 of the Revised Code. 12104

~~(J) "Medicare" means the program established by Title XVIII~~ 12105
~~of the "Social Security Act."~~ 12106

~~(K) "Medicaid" means the program established by Title XIX of~~ 12107
~~the "Social Security Act" and Chapter 5111. of the Revised Code.~~ 12108

Sec. 3721.12. (A) The administrator of a home shall: 12109

(1) With the advice of residents, their sponsors, or both, 12110
establish and review at least annually, written policies regarding 12111
the applicability and implementation of residents' rights under 12112
sections 3721.10 to 3721.17 of the Revised Code, the 12113
responsibilities of residents regarding the rights, and the home's 12114
grievance procedure established under division (A)(2) of this 12115
section. The administrator is responsible for the development of, 12116
and adherence to, procedures implementing the policies. 12117

(2) Establish a grievance committee for review of complaints 12118
by residents. The grievance committee shall be comprised of the 12119
home's staff and residents, sponsors, or outside representatives 12120
in a ratio of not more than one staff member to every two 12121
residents, sponsors, or outside representatives. 12122

(3) Furnish to each resident and sponsor prior to or at the 12123
time of admission, and to each member of the home's staff, at 12124
least one of each of the following: 12125

(a) A copy of the rights established under sections 3721.10 12126
to 3721.17 of the Revised Code; 12127

(b) A written explanation of the provisions of sections 3721.16 to 3721.162 of the Revised Code; 12128 12129

(c) A copy of the home's policies and procedures established under this section; 12130 12131

(d) A copy of the home's rules; 12132

(e) A copy of the addresses and telephone numbers of the board of health of the health district of the county in which the home is located, the county department of job and family services of the county in which the home is located, the state departments of health and job and family services, the state and local offices of the department of aging, and any Ohio nursing home ombudsperson program. 12133 12134 12135 12136 12137 12138 12139

(B) Written acknowledgment of the receipt of copies of the materials listed in this section shall be made part of the resident's record and the staff member's personnel record. 12140 12141 12142

(C) The administrator shall post all of the following prominently within the home: 12143 12144

(1) A copy of the rights of residents as listed in division (A) of section 3721.13 of the Revised Code; 12145 12146

(2) A copy of the home's rules and its policies and procedures regarding the rights and responsibilities of residents; 12147 12148

(3) A notice that a copy of this chapter, rules of the department of health applicable to the home, and federal regulations adopted under the medicare and medicaid programs, and the materials required to be available in the home under section 3721.021 of the Revised Code, are available for inspection in the home at reasonable hours; 12149 12150 12151 12152 12153 12154

(4) A list of residents' rights advocates; 12155

(5) A notice that the following are available in a place readily accessible to residents: 12156 12157

(a) If the home is licensed under section 3721.02 of the Revised Code, a copy of the most recent licensure inspection report prepared for the home under that section; 12158 12159 12160

(b) If the home is a facility, a copy of the most recent statement of deficiencies issued to the home under section ~~5111.42~~ 5164.58 of the Revised Code. 12161 12162 12163

(D) The administrator of a home may, with the advice of residents, their sponsors, or both, establish written policies regarding the applicability and administration of any additional residents' rights beyond those set forth in sections 3721.10 to 3721.17 of the Revised Code, and the responsibilities of residents regarding the rights. Policies established under this division shall be reviewed, and procedures developed and adhered to as in division (A)(1) of this section. 12164 12165 12166 12167 12168 12169 12170 12171

Sec. 3721.121. (A) As used in this section: 12172

(1) "Adult day-care program" means a program operated pursuant to rules adopted by the public health council under section 3721.04 of the Revised Code and provided by and on the same site as homes licensed under this chapter. 12173 12174 12175 12176

(2) "Applicant" means a person who is under final consideration for employment with a home or adult day-care program in a full-time, part-time, or temporary position that involves providing direct care to an older adult. "Applicant" does not include a person who provides direct care as a volunteer without receiving or expecting to receive any form of remuneration other than reimbursement for actual expenses. 12177 12178 12179 12180 12181 12182 12183

(3) "Criminal records check" and "older adult" have the same meanings as in section 109.572 of the Revised Code. 12184 12185

(4) "Home" means a home as defined in section 3721.10 of the Revised Code. 12186 12187

(B)(1) Except as provided in division (I) of this section, the chief administrator of a home or adult day-care program shall request that the superintendent of the bureau of criminal identification and investigation conduct a criminal records check with respect to each applicant. If an applicant for whom a criminal records check request is required under this division does not present proof of having been a resident of this state for the five-year period immediately prior to the date the criminal records check is requested or provide evidence that within that five-year period the superintendent has requested information about the applicant from the federal bureau of investigation in a criminal records check, the chief administrator shall request that the superintendent obtain information from the federal bureau of investigation as part of the criminal records check of the applicant. Even if an applicant for whom a criminal records check request is required under this division presents proof of having been a resident of this state for the five-year period, the chief administrator may request that the superintendent include information from the federal bureau of investigation in the criminal records check. 12188 12189 12190 12191 12192 12193 12194 12195 12196 12197 12198 12199 12200 12201 12202 12203 12204 12205 12206 12207

(2) A person required by division (B)(1) of this section to request a criminal records check shall do both of the following: 12208 12209

(a) Provide to each applicant for whom a criminal records check request is required under that division a copy of the form prescribed pursuant to division (C)(1) of section 109.572 of the Revised Code and a standard fingerprint impression sheet prescribed pursuant to division (C)(2) of that section, and obtain the completed form and impression sheet from the applicant; 12210 12211 12212 12213 12214 12215

(b) Forward the completed form and impression sheet to the superintendent of the bureau of criminal identification and investigation. 12216 12217 12218

(3) An applicant provided the form and fingerprint impression 12219

sheet under division (B)(2)(a) of this section who fails to complete the form or provide fingerprint impressions shall not be employed in any position for which a criminal records check is required by this section. 12220 12221 12222 12223

(C)(1) Except as provided in rules adopted by the director of health in accordance with division (F) of this section and subject to division (C)(2) of this section, no home or adult day-care program shall employ a person in a position that involves providing direct care to an older adult if the person has been convicted of or pleaded guilty to any of the following: 12224 12225 12226 12227 12228 12229

(a) A violation of section 2903.01, 2903.02, 2903.03, 2903.04, 2903.11, 2903.12, 2903.13, 2903.16, 2903.21, 2903.34, 2905.01, 2905.02, 2905.11, 2905.12, 2907.02, 2907.03, 2907.05, 2907.06, 2907.07, 2907.08, 2907.09, 2907.12, 2907.25, 2907.31, 2907.32, 2907.321, 2907.322, 2907.323, 2911.01, 2911.02, 2911.11, 2911.12, 2911.13, 2913.02, 2913.03, 2913.04, 2913.11, 2913.21, 2913.31, 2913.40, 2913.43, 2913.47, 2913.51, 2919.25, 2921.36, 2923.12, 2923.13, 2923.161, 2925.02, 2925.03, 2925.11, 2925.13, 2925.22, 2925.23, or 3716.11 of the Revised Code. 12230 12231 12232 12233 12234 12235 12236 12237 12238

(b) A violation of an existing or former law of this state, any other state, or the United States that is substantially equivalent to any of the offenses listed in division (C)(1)(a) of this section. 12239 12240 12241 12242

(2)(a) A home or an adult day-care program may employ conditionally an applicant for whom a criminal records check request is required under division (B) of this section prior to obtaining the results of a criminal records check regarding the individual, provided that the home or program shall request a criminal records check regarding the individual in accordance with division (B)(1) of this section not later than five business days after the individual begins conditional employment. In the circumstances described in division (I)(2) of this section, a home 12243 12244 12245 12246 12247 12248 12249 12250 12251

or adult day-care program may employ conditionally an applicant who has been referred to the home or adult day-care program by an employment service that supplies full-time, part-time, or temporary staff for positions involving the direct care of older adults and for whom, pursuant to that division, a criminal records check is not required under division (B) of this section. 12252 12253 12254 12255 12256 12257

(b) A home or adult day-care program that employs an individual conditionally under authority of division (C)(2)(a) of this section shall terminate the individual's employment if the results of the criminal records check requested under division (B) of this section or described in division (I)(2) of this section, other than the results of any request for information from the federal bureau of investigation, are not obtained within the period ending thirty days after the date the request is made. Regardless of when the results of the criminal records check are obtained, if the results indicate that the individual has been convicted of or pleaded guilty to any of the offenses listed or described in division (C)(1) of this section, the home or program shall terminate the individual's employment unless the home or program chooses to employ the individual pursuant to division (F) of this section. Termination of employment under this division shall be considered just cause for discharge for purposes of division (D)(2) of section 4141.29 of the Revised Code if the individual makes any attempt to deceive the home or program about the individual's criminal record. 12258 12259 12260 12261 12262 12263 12264 12265 12266 12267 12268 12269 12270 12271 12272 12273 12274 12275 12276

(D)(1) Each home or adult day-care program shall pay to the bureau of criminal identification and investigation the fee prescribed pursuant to division (C)(3) of section 109.572 of the Revised Code for each criminal records check conducted pursuant to a request made under division (B) of this section. 12277 12278 12279 12280 12281

(2) A home or adult day-care program may charge an applicant a fee not exceeding the amount the home or program pays under 12282 12283

division (D)(1) of this section. A home or program may collect a fee only if both of the following apply: 12284 12285

(a) The home or program notifies the person at the time of initial application for employment of the amount of the fee and that, unless the fee is paid, the person will not be considered for employment; 12286 12287 12288 12289

(b) The ~~medical assistance~~ medicaid program ~~established under Chapter 5111. of the Revised Code~~ does not reimburse the home or program the fee it pays under division (D)(1) of this section. 12290 12291 12292

(E) The report of any criminal records check conducted pursuant to a request made under this section is not a public record for the purposes of section 149.43 of the Revised Code and shall not be made available to any person other than the following: 12293 12294 12295 12296 12297

(1) The individual who is the subject of the criminal records check or the individual's representative; 12298 12299

(2) The chief administrator of the home or program requesting the criminal records check or the administrator's representative; 12300 12301

(3) The administrator of any other facility, agency, or program that provides direct care to older adults that is owned or operated by the same entity that owns or operates the home or program; 12302 12303 12304 12305

(4) A court, hearing officer, or other necessary individual involved in a case dealing with a denial of employment of the applicant or dealing with employment or unemployment benefits of the applicant; 12306 12307 12308 12309

(5) Any person to whom the report is provided pursuant to, and in accordance with, division (I)(1) or (2) of this section; 12310 12311

(6) The board of nursing for purposes of accepting and processing an application for a medication aide certificate issued 12312 12313

under Chapter 4723. of the Revised Code. 12314

(F) In accordance with section 3721.11 of the Revised Code, the director of health shall adopt rules to implement this section. The rules shall specify circumstances under which a home or adult day-care program may employ a person who has been convicted of or pleaded guilty to an offense listed or described in division (C)(1) of this section but meets personal character standards set by the director. 12315 12316 12317 12318 12319 12320 12321

(G) The chief administrator of a home or adult day-care program shall inform each individual, at the time of initial application for a position that involves providing direct care to an older adult, that the individual is required to provide a set of fingerprint impressions and that a criminal records check is required to be conducted if the individual comes under final consideration for employment. 12322 12323 12324 12325 12326 12327 12328

(H) In a tort or other civil action for damages that is brought as the result of an injury, death, or loss to person or property caused by an individual who a home or adult day-care program employs in a position that involves providing direct care to older adults, all of the following shall apply: 12329 12330 12331 12332 12333

(1) If the home or program employed the individual in good faith and reasonable reliance on the report of a criminal records check requested under this section, the home or program shall not be found negligent solely because of its reliance on the report, even if the information in the report is determined later to have been incomplete or inaccurate; 12334 12335 12336 12337 12338 12339

(2) If the home or program employed the individual in good faith on a conditional basis pursuant to division (C)(2) of this section, the home or program shall not be found negligent solely because it employed the individual prior to receiving the report of a criminal records check requested under this section; 12340 12341 12342 12343 12344

(3) If the home or program in good faith employed the individual according to the personal character standards established in rules adopted under division (F) of this section, the home or program shall not be found negligent solely because the individual prior to being employed had been convicted of or pleaded guilty to an offense listed or described in division (C)(1) of this section. 12345 12346 12347 12348 12349 12350 12351

(I)(1) The chief administrator of a home or adult day-care program is not required to request that the superintendent of the bureau of criminal identification and investigation conduct a criminal records check of an applicant if the applicant has been referred to the home or program by an employment service that supplies full-time, part-time, or temporary staff for positions involving the direct care of older adults and both of the following apply: 12352 12353 12354 12355 12356 12357 12358 12359

(a) The chief administrator receives from the employment service or the applicant a report of the results of a criminal records check regarding the applicant that has been conducted by the superintendent within the one-year period immediately preceding the applicant's referral; 12360 12361 12362 12363 12364

(b) The report of the criminal records check demonstrates that the person has not been convicted of or pleaded guilty to an offense listed or described in division (C)(1) of this section, or the report demonstrates that the person has been convicted of or pleaded guilty to one or more of those offenses, but the home or adult day-care program chooses to employ the individual pursuant to division (F) of this section. 12365 12366 12367 12368 12369 12370 12371

(2) The chief administrator of a home or adult day-care program is not required to request that the superintendent of the bureau of criminal identification and investigation conduct a criminal records check of an applicant and may employ the applicant conditionally as described in this division, if the 12372 12373 12374 12375 12376

applicant has been referred to the home or program by an employment service that supplies full-time, part-time, or temporary staff for positions involving the direct care of older adults and if the chief administrator receives from the employment service or the applicant a letter from the employment service that is on the letterhead of the employment service, dated, and signed by a supervisor or another designated official of the employment service and that states that the employment service has requested the superintendent to conduct a criminal records check regarding the applicant, that the requested criminal records check will include a determination of whether the applicant has been convicted of or pleaded guilty to any offense listed or described in division (C)(1) of this section, that, as of the date set forth on the letter, the employment service had not received the results of the criminal records check, and that, when the employment service receives the results of the criminal records check, it promptly will send a copy of the results to the home or adult day-care program. If a home or adult day-care program employs an applicant conditionally in accordance with this division, the employment service, upon its receipt of the results of the criminal records check, promptly shall send a copy of the results to the home or adult day-care program, and division (C)(2)(b) of this section applies regarding the conditional employment. 12377 12378 12379 12380 12381 12382 12383 12384 12385 12386 12387 12388 12389 12390 12391 12392 12393 12394 12395 12396 12397 12398 12399

Sec. 3721.13. (A) The rights of residents of a home shall include, but are not limited to, the following: 12400 12401

(1) The right to a safe and clean living environment pursuant to the medicare and medicaid programs and applicable state laws and regulations prescribed by the public health council; 12402 12403 12404

(2) The right to be free from physical, verbal, mental, and emotional abuse and to be treated at all times with courtesy, respect, and full recognition of dignity and individuality; 12405 12406 12407

(3) Upon admission and thereafter, the right to adequate and appropriate medical treatment and nursing care and to other ancillary services that comprise necessary and appropriate care consistent with the program for which the resident contracted. This care shall be provided without regard to considerations such as race, color, religion, national origin, age, or source of payment for care. 12408 12409 12410 12411 12412 12413 12414

(4) The right to have all reasonable requests and inquiries responded to promptly; 12415 12416

(5) The right to have clothes and bed sheets changed as the need arises, to ensure the resident's comfort or sanitation; 12417 12418

(6) The right to obtain from the home, upon request, the name and any specialty of any physician or other person responsible for the resident's care or for the coordination of care; 12419 12420 12421

(7) The right, upon request, to be assigned, within the capacity of the home to make the assignment, to the staff physician of the resident's choice, and the right, in accordance with the rules and written policies and procedures of the home, to select as the attending physician a physician who is not on the staff of the home. If the cost of a physician's services is to be met under a federally supported program, the physician shall meet the federal laws and regulations governing such services. 12422 12423 12424 12425 12426 12427 12428 12429

(8) The right to participate in decisions that affect the resident's life, including the right to communicate with the physician and employees of the home in planning the resident's treatment or care and to obtain from the attending physician complete and current information concerning medical condition, prognosis, and treatment plan, in terms the resident can reasonably be expected to understand; the right of access to all information in the resident's medical record; and the right to give or withhold informed consent for treatment after the 12430 12431 12432 12433 12434 12435 12436 12437 12438

consequences of that choice have been carefully explained. When the attending physician finds that it is not medically advisable to give the information to the resident, the information shall be made available to the resident's sponsor on the resident's behalf, if the sponsor has a legal interest or is authorized by the resident to receive the information. The home is not liable for a violation of this division if the violation is found to be the result of an act or omission on the part of a physician selected by the resident who is not otherwise affiliated with the home. 12439 12440 12441 12442 12443 12444 12445 12446 12447

(9) The right to withhold payment for physician visitation if the physician did not visit the resident; 12448 12449

(10) The right to confidential treatment of personal and medical records, and the right to approve or refuse the release of these records to any individual outside the home, except in case of transfer to another home, hospital, or health care system, as required by law or rule, or as required by a third-party payment contract; 12450 12451 12452 12453 12454 12455

(11) The right to privacy during medical examination or treatment and in the care of personal or bodily needs; 12456 12457

(12) The right to refuse, without jeopardizing access to appropriate medical care, to serve as a medical research subject; 12458 12459

(13) The right to be free from physical or chemical restraints or prolonged isolation except to the minimum extent necessary to protect the resident from injury to self, others, or to property and except as authorized in writing by the attending physician for a specified and limited period of time and documented in the resident's medical record. Prior to authorizing the use of a physical or chemical restraint on any resident, the attending physician shall make a personal examination of the resident and an individualized determination of the need to use the restraint on that resident. 12460 12461 12462 12463 12464 12465 12466 12467 12468 12469

Physical or chemical restraints or isolation may be used in an emergency situation without authorization of the attending physician only to protect the resident from injury to self or others. Use of the physical or chemical restraints or isolation shall not be continued for more than twelve hours after the onset of the emergency without personal examination and authorization by the attending physician. The attending physician or a staff physician may authorize continued use of physical or chemical restraints for a period not to exceed thirty days, and at the end of this period and any subsequent period may extend the authorization for an additional period of not more than thirty days. The use of physical or chemical restraints shall not be continued without a personal examination of the resident and the written authorization of the attending physician stating the reasons for continuing the restraint. 12470 12471 12472 12473 12474 12475 12476 12477 12478 12479 12480 12481 12482 12483 12484

If physical or chemical restraints are used under this division, the home shall ensure that the restrained resident receives a proper diet. In no event shall physical or chemical restraints or isolation be used for punishment, incentive, or convenience. 12485 12486 12487 12488 12489

(14) The right to the pharmacist of the resident's choice and the right to receive pharmaceutical supplies and services at reasonable prices not exceeding applicable and normally accepted prices for comparably packaged pharmaceutical supplies and services within the community; 12490 12491 12492 12493 12494

(15) The right to exercise all civil rights, unless the resident has been adjudicated incompetent pursuant to Chapter 2111. of the Revised Code and has not been restored to legal capacity, as well as the right to the cooperation of the home's administrator in making arrangements for the exercise of the right to vote; 12495 12496 12497 12498 12499 12500

(16) The right of access to opportunities that enable the 12501

resident, at the resident's own expense or at the expense of a third-party payer, to achieve the resident's fullest potential, including educational, vocational, social, recreational, and habilitation programs; 12502 12503 12504 12505

(17) The right to consume a reasonable amount of alcoholic beverages at the resident's own expense, unless not medically advisable as documented in the resident's medical record by the attending physician or unless contradictory to written admission policies; 12506 12507 12508 12509 12510

(18) The right to use tobacco at the resident's own expense under the home's safety rules and under applicable laws and rules of the state, unless not medically advisable as documented in the resident's medical record by the attending physician or unless contradictory to written admission policies; 12511 12512 12513 12514 12515

(19) The right to retire and rise in accordance with the resident's reasonable requests, if the resident does not disturb others or the posted meal schedules and upon the home's request remains in a supervised area, unless not medically advisable as documented by the attending physician; 12516 12517 12518 12519 12520

(20) The right to observe religious obligations and participate in religious activities; the right to maintain individual and cultural identity; and the right to meet with and participate in activities of social and community groups at the resident's or the group's initiative; 12521 12522 12523 12524 12525

(21) The right upon reasonable request to private and unrestricted communications with the resident's family, social worker, and any other person, unless not medically advisable as documented in the resident's medical record by the attending physician, except that communications with public officials or with the resident's attorney or physician shall not be restricted. Private and unrestricted communications shall include, but are not 12526 12527 12528 12529 12530 12531 12532

limited to, the right to: 12533

(a) Receive, send, and mail sealed, unopened correspondence; 12534

(b) Reasonable access to a telephone for private communications; 12535 12536

(c) Private visits at any reasonable hour. 12537

(22) The right to assured privacy for visits by the spouse, or if both are residents of the same home, the right to share a room within the capacity of the home, unless not medically advisable as documented in the resident's medical record by the attending physician; 12538 12539 12540 12541 12542

(23) The right upon reasonable request to have room doors closed and to have them not opened without knocking, except in the case of an emergency or unless not medically advisable as documented in the resident's medical record by the attending physician; 12543 12544 12545 12546 12547

(24) The right to retain and use personal clothing and a reasonable amount of possessions, in a reasonably secure manner, unless to do so would infringe on the rights of other residents or would not be medically advisable as documented in the resident's medical record by the attending physician; 12548 12549 12550 12551 12552

(25) The right to be fully informed, prior to or at the time of admission and during the resident's stay, in writing, of the basic rate charged by the home, of services available in the home, and of any additional charges related to such services, including charges for services not covered under the medicare or medicaid program. The basic rate shall not be changed unless thirty days notice is given to the resident or, if the resident is unable to understand this information, to the resident's sponsor. 12553 12554 12555 12556 12557 12558 12559 12560

(26) The right of the resident and person paying for the care to examine and receive a bill at least monthly for the resident's 12561 12562

care from the home that itemizes charges not included in the basic rates; 12563 12564

(27)(a) The right to be free from financial exploitation; 12565

(b) The right to manage the resident's own personal financial affairs, or, if the resident has delegated this responsibility in writing to the home, to receive upon written request at least a quarterly accounting statement of financial transactions made on the resident's behalf. The statement shall include: 12566 12567 12568 12569 12570

(i) A complete record of all funds, personal property, or possessions of a resident from any source whatsoever, that have been deposited for safekeeping with the home for use by the resident or the resident's sponsor; 12571 12572 12573 12574

(ii) A listing of all deposits and withdrawals transacted, which shall be substantiated by receipts which shall be available for inspection and copying by the resident or sponsor. 12575 12576 12577

(28) The right of the resident to be allowed unrestricted access to the resident's property on deposit at reasonable hours, unless requests for access to property on deposit are so persistent, continuous, and unreasonable that they constitute a nuisance; 12578 12579 12580 12581 12582

(29) The right to receive reasonable notice before the resident's room or roommate is changed, including an explanation of the reason for either change. 12583 12584 12585

(30) The right not to be transferred or discharged from the home unless the transfer is necessary because of one of the following: 12586 12587 12588

(a) The welfare and needs of the resident cannot be met in the home. 12589 12590

(b) The resident's health has improved sufficiently so that the resident no longer needs the services provided by the home. 12591 12592

(c) The safety of individuals in the home is endangered. 12593

(d) The health of individuals in the home would otherwise be endangered. 12594 12595

(e) The resident has failed, after reasonable and appropriate notice, to pay or to have the medicare or medicaid program pay on the resident's behalf, for the care provided by the home. A resident shall not be considered to have failed to have the resident's care paid for if the resident has applied for medicaid, unless both of the following are the case: 12596 12597 12598 12599 12600 12601

(i) The resident's application, or a substantially similar previous application, has been denied by the county department of job and family services. 12602 12603 12604

(ii) If the resident appealed the denial pursuant to division (C) of section ~~5101.35~~ 5160.34 of the Revised Code, the director of job and family services has upheld the denial. 12605 12606 12607

(f) The home's license has been revoked, the home is being closed pursuant to section 3721.08, sections ~~5111.35~~ 5164.50 to ~~5111.62~~ 5164.78, or section 5155.31 of the Revised Code, or the home otherwise ceases to operate. 12608 12609 12610 12611

(g) The resident is a recipient of medicaid, and the home's participation in the medicaid program is involuntarily terminated or denied. 12612 12613 12614

(h) The resident is a beneficiary under the medicare program, and the home's participation in the medicare program is involuntarily terminated or denied. 12615 12616 12617

(31) The right to voice grievances and recommend changes in policies and services to the home's staff, to employees of the department of health, or to other persons not associated with the operation of the home, of the resident's choice, free from restraint, interference, coercion, discrimination, or reprisal. 12618 12619 12620 12621 12622

This right includes access to a residents' rights advocate, and the right to be a member of, to be active in, and to associate with persons who are active in organizations of relatives and friends of nursing home residents and other organizations engaged in assisting residents. 12623 12624 12625 12626 12627

(32) The right to have any significant change in the resident's health status reported to the resident's sponsor. As soon as such a change is known to the home's staff, the home shall make a reasonable effort to notify the sponsor within twelve hours. 12628 12629 12630 12631 12632

(B) A sponsor may act on a resident's behalf to assure that the home does not deny the residents' rights under sections 3721.10 to 3721.17 of the Revised Code. 12633 12634 12635

(C) Any attempted waiver of the rights listed in division (A) of this section is void. 12636 12637

Sec. 3721.15. (A) Authorization from a resident or a sponsor with a power of attorney for a home to manage the resident's financial affairs shall be in writing and shall be attested to by a witness who is not connected in any manner whatsoever with the home or its administrator. The home shall maintain accounts pursuant to division (A)(27) of section 3721.13 of the Revised Code. Upon the resident's transfer, discharge, or death, the account shall be closed and a final accounting made. All remaining funds shall be returned to the resident or resident's sponsor, except in the case of death, when all remaining funds shall be transferred or used in accordance with section ~~5111.113~~ <u>5162.37</u> of the Revised Code. 12638 12639 12640 12641 12642 12643 12644 12645 12646 12647 12648 12649

(B) A home that manages a resident's financial affairs shall deposit the resident's funds in excess of one hundred dollars, and may deposit the resident's funds that are one hundred dollars or less, in an interest-bearing account separate from any of the 12650 12651 12652 12653

home's operating accounts. Interest earned on the resident's funds 12654
shall be credited to the resident's account. A resident's funds 12655
that are one hundred dollars or less and have not been deposited 12656
in an interest-bearing account may be deposited in a 12657
noninterest-bearing account or petty cash fund. 12658

(C) Each resident whose financial affairs are managed by a 12659
home shall be promptly notified by the home when the total of the 12660
amount of funds in the resident's accounts and the petty cash fund 12661
plus other nonexempt resources reaches two hundred dollars less 12662
than the maximum amount permitted a recipient of medicaid. The 12663
notice shall include an explanation of the potential effect on the 12664
resident's eligibility for medicaid if the amount in the 12665
resident's accounts and the petty cash fund, plus the value of 12666
other nonexempt resources, exceeds the maximum assets a medicaid 12667
recipient may retain. 12668

(D) Each home that manages the financial affairs of residents 12669
shall purchase a surety bond or otherwise provide assurance 12670
satisfactory to the director of health, or, in the case of a home 12671
that participates in the medicaid program, to the director of ~~job~~ 12672
~~and family services~~ health care administration, to assure the 12673
security of all residents' funds managed by the home. 12674

Sec. 3721.16. For each resident of a home, notice of a 12675
proposed transfer or discharge shall be in accordance with this 12676
section. 12677

(A)(1) The administrator of a home shall notify a resident in 12678
writing, and the resident's sponsor in writing by certified mail, 12679
return receipt requested, in advance of any proposed transfer or 12680
discharge from the home. The administrator shall send a copy of 12681
the notice to the state department of health. The notice shall be 12682
provided at least thirty days in advance of the proposed transfer 12683
or discharge, unless any of the following applies: 12684

(a) The resident's health has improved sufficiently to allow a more immediate discharge or transfer to a less skilled level of care; 12685 12686 12687

(b) The resident has resided in the home less than thirty days; 12688 12689

(c) An emergency arises in which the safety of individuals in the home is endangered; 12690 12691

(d) An emergency arises in which the health of individuals in the home would otherwise be endangered; 12692 12693

(e) An emergency arises in which the resident's urgent medical needs necessitate a more immediate transfer or discharge. 12694 12695

In any of the circumstances described in divisions (A)(1)(a) to (e) of this section, the notice shall be provided as many days in advance of the proposed transfer or discharge as is practicable. 12696 12697 12698 12699

(2) The notice required under division (A)(1) of this section shall include all of the following: 12700 12701

(a) The reasons for the proposed transfer or discharge; 12702

(b) The proposed date the resident is to be transferred or discharged; 12703 12704

(c) The proposed location to which the resident is to be transferred or discharged; 12705 12706

(d) Notice of the right of the resident and the resident's sponsor to an impartial hearing at the home on the proposed transfer or discharge, and of the manner in which and the time within which the resident or sponsor may request a hearing pursuant to section 3721.161 of the Revised Code; 12707 12708 12709 12710 12711

(e) A statement that the resident will not be transferred or discharged before the date specified in the notice unless the home and the resident or, if the resident is not competent to make a 12712 12713 12714

decision, the home and the resident's sponsor, agree to an earlier date; 12715 12716

(f) The address of the legal services office of the department of health; 12717 12718

(g) The name, address, and telephone number of a representative of the state long-term care ombudsperson program and, if the resident or patient has a developmental disability or mental illness, the name, address, and telephone number of the Ohio legal rights service. 12719 12720 12721 12722 12723

(B) No home shall transfer or discharge a resident before the date specified in the notice required by division (A) of this section unless the home and the resident or, if the resident is not competent to make a decision, the home and the resident's sponsor, agree to an earlier date. 12724 12725 12726 12727 12728

(C) Transfer or discharge actions shall be documented in the resident's medical record by the home if there is a medical basis for the action. 12729 12730 12731

(D) A resident or resident's sponsor may challenge a transfer or discharge by requesting an impartial hearing pursuant to section 3721.161 of the Revised Code, unless the transfer or discharge is required because of one of the following reasons: 12732 12733 12734 12735

(1) The home's license has been revoked under this chapter; 12736

(2) The home is being closed pursuant to section 3721.08~~,~~ ~~sections 5111.35 to 5111.62,~~ or ~~section~~ 5155.31, or sections 5164.50 to 5164.78 of the Revised Code; 12737 12738 12739

(3) The resident is a recipient of medicaid and the home's participation in the medicaid program has been involuntarily terminated or denied by the federal government; 12740 12741 12742

(4) The resident is a beneficiary under the medicare program and the home's certification under the medicare program has been 12743 12744

involuntarily terminated or denied by the federal government. 12745

(E) If a resident is transferred or discharged pursuant to this section, the home from which the resident is being transferred or discharged shall provide the resident with adequate preparation prior to the transfer or discharge to ensure a safe and orderly transfer or discharge from the home, and the home or alternative setting to which the resident is to be transferred or discharged shall have accepted the resident for transfer or discharge. 12746 12747 12748 12749 12750 12751 12752 12753

(F) At the time of a transfer or discharge of a resident who is a recipient of medicaid from a home to a hospital or for therapeutic leave, the home shall provide notice in writing to the resident and in writing by certified mail, return receipt requested, to the resident's sponsor, specifying the number of days, if any, during which the resident will be permitted under the medicaid program to return and resume residence in the home and specifying the medicaid program's coverage of the days during which the resident is absent from the home. An individual who is absent from a home for more than the number of days specified in the notice and continues to require the services provided by the facility shall be given priority for the first available bed in a semi-private room. 12754 12755 12756 12757 12758 12759 12760 12761 12762 12763 12764 12765 12766

Sec. 3721.17. (A) Any resident who believes that the resident's rights under sections 3721.10 to 3721.17 of the Revised Code have been violated may file a grievance under procedures adopted pursuant to division (A)(2) of section 3721.12 of the Revised Code. 12767 12768 12769 12770 12771

When the grievance committee determines a violation of sections 3721.10 to 3721.17 of the Revised Code has occurred, it shall notify the administrator of the home. If the violation cannot be corrected within ten days, or if ten days have elapsed 12772 12773 12774 12775

without correction of the violation, the grievance committee shall refer the matter to the department of health. 12776 12777

(B) Any person who believes that a resident's rights under sections 3721.10 to 3721.17 of the Revised Code have been violated may report or cause reports to be made of the information directly to the department of health. No person who files a report is liable for civil damages resulting from the report. 12778 12779 12780 12781 12782

(C)(1) Within thirty days of receiving a complaint under this section, the department of health shall investigate any complaint referred to it by a home's grievance committee and any complaint from any source that alleges that the home provided substantially less than adequate care or treatment, or substantially unsafe conditions, or, within seven days of receiving a complaint, refer it to the attorney general, if the attorney general agrees to investigate within thirty days. 12783 12784 12785 12786 12787 12788 12789 12790

(2) Within thirty days of receiving a complaint under this section, the department of health may investigate any alleged violation of sections 3721.10 to 3721.17 of the Revised Code, or of rules, policies, or procedures adopted pursuant to those sections, not covered by division (C)(1) of this section, or it may, within seven days of receiving a complaint, refer the complaint to the grievance committee at the home where the alleged violation occurred, or to the attorney general if the attorney general agrees to investigate within thirty days. 12791 12792 12793 12794 12795 12796 12797 12798 12799

(D) If, after an investigation, the department of health finds probable cause to believe that a violation of sections 3721.10 to 3721.17 of the Revised Code, or of rules, policies, or procedures adopted pursuant to those sections, has occurred at a home that is certified under the medicare or medicaid program, it shall cite one or more findings or deficiencies under sections ~~5111.35~~ 5164.50 to ~~5111.62~~ 5164.78 of the Revised Code. If the home is not so certified, the department shall hold an 12800 12801 12802 12803 12804 12805 12806 12807

adjudicative hearing within thirty days under Chapter 119. of the Revised Code. 12808 12809

(E) Upon a finding at an adjudicative hearing under division (D) of this section that a violation of sections 3721.10 to 3721.17 of the Revised Code, or of rules, policies, or procedures adopted pursuant thereto, has occurred, the department of health shall make an order for compliance, set a reasonable time for compliance, and assess a fine pursuant to division (F) of this section. The fine shall be paid to the general revenue fund only if compliance with the order is not shown to have been made within the reasonable time set in the order. The department of health may issue an order prohibiting the continuation of any violation of sections 3721.10 to 3721.17 of the Revised Code. 12810 12811 12812 12813 12814 12815 12816 12817 12818 12819 12820

Findings at the hearings conducted under this section may be appealed pursuant to Chapter 119. of the Revised Code, except that an appeal may be made to the court of common pleas of the county in which the home is located. 12821 12822 12823 12824

The department of health shall initiate proceedings in court to collect any fine assessed under this section that is unpaid thirty days after the violator's final appeal is exhausted. 12825 12826 12827

(F) Any home found, pursuant to an adjudication hearing under division (D) of this section, to have violated sections 3721.10 to 3721.17 of the Revised Code, or rules, policies, or procedures adopted pursuant to those sections may be fined not less than one hundred nor more than five hundred dollars for a first offense. For each subsequent offense, the home may be fined not less than two hundred nor more than one thousand dollars. 12828 12829 12830 12831 12832 12833 12834

A violation of sections 3721.10 to 3721.17 of the Revised Code is a separate offense for each day of the violation and for each resident who claims the violation. 12835 12836 12837

(G) No home or employee of a home shall retaliate against any 12838

person who: 12839

(1) Exercises any right set forth in sections 3721.10 to 3721.17 of the Revised Code, including, but not limited to, filing a complaint with the home's grievance committee or reporting an alleged violation to the department of health; 12840 12841 12842 12843

(2) Appears as a witness in any hearing conducted under this section or section 3721.162 of the Revised Code; 12844 12845

(3) Files a civil action alleging a violation of sections 3721.10 to 3721.17 of the Revised Code, or notifies a county prosecuting attorney or the attorney general of a possible violation of sections 3721.10 to 3721.17 of the Revised Code. 12846 12847 12848 12849

If, under the procedures outlined in this section, a home or its employee is found to have retaliated, the violator may be fined up to one thousand dollars. 12850 12851 12852

(H) When legal action is indicated, any evidence of criminal activity found in an investigation under division (C) of this section shall be given to the prosecuting attorney in the county in which the home is located for investigation. 12853 12854 12855 12856

(I)(1)(a) Any resident whose rights under sections 3721.10 to 3721.17 of the Revised Code are violated has a cause of action against any person or home committing the violation. 12857 12858 12859

(b) An action under division (I)(1)(a) of this section may be commenced by the resident or by the resident's legal guardian or other legally authorized representative on behalf of the resident or the resident's estate. If the resident or the resident's legal guardian or other legally authorized representative is unable to commence an action under that division on behalf of the resident, the following persons in the following order of priority have the right to and may commence an action under that division on behalf of the resident or the resident's estate: 12860 12861 12862 12863 12864 12865 12866 12867 12868

(i) The resident's spouse; 12869

(ii) The resident's parent or adult child; 12870

(iii) The resident's guardian if the resident is a minor child; 12871 12872

(iv) The resident's brother or sister; 12873

(v) The resident's niece, nephew, aunt, or uncle. 12874

(c) Notwithstanding any law as to priority of persons entitled to commence an action, if more than one eligible person within the same level of priority seeks to commence an action on behalf of a resident or the resident's estate, the court shall determine, in the best interest of the resident or the resident's estate, the individual to commence the action. A court's determination under this division as to the person to commence an action on behalf of a resident or the resident's estate shall bar another person from commencing the action on behalf of the resident or the resident's estate. 12875 12876 12877 12878 12879 12880 12881 12882 12883 12884

(d) The result of an action commenced pursuant to division (I)(1)(a) of this section by a person authorized under division (I)(1)(b) of this section shall bind the resident or the resident's estate that is the subject of the action. 12885 12886 12887 12888

(e) A cause of action under division (I)(1)(a) of this section shall accrue, and the statute of limitations applicable to that cause of action shall begin to run, based upon the violation of a resident's rights under sections 3721.10 to 3721.17 of the Revised Code, regardless of the party commencing the action on behalf of the resident or the resident's estate as authorized under divisions (I)(1)(b) and (c) of this section. 12889 12890 12891 12892 12893 12894 12895

(2)(a) The plaintiff in an action filed under division (I)(1) of this section may obtain injunctive relief against the violation of the resident's rights. The plaintiff also may recover 12896 12897 12898

compensatory damages based upon a showing, by a preponderance of the evidence, that the violation of the resident's rights resulted from a negligent act or omission of the person or home and that the violation was the proximate cause of the resident's injury, death, or loss to person or property. 12899 12900 12901 12902 12903

(b) If compensatory damages are awarded for a violation of the resident's rights, section 2315.21 of the Revised Code shall apply to an award of punitive or exemplary damages for the violation. 12904 12905 12906 12907

(c) The court, in a case in which only injunctive relief is granted, may award to the prevailing party reasonable attorney's fees limited to the work reasonably performed. 12908 12909 12910

(3) Division (I)(2) (b) of this section shall be considered to be purely remedial in operation and shall be applied in a remedial manner in any civil action in which this section is relevant, whether the action is pending in court or commenced on or after July 9, 1998. 12911 12912 12913 12914 12915

(4) Within thirty days after the filing of a complaint in an action for damages brought against a home under division (I)(1)(a) of this section by or on behalf of a resident or former resident of the home, the plaintiff or plaintiff's counsel shall send written notice of the filing of the complaint to the department of job and family services if the department has a right of recovery under section ~~5101.58~~ 5160.38 of the Revised Code against the liability of the home for the cost of medical services and care arising out of injury, disease, or disability of the resident or former resident. 12916 12917 12918 12919 12920 12921 12922 12923 12924 12925

Sec. 3721.19. (A) As used in this section: 12926

(1) "Home" and "residential care facility" have the same meanings as in section 3721.01 of the Revised Code; 12927 12928

(2) "Sponsor" and "residents' rights advocate" have the same 12929
meanings as in section 3721.10 of the Revised Code. 12930

A home licensed under this chapter that is not a party to a 12931
provider agreement, as defined in section ~~5111.20~~ 5164.01 of the 12932
Revised Code, shall provide each prospective resident, before 12933
admission, with the following information, orally and in a 12934
separate written notice on which is printed in a conspicuous 12935
manner: "This home is not a participant in the ~~medical assistance~~ 12936
medicaid program administered by the Ohio department of ~~job and~~ 12937
~~family services~~ health care administration. Consequently, you may 12938
be discharged from this home if you are unable to pay for the 12939
services provided by this home." 12940

If the prospective resident has a sponsor whose identity is 12941
made known to the home, the home shall also inform the sponsor, 12942
before admission of the resident, of the home's status relative to 12943
the ~~medical assistance~~ medicaid program. Written ~~acknowledgement~~ 12944
acknowledgment of the receipt of the information shall be provided 12945
by the resident and, if the prospective resident has a sponsor who 12946
has been identified to the home, by the sponsor. The written 12947
~~acknowledgement~~ acknowledgment shall be made part of the 12948
resident's record by the home. 12949

No home shall terminate its status as a provider under the 12950
medicaid program unless it has complied with section ~~5111.66~~ 12951
5164.83 of the Revised Code and, at least ninety days prior to 12952
such termination, provided written notice to the residents of the 12953
home and their sponsors of such action. This requirement shall not 12954
apply in cases where the department of ~~job and family services~~ 12955
health care administration terminates a home's provider agreement 12956
or provider status. 12957

(B) A home licensed under this chapter as a residential care 12958
facility shall provide notice to each prospective resident or the 12959
individual's sponsor of the services offered by the facility and 12960

the types of skilled nursing care that the facility may provide. A residential care facility that, pursuant to section 3721.012 of the Revised Code, has a policy of entering into risk agreements with residents or their sponsors shall provide each prospective resident or the individual's sponsor a written explanation of the policy and the provisions that may be contained in a risk agreement. At the time the information is provided, the facility shall obtain a statement signed by the individual receiving the information acknowledging that the individual received the information. The facility shall maintain on file the individual's signed statement. 12961–12971

(C) A resident has a cause of action against a home for breach of any duty imposed by this section. The action may be commenced by the resident, or on the resident's behalf by the resident's sponsor or a residents' rights advocate, by the filing of a civil action in the court of common pleas of the county in which the home is located, or in the court of common pleas of Franklin county. 12972–12978

If the court finds that a breach of any duty imposed by this section has occurred, the court shall enjoin the home from discharging the resident from the home until arrangements satisfactory to the court are made for the orderly transfer of the resident to another mode of health care including, but not limited to, another home, and may award the resident and a person or public agency that brings an action on behalf of a resident reasonable attorney's fees. If a home discharges a resident to whom or to whose sponsor information concerning its status relative to the ~~medical assistance~~ <u>medicaid</u> program was not provided as required under this section, the court shall grant any appropriate relief including, but not limited to, actual damages, reasonable attorney's fees, and costs. 12979–12991

Sec. 3721.21. As used in sections 3721.21 to 3721.34 of the 12992
Revised Code: 12993

(A) "Long-term care facility" means either of the following: 12994

(1) A nursing home as defined in section 3721.01 of the 12995
Revised Code, other than a nursing home or part of a nursing home 12996
certified as an intermediate care facility for the mentally 12997
retarded under ~~Title XIX of~~ the ~~"Social Security Act," 49 Stat.~~ 12998
~~620 (1935), 42 U.S.C.A. 301, as amended~~ medicaid program; 12999

(2) A facility or part of a facility that is certified as a 13000
skilled nursing facility or a nursing facility under ~~Title XVIII~~ 13001
~~or XIX of~~ the ~~"Social Security Act~~ medicare program and medicaid 13002
program.~~"~~ 13003

(B) "Residential care facility" has the same meaning as in 13004
section 3721.01 of the Revised Code. 13005

(C) "Abuse" means knowingly causing physical harm or 13006
recklessly causing serious physical harm to a resident by physical 13007
contact with the resident or by use of physical or chemical 13008
restraint, medication, or isolation as punishment, for staff 13009
convenience, excessively, as a substitute for treatment, or in 13010
amounts that preclude habilitation and treatment. 13011

(D) "Neglect" means recklessly failing to provide a resident 13012
with any treatment, care, goods, or service necessary to maintain 13013
the health or safety of the resident when the failure results in 13014
serious physical harm to the resident. "Neglect" does not include 13015
allowing a resident, at the resident's option, to receive only 13016
treatment by spiritual means through prayer in accordance with the 13017
tenets of a recognized religious denomination. 13018

(E) "Misappropriation" means depriving, defrauding, or 13019
otherwise obtaining the real or personal property of a resident by 13020
any means prohibited by the Revised Code, including violations of 13021

Chapter 2911. or 2913. of the Revised Code. 13022

(F) "Resident" includes a resident, patient, former resident or patient, or deceased resident or patient of a long-term care facility or a residential care facility. 13023 13024 13025

(G) "Physical restraint" has the same meaning as in section 3721.10 of the Revised Code. 13026 13027

(H) "Chemical restraint" has the same meaning as in section 3721.10 of the Revised Code. 13028 13029

(I) "Nursing and nursing-related services" means the personal care services and other services not constituting skilled nursing care that are specified in rules the public health council shall adopt in accordance with Chapter 119. of the Revised Code. 13030 13031 13032 13033

(J) "Personal care services" has the same meaning as in section 3721.01 of the Revised Code. 13034 13035

(K)(1) Except as provided in division (K)(2) of this section, "nurse aide" means an individual who provides nursing and nursing-related services to residents in a long-term care facility, either as a member of the staff of the facility for monetary compensation or as a volunteer without monetary compensation. 13036 13037 13038 13039 13040 13041

(2) "Nurse aide" does not include either of the following: 13042

(a) A licensed health professional practicing within the scope of the professional's license; 13043 13044

(b) An individual providing nursing and nursing-related services in a religious nonmedical health care institution, if the individual has been trained in the principles of nonmedical care and is recognized by the institution as being competent in the administration of care within the religious tenets practiced by the residents of the institution. 13045 13046 13047 13048 13049 13050

(L) "Licensed health professional" means all of the 13051

following: 13052

(1) An occupational therapist or occupational therapy assistant licensed under Chapter 4755. of the Revised Code; 13053 13054

(2) A physical therapist or physical therapy assistant licensed under Chapter 4755. of the Revised Code; 13055 13056

(3) A physician authorized under Chapter 4731. of the Revised Code to practice medicine and surgery, osteopathic medicine and surgery, or podiatry; 13057 13058 13059

(4) A physician assistant authorized under Chapter 4730. of the Revised Code to practice as a physician assistant; 13060 13061

(5) A registered nurse or licensed practical nurse licensed under Chapter 4723. of the Revised Code; 13062 13063

(6) A social worker or independent social worker licensed under Chapter 4757. of the Revised Code or a social work assistant registered under that chapter; 13064 13065 13066

(7) A speech-language pathologist or audiologist licensed under Chapter 4753. of the Revised Code; 13067 13068

(8) A dentist or dental hygienist licensed under Chapter 4715. of the Revised Code; 13069 13070

(9) An optometrist licensed under Chapter 4725. of the Revised Code; 13071 13072

(10) A pharmacist licensed under Chapter 4729. of the Revised Code; 13073 13074

(11) A psychologist licensed under Chapter 4732. of the Revised Code; 13075 13076

(12) A chiropractor licensed under Chapter 4734. of the Revised Code; 13077 13078

(13) A nursing home administrator licensed or temporarily licensed under Chapter 4751. of the Revised Code; 13079 13080

(14) A professional counselor or professional clinical counselor licensed under Chapter 4757. of the Revised Code. 13081 13082

(M) "Religious nonmedical health care institution" means an institution that meets or exceeds the conditions to receive payment under the medicare program ~~established under Title XVIII of the "Social Security Act"~~ for inpatient hospital services or post-hospital extended care services furnished to an individual in a religious nonmedical health care institution, as defined in section 1861(ss)(1) of the "Social Security Act," 79 Stat. 286 (1965), 42 U.S.C. 1395x(ss)(1), as amended. 13083 13084 13085 13086 13087 13088 13089 13090

(N) "Competency evaluation program" means a program through which the competency of a nurse aide to provide nursing and nursing-related services is evaluated. 13091 13092 13093

(O) "Training and competency evaluation program" means a program of nurse aide training and evaluation of competency to provide nursing and nursing-related services. 13094 13095 13096

Sec. 3721.28. (A)(1) Each nurse aide used by a long-term care facility on a full-time, temporary, per diem, or other basis on July 1, 1989, shall be provided by the facility a competency evaluation program approved by the director of health under division (A) of section 3721.31 of the Revised Code or conducted by ~~him~~ <u>the director</u> under division (C) of that section. Each long-term care facility using a nurse aide on July 1, 1989, shall provide the nurse aide the preparation necessary to complete the competency evaluation program by January 1, 1990. 13097 13098 13099 13100 13101 13102 13103 13104 13105

(2) Each nurse aide used by a long-term care facility on a full-time, temporary, per diem, or other basis on January 1, 1990, who either was not used by the facility on July 1, 1989, or was used by the facility on July 1, 1989, but had not successfully completed a competency evaluation program by January 1, 1990, shall be provided by the facility a competency evaluation program 13106 13107 13108 13109 13110 13111

approved by the director under division (A) of section 3721.31 of the Revised Code or conducted by ~~him~~ the director under division (C) of that section. Each long-term care facility using a nurse aide described in division (A)(2) of this section shall provide the nurse aide the preparation necessary to complete the competency evaluation program by October 1, 1990, and shall assist the nurse aide in registering for the program. 13112 13113 13114 13115 13116 13117 13118

(B) Effective June 1, 1990, no long-term care facility shall use an individual as a nurse aide for more than four months unless the individual is competent to provide the services ~~he~~ the individual is to provide, the facility has received from the nurse aide registry established under section 3721.32 of the Revised Code the information concerning the individual provided through the registry, and one of the following is the case: 13119 13120 13121 13122 13123 13124 13125

(1) The individual was used by a facility as a nurse aide on a full-time, temporary, per diem, or other basis at any time during the period commencing July 1, 1989, and ending January 1, 1990, and successfully completed, not later than October 1, 1990, a competency evaluation program approved by the director under division (A) of section 3721.31 of the Revised Code or conducted by ~~him~~ the director under division (C) of that section. 13126 13127 13128 13129 13130 13131 13132

(2) The individual has successfully completed a training and competency evaluation program approved by the director under division (A) of section 3721.31 of the Revised Code or conducted by ~~him~~ the director under division (C) of that section or has met the conditions specified in division (F) of this section and, in addition, if the training and competency evaluation program or the training, instruction, or education the individual completed in meeting the conditions specified in division (F) of this section was conducted by or in a long-term care facility, or if the director pursuant to division (E) of section 3721.31 of the Revised Code so requires, the individual has successfully 13133 13134 13135 13136 13137 13138 13139 13140 13141 13142 13143

completed a competency evaluation program conducted by the director.

(3) Prior to July 1, 1989, if the long-term care facility is certified as a skilled nursing facility or a nursing facility under ~~Title XVIII or XIX of~~ the ~~"Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended~~ medicare program or medicaid program, or prior to January 1, 1990, if the facility is not so certified, the individual completed a program that the director determines included a competency evaluation component no less stringent than the competency evaluation programs approved by ~~him~~ the director under division (A) of section 3721.31 of the Revised Code or conducted by ~~him~~ the director under division (C) of that section, and was otherwise comparable to the training and competency evaluation programs being approved by the director under division (A) of that section.

(4) The individual is listed in a nurse aide registry maintained by another state and that state certifies that its program for training and evaluation of competency of nurse aides complies with ~~Titles XVIII and XIX of~~ the ~~"Social Security Act"~~ medicare program and medicaid program and regulations adopted thereunder.

(5) Prior to July 1, 1989, the individual was found competent to serve as a nurse aide after the completion of a course of nurse aide training of at least one hundred hours' duration.

(6) The individual is enrolled in a prelicensure program of nursing education approved by the board of nursing or by an agency of another state that regulates nursing education, has provided the long-term care facility with a certificate from the program indicating that the individual has successfully completed the courses that teach basic nursing skills including infection control, safety and emergency procedures, and personal care, and has successfully completed a competency evaluation program

conducted by the director under division (C) of section 3721.31 of the Revised Code. 13176 13177

(7) The individual has the equivalent of twelve months or more of full-time employment in the preceding five years as a hospital aide or orderly and has successfully completed a competency evaluation program conducted by the director under division (C) of section 3721.31 of the Revised Code. 13178 13179 13180 13181 13182

(C) Effective June 1, 1990, no long-term care facility shall continue for longer than four months to use as a nurse aide an individual who previously met the requirements of division (B) of this section but since most recently doing so has not performed nursing and nursing-related services for monetary compensation for twenty-four consecutive months, unless the individual successfully completes additional training and competency evaluation by complying with divisions (C)(1) and (2) of this section: 13183 13184 13185 13186 13187 13188 13189 13190

(1) Doing one of the following: 13191

(a) Successfully completing a training and competency evaluation program approved by the director under division (A) of section 3721.31 of the Revised Code or conducted by ~~him~~ the director under division (C) of that section; 13192 13193 13194 13195

(b) Successfully completing a training and competency evaluation program described in division (B)(4) of this section; 13196 13197

(c) Meeting the requirements specified in division (B)(6) or (7) of this section. 13198 13199

(2) If the training and competency evaluation program completed under division (C)(1)(a) of this section was conducted by or in a long-term care facility, or if the director pursuant to division (E) of section 3721.31 of the Revised Code so requires, successfully completing a competency evaluation program conducted by the director. 13200 13201 13202 13203 13204 13205

(D)(1) The four-month periods provided for in divisions (B) and (C) of this section include any time, on or after June 1, 1990, that an individual is used as a nurse aide on a full-time, temporary, per diem, or any other basis by the facility or any other long-term care facility. 13206 13207 13208 13209 13210

(2) During the four-month period provided for in division (B) of this section, during which a long-term care facility may, subject to division (E) of this section, use as a nurse aide an individual who does not have the qualifications specified in divisions (B)(1) to (7) of this section, a facility shall require the individual to comply with divisions (D)(2)(a) and (b) of this section: 13211 13212 13213 13214 13215 13216 13217

(a) Participate in one of the following: 13218

(i) If the individual has successfully completed a training and competency evaluation program approved by the director under division (A) of section 3721.31 of the Revised Code, and the program was conducted by or in a long-term care facility, or the director pursuant to division (E) of section 3721.31 of the Revised Code so requires, a competency evaluation program conducted by the director; 13219 13220 13221 13222 13223 13224 13225

(ii) If the individual is enrolled in a prelicensure program of nursing education described in division (B)(6) of this section and has completed or is working toward completion of the courses described in that division, or the individual has the experience described in division (B)(7) of this section, a competency evaluation program conducted by the director; 13226 13227 13228 13229 13230 13231

(iii) A training and competency evaluation program approved by the director under division (A) of section 3721.31 of the Revised Code or conducted by ~~him~~ <u>the director</u> under division (C) of that section. 13232 13233 13234 13235

(b) If the individual participates in or has successfully 13236

completed a training and competency evaluation program under 13237
division (D)(2)(a)(iii) of this section that is conducted by or in 13238
a long-term care facility, or the director pursuant to division 13239
(E) of section 3721.31 of the Revised Code so requires, ~~paticipate~~ 13240
participate in a competency evaluation program conducted by the 13241
director. 13242

(3) During the four-month period provided for in division (C) 13243
of this section, during which a long-term care facility may, 13244
subject to division (E) of this section, use as a nurse aide an 13245
individual who does not have the qualifications specified in 13246
divisions (C)(1) and (2) of this section, a facility shall require 13247
the individual to comply with divisions (D)(3)(a) and (b) of this 13248
section: 13249

(a) Participate in one of the following: 13250

(i) If the individual has successfully completed a training 13251
and competency evaluation program approved by the director, and 13252
the program was conducted by or in a long-term care facility, or 13253
the director pursuant to division (E) of section 3721.31 of the 13254
Revised Code so requires, a competency evaluation program 13255
conducted by the director; 13256

(ii) If the individual is enrolled in a prelicensure program 13257
of nursing education described in division (B)(6) of this section 13258
and has completed or is working toward completion of the courses 13259
described in that division, or the individual has the experience 13260
described in division (B)(7) of this section, a competency 13261
evaluation program conducted by the director; 13262

(iii) A training and competency evaluation program approved 13263
or conducted by the director. 13264

(b) If the individual participates in or has successfully 13265
completed a training and competency evaluation program under 13266
division (D)(3)(a)(iii) of this section that is conducted by or in 13267

a long-term care facility, or the director pursuant to division 13268
(E) of section 3721.31 of the Revised Code so requires, 13269
participate in a competency evaluation program conducted by the 13270
director. 13271

(E) A long-term care facility shall not permit an individual 13272
used by the facility as a nurse aide while participating in a 13273
training and competency evaluation program to provide nursing and 13274
nursing-related services unless both of the following are the 13275
case: 13276

(1) The individual has completed the number of hours of 13277
training that ~~he~~ must ~~complete~~ be completed prior to providing 13278
services to residents as prescribed by rules that shall be adopted 13279
by the director in accordance with Chapter 119. of the Revised 13280
Code; 13281

(2) The individual is under the personal supervision of a 13282
registered or licensed practical nurse licensed under Chapter 13283
4723. of the Revised Code. 13284

(F) An individual shall be considered to have satisfied the 13285
requirement, under division (B)(2) of this section, of having 13286
successfully completed a training and competency evaluation 13287
program conducted or approved by the director, if the individual 13288
meets both of the following conditions: 13289

(1) The individual, as of July 1, 1989, completed at least 13290
sixty hours divided between skills training and classroom 13291
instruction in the topic areas described in divisions (B)(1) to 13292
(8) of section 3721.30 of the Revised Code; 13293

(2) The individual received, as of that date, at least the 13294
difference between seventy-five hours and the number of hours 13295
actually spent in training and competency evaluation in supervised 13296
practical nurse aide training or regular in-service nurse aide 13297
education. 13298

(G) The public health council shall adopt rules in accordance with Chapter 119. of the Revised Code specifying persons, in addition to the director, who may establish competence of nurse aides under division (B)(5) of this section, and establishing criteria for determining whether an individual meets the conditions specified in division (F) of this section. 13299 13300 13301 13302 13303 13304

(H) The rules adopted pursuant to divisions (E)(1) and (G) of this section shall be no less stringent than the requirements, guidelines, and procedures established by the United States secretary of health and human services under sections 1819 and 1919 of the "Social Security Act." 13305 13306 13307 13308 13309

Sec. 3721.32. (A) The director of health shall establish a state nurse aide registry listing all individuals who have done any of the following: 13310 13311 13312

(1) Were used by a long-term care facility as nurse aides on a full-time, temporary, per diem, or other basis at any time during the period commencing July 1, 1989, and ending January 1, 1990, and successfully completed, not later than October 1, 1990, a competency evaluation program approved by the director under division (A) of section 3721.31 of the Revised Code or conducted by the director under division (C) of that section; 13313 13314 13315 13316 13317 13318 13319

(2) Successfully completed a training and competency evaluation program approved by the director under division (A) of section 3721.31 of the Revised Code or met the conditions specified in division (F) of section 3721.28 of the Revised Code, and, if the training and competency evaluation program or the training, instruction, or education the individual completed in meeting the conditions specified in division (F) of section 3721.28 of the Revised Code was conducted in or by a long-term care facility, or if the director so required pursuant to division (E) of section 3721.31 of the Revised Code, has successfully 13320 13321 13322 13323 13324 13325 13326 13327 13328 13329

completed a competency evaluation program conducted by the 13330
director; 13331

(3) Successfully completed a training and competency 13332
evaluation program conducted by the director under division (C) of 13333
section 3721.31 of the Revised Code; 13334

(4) Successfully completed, prior to July 1, 1989, a program 13335
that the director has determined under division (B)(3) of section 13336
3721.28 of the Revised Code included a competency evaluation 13337
component no less stringent than the competency evaluation 13338
programs approved or conducted by the director under section 13339
3721.31 of the Revised Code, and was otherwise comparable to the 13340
training and competency evaluation program being approved by the 13341
director under section 3721.31 of the Revised Code; 13342

(5) Are listed in a nurse aide registry maintained by another 13343
state that certifies that its program for training and evaluation 13344
of competency of nurse aides complies with ~~Titles XVIII and XIX of~~ 13345
the ~~"Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301,~~ 13346
~~as amended~~ medicare program and medicaid program, or regulations 13347
adopted thereunder; 13348

(6) Were found competent, as provided in division (B)(5) of 13349
section 3721.28 of the Revised Code, prior to July 1, 1989, after 13350
the completion of a course of nurse aide training of at least one 13351
hundred hours' duration; 13352

(7) Are enrolled in a prelicensure program of nursing 13353
education approved by the board of nursing or by an agency of 13354
another state that regulates nursing education, have provided the 13355
long-term care facility with a certificate from the program 13356
indicating that the individual has successfully completed the 13357
courses that teach basic nursing skills including infection 13358
control, safety and emergency procedures, and personal care, and 13359
have successfully completed a competency evaluation program 13360

conducted by the director under division (A) of section 3721.31 of the Revised Code; 13361 13362

(8) Have the equivalent of twelve months or more of full-time employment in the five years preceding listing in the registry as a hospital aide or orderly and have successfully completed a competency evaluation program conducted by the director under division (C) of section 3721.31 of the Revised Code. 13363 13364 13365 13366 13367

(B) The registry shall include both of the following: 13368

(1) The statement required by section 3721.23 of the Revised Code detailing findings by the director under that section regarding alleged abuse or neglect of a resident or misappropriation of resident property; 13369 13370 13371 13372

(2) Any statement provided by an individual under section 3721.23 of the Revised Code disputing the director's findings. 13373 13374

Whenever an inquiry is received as to the information contained in the registry concerning an individual about whom a statement required by section 3721.23 of the Revised Code is included in the registry, the director shall disclose the statement or a summary of the statement together with any statement provided by the individual under section 3721.23 or a clear and accurate summary of that statement. 13375 13376 13377 13378 13379 13380 13381

(C) The director may by rule specify additional information that must be provided the registry by long-term care facilities and persons or government agencies conducting approved competency evaluation programs and training and competency evaluation programs. 13382 13383 13384 13385 13386

(D) Information contained in the registry is a public record for the purposes of section 149.43 of the Revised Code, and is subject to inspection and copying under section 1347.08 of the Revised Code. 13387 13388 13389 13390

Sec. 3722.10. (A) The public health council shall have the 13391
exclusive authority to adopt and shall adopt rules in accordance 13392
with Chapter 119. of the Revised Code governing the licensing and 13393
operation of adult care facilities. The rules shall specify: 13394

(1) Procedures for the issuance, renewal, and revocation of 13395
licenses and temporary licenses, for the granting and denial of 13396
waivers, and for the issuance and termination of orders of 13397
suspension of admission pursuant to section 3722.07 of the Revised 13398
Code; 13399

(2) The qualifications required for owners, managers, and 13400
employees of adult care facilities, including character, training, 13401
education, experience, and financial resources and the number of 13402
staff members required in a facility; 13403

(3) Adequate space, equipment, safety, and sanitation 13404
standards for the premises of adult care facilities, and fire 13405
protection standards for adult family homes as required by section 13406
3722.041 of the Revised Code; 13407

(4) The personal, social, dietary, and recreational services 13408
to be provided to each resident of adult care facilities; 13409

(5) Rights of residents of adult care facilities, in addition 13410
to the rights enumerated under section 3722.12 of the Revised 13411
Code, and procedures to protect and enforce the rights of these 13412
residents; 13413

(6) Provisions for keeping records of residents and for 13414
maintaining the confidentiality of the records as required by 13415
division (B) of section 3722.12 of the Revised Code. The 13416
provisions for maintaining the confidentiality of records shall, 13417
at the minimum, meet the requirements for maintaining the 13418
confidentiality of records under ~~Title XIX of~~ the ~~Social Security~~ 13419
~~Act, 49 Stat. 620, 42 U.S.C. 301, as amended~~ medicaid program, and 13420

regulations promulgated thereunder. 13421

(7) Measures to be taken by adult care facilities relative to residents' medication, including policies and procedures concerning medication, storage of medication in a locked area, and disposal of medication and assistance with self-administration of medication, if the facility provides assistance; 13422 13423 13424 13425 13426

(8) Requirements for initial and periodic health assessments of prospective and current adult care facility residents by physicians or other health professionals to ensure that they do not require a level of care beyond that which is provided by the adult care facility, including assessment of their capacity to self-administer the medications prescribed for them; 13427 13428 13429 13430 13431 13432

(9) Requirements relating to preparation of special diets; 13433

(10) The amount of the fees for new and renewal license applications made pursuant to sections 3722.02 and 3722.04 of the Revised Code; 13434 13435 13436

(11) Measures to be taken by any employee of the state or any political subdivision of the state authorized by this chapter to enter an adult care facility to inspect the facility or for any other purpose, to ensure that the employee respects the privacy and dignity of residents of the facility, cooperates with residents of the facility and behaves in a congenial manner toward them, and protects the rights of residents; 13437 13438 13439 13440 13441 13442 13443

(12) How an owner or manager of an adult care facility is to comply with section 3722.18 of the Revised Code. The rules shall do at least both of the following: 13444 13445 13446

(a) Establish the procedures an owner or manager is to follow under division (A)(2) of section 3722.18 of the Revised Code regarding referrals to the facility of prospective residents with mental illness or severe mental disability and effective arrangements for ongoing mental health services for such 13447 13448 13449 13450 13451

prospective residents. The procedures may provide for any of the following: 13452 13453

(i) That the owner or manager sign written agreements with the mental health agencies and boards of alcohol, drug addiction, and mental health services that refer such prospective residents to the facility. Each agreement shall cover all such prospective residents referred by the agency or board with which the owner or manager enters into the agreement. 13454 13455 13456 13457 13458 13459

(ii) That the owner or manager and the mental health agencies and boards of alcohol, drug addiction, and mental health services that refer such prospective residents to the facility develop and sign a plan for services for each such prospective resident; 13460 13461 13462 13463

(iii) Any other process regarding referrals and effective arrangements for ongoing mental health services. 13464 13465

(b) Specify the date an owner or manager must begin to follow the procedures established by division (A)(12)(a) of this section. 13466 13467

(13) Any other rules necessary for the administration and enforcement of this chapter. 13468 13469

(B) After consulting with relevant constituencies, the director of mental health shall prepare and submit to the director of health recommendations for the content of rules to be adopted under division (A)(12) of this section. The public health council shall adopt the rules required by division (A)(12) of this section no later than July 1, 2000. 13470 13471 13472 13473 13474 13475

(C) The director of health shall advise adult care facilities regarding compliance with the requirements of this chapter and with the rules adopted pursuant to this chapter. 13476 13477 13478

(D) Any duty or responsibility imposed upon the director of health by this chapter may be carried out by an employee of the department of health. 13479 13480 13481

(E) Employees of the department of health may enter, for the 13482
purposes of investigation, any institution, residence, facility, 13483
or other structure which has been reported to the department as, 13484
or that the department has reasonable cause to believe is, 13485
operating as an adult care facility without a valid license. 13486

Sec. 3722.16. (A) No person shall: 13487

(1) Operate an adult care facility unless the facility is 13488
validly licensed by the director of health under section 3722.04 13489
of the Revised Code; 13490

(2) Admit to an adult care facility more residents than the 13491
number authorized in the facility's license; 13492

(3) Admit a resident to an adult care facility after the 13493
director has issued an order pursuant to section 3722.07 of the 13494
Revised Code suspending admissions to the facility. Violation of 13495
division (A)(3) of this section is cause for revocation of the 13496
facility's license. 13497

(4) Interfere with any authorized inspection of an adult care 13498
facility conducted pursuant to section 3722.02 or 3722.04 of the 13499
Revised Code; 13500

(5) Violate any of the provisions of this chapter or any of 13501
the rules adopted pursuant to it. 13502

(B) No adult care facility shall provide, or admit or retain 13503
any resident in need of, skilled nursing care unless all of the 13504
following are the case: 13505

(1) The care will be provided on a part-time, intermittent 13506
basis for not more than a total of one hundred twenty days in any 13507
twelve-month period by one or more of the following: 13508

(a) A home health agency certified under ~~Title XVIII of~~ the 13509
~~"Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as~~ 13510
~~amended:~~ medicare program; 13511

(b) A hospice care program licensed under Chapter 3712. of 13512
the Revised Code; 13513

(c) A nursing home licensed under Chapter 3721. of the 13514
Revised Code and owned and operated by the same person and located 13515
on the same site as the adult care facility; 13516

(d) A mental health agency or, pursuant to division (A)(8)(b) 13517
of section 340.03 of the Revised Code, a board of alcohol, drug 13518
addiction, and mental health services. 13519

(2) The staff of the home health agency, hospice care 13520
program, nursing home, mental health agency, or board of alcohol, 13521
drug addiction, and mental health services does not train facility 13522
staff to provide the skilled nursing care; 13523

(3) The individual to whom the skilled nursing care is 13524
provided is suffering from a short-term illness; 13525

(4) If the skilled nursing care is to be provided by the 13526
nursing staff of a nursing home, all of the following are the 13527
case: 13528

(a) The adult care facility evaluates the individual 13529
receiving the skilled nursing care at least once every seven days 13530
to determine whether the individual should be transferred to a 13531
nursing home; 13532

(b) The adult care facility meets at all times staffing 13533
requirements established by rules adopted under section 3722.10 of 13534
the Revised Code; 13535

(c) The nursing home does not include the cost of providing 13536
skilled nursing care to the adult care facility residents in a 13537
cost report filed under section ~~5111.26~~ 5164.37 of the Revised 13538
Code; 13539

(d) The nursing home meets at all times the nursing home 13540
licensure staffing ratios established by rules adopted under 13541

section 3721.04 of the Revised Code; 13542

(e) The nursing home staff providing skilled nursing care to adult care facility residents are registered nurses or licensed practical nurses licensed under Chapter 4723. of the Revised Code and meet the personnel qualifications for nursing home staff established by rules adopted under section 3721.04 of the Revised Code; 13543 13544 13545 13546 13547 13548

(f) The skilled nursing care is provided in accordance with rules established for nursing homes under section 3721.04 of the Revised Code; 13549 13550 13551

(g) The nursing home meets the skilled nursing care needs of the adult care facility residents; 13552 13553

(h) Using the nursing home's nursing staff does not prevent the nursing home or adult care facility from meeting the needs of the nursing home and adult care facility residents in a quality and timely manner. 13554 13555 13556 13557

Notwithstanding section 3721.01 of the Revised Code, an adult care facility in which residents receive skilled nursing care as described in division (B) of this section is not a nursing home. No adult care facility shall provide skilled nursing care. 13558 13559 13560 13561

(C) A home health agency or hospice care program that provides skilled nursing care pursuant to division (B) of this section may not be associated with the adult care facility unless the facility is part of a home for the aged as defined in section 5701.13 of the Revised Code or the adult care facility is owned and operated by the same person and located on the same site as a nursing home licensed under Chapter 3721. of the Revised Code that is associated with the home health agency or hospice care program. In addition, the following requirements shall be met: 13562 13563 13564 13565 13566 13567 13568 13569 13570

(1) The adult care facility shall evaluate the individual receiving the skilled nursing care not less than once every seven 13571 13572

days to determine whether the individual should be transferred to 13573
a nursing home; 13574

(2) If the costs of providing the skilled nursing care are 13575
included in a cost report filed pursuant to section ~~5111.26~~ 13576
5164.37 of the Revised Code by the nursing home that is part of 13577
the same home for the aged, the home health agency or hospice care 13578
program shall not seek reimbursement for the care under the 13579
~~medical assistance~~ medicaid program ~~established under Chapter~~ 13580
~~5111. of the Revised Code~~. 13581

(D)(1) No person knowingly shall place or recommend placement 13582
of any person in an adult care facility that is operating without 13583
a license. 13584

(2) No employee of a unit of local or state government, board 13585
of alcohol, drug addiction, and mental health services, mental 13586
health agency, or PASSPORT administrative agency shall place or 13587
recommend placement of any person in an adult care facility if the 13588
employee knows that the facility cannot meet the needs of the 13589
potential resident. 13590

(3) No person who has reason to believe that an adult care 13591
facility is operating without a license shall fail to report this 13592
information to the director of health. 13593

(E) In accordance with Chapter 119. of the Revised Code, the 13594
public health council shall adopt rules that define a short-term 13595
illness for purposes of division (B)(3) of this section and 13596
specify, consistent with rules pertaining to home health care 13597
adopted by the director of ~~job and family services~~ health care 13598
administration under the ~~medical assistance~~ medicaid program 13599
~~established under Chapter 5111. of the Revised Code and Title XIX~~ 13600
~~of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C. 301,~~ 13601
~~as amended~~, what constitutes a part-time, intermittent basis for 13602
purposes of division (B)(1) of this section. 13603

Sec. 3727.02. (A) No person and no political subdivision, agency, or instrumentality of this state shall operate a hospital unless it is certified ~~under Title XVIII of~~ for the ~~"Social Security Act," 49 Stat. 620 (1935), 42 U.S.C. 301, as amended,~~ medicare program or is accredited by the joint commission or the American osteopathic association.

(B) No person and no political subdivision, agency, or instrumentality of this state shall hold out as a hospital any health facility that is not certified or accredited as required in division (A) of this section.

Sec. 3742.30. Each child at risk of lead poisoning shall undergo a blood lead screening test to determine whether the child has lead poisoning. The at-risk children shall undergo the test at times determined by rules the public health council shall adopt in accordance with Chapter 119. of the Revised Code that are consistent with the guidelines established by the centers for disease control and prevention in the public health service of the United States department of health and human services. The rules shall specify which children are at risk of lead poisoning.

Neither this section nor the rules adopted under it affect the coverage of blood lead screening tests by any publicly funded health program, including the medicaid program ~~established by Chapter 5111. of the Revised Code~~. Neither this section nor the rules adopted under it apply to a child if a parent of the child objects to the test on the grounds that the test conflicts with the parent's religious tenets and practices.

Sec. 3742.51. (A) There is hereby created in the state treasury the lead poisoning prevention fund. The fund shall include all moneys appropriated to the department of health for the administration and enforcement of sections 3742.31 to 3742.50

of the Revised Code and the rules adopted under those sections. 13634
Any grants, contributions, or other moneys collected by the 13635
department for purposes of preventing lead poisoning shall be 13636
deposited in the state treasury to the credit of the fund. 13637

(B) Moneys in the fund shall be used solely for the purposes 13638
of the child lead poisoning prevention program established under 13639
section 3742.31 of the Revised Code, including providing financial 13640
assistance to individuals who are unable to pay for the following: 13641

(1) Costs associated with obtaining lead tests and lead 13642
poisoning treatment for children under six years of age who are 13643
not covered by private medical insurance or are underinsured, are 13644
not eligible for the medicaid program ~~established under Chapter~~ 13645
~~5111. of the Revised Code~~ or any other government health program, 13646
and do not have access to another source of funds to cover the 13647
cost of lead tests and any indicated treatments; 13648

(2) Costs associated with having lead abatement performed or 13649
having the preventive treatments specified in section 3742.41 of 13650
the Revised Code performed. 13651

Sec. 3793.07. ~~(A) As used in this section:~~ 13652

~~(1) "Medicare program" means the program established under~~ 13653
~~Title XVIII of the "Social Security Act," 49 Stat. 620 (1935), 42~~ 13654
~~U.S.C. 301, as amended;~~ 13655

~~(2) "Medicaid program" means the program established under~~ 13656
~~Title XIX of the "Social Security Act."~~ 13657

~~(B)~~(A) Except as provided in division ~~(D)~~(C) of this section, 13658
the department of alcohol and drug addiction services shall 13659
establish and administer a process for the certification or 13660
credentialing of chemical dependency counselors and alcohol and 13661
other drug prevention specialists for the purpose of qualifying 13662
their services for reimbursement under the medicare or medicaid 13663

program. The process shall be made available to any individual who 13664
is a member of the profession of drug abuse counseling or chemical 13665
dependency counseling or any individual who is an alcohol and 13666
other drug prevention specialist. Nothing in this section shall be 13667
construed as requiring such certification or credentials for 13668
services that are not reimbursed by medicare or medicaid. 13669

The department shall cease to administer its process for the 13670
certification or credentialing of chemical dependency counselors 13671
and alcohol and other drug prevention specialists under this 13672
section at the earlier of the following: 13673

(1) The date, which shall be specified in an agreement 13674
between the department and chemical dependency professionals 13675
board, on which the board is to assume, under Chapter 4758. of the 13676
Revised Code, the department's certification duties; 13677

(2) Two years after ~~the effective date of this amendment~~ 13678
December 23, 2002. 13679

~~(C)~~(B) The department shall adopt rules in accordance with 13680
Chapter 119. of the Revised Code establishing standards and 13681
procedures for the certification or credentialing process. The 13682
rules shall include the following: 13683

(1) Eligibility requirements; 13684

(2) Application procedures; 13685

(3) Minimum educational and clinical training requirements 13686
that must be met for initial certification or credentialing; 13687

(4) Continuing education and training requirements for 13688
certified or credentialed individuals; 13689

(5) Application and renewal fees that do not exceed the cost 13690
incurred by the department in implementing and administering the 13691
process; 13692

(6) Administration or approval of examinations; 13693

(7) Investigation of complaints and alleged violations of 13694
this section; 13695

(8) Maintenance of the confidentiality of the department's 13696
investigative records; 13697

(9) Disciplinary actions, including application denial and 13698
suspension or revocation of certification or credentials; 13699

(10) Any other rules the department considers necessary to 13700
establish or administer the certification or credentialing 13701
process. 13702

~~(D)~~(C)(1) Except as provided in division ~~(D)~~(C)(2) of this 13703
section, the department shall not issue an initial certificate or 13704
credential to practice as a chemical dependency counselor I, but 13705
may renew such a certificate or credential issued prior to ~~the~~ 13706
~~effective date of this amendment~~ December 23, 2002, or pursuant to 13707
division ~~(D)~~(C)(2) of this section until the department ceases to 13708
administer the certification and credentialing process under this 13709
section. 13710

(2) The department may issue an initial certificate or 13711
credential to practice as a chemical dependency counselor I to an 13712
individual if the individual submitted the application for 13713
certification or credentials to the department prior to ~~the~~ 13714
~~effective date of this amendment~~ December 23, 2002. 13715

~~(E)~~(D) The department shall investigate alleged violations of 13716
this section or the rules adopted under it. As part of its 13717
investigation, the department may issue subpoenas, examine 13718
witnesses, and administer oaths. The department shall ensure that 13719
all records it holds pertaining to an investigation remain 13720
confidential. 13721

~~(F)~~(E) With respect to hearings conducted by the department 13722
as part of the certification or credentialing process, both of the 13723
following apply: 13724

(1) An individual whose application for certification or credentials issued under this section has been denied by the department may request a hearing in accordance with Chapter 119. of the Revised Code and the rules adopted under this section.

(2) The department may appoint a referee or hearing examiner to conduct the proceedings and make recommendations to the department as appropriate.

~~(G)~~(F) The department shall maintain a record of all fees collected under this section. All fees collected shall be paid into the state treasury to the credit of the credentialing fund, which is hereby created. Money credited to the fund shall be used solely to pay the costs of establishing and administering the process for certification or credentialing of chemical dependency professionals under this section.

Money credited to the credentialing fund under this section shall be transferred to the occupational licensing and regulatory fund created under section 4743.05 of the Revised Code at the earlier of the following:

(1) The date, which shall be specified in an agreement between the department and chemical dependency professionals board, on which the board is to assume, under Chapter 4758. of the Revised Code, the department's certification duties;

(2) Two years after ~~the effective date of this amendment~~ December 23, 2002.

~~(H)~~(G) Certifications made and credentials issued by the Ohio credentialing board for chemical dependency professionals prior to the date the department establishes its certification or credentialing process under this section shall continue to be accepted by the department until, with respect to any particular individual, one of the following occurs:

(1) The individual's certification or credentials from the

board have expired.

(2) The individual's certification or credentials from the board would be suspended or revoked by the department if the certification or credentials had been issued by the department under this section.

Sec. 3901.3814. Sections 3901.38 and 3901.381 to 3901.3813 of the Revised Code do not apply to the following:

(A) Policies offering coverage that is regulated under Chapters 3935. and 3937. of the Revised Code;

(B) An employer's self-insurance plan and any of its administrators, as defined in section 3959.01 of the Revised Code, to the extent that federal law supersedes, preempts, prohibits, or otherwise precludes the application of any provisions of those sections to the plan and its administrators;

(C) A third-party payer for coverage provided under the medicare advantage program operated under ~~Title XVIII of~~ the ~~"Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended~~ medicare program;

(D) A third-party payer for coverage provided under the medicaid program ~~operated under Title XIX of the "Social Security Act~~,~~"~~ except that if a federal waiver applied for under section ~~5111.178~~ 5165.16 of the Revised Code is granted or the director of ~~job and family services~~ health care administration determines that this provision can be implemented without a waiver, sections 3901.38 and 3901.381 to 3901.3813 of the Revised Code apply to claims submitted electronically or non-electronically that are made with respect to coverage of medicaid recipients by health insuring corporations licensed under Chapter 1751. of the Revised Code, instead of the prompt payment requirements of 42 C.F.R. 447.46;

(E) A third-party payer for coverage provided under the tricare program offered by the United States department of defense. 13786 13787 13788

(F) A third-party payer for coverage provided under the children's buy-in program ~~established under sections 5101.5211 to 5101.5216 of the Revised Code~~. 13789 13790 13791

Sec. 3903.14. (A) The superintendent of insurance as rehabilitator may appoint one or more special deputies, who shall have all the powers and responsibilities of the rehabilitator granted under this section, and the superintendent may employ such clerks and assistants as considered necessary. The compensation of the special deputies, clerks, and assistants and all expenses of taking possession of the insurer and of conducting the proceedings shall be fixed by the superintendent, with the approval of the court and shall be paid out of the funds or assets of the insurer. The persons appointed under this section shall serve at the pleasure of the superintendent. In the event that the property of the insurer does not contain sufficient cash or liquid assets to defray the costs incurred, the superintendent may advance the costs so incurred out of any appropriation for the maintenance of the department of insurance. Any amounts so advanced for expenses of administration shall be repaid to the superintendent for the use of the department out of the first available money of the insurer. 13792 13793 13794 13795 13796 13797 13798 13799 13800 13801 13802 13803 13804 13805 13806 13807 13808 13809

(B) The rehabilitator may take such action as the rehabilitator considers necessary or appropriate to reform and revitalize the insurer. The rehabilitator shall have all the powers of the directors, officers, and managers, whose authority shall be suspended, except as they are redelegated by the rehabilitator. The rehabilitator shall have full power to direct and manage, to hire and discharge employees subject to any 13810 13811 13812 13813 13814 13815 13816

contract rights they may have, and to deal with the property and business of the insurer. 13817 13818

(C) If it appears to the rehabilitator that there has been criminal or tortious conduct, or breach of any contractual or fiduciary obligation detrimental to the insurer by any officer, manager, agent, director, trustee, broker, employee, or other person, the rehabilitator may pursue all appropriate legal remedies on behalf of the insurer. 13819 13820 13821 13822 13823 13824

(D) If the rehabilitator determines that reorganization, consolidation, conversion, reinsurance, merger, or other transformation of the insurer is appropriate, the rehabilitator shall prepare a plan to effect such changes. Upon application of the rehabilitator for approval of the plan, and after such notice and hearings as the court may prescribe, the court may either approve or disapprove the plan proposed, or may modify it and approve it as modified. Any plan approved under this section shall be, in the judgment of the court, fair and equitable to all parties concerned. If the plan is approved, the rehabilitator shall carry out the plan. In the case of a life insurer, the plan proposed may include the imposition of liens upon the policies of the company, if all rights of shareholders are first relinquished. A plan for a life insurer may also propose imposition of a moratorium upon loan and cash surrender rights under policies, for such period and to such an extent as may be necessary. 13825 13826 13827 13828 13829 13830 13831 13832 13833 13834 13835 13836 13837 13838 13839 13840

(E) In the case of a medicaid health insuring corporation that has posted a bond or deposited securities in accordance with section 1751.271 of the Revised Code, the plan proposed under division (D) of this section may include the use of the proceeds of the bond or securities to first pay the claims of contracted providers for covered health care services provided to medicaid recipients, then next to pay other claimants with any remaining funds, consistent with the priorities set forth in sections 13841 13842 13843 13844 13845 13846 13847 13848

3903.421 and 3903.42 of the Revised Code.

(F) The rehabilitator shall have the power under sections 3903.26 and 3903.27 of the Revised Code to avoid fraudulent transfers.

(G) As used in this section:

(1) "Contracted provider" means a provider with a contract with a medicaid health insuring corporation to provide covered health care services to medicaid recipients.

(2) "Medicaid recipient" means a person eligible for ~~assistance under~~ the medicaid program ~~operated pursuant to Chapter 5111. of the Revised Code~~.

Sec. 3916.06. (A)(1) With each application for a viatical settlement, a viatical settlement provider or viatical settlement broker shall disclose at least the following to a viator no later than the time all parties sign the application for the viatical settlement contract:

(a) That there are possible alternatives to viatical settlement contracts, including any accelerated death benefits offered under the viator's policy;

(b) That some or all of the proceeds of the viatical settlement may be subject to federal income taxation and state franchise and income taxation, and that assistance should be sought from a professional tax advisor;

(c) That the proceeds of the viatical settlement could be subject to the claims of creditors;

(d) That receipt of the proceeds of the viatical settlement may adversely affect the viator's eligibility for ~~medical assistance under Chapter 5111. of the Revised Code~~ <u>the medicaid program</u> or other government benefits or entitlements, and that advice should be obtained from the appropriate government

agencies; 13879

(e) That the viator has a right to rescind the viatical settlement contract for at least fifteen calendar days after the viator receives the viatical settlement proceeds, as provided in section 3916.08 of the Revised Code. If the insured dies during the rescission period, the viatical settlement contract shall be deemed to have been rescinded, subject to repayment of all viatical settlement proceeds to the viatical settlement company. 13880 13881 13882 13883 13884 13885 13886

(f) That funds will be sent to the viator within three business days after the viatical settlement provider has received written acknowledgment from the insurer or group administrator that ownership of the policy or interest in the certificate has been transferred and that the beneficiary has been designated pursuant to the viatical settlement contract; 13887 13888 13889 13890 13891 13892

(g) That entering into a viatical settlement contract may cause other rights or benefits, including conversion rights and waiver of premium benefits that may exist under the policy, to be forfeited by the viator and that assistance should be sought from a financial advisor. 13893 13894 13895 13896 13897

(h) That following execution of the viatical settlement contract, the viatical settlement provider or the authorized representative of the viatical settlement provider may contact the insured for the purpose of determining the insured's health status and to confirm the insured's residential or business address and telephone number or for other purposes permitted by law. Any such contact shall be limited to once in any three-month period if the insured has a life expectancy of more than one year or to once per month if the insured has a life expectancy of one year or less. 13898 13899 13900 13901 13902 13903 13904 13905 13906 13907

(2) The viatical settlement provider or viatical settlement broker shall provide the disclosures under division (A)(1) of this 13908 13909

section in a separate document that is signed by the viator and the viatical settlement provider or viatical settlement broker. 13910 13911 13912

(3) Disclosure to a viator under division (A)(1) of this section shall include distribution of a brochure describing the process of viatical settlements. The viatical settlement provider or viatical settlement broker shall use the NAIC's form for the brochure unless another form is developed or approved by the superintendent. 13913 13914 13915 13916 13917 13918

(4) The disclosure document under division (A)(1) of this section shall contain the following language: 13919 13920

"All medical, financial, or personal information solicited or obtained by a viatical settlement provider or viatical settlement broker about an insured, including the insured's identity or the identity of family members, a spouse, or a significant other may be disclosed as necessary to effect the viatical settlement between the viator and the viatical settlement provider. If you are asked to provide this information, you will be asked to consent to the disclosure. The information may be provided to someone who buys the policy or provides funds for the purchase. You may be asked to renew your permission to share information every two years." 13921 13922 13923 13924 13925 13926 13927 13928 13929 13930 13931

(B)(1) A viatical settlement provider shall disclose at least the following to a viator prior to the date the viatical settlement contract is signed by all the necessary parties: 13932 13933 13934

(a) The affiliation, if any, between the viatical settlement provider and the issuer of the policy to be viaticated; 13935 13936

(b) The name, business address, and telephone number of the viatical settlement provider; 13937 13938

(c) Regarding a viatical settlement broker, the amount and method of calculating the broker's compensation. As used in this 13939 13940

division, "compensation" includes anything of value paid or given to a viatical settlement broker for the placement of a policy or certificate. 13941 13942 13943

(d) Any affiliations or contractual arrangements between the viatical settlement provider and the viatical settlement broker; 13944 13945

(e) If a policy to be viaticated has been issued as a joint policy or involves family riders or any coverage of a life other than the insured under the policy to be viaticated, the possible loss of coverage on the other lives under the policy and that advice should be sought from the viator's insurance agent or the company issuing the policy; 13946 13947 13948 13949 13950 13951

(f) The dollar amount of the current death benefit payable to the viatical settlement provider under the policy, and, if known, the availability of any additional guaranteed insurance benefits, the dollar amount of any accidental death and dismemberment benefits under the policy, and the extent to which the viator's interest in those benefits will be transferred as a result of the viatical settlement contract. 13952 13953 13954 13955 13956 13957 13958

(g) That an escrow agent shall provide escrow services to the parties pursuant to a written agreement, signed by the viatical settlement provider, the viatical settlement broker, and the viator. At the close of escrow, the escrow agent will distribute the proceeds of the sale to the viator, minus any compensation to be paid to any other persons who provided services and to whom the viator has agreed to compensate out of the gross amount offered by the viatical settlement purchaser. All persons receiving any form of compensation under the escrow agreement shall be clearly identified, including name, business address, telephone number, and tax identification number. 13959 13960 13961 13962 13963 13964 13965 13966 13967 13968 13969

(2) The viatical settlement broker shall disclose at least the following to a viator prior to the execution of the viatical 13970 13971

settlement contract: 13972

(a) The name, business address, and telephone number of the viatical settlement broker; 13973 13974

(b) A full, complete, and accurate description of all offers, counteroffers, acceptances, and rejections relating to the proposed viatical settlement contract; 13975 13976 13977

(c) Any affiliations or contractual agreements between the viatical settlement broker and any person making an offer in connection with the proposed viatical settlement contract; 13978 13979 13980

(d) The amount and method of calculating the viatical settlement broker's compensation and, if any portion of the viatical settlement broker's compensation is taken from the viatical settlement offer, the total amount of the viatical settlement offer and the viatical settlement broker's compensation as a percentage of that total. As used in this division, "compensation" includes anything of value paid or given to a viatical settlement broker related to the settlement of a policy. 13981 13982 13983 13984 13985 13986 13987 13988 13989

(3) The viatical settlement provider or viatical settlement broker shall conspicuously display the disclosures required under divisions (B)(1) and (2) of this section in the viatical settlement contract or in a separate document signed by the viator and the viatical settlement provider or viatical settlement broker, as appropriate. 13990 13991 13992 13993 13994 13995

(C) If the viatical settlement provider transfers ownership or changes the beneficiary of the policy, the viatical settlement provider shall communicate in writing the change in ownership or beneficiary to the insured within twenty days after the change. 13996 13997 13998 13999 14000

Sec. 3923.122. (A) Every policy of group sickness and 14001

accident insurance providing hospital, surgical, or medical expense coverage for other than specific diseases or accidents only, and delivered, issued for delivery, or renewed in this state on or after January 1, 1976, shall include a provision giving each insured the option to convert to the following: 14002 14003 14004 14005 14006

(1) In the case of an individual who is not a federally eligible individual, any of the individual policies of hospital, surgical, or medical expense insurance then being issued by the insurer with benefit limits not to exceed those in effect under the group policy; 14007 14008 14009 14010 14011

(2) In the case of a federally eligible individual, a basic or standard plan established by the board of directors of the Ohio health reinsurance program or plans substantially similar to the basic and standard plan in benefit design and scope of covered services. For purposes of division (A)(2) of this section, the superintendent of insurance shall determine whether a plan is substantially similar to the basic or standard plan in benefit design and scope of covered services. 14012 14013 14014 14015 14016 14017 14018 14019

(B) An option for conversion to an individual policy shall be available without evidence of insurability to every insured, including any person eligible under division (D) of this section, who terminates employment or membership in the group holding the policy after having been continuously insured thereunder for at least one year. 14020 14021 14022 14023 14024 14025

Upon receipt of the insured's written application and upon payment of at least the first quarterly premium not later than thirty-one days after the termination of coverage under the group policy, the insurer shall issue a converted policy on a form then available for conversion. The premium shall be in accordance with the insurer's table of premium rates in effect on the later of the following dates: 14026 14027 14028 14029 14030 14031 14032

(1) The effective date of the converted policy;

(2) The date of application therefor; and shall be applicable to the class of risk to which each person covered belongs and to the form and amount of the policy at the person's then attained age. However, premiums charged federally eligible individuals may not exceed an amount that is two times the midpoint of the standard rate charged any other individual of a group to which the insurer is currently accepting new business and for which similar copayments and deductibles are applied.

At the election of the insurer, a separate converted policy may be issued to cover any dependent of an employee or member of the group.

Except as provided in division (H) of this section, any converted policy shall become effective as of the day following the date of termination of insurance under the group policy.

Any probationary or waiting period set forth in the converted policy is deemed to commence on the effective date of the insured's coverage under the group policy.

(C) No insurer shall be required to issue a converted policy to any person who is, or is eligible to be, covered for benefits at least comparable to the group policy under:

(1) ~~Title XVIII of the Social Security Act, as amended or superseded~~ <u>The medicare program</u>;

(2) Any act of congress or law under this or any other state of the United States that duplicates coverage offered under division (C)(1) of this section;

(3) Any policy that duplicates coverage offered under division (C)(1) of this section;

(4) Any other group sickness and accident insurance providing hospital, surgical, or medical expense coverage for other than

specific diseases or accidents only. 14063

(D) The option for conversion shall be available: 14064

(1) Upon the death of the employee or member, to the 14065
surviving spouse with respect to such of the spouse and dependents 14066
as are then covered by the group policy; 14067

(2) To a child solely with respect to the child upon 14068
attaining the limiting age of coverage under the group policy 14069
while covered as a dependent thereunder; 14070

(3) Upon the divorce, dissolution, or annulment of the 14071
marriage of the employee or member, to the divorced spouse, or 14072
former spouse in the event of annulment, of such employee or 14073
member, or upon the legal separation of the spouse from such 14074
employee or member, to the spouse. 14075

Persons possessing the option for conversion pursuant to this 14076
division shall be considered members for the purposes of division 14077
(H) of this section. 14078

(E) If coverage is continued under a group policy on an 14079
employee following retirement prior to the time the employee is, 14080
or is eligible to be, covered by ~~Title XVIII of~~ the ~~Social~~ 14081
~~Security Act~~ medicare program, the employee may elect, in lieu of 14082
the continuance of group insurance, to have the same conversion 14083
rights as would apply had the employee's insurance terminated at 14084
retirement by reason of termination of employment. 14085

(F) If the insurer and the group policyholder agree upon one 14086
or more additional plans of benefits to be available for converted 14087
policies, the applicant for the converted policy may elect such a 14088
plan in lieu of a converted policy. 14089

(G) The converted policy may contain provisions for avoiding 14090
duplication of benefits provided pursuant to divisions (C)(1), 14091
(2), (3), and (4) of this section or provided under any other 14092

insured or noninsured plan or program. 14093

(H) If an employee or member becomes entitled to obtain a converted policy pursuant to this section, and if the employee or member has not received notice of the conversion privilege at least fifteen days prior to the expiration of the thirty-one-day conversion period provided in division (B) of this section, then the employee or member has an additional period within which to exercise the privilege. This additional period shall expire fifteen days after the employee or member receives notice, but in no event shall the period extend beyond sixty days after the expiration of the thirty-one-day conversion period. 14094 14095 14096 14097 14098 14099 14100 14101 14102 14103

Written notice presented to the employee or member, or mailed by the policyholder to the last known address of the employee or member as indicated on its records, constitutes notice for the purpose of this division. In the case of a person who is eligible for a converted policy under division (D)(2) or (D)(3) of this section, a policyholder shall not be responsible for presenting or mailing such notice, unless such policyholder has actual knowledge of the person's eligibility for a converted policy. 14104 14105 14106 14107 14108 14109 14110 14111

If an additional period is allowed by an employee or member for the exercise of a conversion privilege, and if written application for the converted policy, accompanied by at least the first quarterly premium, is made after the expiration of the thirty-one-day conversion period, but within the additional period allowed an employee or member in accordance with this division, the effective date of the converted policy shall be the date of application. 14112 14113 14114 14115 14116 14117 14118 14119

(I) The converted policy may provide that any hospital, surgical, or medical expense benefits otherwise payable with respect to any person may be reduced by the amount of any such benefits payable under the group policy for the same loss after termination of coverage. 14120 14121 14122 14123 14124

(J) The converted policy may contain: 14125

(1) Any exclusion, reduction, or limitation contained in the group policy or customarily used in individual policies issued by the insurer; 14126 14127 14128

(2) Any provision permitted in this section; 14129

(3) Any other provision not prohibited by law. 14130

Any provision required or permitted in this section may be made a part of any converted policy by means of an endorsement or rider. 14131 14132 14133

(K) The time limit specified in a converted policy for certain defenses with respect to any person who was covered by a group policy shall commence on the effective date of such person's coverage under the group policy. 14134 14135 14136 14137

(L) No insurer shall use deterioration of health as the basis for refusing to renew a converted policy. 14138 14139

(M) No insurer shall use age as the basis for refusing to renew a converted policy. 14140 14141

(N) A converted policy made available pursuant to this section shall, if delivery of the policy is to be made in this state, comply with this section. If delivery of a converted policy is to be made in another state, it may be on a form offered by the insurer in the jurisdiction where the delivery is to be made and which provides benefits substantially in compliance with those required in a policy delivered in this state. 14142 14143 14144 14145 14146 14147 14148

(O) As used in this section, "federally eligible individual" means an eligible individual as defined in 45 C.F.R. 148.103. 14149 14150

Sec. 3923.27. No policy of sickness and accident insurance delivered, issued for delivery, or renewed in this state after August 26, 1976, including both individual and group policies, 14151 14152 14153

that provides hospitalization coverage for mental illness shall 14154
exclude such coverage for the reason that the insured is 14155
hospitalized in an institution or facility receiving tax support 14156
from the state, any municipal corporation, county, or joint county 14157
board, whether such institution or facility is deemed charitable 14158
or otherwise, provided the institution or facility or portion 14159
thereof is fully accredited by the joint commission on 14160
accreditation of hospitals or certified under ~~Titles XVIII and XIX~~ 14161
~~of~~ the ~~"Social Security Act of 1935," 79 Stat. 291, 42 U.S.C.A.~~ 14162
~~1395, as amended~~ medicare program and medicaid program. The 14163
insurance coverage shall provide payment amounting to the lesser 14164
of either the full amount of the statutory charge for the cost of 14165
the services pursuant to section 5121.33 of the Revised Code or 14166
the benefits payable for the services under the applicable 14167
insurance policy. Insurance benefits for the coverage shall be 14168
paid so long as patients and their liable relatives retain their 14169
statutory liability pursuant to section 5121.33 of the Revised 14170
Code. Only that portion or per cent of the benefits shall be 14171
payable that has been assigned, or ordered to be paid, to the 14172
state or other appropriate provider for services rendered by the 14173
institution or facility. 14174

Sec. 3923.281. (A) As used in this section: 14175

(1) "Biologically based mental illness" means schizophrenia, 14176
schizoaffective disorder, major depressive disorder, bipolar 14177
disorder, paranoia and other psychotic disorders, 14178
obsessive-compulsive disorder, and panic disorder, as these terms 14179
are defined in the most recent edition of the diagnostic and 14180
statistical manual of mental disorders published by the American 14181
psychiatric association. 14182

(2) "Policy of sickness and accident insurance" has the same 14183
meaning as in section 3923.01 of the Revised Code, but excludes 14184

any hospital indemnity, medicare supplement, long-term care, disability income, one-time-limited-duration policy of not longer than six months, supplemental benefit, or other policy that provides coverage for specific diseases or accidents only; any policy that provides coverage for workers' compensation claims compensable pursuant to Chapters 4121. and 4123. of the Revised Code; any policy that provides coverage to beneficiaries enrolled in ~~Title XIX of~~ the ~~"Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended, known as the medical assistance program or~~ medicaid~~, as provided by the Ohio department of job and family services under Chapter 5111. of the Revised Code~~ program; and any policy that provides coverage to beneficiaries enrolled in the children's buy-in program ~~established under sections 5101.5211 to 5101.5216 of the Revised Code~~.

(B) Notwithstanding section 3901.71 of the Revised Code, and subject to division (E) of this section, every policy of sickness and accident insurance shall provide benefits for the diagnosis and treatment of biologically based mental illnesses on the same terms and conditions as, and shall provide benefits no less extensive than, those provided under the policy of sickness and accident insurance for the treatment and diagnosis of all other physical diseases and disorders, if both of the following apply:

(1) The biologically based mental illness is clinically diagnosed by a physician authorized under Chapter 4731. of the Revised Code to practice medicine and surgery or osteopathic medicine and surgery; a psychologist licensed under Chapter 4732. of the Revised Code; a professional clinical counselor, professional counselor, or independent social worker licensed under Chapter 4757. of the Revised Code; or a clinical nurse specialist licensed under Chapter 4723. of the Revised Code whose nursing specialty is mental health.

(2) The prescribed treatment is not experimental or investigational, having proven its clinical effectiveness in accordance with generally accepted medical standards. 14217 14218 14219

(C) Division (B) of this section applies to all coverages and terms and conditions of the policy of sickness and accident insurance, including, but not limited to, coverage of inpatient hospital services, outpatient services, and medication; maximum lifetime benefits; copayments; and individual and family deductibles. 14220 14221 14222 14223 14224 14225

(D) Nothing in this section shall be construed as prohibiting a sickness and accident insurance company from taking any of the following actions: 14226 14227 14228

(1) Negotiating separately with mental health care providers with regard to reimbursement rates and the delivery of health care services; 14229 14230 14231

(2) Offering policies that provide benefits solely for the diagnosis and treatment of biologically based mental illnesses; 14232 14233

(3) Managing the provision of benefits for the diagnosis or treatment of biologically based mental illnesses through the use of pre-admission screening, by requiring beneficiaries to obtain authorization prior to treatment, or through the use of any other mechanism designed to limit coverage to that treatment determined to be necessary; 14234 14235 14236 14237 14238 14239

(4) Enforcing the terms and conditions of a policy of sickness and accident insurance. 14240 14241

(E) An insurer that offers any policy of sickness and accident insurance is not required to provide benefits for the diagnosis and treatment of biologically based mental illnesses pursuant to division (B) of this section if all of the following apply: 14242 14243 14244 14245 14246

(1) The insurer submits documentation certified by an independent member of the American academy of actuaries to the superintendent of insurance showing that incurred claims for diagnostic and treatment services for biologically based mental illnesses for a period of at least six months independently caused the insurer's costs for claims and administrative expenses for the coverage of all other physical diseases and disorders to increase by more than one per cent per year. 14247 14248 14249 14250 14251 14252 14253 14254

(2) The insurer submits a signed letter from an independent member of the American academy of actuaries to the superintendent of insurance opining that the increase described in division (E)(1) of this section could reasonably justify an increase of more than one per cent in the annual premiums or rates charged by the insurer for the coverage of all other physical diseases and disorders. 14255 14256 14257 14258 14259 14260 14261

(3) The superintendent of insurance makes the following determinations from the documentation and opinion submitted pursuant to divisions (E)(1) and (2) of this section: 14262 14263 14264

(a) Incurred claims for diagnostic and treatment services for biologically based mental illnesses for a period of at least six months independently caused the insurer's costs for claims and administrative expenses for the coverage of all other physical diseases and disorders to increase by more than one per cent per year. 14265 14266 14267 14268 14269 14270

(b) The increase in costs reasonably justifies an increase of more than one per cent in the annual premiums or rates charged by the insurer for the coverage of all other physical diseases and disorders. 14271 14272 14273 14274

Any determination made by the superintendent under this division is subject to Chapter 119. of the Revised Code. 14275 14276

Sec. 3923.33. As used in section 3923.33 and sections 3923.331 to 3923.339 of the Revised Code: 14277 14278

(A) "Applicant" means: 14279

(1) In the case of an individual medicare supplement policy, the person who seeks to contract for insurance benefits; and 14280 14281

(2) In the case of a group medicare supplement policy, the proposed certificate holder. 14282 14283

(B) "Certificate" means, for purposes of section 3923.33 and sections 3923.331 to 3923.339 of the Revised Code, any certificate delivered or issued for delivery in this state under a group medicare supplement policy. 14284 14285 14286 14287

(C) "Certificate form" means the form on which the certificate is delivered or issued for delivery by the issuer. 14288 14289

(D) "Direct response insurance policy" means a medicare supplement policy or certificate marketed without the direct involvement of an insurance agent. 14290 14291 14292

(E) "Issuer" includes insurance companies, fraternal benefit societies, health insuring corporations, and any other entities delivering or issuing for delivery in this state medicare supplement policies or certificates. 14293 14294 14295 14296

(F) ~~"Medicare" means the "Health Insurance for the Aged Act," Title XVIII of the Social Security Amendments of 1965, 79 Stat. 291, 42 U.S.C.A. 1395, as then constituted or later amended.~~ 14297 14298 14299

~~(G)~~ "Medicare supplement policy" means a group or individual policy of sickness and accident insurance or a subscriber contract of health insuring corporations or any other issuers, other than a policy issued pursuant to a contract under section 1876 of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A., 1395mm, as amended, or an issued policy under any demonstration project specified in 42 U.S.C.A. 1395ss(g)(1), which is advertised, 14300 14301 14302 14303 14304 14305 14306

marketed, or designed primarily as a supplement to reimbursements 14307
under medicare for the hospital, medical, or surgical expenses of 14308
persons eligible for medicare. 14309

~~(H)~~(G) "Policy form" means the form on which the policy is 14310
delivered or issued for delivery by the issuer. 14311

Sec. 3923.38. (A) As used in this section: 14312

(1) "Group policy" includes any group sickness and accident 14313
policy or contract delivered, issued for delivery, or renewed in 14314
this state on or after June 28, 1984, and any private or public 14315
employer self-insurance plan or other plan that provides, or 14316
provides payment for, health care benefits for employees resident 14317
in this state other than through an insurer or health insuring 14318
corporation, to which both of the following apply: 14319

(a) The policy insures employees for hospital, surgical, or 14320
major medical insurance on an expense incurred or service basis, 14321
other than for specified diseases or for accidental injuries only. 14322

(b) The policy is in effect and covers an eligible employee 14323
at the time the employee's employment is terminated. 14324

(2) "Eligible employee" includes only an employee to whom all 14325
of the following apply: 14326

(a) The employee has been continuously insured under a group 14327
policy or under the policy and any prior similar group coverage 14328
replaced by the policy, during the entire three-month period 14329
preceding the termination of the employee's employment. 14330

(b) The employee is entitled, at the time of the termination 14331
of the employee's employment, to unemployment compensation 14332
benefits under Chapter 4141. of the Revised Code. 14333

(c) The employee is not, and does not become, covered by or 14334
eligible for coverage by medicare ~~under Title XVIII of the Social~~ 14335
~~Security Act, as amended~~. 14336

(d) The employee is not, and does not become, covered by or eligible for coverage by any other insured or uninsured arrangement that provides hospital, surgical, or medical coverage for individuals in a group and under which the person was not covered immediately prior to such termination. A person eligible for continuation of coverage under this section, who is also eligible for coverage under section 3923.123 of the Revised Code, may elect either coverage, but not both. A person who elects continuation of coverage may elect any coverage available under section 3923.123 of the Revised Code upon the termination of the continuation of coverage. 14337 14338 14339 14340 14341 14342 14343 14344 14345 14346 14347

(3) "Group rate" means, in the case of an employer self-insurance or other health benefits plan, the average monthly cost per employee, over a period of at least twelve months, of the operation of the plan that would represent a group insurance rate if the same coverage had been provided under a group sickness and accident insurance policy. 14348 14349 14350 14351 14352 14353

(B) A group policy shall provide that any eligible employee may continue the employee's hospital, surgical, and medical insurance under the policy, for the employee and the employee's eligible dependents, for a period of six months after the date that the insurance coverage would otherwise terminate by reason of the termination of the employee's employment. Each certificate of coverage, or other notice of coverage, issued to employees under the policy shall include a notice of the employee's privilege of continuation. 14354 14355 14356 14357 14358 14359 14360 14361 14362

(C) All of the following apply to the continuation of coverage required under division (B) of this section: 14363 14364

(1) Continuation need not include dental, vision care, prescription drug benefits, or any other benefits provided under the policy in addition to its hospital, surgical, or major medical benefits. 14365 14366 14367 14368

(2) The employer shall notify the employee of the right of continuation at the time the employer notifies the employee of the termination of employment. The notice shall inform the employee of the amount of contribution required by the employer under division (C)(4) of this section. 14369 14370 14371 14372 14373

(3) The employee shall file a written election of continuation with the employer and pay the employer the first contribution required under division (C)(4) of this section. The request and payment must be received by the employer no later than the earlier of any of the following dates: 14374 14375 14376 14377 14378

(a) Thirty-one days after the date on which the employee's coverage would otherwise terminate; 14379 14380

(b) Ten days after the date on which the employee's coverage would otherwise terminate, if the employer has notified the employee of the right of continuation prior to such date; 14381 14382 14383

(c) Ten days after the employer notifies the employee of the right of continuation, if the notice is given after the date on which the employee's coverage would otherwise terminate. 14384 14385 14386

(4) The employee must pay to the employer, on a monthly basis, in advance, the amount of contribution required by the employer. The amount required shall not exceed the group rate for the insurance being continued under the policy on the due date of each payment. 14387 14388 14389 14390 14391

(5) The employee's privilege to continue coverage and the coverage under any continuation ceases if any of the following occurs: 14392 14393 14394

(a) The employee ceases to be an eligible employee under division (A)(2)(c) or (d) of this section; 14395 14396

(b) A period of six months expires after the date that the employee's insurance under the policy would otherwise have 14397 14398

terminated because of the termination of employment; 14399

(c) The employee fails to make a timely payment of a required contribution, in which event the coverage shall cease at the end of the coverage for which contributions were made; 14400 14401 14402

(d) The policy is terminated, or the employer terminates participation under the policy, unless the employer replaces the coverage by similar coverage under another group policy or other group health arrangement. 14403 14404 14405 14406

If the employer replaces the policy with similar group health coverage, all of the following apply: 14407 14408

(i) The member shall be covered under the replacement coverage, for the balance of the period that the member would have remained covered under the terminated coverage if it had not been terminated. 14409 14410 14411 14412

(ii) The minimum level of benefits under the replacement coverage shall be the applicable level of benefits of the policy replaced reduced by any benefits payable under the policy replaced. 14413 14414 14415 14416

(iii) The policy replaced shall continue to provide benefits to the extent of its accrued liabilities and extensions of benefits as if the replacement had not occurred. 14417 14418 14419

(D) This section does not apply to an employer's self-insurance plan if federal law supersedes, preempts, prohibits, or otherwise precludes its application to such plans. 14420 14421 14422

Sec. 3923.49. The department of insurance shall establish an outreach program to educate consumers about the following: 14423 14424

(A) The need for long-term care insurance; 14425

(B) Mechanisms for financing long-term care; 14426

(C) The availability of long-term care insurance; 14427

(D) The resource protection provided by the Ohio long-term care insurance program under section ~~5111.18~~ 5162.43 of the Revised Code;

(E) That a consumer who purchased a long-term care insurance policy that does not meet the requirements of section 3923.50 of the Revised Code may purchase a policy that meets those requirements.

The department shall develop and make available to consumers information to assist them in choosing long-term care insurance coverage.

Sec. 3923.50. For the purposes of the Ohio long-term care insurance program established under section ~~5111.18~~ 5162.43 of the Revised Code, the department of insurance shall notify the department of ~~job and family services~~ health care administration of all long-term care insurance policies that meet all of the following requirements:

(A) Comply with sections 3923.41 to 3923.48 of the Revised Code and the rules adopted under section 3923.47 of the Revised Code;

(B) Provide benefits for home and community-based services in addition to nursing home care;

(C) Include case management services in its coverage of home and community-based services;

(D) Provide five per cent inflation protection compounded annually;

(E) Provide for the keeping of records and explanation-of-benefit reports on insurance payments that count toward resource exclusion for the ~~medical assistance~~ medicaid program;

(F) Provide the information the director of ~~job and family~~

~~services~~ <u>health care administration</u> determines is necessary to document the extent of resource exclusion and to evaluate the Ohio long-term care insurance program; 14458 14459 14460

(G) Comply with other requirements established in rules adopted under this section. 14461 14462

The superintendent of insurance shall adopt rules in accordance with Chapter 119. of the Revised Code establishing requirements under division (G) of this section that policies must meet to qualify under the Ohio long-term care insurance program. The superintendent shall consult with the departments of aging and ~~job and family services~~ <u>health care administration</u> in adopting those rules. 14463 14464 14465 14466 14467 14468 14469

Sec. 3923.58. (A) As used in sections 3923.58 and 3923.59 of the Revised Code: 14470 14471

(1) "Health benefit plan" and "MEWA" have the same meanings as in section 3924.01 of the Revised Code. 14472 14473

(2) "Insurer" means any sickness and accident insurance company authorized to do business in this state, or MEWA authorized to issue insured health benefit plans in this state. "Insurer" does not include any health insuring corporation that is owned or operated by an insurer. 14474 14475 14476 14477 14478

(3) "Pre-existing conditions provision" means a policy provision that excludes or limits coverage for charges or expenses incurred during a specified period following the insured's effective date of coverage as to a condition which, during a specified period immediately preceding the effective date of coverage, had manifested itself in such a manner as would cause an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment or for which medical advice, diagnosis, care, or treatment was recommended or received, or a pregnancy existing on 14479 14480 14481 14482 14483 14484 14485 14486 14487

the effective date of coverage. 14488

(B) Beginning in January of each year, insurers in the 14489
business of issuing individual policies of sickness and accident 14490
insurance as contemplated by section 3923.021 of the Revised Code, 14491
except individual policies issued pursuant to section 3923.122 of 14492
the Revised Code, shall accept applicants for open enrollment 14493
coverage, as set forth in this division, in the order in which 14494
they apply for coverage and subject to the limitation set forth in 14495
division (G) of this section. Insurers shall accept for coverage 14496
pursuant to this section individuals to whom both of the following 14497
conditions apply: 14498

(1) The individual is not applying for coverage as an 14499
employee of an employer, as a member of an association, or as a 14500
member of any other group. 14501

(2) The individual is not covered, and is not eligible for 14502
coverage, under any other private or public health benefits 14503
arrangement, including the medicare program ~~established under~~ 14504
~~Title XVIII of the "Social Security Act," 49 Stat. 620 (1935), 42~~ 14505
~~U.S.C.A. 301, as amended~~, or any other act of congress or law of 14506
this or any other state of the United States that provides 14507
benefits comparable to the benefits provided under this section, 14508
any medicare supplement policy, or any continuation of coverage 14509
policy under state or federal law. 14510

(C) An insurer shall offer to any individual accepted under 14511
this section the Ohio health care basic and standard plans 14512
established by the board of directors of the Ohio health 14513
reinsurance program under division (A) of section 3924.10 of the 14514
Revised Code or health benefit plans that are substantially 14515
similar to the Ohio health care basic and standard plans in 14516
benefit plan design and scope of covered services. 14517

An insurer may offer other health benefit plans in addition 14518

to, but not in lieu of, the plans required to be offered under this division. A basic health benefit plan shall provide, at a minimum, the coverage provided by the Ohio health care basic plan or any health benefit plan that is substantially similar to the Ohio health care basic plan in benefit plan design and scope of covered services. A standard health benefit plan shall provide, at a minimum, the coverage provided by the Ohio health care standard plan or any health benefit plan that is substantially similar to the Ohio health care standard plan in benefit plan design and scope of covered services. 14519 14520 14521 14522 14523 14524 14525 14526 14527 14528

For purposes of this division, the superintendent of insurance shall determine whether a health benefit plan is substantially similar to the Ohio health care basic and standard plans in benefit plan design and scope of covered services. 14529 14530 14531 14532

(D) Health benefit plans issued under this section may establish pre-existing conditions provisions that exclude or limit coverage for a period of up to twelve months following the individual's effective date of coverage and that may relate only to conditions during the six months immediately preceding the effective date of coverage. 14533 14534 14535 14536 14537 14538

(E) Premiums charged to individuals under this section may not exceed an amount that is two and one-half times the highest rate charged any other individual to which the insurer is currently accepting new business, and for which similar copayments and deductibles are applied. 14539 14540 14541 14542 14543

(F) In offering health benefit plans under this section, an insurer may require the purchase of health benefit plans that condition the reimbursement of health services upon the use of a specific network of providers. 14544 14545 14546 14547

(G)(1) In no event shall an insurer be required to accept annually under this section individuals who, in the aggregate, 14548 14549

would cause the insurer to have a total number of new insureds that is more than one-half per cent of its total number of insured individuals in this state per year, as contemplated by section 3923.021 of the Revised Code, calculated as of the immediately preceding thirty-first day of December and excluding the insurer's medicare supplement policies and conversion or continuation of coverage policies under state or federal law and any policies described in division (L) of this section. 14550 14551 14552 14553 14554 14555 14556 14557

(2) An officer of the insurer shall certify to the department of insurance when it has met the enrollment limit set forth in division (G)(1) of this section. Upon providing such certification, the insurer shall be relieved of its open enrollment requirement under this section for the remainder of the calendar year. 14558 14559 14560 14561 14562 14563

(H) An insurer shall not be required to accept under this section applicants who, at the time of enrollment, are confined to a health care facility because of chronic illness, permanent injury, or other infirmity that would cause economic impairment to the insurer if the applicants were accepted, or to make the effective date of benefits for individuals accepted under this section earlier than ninety days after the date of acceptance. 14564 14565 14566 14567 14568 14569 14570

(I) The requirements of this section do not apply to any insurer that is currently in a state of supervision, insolvency, or liquidation. If an insurer demonstrates to the satisfaction of the superintendent that the requirements of this section would place the insurer in a state of supervision, insolvency, or liquidation, the superintendent may waive or modify the requirements of division (B) or (G) of this section. The actions of the superintendent under this division shall be effective for a period of not more than one year. At the expiration of such time, a new showing of need for a waiver or modification by the insurer shall be made before a new waiver or modification is issued or 14571 14572 14573 14574 14575 14576 14577 14578 14579 14580 14581

imposed. 14582

(J) No hospital, health care facility, or health care practitioner, and no person who employs any health care practitioner, shall balance bill any individual or dependent of an individual for any health care supplies or services provided to the individual or dependent who is insured under a policy issued under this section. The hospital, health care facility, or health care practitioner, or any person that employs the health care practitioner, shall accept payments made to it by the insurer under the terms of the policy or contract insuring or covering such individual as payment in full for such health care supplies or services. 14583 14584 14585 14586 14587 14588 14589 14590 14591 14592 14593

As used in this division, "hospital" has the same meaning as in section 3727.01 of the Revised Code; "health care practitioner" has the same meaning as in section 4769.01 of the Revised Code; and "balance bill" means charging or collecting an amount in excess of the amount reimbursable or payable under the policy or health care service contract issued to an individual under this section for such health care supply or service. "Balance bill" does not include charging for or collecting copayments or deductibles required by the policy or contract. 14594 14595 14596 14597 14598 14599 14600 14601 14602

(K) An insurer shall pay an agent a commission in the amount of five per cent of the premium charged for initial placement or for otherwise securing the issuance of a policy or contract issued to an individual under this section, and four per cent of the premium charged for the renewal of such a policy or contract. The superintendent may adopt, in accordance with Chapter 119. of the Revised Code, such rules as are necessary to enforce this division. 14603 14604 14605 14606 14607 14608 14609 14610

(L) This section does not apply to any policy that provides coverage for specific diseases or accidents only, or to any hospital indemnity, medicare supplement, long-term care, 14611 14612 14613

disability income, one-time-limited-duration policy of no longer 14614
than six months, or other policy that offers only supplemental 14615
benefits. 14616

Sec. 3923.601. (A)(1) This section applies to both of the 14617
following: 14618

(a) A sickness and accident insurer that issues or requires 14619
the use of a standardized identification card or an electronic 14620
technology for submission and routing of prescription drug claims 14621
pursuant to a policy, contract, or agreement for health care 14622
services; 14623

(b) A person that a sickness and accident insurer contracts 14624
with to issue a standardized identification card or an electronic 14625
technology described in division (A)(1)(a) of this section. 14626

(2) Notwithstanding division (A)(1) of this section, this 14627
section does not apply to the issuance or required use of a 14628
standardized identification card or an electronic technology for 14629
the submission and routing of prescription drug claims in 14630
connection with any of the following: 14631

(a) Any individual or group policy of sickness and accident 14632
insurance covering only accident, credit, dental, disability 14633
income, long-term care, hospital indemnity, medicare supplement, 14634
medicare, tricare, specified disease, or vision care; coverage 14635
under a one-time-limited-duration policy of not longer than six 14636
months; coverage issued as a supplement to liability insurance; 14637
insurance arising out of workers' compensation or similar law; 14638
automobile medical payment insurance; or insurance under which 14639
benefits are payable with or without regard to fault and which is 14640
statutorily required to be contained in any liability insurance 14641
policy or equivalent self-insurance. 14642

(b) Coverage provided under the medicaid~~, as defined in~~ 14643

~~section 5111.01 of the Revised Code~~ program. 14644

(c) Coverage provided under an employer's self-insurance plan 14645
or by any of its administrators, as defined in section 3959.01 of 14646
the Revised Code, to the extent that federal law supersedes, 14647
preempts, prohibits, or otherwise precludes the application of 14648
this section to the plan and its administrators. 14649

(B) A standardized identification card or an electronic 14650
technology issued or required to be used as provided in division 14651
(A)(1) of this section shall contain uniform prescription drug 14652
information in accordance with either division (B)(1) or (2) of 14653
this section. 14654

(1) The standardized identification card or the electronic 14655
technology shall be in a format and contain information fields 14656
approved by the national council for prescription drug programs or 14657
a successor organization, as specified in the council's or 14658
successor organization's pharmacy identification card 14659
implementation guide in effect on the first day of October most 14660
immediately preceding the issuance or required use of the 14661
standardized identification card or the electronic technology. 14662

(2) If the insurer or person under contract with the insurer 14663
to issue a standardized identification card or an electronic 14664
technology requires the information for the submission and routing 14665
of a claim, the standardized identification card or the electronic 14666
technology shall contain any of the following information: 14667

(a) The insurer's name; 14668

(b) The insured's name, group number, and identification 14669
number; 14670

(c) A telephone number to inquire about pharmacy-related 14671
issues; 14672

(d) The issuer's international identification number, labeled 14673

as "ANSI BIN" or "RxBIN"; 14674

(e) The processor's control number, labeled as "RxPCN"; 14675

(f) The insured's pharmacy benefits group number if different from the insured's medical group number, labeled as "RxGrp." 14676 14677

(C) If the standardized identification card or the electronic technology issued or required to be used as provided in division (A)(1) of this section is also used for submission and routing of nonpharmacy claims, the designation "Rx" is required to be included as part of the labels identified in divisions (B)(2)(d) and (e) of this section if the issuer's international identification number or the processor's control number is different for medical and pharmacy claims. 14678 14679 14680 14681 14682 14683 14684 14685

(D) Each sickness and accident insurer described in division (A) of this section shall annually file a certificate with the superintendent of insurance certifying that it or any person it contracts with to issue a standardized identification card or electronic technology for submission and routing of prescription drug claims complies with this section. 14686 14687 14688 14689 14690 14691

(E)(1) Except as provided in division (E)(2) of this section, if there is a change in the information contained in the standardized identification card or the electronic technology issued to an insured, the insurer or person under contract with the insurer to issue a standardized identification card or an electronic technology shall issue a new card or electronic technology to the insured. 14692 14693 14694 14695 14696 14697 14698

(2) An insurer or person under contract with the insurer is not required under division (E)(1) of this section to issue a new card or electronic technology to an insured more than once during a twelve-month period. 14699 14700 14701 14702

(F) Nothing in this section shall be construed as requiring an insurer to produce more than one standardized identification 14703 14704

card or one electronic technology for use by insureds accessing health care benefits provided under a policy of sickness and accident insurance. 14705 14706 14707

Sec. 3923.70. Consistent with the Rules of Evidence, a written decision or opinion prepared by an independent review organization under section 3923.67 or 3923.68 of the Revised Code shall be admissible in any civil action related to the coverage decision that was the subject of the decision or opinion. The independent review organization's decision or opinion shall be presumed to be a scientifically valid and accurate description of the state of medical knowledge at the time it was written. 14708 14709 14710 14711 14712 14713 14714 14715

Consistent with the Rules of Evidence, any party to a civil action related to an insurer's decision involving an investigational or experimental drug, device, or treatment may introduce into evidence any applicable medicare reimbursement standards established under ~~Title XVIII of~~ the ~~"Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended~~ medicare program. 14716 14717 14718 14719 14720 14721 14722

Sec. 3923.79. Consistent with the Rules of Evidence, a written decision or opinion prepared by an independent review organization under section 3923.76 or 3923.77 of the Revised Code shall be admissible in any civil action related to the coverage decision that was the subject of the decision or opinion. The independent review organization's decision or opinion shall be presumed to be a scientifically valid and accurate description of the state of medical knowledge at the time it was written. 14723 14724 14725 14726 14727 14728 14729 14730

Consistent with the Rules of Evidence, any party to a civil action related to a plan's decision involving an investigational or experimental drug, device, or treatment may introduce into evidence any applicable medicare reimbursement standards 14731 14732 14733 14734

established under ~~Title XVIII of~~ the ~~"Social Security Act," 49~~ 14735
~~Stat. 620 (1935), 42 U.S.C.A. 301, as amended~~ medicare program. 14736

Sec. 3923.83. (A)(1) This section applies to both of the 14737
following: 14738

(a) A public employee benefit plan that issues or requires 14739
the use of a standardized identification card or an electronic 14740
technology for submission and routing of prescription drug claims 14741
pursuant to a policy, contract, or agreement for health care 14742
services; 14743

(b) A person or entity that a public employee benefit plan 14744
contracts with to issue a standardized identification card or an 14745
electronic technology described in division (A)(1)(a) of this 14746
section. 14747

(2) Notwithstanding division (A)(1) of this section, this 14748
section does not apply to the issuance or required use of a 14749
standardized identification card or an electronic technology for 14750
the submission and routing of prescription drug claims in 14751
connection with either of the following: 14752

(a) Any individual or group policy of insurance covering only 14753
accident, credit, dental, disability income, long-term care, 14754
hospital indemnity, medicare supplement, medicare, tricare, 14755
specified disease, or vision care; coverage under a 14756
one-time-limited-duration policy of not longer than six months; 14757
coverage issued as a supplement to liability insurance; insurance 14758
arising out of workers' compensation or similar law; automobile 14759
medical payment insurance; or insurance under which benefits are 14760
payable with or without regard to fault and which is statutorily 14761
required to be contained in any liability insurance policy or 14762
equivalent self-insurance. 14763

(b) Coverage provided under the medicaid~~, as defined in~~ 14764

~~section 5111.01 of the Revised Code~~ program. 14765

(B) A standardized identification card or an electronic technology issued or required to be used as provided in division (A)(1) of this section shall contain uniform prescription drug information in accordance with either division (B)(1) or (2) of this section. 14766 14767 14768 14769 14770

(1) The standardized identification card or the electronic technology shall be in a format and contain information fields approved by the national council for prescription drug programs or a successor organization, as specified in the council's or successor organization's pharmacy identification card implementation guide in effect on the first day of October most immediately preceding the issuance or required use of the standardized identification card or the electronic technology. 14771 14772 14773 14774 14775 14776 14777 14778

(2) If the public employee benefit plan or person under contract with the plan to issue a standardized identification card or an electronic technology requires the information for the submission and routing of a claim, the standardized identification card or the electronic technology shall contain any of the following information: 14779 14780 14781 14782 14783 14784

(a) The plan's name; 14785

(b) The insured's name, group number, and identification number; 14786 14787

(c) A telephone number to inquire about pharmacy-related issues; 14788 14789

(d) The issuer's international identification number, labeled as "ANSI BIN" or "RxBIN"; 14790 14791

(e) The processor's control number, labeled as "RxPCN"; 14792

(f) The insured's pharmacy benefits group number if different from the insured's medical group number, labeled as "RxGrp." 14793 14794

(C) If the standardized identification card or the electronic technology issued or required to be used as provided in division (A)(1) of this section is also used for submission and routing of nonpharmacy claims, the designation "Rx" is required to be included as part of the labels identified in divisions (B)(2)(d) and (e) of this section if the issuer's international identification number or the processor's control number is different for medical and pharmacy claims. 14795 14796 14797 14798 14799 14800 14801 14802

(D)(1) Except as provided in division (D)(2) of this section, if there is a change in the information contained in the standardized identification card or the electronic technology issued to an insured, the public employee benefit plan or person under contract with the plan to issue a standardized identification card or electronic technology shall issue a new card or electronic technology to the insured. 14803 14804 14805 14806 14807 14808 14809

(2) A public employee benefit plan or person under contract with the plan is not required under division (D)(1) of this section to issue a new card or electronic technology to an insured more than once during a twelve-month period. 14810 14811 14812 14813

~~(F)~~(E) Nothing in this section shall be construed as requiring a public employee benefit plan to produce more than one standardized identification card or one electronic technology for use by insureds accessing health care benefits provided under a health benefit plan. 14814 14815 14816 14817 14818

Sec. 3924.41. (A) As used in sections 3924.41 and 3924.42 of the Revised Code, "health insurer" means any sickness and accident insurer or health insuring corporation. "Health insurer" also includes any group health plan as defined in section 607 of the federal "Employee Retirement Income Security Act of 1974," 88 Stat. 832, 29 U.S.C.A. 1167. 14819 14820 14821 14822 14823 14824

(B) Notwithstanding any other provision of the Revised Code, 14825

no health insurer shall take into consideration the availability 14826
of, or eligibility for, ~~medical assistance~~ the medicaid program in 14827
this state ~~under Chapter 5111. of the Revised Code~~ or in any other 14828
state ~~pursuant to Title XIX of the "Social Security Act," 49 Stat.~~ 14829
~~620 (1935), 42 U.S.C.A. 301, as amended,~~ when determining an 14830
individual's eligibility for coverage or when making payments to 14831
or on behalf of an enrollee, subscriber, policyholder, or 14832
certificate holder. 14833

Sec. 3924.42. No health insurer shall impose requirements on 14834
the department of ~~job and family services~~ health care 14835
administration, when it has been assigned the rights of an 14836
individual who is eligible for ~~medical assistance under Chapter~~ 14837
~~5111. of the Revised Code~~ the medicaid program and who is covered 14838
under a health care policy, contract, or plan issued by the health 14839
insurer, that are different from the requirements applicable to an 14840
agent or assignee of any other individual so covered. 14841

Sec. 3963.01. As used in this chapter: 14842

(A) "Affiliate" means any person or entity that has ownership 14843
or control of a contracting entity, is owned or controlled by a 14844
contracting entity, or is under common ownership or control with a 14845
contracting entity. 14846

(B) "Basic health care services" has the same meaning as in 14847
division (A) of section 1751.01 of the Revised Code, except that 14848
it does not include any services listed in that division that are 14849
provided by a pharmacist or nursing home. 14850

(C) "Contracting entity" means any person that has a primary 14851
business purpose of contracting with participating providers for 14852
the delivery of health care services. 14853

(D) "Credentialing" means the process of assessing and 14854
validating the qualifications of a provider applying to be 14855

approved by a contracting entity to provide basic health care 14856
services, specialty health care services, or supplemental health 14857
care services to enrollees. 14858

(E) "Edit" means adjusting one or more procedure codes billed 14859
by a participating provider on a claim for payment or a practice 14860
that results in any of the following: 14861

(1) Payment for some, but not all of the procedure codes 14862
originally billed by a participating provider; 14863

(2) Payment for a different procedure code than the procedure 14864
code originally billed by a participating provider; 14865

(3) A reduced payment as a result of services provided to an 14866
enrollee that are claimed under more than one procedure code on 14867
the same service date. 14868

(F) "Electronic claims transport" means to accept and 14869
digitize claims or to accept claims already digitized, to place 14870
those claims into a format that complies with the electronic 14871
transaction standards issued by the United States department of 14872
health and human services pursuant to the "Health Insurance 14873
Portability and Accountability Act of 1996," 110 Stat. 1955, 42 14874
U.S.C. 1320d, et seq., as those electronic standards are 14875
applicable to the parties and as those electronic standards are 14876
updated from time to time, and to electronically transmit those 14877
claims to the appropriate contracting entity, payer, or 14878
third-party administrator. 14879

(G) "Enrollee" means any person eligible for health care 14880
benefits under a health benefit plan, including an eligible 14881
recipient of medicaid ~~under Chapter 5111. of the Revised Code~~, and 14882
includes all of the following terms: 14883

(1) "Enrollee" and "subscriber" as defined by section 1751.01 14884
of the Revised Code; 14885

(2) "Member" as defined by section 1739.01 of the Revised Code; 14886 14887

(3) "Insured" and "plan member" pursuant to Chapter 3923. of the Revised Code; 14888 14889

(4) "Beneficiary" as defined by section 3901.38 of the Revised Code. 14890 14891

(H) "Health care contract" means a contract entered into, materially amended, or renewed between a contracting entity and a participating provider for the delivery of basic health care services, specialty health care services, or supplemental health care services to enrollees. 14892 14893 14894 14895 14896

(I) "Health care services" means basic health care services, specialty health care services, and supplemental health care services. 14897 14898 14899

(J) "Material amendment" means an amendment to a health care contract that decreases the participating provider's payment or compensation, changes the administrative procedures in a way that may reasonably be expected to significantly increase the provider's administrative expenses, or adds a new product. A material amendment does not include any of the following: 14900 14901 14902 14903 14904 14905

(1) A decrease in payment or compensation resulting solely from a change in a published fee schedule upon which the payment or compensation is based and the date of applicability is clearly identified in the contract; 14906 14907 14908 14909

(2) A decrease in payment or compensation that was anticipated under the terms of the contract, if the amount and date of applicability of the decrease is clearly identified in the contract; 14910 14911 14912 14913

(3) An administrative change that may significantly increase the provider's administrative expense, the specific applicability 14914 14915

of which is clearly identified in the contract; 14916

(4) Changes to an existing prior authorization, precertification, notification, or referral program that do not substantially increase the provider's administrative expense; 14917 14918 14919

(5) Changes to an edit program or to specific edits if the participating provider is provided notice of the changes pursuant to division (A)(1) of section 3963.04 of the Revised Code and the notice includes information sufficient for the provider to determine the effect of the change; 14920 14921 14922 14923 14924

(6) Changes to a health care contract described in division (B) of section 3963.04 of the Revised Code. 14925 14926

(K) "Participating provider" means a provider that has a health care contract with a contracting entity and is entitled to reimbursement for health care services rendered to an enrollee under the health care contract. 14927 14928 14929 14930

(L) "Payer" means any person that assumes the financial risk for the payment of claims under a health care contract or the reimbursement for health care services provided to enrollees by participating providers pursuant to a health care contract. 14931 14932 14933 14934

(M) "Primary enrollee" means a person who is responsible for making payments for participation in a health care plan or an enrollee whose employment or other status is the basis of eligibility for enrollment in a health care plan. 14935 14936 14937 14938

(N) "Procedure codes" includes the American medical association's current procedural terminology code, the American dental association's current dental terminology, and the centers for medicare and medicaid services health care common procedure coding system. 14939 14940 14941 14942 14943

(O) "Product" means one of the following types of categories of coverage for which a participating provider may be obligated to 14944 14945

provide health care services pursuant to a health care contract: 14946
14947

(1) A health maintenance organization or other product provided by a health insuring corporation; 14948 14949

(2) A preferred provider organization; 14950

(3) Medicare; 14951

(4) Medicaid or the children's buy-in program ~~established under section 5101.5211 to 5101.5216 of the Revised Code~~; 14952 14953

(5) Workers' compensation. 14954

(P) "Provider" means a physician, podiatrist, dentist, chiropractor, optometrist, psychologist, physician assistant, advanced practice nurse, occupational therapist, massage therapist, physical therapist, professional counselor, professional clinical counselor, hearing aid dealer, orthotist, prosthetist, home health agency, hospice care program, or hospital, or a provider organization or physician-hospital organization that is acting exclusively as an administrator on behalf of a provider to facilitate the provider's participation in health care contracts. "Provider" does not mean a pharmacist, pharmacy, nursing home, or a provider organization or physician-hospital organization that leases the provider organization's or physician-hospital organization's network to a third party or contracts directly with employers or health and welfare funds. 14955 14956 14957 14958 14959 14960 14961 14962 14963 14964 14965 14966 14967 14968 14969

(Q) "Specialty health care services" has the same meaning as in section 1751.01 of the Revised Code, except that it does not include any services listed in division (B) of section 1751.01 of the Revised Code that are provided by a pharmacist or a nursing home. 14970 14971 14972 14973 14974

(R) "Supplemental health care services" has the same meaning 14975

as in division (B) of section 1751.01 of the Revised Code, except that it does not include any services listed in that division that are provided by a pharmacist or nursing home. 14976 14977 14978

Sec. 4123.27. Information contained in the annual statement provided for in section 4123.26 of the Revised Code, and such other information as may be furnished to the bureau of workers' compensation by employers in pursuance of that section, is for the exclusive use and information of the bureau in the discharge of its official duties, and shall not be open to the public nor be used in any court in any action or proceeding pending therein unless the bureau is a party to the action or proceeding; but the information contained in the statement may be tabulated and published by the bureau in statistical form for the use and information of other state departments and the public. No person in the employ of the bureau, except those who are authorized by the administrator of workers' compensation, shall divulge any information secured by the person while in the employ of the bureau in respect to the transactions, property, claim files, records, or papers of the bureau or in respect to the business or mechanical, chemical, or other industrial process of any company, firm, corporation, person, association, partnership, or public utility to any person other than the administrator or to the superior of such employee of the bureau. 14979 14980 14981 14982 14983 14984 14985 14986 14987 14988 14989 14990 14991 14992 14993 14994 14995 14996 14997 14998

Notwithstanding the restrictions imposed by this section, the governor, select or standing committees of the general assembly, the auditor of state, the attorney general, or their designees, pursuant to the authority granted in this chapter and Chapter 4121. of the Revised Code, may examine any records, claim files, or papers in possession of the industrial commission or the bureau. They also are bound by the privilege that attaches to these papers. 14999 15000 15001 15002 15003 15004 15005 15006

The administrator shall report to the director of job and 15007
family services or to the county director of job and family 15008
services the name, address, and social security number or other 15009
identification number of any person receiving workers' 15010
compensation whose name or social security number or other 15011
identification number is the same as that of a person required by 15012
a court or child support enforcement agency to provide support 15013
payments to a recipient or participant of public assistance, and 15014
whose name is submitted to the administrator by the director under 15015
section 5101.36 of the Revised Code. The administrator shall 15016
report to the director of health care administration or to the 15017
county director of job and family services the name, address, and 15018
social security number or other identification number of any 15019
person receiving workers' compensation whose name or social 15020
security number or other identification number is the same as that 15021
of a person required by a court or child support enforcement 15022
agency to provide support payments to a public medical assistance 15023
program recipient, and whose name is submitted to the 15024
administrator by the director under section 5160.42 of the Revised 15025
Code. The administrator also shall inform the appropriate director 15026
of the amount of workers' compensation paid to the person during 15027
such period as the director specifies. 15028

Within fourteen days after receiving ~~from the director of job~~ 15029
~~and family services~~ a list of the names and social security 15030
numbers of recipients or participants of public assistance 15031
pursuant to section 5101.181 of the Revised Code or a list of the 15032
names and social security numbers of public medical assistance 15033
program recipients pursuant to section 5160.43 of the Revised 15034
Code, the administrator shall inform the auditor of state of the 15035
name, current or most recent address, and social security number 15036
of each person receiving workers' compensation pursuant to this 15037
chapter whose name and social security number are the same as that 15038
of a person whose name or social security number ~~was submitted by~~ 15039

~~the director~~ is included in the list. The administrator also shall 15040
inform the auditor of state of the amount of workers' compensation 15041
paid to the person during such period as the director specifies. 15042

The bureau and its employees, except for purposes of 15043
furnishing the auditor of state with information required by this 15044
section, shall preserve the confidentiality of recipients or 15045
participants of public assistance in compliance with ~~division (A)~~ 15046
~~of~~ section 5101.181 of the Revised Code and preserve the 15047
confidentiality of public medical assistance program recipients in 15048
compliance with section 5160.43 of the Revised Code. 15049

For the purposes of this section, "public assistance" means 15050
~~medical assistance provided through the medical assistance program~~ 15051
~~established under section 5111.01 of the Revised Code,~~ Ohio works 15052
first provided under Chapter 5107. of the Revised Code, 15053
prevention, retention, and contingency benefits and services 15054
provided under Chapter 5108. of the Revised Code, disability 15055
financial assistance provided under Chapter 5115. of the Revised 15056
Code, or the disability medical assistance ~~provided under Chapter~~ 15057
~~5115. of the Revised Code~~ program. 15058

Sec. 4141.162. (A) The director of job and family services, 15059
in collaboration with the director of health care administration, 15060
shall establish an income and eligibility verification system that 15061
complies with section 1137 of the "Social Security Act." The 15062
programs included in the system are all of the following: 15063

(1) Unemployment compensation pursuant to section 3304 of the 15064
"Internal Revenue Code of 1954"; 15065

(2) The state programs funded in part under part A of Title 15066
IV of the "Social Security Act" and administered under Chapters 15067
5107. and 5108. of the Revised Code; 15068

(3) Medicaid ~~pursuant to Title XIX of the "Social Security~~ 15069

~~Act"~~; 15070

(4) Food stamps pursuant to the "Food Stamp Act of 1977," 91 15071
Stat. 958, 7 U.S.C.A. 2011, as amended; 15072

(5) Any Ohio program under a plan approved under Title I, X, 15073
XIV, or XVI of the "Social Security Act." 15074

Wage information provided by employers to the director shall 15075
be furnished to the income and eligibility verification system. 15076
Such information shall be used by the director to determine 15077
eligibility of individuals for unemployment compensation benefits 15078
and the amount of those benefits and used by the agencies that 15079
administer the programs identified in divisions (A)(2) to (5) of 15080
this section to determine or verify eligibility for or the amount 15081
of benefits under those programs. 15082

The director shall fully implement the use of wage 15083
information to determine eligibility for and the amount of 15084
unemployment compensation benefits by September 30, 1988. 15085

Information furnished under the system shall also be made 15086
available to the appropriate state or local child support 15087
enforcement agency for the purposes of an approved plan under 15088
Title IV-D of the "Social Security Act" and to the appropriate 15089
federal agency for the purposes of Titles II and XVI of the 15090
"Social Security Act." 15091

(B) The director shall adopt rules as necessary under which 15092
the department of job and family services and other state agencies 15093
that the director determines must participate in order to ensure 15094
compliance with section 1137 of the "Social Security Act" exchange 15095
information with each other or authorized federal agencies about 15096
individuals who are applicants for or recipients of benefits under 15097
any of the programs enumerated in division (A) of this section. 15098
The rules shall extend to all of the following: 15099

(1) A requirement for standardized formats and procedures for 15100

a participating agency to request and receive information about an individual, which information shall include the individual's social security number; 15101 15102 15103

(2) A requirement that all applicants for and recipients of benefits under any program enumerated in division (A) of this section be notified at the time of application, and periodically thereafter, that information available through the system may be shared with agencies that administer other benefit programs and utilized in establishing or verifying eligibility or benefit amounts under the other programs enumerated in division (A) of this section; 15104 15105 15106 15107 15108 15109 15110 15111

(3) A requirement that information is made available only to the extent necessary to assist in the valid administrative needs of the program receiving the information and is targeted for use in ways which are most likely to be productive in identifying and preventing ineligibility and incorrect payments; 15112 15113 15114 15115 15116

(4) A requirement that information is adequately protected against unauthorized disclosures for purposes other than to establish or verify eligibility or benefit amounts under the programs enumerated in division (A) of this section; 15117 15118 15119 15120

(5) A requirement that a program providing information is reimbursed by the program using the information for the actual costs of furnishing the information and that the director be reimbursed by the participating programs for any actual costs incurred in operating the system; 15121 15122 15123 15124 15125

(6) Requirements for any other matters necessary to ensure the effective, efficient, and timely exchange of necessary information or that the director determines must be addressed in order to ensure compliance with the requirements of section 1137 of the "Social Security Act." 15126 15127 15128 15129 15130

(C) Each participating agency shall furnish to the income and 15131

eligibility verification system established in division (A) of this section that information, which the director, by rule, determines is necessary in order to comply with section 1137 of the "Social Security Act." 15132 15133 15134 15135

(D) Notwithstanding the information disclosure requirements of this section and section 4141.21 and division (A) of section 4141.284 of the Revised Code, the director shall administer those provisions of law so as to comply with section 1137 of the "Social Security Act." 15136 15137 15138 15139 15140

(E) Requirements in section 4141.21 of the Revised Code with respect to confidentiality of information obtained in the administration of Chapter 4141. of the Revised Code and any sanctions imposed for improper disclosure of such information shall apply to the redisclosure of information disclosed under this section. 15141 15142 15143 15144 15145 15146

Sec. 4719.01. (A) As used in sections 4719.01 to 4719.18 of the Revised Code: 15147 15148

(1) "Affiliate" means a business entity that is owned by, operated by, controlled by, or under common control with another business entity. 15149 15150 15151

(2) "Communication" means a written or oral notification or advertisement that meets both of the following criteria, as applicable: 15152 15153 15154

(a) The notification or advertisement is transmitted by or on behalf of the seller of goods or services and by or through any printed, audio, video, cinematic, telephonic, or electronic means. 15155 15156 15157

(b) In the case of a notification or advertisement other than by telephone, either of the following conditions is met: 15158 15159

(i) The notification or advertisement is followed by a telephone call from a telephone solicitor or salesperson. 15160 15161

(ii) The notification or advertisement invites a response by telephone, and, during the course of that response, a telephone solicitor or salesperson attempts to make or makes a sale of goods or services. As used in division (A)(2)(b)(ii) of this section, "invites a response by telephone" excludes the mere listing or inclusion of a telephone number in a notification or advertisement. 15162 15163 15164 15165 15166 15167 15168

(3) "Gift, award, or prize" means anything of value that is offered or purportedly offered, or given or purportedly given by chance, at no cost to the receiver and with no obligation to purchase goods or services. As used in this division, "chance" includes a situation in which a person is guaranteed to receive an item and, at the time of the offer or purported offer, the telephone solicitor does not identify the specific item that the person will receive. 15169 15170 15171 15172 15173 15174 15175 15176

(4) "Goods or services" means any real property or any tangible or intangible personal property, or services of any kind provided or offered to a person. "Goods or services" includes, but is not limited to, advertising; labor performed for the benefit of a person; personal property intended to be attached to or installed in any real property, regardless of whether it is so attached or installed; timeshare estates or licenses; and extended service contracts. 15177 15178 15179 15180 15181 15182 15183 15184

(5) "Purchaser" means a person that is solicited to become or does become financially obligated as a result of a telephone solicitation. 15185 15186 15187

(6) "Salesperson" means an individual who is employed, appointed, or authorized by a telephone solicitor to make telephone solicitations but does not mean any of the following: 15188 15189 15190

(a) An individual who comes within one of the exemptions in division (B) of this section; 15191 15192

(b) An individual employed, appointed, or authorized by a person who comes within one of the exemptions in division (B) of this section; 15193 15194 15195

(c) An individual under a written contract with a person who comes within one of the exemptions in division (B) of this section, if liability for all transactions with purchasers is assumed by the person so exempted. 15196 15197 15198 15199

(7) "Telephone solicitation" means a communication to a person that meets both of the following criteria: 15200 15201

(a) The communication is initiated by or on behalf of a telephone solicitor or by a salesperson. 15202 15203

(b) The communication either represents a price or the quality or availability of goods or services or is used to induce the person to purchase goods or services, including, but not limited to, inducement through the offering of a gift, award, or prize. 15204 15205 15206 15207 15208

(8) "Telephone solicitor" means a person that engages in telephone solicitation directly or through one or more salespersons either from a location in this state, or from a location outside this state to persons in this state. "Telephone solicitor" includes, but is not limited to, any such person that is an owner, operator, officer, or director of, partner in, or other individual engaged in the management activities of, a business. 15209 15210 15211 15212 15213 15214 15215 15216

(B) A telephone solicitor is exempt from the provisions of sections 4719.02 to 4719.18 and section 4719.99 of the Revised Code if the telephone solicitor is any one of the following: 15217 15218 15219

(1) A person engaging in a telephone solicitation that is a one-time or infrequent transaction not done in the course of a pattern of repeated transactions of a like nature; 15220 15221 15222

(2) A person engaged in telephone solicitation solely for religious or political purposes; a charitable organization, fund-raising counsel, or professional solicitor in compliance with the registration and reporting requirements of Chapter 1716. of the Revised Code; or any person or other entity exempt under section 1716.03 of the Revised Code from filing a registration statement under section 1716.02 of the Revised Code; 15223 15224 15225 15226 15227 15228 15229

(3) A person, making a telephone solicitation involving a home solicitation sale as defined in section 1345.21 of the Revised Code, that makes the sales presentation and completes the sale at a later, face-to-face meeting between the seller and the purchaser rather than during the telephone solicitation. However, if the person, following the telephone solicitation, causes another person to collect the payment of any money, this exemption does not apply. 15230 15231 15232 15233 15234 15235 15236 15237

(4) A licensed securities, commodities, or investment broker, dealer, investment advisor, or associated person when making a telephone solicitation within the scope of the person's license. As used in division (B)(4) of this section, "licensed securities, commodities, or investment broker, dealer, investment advisor, or associated person" means a person subject to licensure or registration as such by the securities and exchange commission; the National Association of Securities Dealers or other self-regulatory organization, as defined by 15 U.S.C.A. 78c; by the division of securities under Chapter 1707. of the Revised Code; or by an official or agency of any other state of the United States. 15238 15239 15240 15241 15242 15243 15244 15245 15246 15247 15248 15249

(5)(a) A person primarily engaged in soliciting the sale of a newspaper of general circulation; 15250 15251

(b) As used in division (B)(5)(a) of this section, "newspaper of general circulation" includes, but is not limited to, both of the following: 15252 15253 15254

(i) A newspaper that is a daily law journal designated as an official publisher of court calendars pursuant to section 2701.09 of the Revised Code; 15255 15256 15257

(ii) A newspaper or publication that has at least twenty-five per cent editorial, non-advertising content, exclusive of inserts, measured relative to total publication space, and an audited circulation to at least fifty per cent of the households in the newspaper's retail trade zone as defined by the audit. 15258 15259 15260 15261 15262

(6)(a) An issuer, or its subsidiary, that has a class of securities to which all of the following apply: 15263 15264

(i) The class of securities is subject to section 12 of the "Securities Exchange Act of 1934," 15 U.S.C.A. 78l, and is registered or is exempt from registration under 15 U.S.C.A. 78l(g)(2)(A), (B), (C), (E), (F), (G), or (H); 15265 15266 15267 15268

(ii) The class of securities is listed on the New York stock exchange, the American stock exchange, or the NASDAQ national market system; 15269 15270 15271

(iii) The class of securities is a reported security as defined in 17 C.F.R. 240.11Aa3-1(a)(4). 15272 15273

(b) An issuer, or its subsidiary, that formerly had a class of securities that met the criteria set forth in division (B)(6)(a) of this section if the issuer, or its subsidiary, has a net worth in excess of one hundred million dollars, files or its parent files with the securities and exchange commission an S.E.C. form 10-K, and has continued in substantially the same business since it had a class of securities that met the criteria in division (B)(6)(a) of this section. As used in division (B)(6)(b) of this section, "issuer" and "subsidiary" include the successor to an issuer or subsidiary. 15274 15275 15276 15277 15278 15279 15280 15281 15282 15283

(7) A person soliciting a transaction regulated by the commodity futures trading commission, if the person is registered 15284 15285

or temporarily registered for that activity with the commission under 7 U.S.C.A. 1 et. seq. and the registration or temporary registration has not expired or been suspended or revoked; 15286 15287 15288

(8) A person soliciting the sale of any book, record, audio tape, compact disc, or video, if the person allows the purchaser to review the merchandise for at least seven days and provides a full refund within thirty days to a purchaser who returns the merchandise or if the person solicits the sale on behalf of a membership club operating in compliance with regulations adopted by the federal trade commission in 16 C.F.R. 425; 15289 15290 15291 15292 15293 15294 15295

(9) A supervised financial institution or its subsidiary. As used in division (B)(9) of this section, "supervised financial institution" means a bank, trust company, savings and loan association, savings bank, credit union, industrial loan company, consumer finance lender, commercial finance lender, or institution described in section 2(c)(2)(F) of the "Bank Holding Company Act of 1956," 12 U.S.C.A. 1841(c)(2)(F), as amended, supervised by an official or agency of the United States, this state, or any other state of the United States; or a licensee or registrant under sections 1321.01 to 1321.19, 1321.51 to 1321.60, or 1321.71 to 1321.83 of the Revised Code. 15296 15297 15298 15299 15300 15301 15302 15303 15304 15305 15306

(10)(a) An insurance company, association, or other organization that is licensed or authorized to conduct business in this state by the superintendent of insurance pursuant to Title XXXIX of the Revised Code or Chapter 1751. of the Revised Code, when soliciting within the scope of its license or authorization. 15307 15308 15309 15310 15311

(b) A licensed insurance broker, agent, or solicitor when soliciting within the scope of the person's license. As used in division (B)(10)(b) of this section, "licensed insurance broker, agent, or solicitor" means any person licensed as an insurance broker, agent, or solicitor by the superintendent of insurance pursuant to Title XXXIX of the Revised Code. 15312 15313 15314 15315 15316 15317

(11) A person soliciting the sale of services provided by a cable television system operating under authority of a governmental franchise or permit; 15318 15319 15320

(12) A person soliciting a business-to-business sale under which any of the following conditions are met: 15321 15322

(a) The telephone solicitor has been operating continuously for at least three years under the same business name under which it solicits purchasers, and at least fifty-one per cent of its gross dollar volume of sales consists of repeat sales to existing customers to whom it has made sales under the same business name. 15323 15324 15325 15326 15327

(b) The purchaser business intends to resell the goods purchased. 15328 15329

(c) The purchaser business intends to use the goods or services purchased in a recycling, reuse, manufacturing, or remanufacturing process. 15330 15331 15332

(d) The telephone solicitor is a publisher of a periodical or of magazines distributed as controlled circulation publications as defined in division (CC) of section 5739.01 of the Revised Code and is soliciting sales of advertising, subscriptions, reprints, lists, information databases, conference participation or sponsorships, trade shows or media products related to the periodical or magazine, or other publishing services provided by the controlled circulation publication. 15333 15334 15335 15336 15337 15338 15339 15340

(13) A person that, not less often than once each year, publishes and delivers to potential purchasers a catalog that complies with both of the following: 15341 15342 15343

(a) It includes all of the following: 15344

(i) The business address of the seller; 15345

(ii) A written description or illustration of each good or service offered for sale; 15346 15347

(iii) A clear and conspicuous disclosure of the sale price of each good or service; shipping, handling, and other charges; and return policy; 15348 15349 15350

(b) One of the following applies: 15351

(i) The catalog includes at least twenty-four pages of written material and illustrations, is distributed in more than one state, and has an annual postage-paid mail circulation of not less than two hundred fifty thousand households; 15352 15353 15354 15355

(ii) The catalog includes at least ten pages of written material or an equivalent amount of material in electronic form on the internet or an on-line computer service, the person does not solicit customers by telephone but solely receives telephone calls made in response to the catalog, and during the calls the person takes orders but does not engage in further solicitation of the purchaser. As used in division (B)(13)(b)(ii) of this section, "further solicitation" does not include providing the purchaser with information about, or attempting to sell, any other item in the catalog that prompted the purchaser's call or in a substantially similar catalog issued by the seller. 15356 15357 15358 15359 15360 15361 15362 15363 15364 15365 15366

(14) A political subdivision or instrumentality of the United States, this state, or any state of the United States; 15367 15368

(15) A college or university or any other public or private institution of higher education in this state; 15369 15370

(16) A public utility as defined in section 4905.02 of the Revised Code or a retail natural gas supplier as defined in section 4929.01 of the Revised Code, if the utility or supplier is subject to regulation by the public utilities commission, or the affiliate of the utility or supplier; 15371 15372 15373 15374 15375

(17) A person that solicits sales through a television program or advertisement that is presented in the same market area no fewer than twenty days per month or offers for sale no fewer 15376 15377 15378

than ten distinct items of goods or services; and offers to the purchaser an unconditional right to return any good or service purchased within a period of at least seven days and to receive a full refund within thirty days after the purchaser returns the good or cancels the service; 15379 15380 15381 15382 15383

(18)(a) A person that, for at least one year, has been operating a retail business under the same name as that used in connection with telephone solicitation and both of the following occur on a continuing basis: 15384 15385 15386 15387

(i) The person either displays goods and offers them for retail sale at the person's business premises or offers services for sale and provides them at the person's business premises. 15388 15389 15390

(ii) At least fifty-one per cent of the person's gross dollar volume of retail sales involves purchases of goods or services at the person's business premises. 15391 15392 15393

(b) An affiliate of a person that meets the requirements in division (B)(18)(a) of this section if the affiliate meets all of the following requirements: 15394 15395 15396

(i) The affiliate has operated a retail business for a period of less than one year; 15397 15398

(ii) The affiliate either displays goods and offers them for retail sale at the affiliate's business premises or offers services for sale and provides them at the affiliate's business premises; 15399 15400 15401 15402

(iii) At least fifty-one per cent of the affiliate's gross dollar volume of retail sales involves purchases of goods or services at the affiliate's business premises. 15403 15404 15405

(c) A person that, for a period of less than one year, has been operating a retail business in this state under the same name as that used in connection with telephone solicitation, as long as 15406 15407 15408

all of the following requirements are met: 15409

(i) The person either displays goods and offers them for retail sale at the person's business premises or offers services for sale and provides them at the person's business premises; 15410 15411 15412

(ii) The goods or services that are the subject of telephone solicitation are sold at the person's business premises, and at least sixty-five per cent of the person's gross dollar volume of retail sales involves purchases of goods or services at the person's business premises; 15413 15414 15415 15416 15417

(iii) The person conducts all telephone solicitation activities according to sections 310.3, 310.4, and 310.5 of the telemarketing sales rule adopted by the federal trade commission in 16 C.F.R. part 310. 15418 15419 15420 15421

(19) A person who performs telephone solicitation sales services on behalf of other persons and to whom one of the following applies: 15422 15423 15424

(a) The person has operated under the same ownership, control, and business name for at least five years, and the person receives at least seventy-five per cent of its gross revenues from written telephone solicitation contracts with persons who come within one of the exemptions in division (B) of this section. 15425 15426 15427 15428 15429

(b) The person is an affiliate of one or more exempt persons and makes telephone solicitations on behalf of only the exempt persons of which it is an affiliate. 15430 15431 15432

(c) The person makes telephone solicitations on behalf of only exempt persons, the person and each exempt person on whose behalf telephone solicitations are made have entered into a written contract that specifies the manner in which the telephone solicitations are to be conducted and that at a minimum requires compliance with the telemarketing sales rule adopted by the federal trade commission in 16 C.F.R. part 310, and the person 15433 15434 15435 15436 15437 15438 15439

conducts the telephone solicitations in the manner specified in the written contract. 15440 15441

(d) The person performs telephone solicitation for religious or political purposes, a charitable organization, a fund-raising council, or a professional solicitor in compliance with the registration and reporting requirements of Chapter 1716. of the Revised Code; and meets all of the following requirements: 15442 15443 15444 15445 15446

(i) The person has operated under the same ownership, control, and business name for at least five years, and the person receives at least fifty-one per cent of its gross revenues from written telephone solicitation contracts with persons who come within the exemption in division (B)(2) of this section; 15447 15448 15449 15450 15451

(ii) The person does not conduct a prize promotion or offer the sale of an investment opportunity; 15452 15453

(iii) The person conducts all telephone solicitation activities according to sections 310.3, 310.4, and 310.5 of the telemarketing sales rules adopted by the federal trade commission in 16 C.F.R. part 310. 15454 15455 15456 15457

(20) A person that is a licensed real estate salesperson or broker under Chapter 4735. of the Revised Code when soliciting within the scope of the person's license; 15458 15459 15460

(21)(a) Either of the following: 15461

(i) A publisher that solicits the sale of the publisher's periodical or magazine of general, paid circulation, or a person that solicits a sale of that nature on behalf of a publisher under a written agreement directly between the publisher and the person. 15462 15463 15464 15465

(ii) A publisher that solicits the sale of the publisher's periodical or magazine of general, paid circulation, or a person that solicits a sale of that nature as authorized by a publisher under a written agreement directly with a publisher's 15466 15467 15468 15469

clearinghouse provided the person is a resident of Ohio for more than three years and initiates all telephone solicitations from Ohio and the person conducts the solicitation and sale in compliance with 16 C.F.R. part 310, as adopted by the federal trade commission. 15470 15471 15472 15473 15474

(b) As used in division (B)(21) of this section, "periodical or magazine of general, paid circulation" excludes a periodical or magazine circulated only as part of a membership package or given as a free gift or prize from the publisher or person. 15475 15476 15477 15478

(22) A person that solicits the sale of food, as defined in section 3715.01 of the Revised Code, or the sale of products of horticulture, as defined in section 5739.01 of the Revised Code, if the person does not intend the solicitation to result in, or the solicitation actually does not result in, a sale that costs the purchaser an amount greater than five hundred dollars. 15479 15480 15481 15482 15483 15484

(23) A funeral director licensed pursuant to Chapter 4717. of the Revised Code when soliciting within the scope of that license, if both of the following apply: 15485 15486 15487

(a) The solicitation and sale are conducted in compliance with 16 C.F.R. part 453, as adopted by the federal trade commission, and with sections 1107.33 and 1345.21 to 1345.28 of the Revised Code; 15488 15489 15490 15491

(b) The person provides to the purchaser of any preneed funeral contract a notice that clearly and conspicuously sets forth the cancellation rights specified in division (G) of section 1107.33 of the Revised Code, and retains a copy of the notice signed by the purchaser. 15492 15493 15494 15495 15496

(24) A person, or affiliate thereof, licensed to sell or issue Ohio instruments designated as travelers checks pursuant to sections 1315.01 to 1315.18 of the Revised Code. 15497 15498 15499

(25) A person that solicits sales from its previous 15500

purchasers and meets all of the following requirements: 15501

(a) The solicitation is made under the same business name that was previously used to sell goods or services to the purchaser; 15502 15503 15504

(b) The person has, for a period of not less than three years, operated a business under the same business name as that used in connection with telephone solicitation; 15505 15506 15507

(c) The person does not conduct a prize promotion or offer the sale of an investment opportunity; 15508 15509

(d) The person conducts all telephone solicitation activities according to sections 310.3, 310.4, and 310.5 of the telemarketing sales rules adopted by the federal trade commission in 16 C.F.R. part 310; 15510 15511 15512 15513

(e) Neither the person nor any of its principals has been convicted of, pleaded guilty to, or has entered a plea of no contest for a felony or a theft offense as defined in sections 2901.02 and 2913.01 of the Revised Code or similar law of another state or of the United States; 15514 15515 15516 15517 15518

(f) Neither the person nor any of its principals has had entered against them an injunction or a final judgment or order, including an agreed judgment or order, an assurance of voluntary compliance, or any similar instrument, in any civil or administrative action involving engaging in a pattern of corrupt practices, fraud, theft, embezzlement, fraudulent conversion, or misappropriation of property; the use of any untrue, deceptive, or misleading representation; or the use of any unfair, unlawful, deceptive, or unconscionable trade act or practice. 15519 15520 15521 15522 15523 15524 15525 15526 15527

(26) An institution defined as a home health agency in section 3701.881 of the Revised Code, that conducts all telephone solicitation activities according to sections 310.3, 310.4, and 310.5 of the telemarketing sales rules adopted by the federal 15528 15529 15530 15531

trade commission in 16 C.F.R. part 310, and engages in telephone 15532
solicitation only within the scope of the institution's 15533
certification, accreditation, contract with the department of 15534
aging, or status as a home health agency; and that meets one of 15535
the following requirements: 15536

(a) The institution is certified as a provider of home health 15537
services under ~~Title XVIII of~~ the ~~Social Security Act, 49 Stat.~~ 15538
~~620, 42 U.S.C. 301, as amended~~ medicare program; 15539

(b) The institution is accredited by either the joint 15540
commission on accreditation of health care organizations or the 15541
community health accreditation program; 15542

(c) The institution is providing passport services under the 15543
direction of the Ohio department of aging under section 173.40 of 15544
the Revised Code; 15545

(d) An affiliate of an institution that meets the 15546
requirements of division (B)(26)(a), (b), or (c) of this section 15547
when offering for sale substantially the same goods and services 15548
as those that are offered by the institution that meets the 15549
requirements of division (B)(26)(a), (b), or (c) of this section. 15550

(27) A person licensed to provide a hospice care program by 15551
the department of health pursuant to section 3712.04 of the 15552
Revised Code when conducting telephone solicitations within the 15553
scope of the person's license and according to sections 310.3, 15554
310.4, and 310.5 of the telemarketing sales rules adopted by the 15555
federal trade commission in 16 C.F.R. part 310. 15556

Sec. 4723.063. (A) As used in this section: 15557

(1) "Health care facility" means: 15558

(a) A hospital registered under section 3701.07 of the 15559
Revised Code; 15560

(b) A nursing home licensed under section 3721.02 of the 15561

Revised Code, or by a political subdivision certified under 15562
section 3721.09 of the Revised Code; 15563

(c) A county home or a county nursing home as defined in 15564
section 5155.31 of the Revised Code that is certified under ~~Title~~ 15565
~~XVIII or XIX of~~ the ~~"Social Security Act," 49 Stat. 620 (1935), 42~~ 15566
~~U.S.C. 301, amended~~ medicare program or medicaid program; 15567

(d) A freestanding dialysis center; 15568

(e) A freestanding inpatient rehabilitation facility; 15569

(f) An ambulatory surgical facility; 15570

(g) A freestanding cardiac catheterization facility; 15571

(h) A freestanding birthing center; 15572

(i) A freestanding or mobile diagnostic imaging center; 15573

(j) A freestanding radiation therapy center. 15574

(2) "Nurse education program" means a prelicensure nurse 15575
education program approved by the board of nursing under section 15576
4723.06 of the Revised Code or a postlicensure nurse education 15577
program approved by the board of regents under section 3333.04 of 15578
the Revised Code. 15579

(B) The state board of nursing shall establish and administer 15580
the nurse education grant program. Under the program, the board 15581
shall award grants to nurse education programs that have 15582
partnerships with other education programs, community health 15583
agencies, or health care facilities. Grant recipients shall use 15584
the money to fund partnerships to increase the nurse education 15585
program's enrollment capacity. Methods of increasing a program's 15586
enrollment capacity may include hiring faculty and preceptors, 15587
purchasing educational equipment and materials, and other actions 15588
acceptable to the board. Grant money shall not be used to 15589
construct or renovate buildings. Partnerships may be developed 15590
between one or more nurse education programs and one or more 15591

health care facilities. 15592

In awarding grants, the board shall give preference to partnerships between nurse education programs and hospitals, nursing homes, and county homes or county nursing homes, but may also award grants to fund partnerships between nurse education programs and other health care facilities. 15593 15594 15595 15596 15597

(C) The board shall adopt rules in accordance with Chapter 119. of the Revised Code establishing the following: 15598 15599

(1) Eligibility requirements for receipt of a grant; 15600

(2) Grant application forms and procedures; 15601

(3) The amounts in which grants may be made and the total amount that may be awarded to a nurse education program that has a partnership with other education programs, a community health agency, or a health care facility; 15602 15603 15604 15605

(4) A method whereby the board may evaluate the effectiveness of a partnership between joint recipients in increasing the nurse education program's enrollment capacity; 15606 15607 15608

(5) The percentage of the money in the fund that must remain in the fund at all times to maintain a fiscally responsible fund balance; 15609 15610 15611

(6) The percentage of available grants to be awarded to licensed practical nurse education programs, registered nurse education programs, and graduate programs; 15612 15613 15614

(7) Any other matters incidental to the operation of the program. 15615 15616

(D) From January 1, 2004, until December 31, 2013, the ten dollars of each biennial nursing license renewal fee collected under section 4723.08 of the Revised Code shall be dedicated to the nurse education grant program fund, which is hereby created in the state treasury. The board shall use money in the fund for 15617 15618 15619 15620 15621

grants awarded under division (A) of this section and for expenses of administering the grant program. The amount used for administrative expenses in any year shall not exceed ten per cent of the amount transferred to the fund in that year. 15622 15623 15624 15625

(E) Each quarter, for the purposes of transferring funds to the nurse education grant program, the board of nursing shall certify to the director of budget and management the number of biennial licenses renewed under this chapter during the preceding quarter and the amount equal to that number times ten dollars. 15626 15627 15628 15629 15630

(F) Notwithstanding the requirements of section 4743.05 of the Revised Code, from January 1, 2004, until December 31, 2013, at the end of each quarter, the director of budget and management shall transfer from the occupational licensing and regulatory fund to the nurse education grant program fund the amount certified under division (E) of this section. 15631 15632 15633 15634 15635 15636

Sec. 4723.17. (A) The board of nursing may authorize a licensed practical nurse to administer to an adult intravenous therapy authorized by an individual who is authorized to practice in this state and is acting within the course of the individual's professional practice, if the licensed practical nurse has a current, valid license issued under this chapter that includes authorization to administer medications and one of the following is the case: 15637 15638 15639 15640 15641 15642 15643 15644

(1) The nurse has successfully completed, within a practical nurse prelicensure education program approved by the board or by another jurisdiction's agency that regulates the practice of nursing, a course of study that prepares the nurse to safely perform the intravenous therapy procedures the board may authorize under this section. To meet this requirement, the course of study must include all of the following: 15645 15646 15647 15648 15649 15650 15651

(a) Both didactic and clinical components; 15652

(b) Curriculum requirements established in rules the board of nursing shall adopt in accordance with Chapter 119. of the Revised Code; 15653 15654 15655

(c) Standards that require the nurse to perform a successful demonstration of the intravenous procedures, including all skills needed to perform them safely. 15656 15657 15658

(2) The nurse has successfully completed a minimum of forty hours of training that includes all of the following: 15659 15660

(a) The curriculum established by rules adopted by the board and in effect on January 1, 1999; 15661 15662

(b) Training in the anatomy and physiology of the cardiovascular system, signs and symptoms of local and systemic complications in the administration of fluids and antibiotic additives, and guidelines for management of these complications; 15663 15664 15665 15666

(c) Any other training or instruction the board considers appropriate. 15667 15668

(d) A testing component that requires the nurse to perform a successful demonstration of the intravenous procedures, including all skills needed to perform them safely. 15669 15670 15671

(B) Except as provided in section 4723.171 of the Revised Code, a licensed practical nurse may perform intravenous therapy only if authorized by the board pursuant to division (A) of this section and only if it is performed in accordance with this section. 15672 15673 15674 15675 15676

A licensed practical nurse authorized by the board to perform intravenous therapy may perform an intravenous therapy procedure only at the direction of one of the following: 15677 15678 15679

(1) A licensed physician, dentist, optometrist, or podiatrist who, except as provided in division (C)(2) of this section, is present and readily available at the facility where the 15680 15681 15682

intravenous therapy procedure is performed; 15683

(2) A registered nurse in accordance with division (C) of this section. 15684 15685

(C)(1) Except as provided in division (C)(2) of this section and section 4723.171 of the Revised Code, when a licensed practical nurse authorized by the board to perform intravenous therapy performs an intravenous therapy procedure at the direction of a registered nurse, the registered nurse or another registered nurse shall be readily available at the site where the intravenous therapy is performed, and before the licensed practical nurse initiates the intravenous therapy, the registered nurse shall personally perform an on-site assessment of the individual who is to receive the intravenous therapy. 15686 15687 15688 15689 15690 15691 15692 15693 15694 15695

(2) When a licensed practical nurse authorized by the board to perform intravenous therapy performs an intravenous therapy procedure in a home as defined in section 3721.10 of the Revised Code, or in an intermediate care facility for the mentally retarded as defined in section ~~5111.20~~ 5164.01 of the Revised Code, at the direction of a registered nurse or licensed physician, dentist, optometrist, or podiatrist, a registered nurse shall be on the premises of the home or facility or accessible by some form of telecommunication. 15696 15697 15698 15699 15700 15701 15702 15703 15704

(D) No licensed practical nurse shall perform any of the following intravenous therapy procedures: 15705 15706

(1) Initiating or maintaining any of the following: 15707

(a) Blood or blood components; 15708

(b) Solutions for total parenteral nutrition; 15709

(c) Any cancer therapeutic medication including, but not limited to, cancer chemotherapy or an anti-neoplastic agent; 15710 15711

(d) Solutions administered through any central venous line or 15712

arterial line or any other line that does not terminate in a peripheral vein, except that a licensed practical nurse authorized by the board to perform intravenous therapy may maintain the solutions specified in division (D)(6)(a) of this section that are being administered through a central venous line or peripherally inserted central catheter; 15713 15714 15715 15716 15717 15718

(e) Any investigational or experimental medication. 15719

(2) Initiating intravenous therapy in any vein, except that a licensed practical nurse authorized by the board to perform intravenous therapy may initiate intravenous therapy in accordance with this section in a vein of the hand, forearm, or antecubital fossa; 15720 15721 15722 15723 15724

(3) Discontinuing a central venous, arterial, or any other line that does not terminate in a peripheral vein; 15725 15726

(4) Initiating or discontinuing a peripherally inserted central catheter; 15727 15728

(5) Mixing, preparing, or reconstituting any medication for intravenous therapy, except that a licensed practical nurse authorized by the board to perform intravenous therapy may prepare or reconstitute an antibiotic additive; 15729 15730 15731 15732

(6) Administering medication via the intravenous route, including all of the following activities: 15733 15734

(a) Adding medication to an intravenous solution or to an existing infusion, except that a licensed practical nurse authorized by the board to perform intravenous therapy may do either of the following: 15735 15736 15737 15738

(i) Initiate an intravenous infusion containing one or more of the following elements: dextrose 5%; normal saline; lactated ringers; sodium chloride .45%; sodium chloride 0.2%; sterile water. 15739 15740 15741 15742

(ii) Hang subsequent containers of the intravenous solutions specified in division (D)(6)(a) of this section that contain vitamins or electrolytes, if a registered nurse initiated the infusion of that same intravenous solution. 15743 15744 15745 15746

(b) Initiating or maintaining an intravenous piggyback infusion, except that a licensed practical nurse authorized by the board to perform intravenous therapy may initiate or maintain an intravenous piggyback infusion containing an antibiotic additive; 15747 15748 15749 15750

(c) Injecting medication via a direct intravenous route, except that a licensed practical nurse authorized by the board to perform intravenous therapy may inject heparin or normal saline to flush an intermittent infusion device or heparin lock including, but not limited to, bolus or push. 15751 15752 15753 15754 15755

(7) Aspirating any intravenous line to maintain patency; 15756

(8) Changing tubing on any line including, but not limited to, an arterial line or a central venous line, except that a licensed practical nurse authorized by the board to perform intravenous therapy may change tubing on an intravenous line that terminates in a peripheral vein; 15757 15758 15759 15760 15761

(9) Programming or setting any function of a patient controlled infusion pump. 15762 15763

(E) Notwithstanding division (D) of this section, at the direction of a physician or a registered nurse, a licensed practical nurse authorized by the board to perform intravenous therapy may perform the following activities for the purpose of performing dialysis: 15764 15765 15766 15767 15768

(1) The routine administration and regulation of saline solution for the purpose of maintaining an established fluid plan; 15769 15770

(2) The administration of a heparin dose intravenously; 15771

(3) The administration of a heparin dose peripherally via a 15772

fistula needle; 15773

(4) The loading and activation of a constant infusion pump or the intermittent injection of a dose of medication prescribed by a licensed physician for dialysis. 15774 15775 15776

(F) No person shall employ or direct a licensed practical nurse to perform an intravenous therapy procedure without first verifying that the licensed practical nurse is authorized by the board to perform intravenous therapy. 15777 15778 15779 15780

(G) The board shall issue an intravenous therapy card to the licensed practical nurses authorized pursuant to division (A) of this section to perform intravenous therapy. A fee for issuing the card shall not be charged under section 4723.08 of the Revised Code if the licensed practical nurse receives the card by meeting the requirements of division (A)(1) of this section. The board shall maintain a registry of the names of licensed practical nurses who hold intravenous therapy cards. 15781 15782 15783 15784 15785 15786 15787 15788

Sec. 4723.63. (A) In consultation with the medication aide advisory council established under section 4723.62 of the Revised Code, the board of nursing shall conduct a pilot program for the use of medication aides in nursing homes and residential care facilities. The board shall conduct the pilot program in a manner consistent with human protection and other ethical concerns typically associated with research studies involving live subjects. The pilot program shall be commenced not later than May 1, 2006, and shall end on the thirty-first day after the report required by division (F)(2) of this section is submitted in accordance with that division. 15789 15790 15791 15792 15793 15794 15795 15796 15797 15798 15799

During the period the pilot program is conducted, a nursing home or residential care facility participating in the pilot program may use one or more medication aides to administer prescription medications to its residents, subject to all of the 15800 15801 15802 15803

following conditions: 15804

(1) Each individual used as a medication aide must hold a current, valid medication aide certificate issued by the board of nursing under this chapter. 15805 15806 15807

(2) The nursing home or residential care facility shall ensure that the requirements of section 4723.67 of the Revised Code are met. 15808 15809 15810

(3) The nursing home or residential care facility shall submit to the board, not later than the thirty-first day after the day the board makes its request under division (F)(1)(a) of this section, the data required by division (F)(1)(a) of this section. 15811 15812 15813 15814

(B) The board, in consultation with the medication aide advisory council, shall do all of the following not later than February 1, 2006: 15815 15816 15817

(1) Design the pilot program; 15818

(2) Establish standards to govern medication aides and the nursing homes and residential care facilities participating in the pilot program, including standards for the training of medication aides and the staff of participating nursing homes and residential care facilities; 15819 15820 15821 15822 15823

(3) Establish standards to protect the health and safety of the residents of the nursing homes and residential care facilities participating in the program; 15824 15825 15826

(4) Implement a process for selecting the nursing homes and residential care facilities to participate in the program. 15827 15828

(C)(1) A nursing home or residential care facility may volunteer to participate in the pilot program by submitting an application to the board on a form prescribed and provided by the board. From among the applicants, the board shall select eighty nursing homes and forty residential care facilities to participate 15829 15830 15831 15832 15833

in the pilot program. When the board denies an application, it shall notify, in writing, the president and minority leader of the senate and the speaker and minority leader of the house of representatives of the denial and the reasons for the denial. 15834 15835 15836 15837

(2) To be eligible to participate, a nursing home or residential care facility shall agree to observe the standards established by the board for the use of medication aides. A nursing home is eligible to participate only if the department of health has found in the most recent survey or inspection of the home that the home is free from deficiencies related to the administration of medication. A residential care facility is eligible to participate only if the department has found that the facility is free from deficiencies related to the provision of skilled nursing care or the administration of medication. 15838 15839 15840 15841 15842 15843 15844 15845 15846 15847

(D) As a condition of participation in the pilot program, a nursing home and residential care facility selected by the board shall pay the participation fee established in rules adopted under section 4723.69 of the Revised Code. The participation fee is not reimbursable under the medicaid program ~~established under Chapter 5111. of the Revised Code~~. 15848 15849 15850 15851 15852 15853

(E) On receipt of evidence found credible by the board that continued participation by a nursing home or residential care facility poses an imminent danger, risk of serious harm, or jeopardy to a resident of the home or facility, the board may terminate the authority of the home or facility to participate in the pilot program. 15854 15855 15856 15857 15858 15859

(F)(1) With the assistance of the medication aide advisory council, the board shall conduct an evaluation of the pilot program. In conducting the evaluation, the board shall do all of the following: 15860 15861 15862 15863

(a) Request from each nursing home and residential care 15864

facility participating in the pilot program, on the ninety-first day after the day the board issues a medication aide certificate under section 4723.651 of the Revised Code to the seventy-fifth individual, the data the board requires participating nursing homes and residential care facilities to report under rules the board adopts under section 4723.69 of the Revised Code. 15865 15866 15867 15868 15869 15870

(b) Assess whether medication aides are able to administer prescription medications safely to nursing home and residential care facility residents; 15871 15872 15873

(c) Determine the financial implications of using medication aides in nursing homes and residential care facilities; 15874 15875

(d) Consider any other issue the board or council considers relevant to the evaluation. 15876 15877

(2) Not later than the one hundred eighty-first day after the day the board issues a medication aide certificate under section 4723.651 of the Revised Code to the seventy-fifth individual, the board shall prepare a report of its findings and recommendations derived from the evaluation of the pilot program. The board shall submit the report to the governor, president and minority leader of the senate, speaker and minority leader of the house of representatives, and director of health. 15878 15879 15880 15881 15882 15883 15884 15885

(G) The board shall, on the day it issues a medication aide certificate to the seventy-fifth individual, post a notice on its web site indicating the date on which any nursing home or residential care facility may use medication aides in accordance with section 4723.64 of the Revised Code. 15886 15887 15888 15889 15890

Sec. 4731.151. (A) Naprapaths who received a certificate to practice from the board prior to March 2, 1992, may continue to practice naprapathy, as defined in rules adopted by the board. Such naprapaths shall practice in accordance with rules adopted by 15891 15892 15893 15894

the board. 15895

(B)(1) As used in this division: 15896

(a) "Mechanotherapy" means all of the following: 15897

(i) Examining patients by verbal inquiry; 15898

(ii) Examination of the musculoskeletal system by hand; 15899

(iii) Visual inspection and observation; 15900

(iv) Diagnosing a patient's condition only as to whether the patient has a disorder of the musculoskeletal system; 15901 15902

(v) In the treatment of patients, employing the techniques of advised or supervised exercise; electrical neuromuscular stimulation; massage or manipulation; or air, water, heat, cold, sound, or infrared ray therapy only to those disorders of the musculoskeletal system that are amenable to treatment by such techniques and that are identifiable by examination performed in accordance with division (B)(1)(a)(i) of this section and diagnosable in accordance with division (B)(1)(a)(ii) of this section. 15903 15904 15905 15906 15907 15908 15909 15910 15911

(b) "Educational requirements" means the completion of a course of study appropriate for certification to practice mechanotherapy on or before November 3, 1985, as determined by rules adopted under this chapter. 15912 15913 15914 15915

(2) Mechanotherapists who received a certificate to practice from the board prior to March 2, 1992, may continue to practice mechanotherapy, as defined in rules adopted by the board. Such mechanotherapists shall practice in accordance with rules adopted by the board. 15916 15917 15918 15919 15920

A person authorized by this division to practice as a mechanotherapist may examine, diagnose, and assume responsibility for the care of patients with due regard for first aid and the hygienic and nutritional care of the patients. Roentgen rays shall 15921 15922 15923 15924

be used by a mechanotherapist only for diagnostic purposes.

(3) A person who holds a certificate to practice mechanotherapy and completed educational requirements in mechanotherapy on or before November 3, 1985, is entitled to use the title "doctor of mechanotherapy" and is a "physician" who performs "medical services" for the purposes of Chapters 4121. and 4123. of the Revised Code and the medicaid program ~~established under section 5111.01 of the Revised Code~~, and shall receive payment or reimbursement as provided under those chapters and that ~~section~~ program.

Sec. 4731.65. As used in sections 4731.65 to 4731.71 of the Revised Code:

(A)(1) "Clinical laboratory services" means either of the following:

(a) Any examination of materials derived from the human body for the purpose of providing information for the diagnosis, prevention, or treatment of any disease or impairment or for the assessment of health;

(b) Procedures to determine, measure, or otherwise describe the presence or absence of various substances or organisms in the body.

(2) "Clinical laboratory services" does not include the mere collection or preparation of specimens.

(B) "Designated health services" means any of the following:

(1) Clinical laboratory services;

(2) Home health care services;

(3) Outpatient prescription drugs.

(C) "Fair market value" means the value in arms-length transactions, consistent with general market value and:

(1) With respect to rentals or leases, the value of rental property for general commercial purposes, not taking into account its intended use; 15954 15955 15956

(2) With respect to a lease of space, not adjusted to reflect the additional value the prospective lessee or lessor would attribute to the proximity or convenience to the lessor if the lessor is a potential source of referrals to the lessee. 15957 15958 15959 15960

(D) "Governmental health care program" means any program providing health care benefits that is administered by the federal government, this state, or a political subdivision of this state, including the medicare program ~~established under Title XVIII of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended~~, health care coverage for public employees, health care benefits administered by the bureau of workers' compensation, the medicaid program ~~established under Chapter 5111. of the Revised Code~~, the disability medical assistance program ~~established under Chapter 5115. of the Revised Code~~, and the children's buy-in program ~~established under sections 5101.5211 to 5101.5216 of the Revised Code~~. 15961 15962 15963 15964 15965 15966 15967 15968 15969 15970 15971 15972

(E)(1) "Group practice" means a group of two or more holders of certificates under this chapter legally organized as a partnership, professional corporation or association, limited liability company, foundation, nonprofit corporation, faculty practice plan, or similar group practice entity, including an organization comprised of a nonprofit medical clinic that contracts with a professional corporation or association of physicians to provide medical services exclusively to patients of the clinic in order to comply with section 1701.03 of the Revised Code and including a corporation, limited liability company, partnership, or professional association described in division (B) of section 4731.226 of the Revised Code formed for the purpose of providing a combination of the professional services of 15973 15974 15975 15976 15977 15978 15979 15980 15981 15982 15983 15984 15985

optometrists who are licensed, certificated, or otherwise legally authorized to practice optometry under Chapter 4725. of the Revised Code, chiropractors who are licensed, certificated, or otherwise legally authorized to practice chiropractic or acupuncture under Chapter 4734. of the Revised Code, psychologists who are licensed, certificated, or otherwise legally authorized to practice psychology under Chapter 4732. of the Revised Code, registered or licensed practical nurses who are licensed, certificated, or otherwise legally authorized to practice nursing under Chapter 4723. of the Revised Code, pharmacists who are licensed, certificated, or otherwise legally authorized to practice pharmacy under Chapter 4729. of the Revised Code, physical therapists who are licensed, certificated, or otherwise legally authorized to practice physical therapy under sections 4755.40 to 4755.56 of the Revised Code, occupational therapists who are licensed, certificated, or otherwise legally authorized to practice occupational therapy under sections 4755.04 to 4755.13 of the Revised Code, mechanotherapists who are licensed, certificated, or otherwise legally authorized to practice mechanotherapy under section 4731.151 of the Revised Code, and doctors of medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery who are licensed, certificated, or otherwise legally authorized for their respective practices under this chapter, to which all of the following apply: 15986 15987 15988 15989 15990 15991 15992 15993 15994 15995 15996 15997 15998 15999 16000 16001 16002 16003 16004 16005 16006 16007 16008 16009

(a) Each physician who is a member of the group practice provides substantially the full range of services that the physician routinely provides, including medical care, consultation, diagnosis, or treatment, through the joint use of shared office space, facilities, equipment, and personnel. 16010 16011 16012 16013 16014

(b) Substantially all of the services of the members of the group are provided through the group and are billed in the name of the group and amounts so received are treated as receipts of the 16015 16016 16017

group. 16018

(c) The overhead expenses of and the income from the practice are distributed in accordance with methods previously determined by members of the group. 16019 16020 16021

(d) The group practice meets any other requirements that the state medical board applies in rules adopted under section 4731.70 of the Revised Code. 16022 16023 16024

(2) In the case of a faculty practice plan associated with a hospital with a medical residency training program in which physician members may provide a variety of specialty services and provide professional services both within and outside the group, as well as perform other tasks such as research, the criteria in division (E)(1) of this section apply only with respect to services rendered within the faculty practice plan. 16025 16026 16027 16028 16029 16030 16031

(F) "Home health care services" and "immediate family" have the same meanings as in the rules adopted under section 4731.70 of the Revised Code. 16032 16033 16034

(G) "Hospital" has the same meaning as in section 3727.01 of the Revised Code. 16035 16036

(H) A "referral" includes both of the following: 16037

(1) A request by a holder of a certificate under this chapter for an item or service, including a request for a consultation with another physician and any test or procedure ordered by or to be performed by or under the supervision of the other physician; 16038 16039 16040 16041

(2) A request for or establishment of a plan of care by a certificate holder that includes the provision of designated health services. 16042 16043 16044

(I) "Third-party payer" has the same meaning as in section 3901.38 of the Revised Code. 16045 16046

Sec. 4731.71. The auditor of state may implement procedures 16047
to detect violations of section 4731.66 or 4731.69 of the Revised 16048
Code within governmental health care programs administered by the 16049
state. The auditor of state shall report any violation of either 16050
section to the state medical board and shall certify to the 16051
attorney general in accordance with section 131.02 of the Revised 16052
Code the amount of any refund owed to a state-administered 16053
governmental health care program under section 4731.69 of the 16054
Revised Code as a result of a violation. If a refund is owed to 16055
the medicaid program ~~established under Chapter 5111. of the~~ 16056
~~Revised Code~~, the disability medical assistance program 16057
~~established under Chapter 5115. of the Revised Code~~, or the 16058
children's buy-in program ~~established under sections 5101.5211 to~~ 16059
~~5101.5216 of the Revised Code~~, the auditor of state also shall 16060
report the amount to the department of ~~job and family services~~ 16061
<u>health care administration</u>. 16062

The state medical board also may implement procedures to 16063
detect violations of section 4731.66 or 4731.69 of the Revised 16064
Code. 16065

Sec. 4752.02. (A) Except as provided in division (B) of this 16066
section, no person shall provide home medical equipment services 16067
or claim to the public to be a home medical equipment services 16068
provider unless either of the following is the case: 16069

(1) The person holds a valid license issued under this 16070
chapter; 16071

(2) The person holds a valid certificate of registration 16072
issued under this chapter. 16073

(B) Division (A) of this section does not apply to any of the 16074
following: 16075

(1) A health care practitioner, as defined in section 4769.01 16076

of the Revised Code, who does not sell or rent home medical 16077
equipment; 16078

(2) A hospital that provides home medical equipment services 16079
only as an integral part of patient care and does not provide the 16080
services through a separate entity that has its own medicare or 16081
medicaid provider number; 16082

(3) A manufacturer or wholesale distributor of home medical 16083
equipment that does not sell directly to the public; 16084

(4) A hospice care program, as defined by section 3712.01 of 16085
the Revised Code, that does not sell or rent home medical 16086
equipment; 16087

(5) A home, as defined by section 3721.01 of the Revised 16088
Code; 16089

(6) A home health agency that is certified under ~~Title XVIII~~ 16090
~~of~~ the ~~"Social Security Act," 79 Stat. 286 (1965), 42 U.S.C. 1395,~~ 16091
<u>medicare program</u> as a provider of home health services and does 16092
not sell or rent home medical equipment; 16093

(7) An individual who holds a current, valid license issued 16094
under Chapter 4741. of the Revised Code to practice veterinary 16095
medicine; 16096

(8) An individual who holds a current, valid license issued 16097
under Chapter 4779. of the Revised Code to practice orthotics, 16098
prosthetics, or pedorthics; 16099

(9) A pharmacy licensed under Chapter 4729. of the Revised 16100
Code that either does not sell or rent home medical equipment or 16101
receives total payments of less than ten thousand dollars per year 16102
from selling or renting home medical equipment; 16103

(10) A home dialysis equipment provider regulated by federal 16104
law. 16105

Sec. 4752.09. (A) The Ohio respiratory care board may, in accordance with Chapter 119. of the Revised Code, suspend or revoke a license issued under this chapter or discipline a license holder by imposing a fine of not more than five thousand dollars or taking other disciplinary action on any of the following grounds: 16106 16107 16108 16109 16110 16111

(1) Violation of any provision of this chapter or an order or rule of the board, as those provisions, orders, or rules are applicable to persons licensed under this chapter; 16112 16113 16114

(2) A plea of guilty to or a judicial finding of guilt of a felony or a misdemeanor that involves dishonesty or is directly related to the provision of home medical equipment services; 16115 16116 16117

(3) Making a material misstatement in furnishing information to the board; 16118 16119

(4) Professional incompetence; 16120

(5) Being guilty of negligence or gross misconduct in providing home medical equipment services; 16121 16122

(6) Aiding, assisting, or willfully permitting another person to violate any provision of this chapter or an order or rule of the board, as those provisions, orders, or rules are applicable to persons licensed under this chapter; 16123 16124 16125 16126

(7) Failing, within sixty days, to provide information in response to a written request by the board; 16127 16128

(8) Engaging in conduct likely to deceive, defraud, or harm the public; 16129 16130

(9) Denial, revocation, suspension, or restriction of a license to provide home medical equipment services, for any reason other than failure to renew, in another state or jurisdiction; 16131 16132 16133

(10) Directly or indirectly giving to or receiving from any 16134

person a fee, commission, rebate, or other form of compensation 16135
for services not rendered; 16136

(11) Knowingly making or filing false records, reports, or 16137
billings in the course of providing home medical equipment 16138
services, including false records, reports, or billings prepared 16139
for or submitted to state and federal agencies or departments; 16140

(12) Failing to comply with federal rules issued pursuant to 16141
the medicare program ~~established under Title XVIII of the "Social~~ 16142
~~Security Act," 49 Stat. 620(1935), 42 U.S.C. 1395, as amended~~, 16143
relating to operations, financial transactions, and general 16144
business practices of home medical services providers. 16145

(B) The respiratory care board immediately may suspend a 16146
license without a hearing if it determines that there is evidence 16147
that the license holder is subject to actions under this section 16148
and that there is clear and convincing evidence that continued 16149
operation by the license holder presents an immediate and serious 16150
harm to the public. The president and executive director of the 16151
board shall make a preliminary determination and describe, by 16152
telephone conference or any other method of communication, the 16153
evidence on which they made their determination to the other 16154
members of the board. The board may by resolution designate 16155
another board member to act in place of the president of the board 16156
or another employee to act in the place of the executive director, 16157
in the event that the board president or executive director is 16158
unavailable or unable to act. On review of the evidence, the board 16159
may by a vote of not less than seven of its members, suspend a 16160
license without a prior hearing. The board may vote on the 16161
suspension by way of a telephone conference call. 16162

Immediately following the decision to suspend a license under 16163
this division, the board shall issue a written order of suspension 16164
and cause it to be delivered in accordance with section 119.07 of 16165
the Revised Code. The order shall not be subject to suspension by 16166

the court during the pendency of any appeal filed under section 119.12 of the Revised Code. If the license holder requests an adjudication hearing, the date set for the hearing shall be within fifteen days but not earlier than seven days after the license holder requests the hearing, unless another date is agreed to by the license holder and the board. The suspension shall remain in effect, unless reversed by the board, until a final adjudication order issued by the board pursuant to this section and Chapter 119. of the Revised Code becomes effective. The board shall issue its final adjudication order not later than ninety days after completion of the hearing. The board's failure to issue the order by that day shall cause the summary suspension to end, but shall not affect the validity of any subsequent final adjudication order. 16167 16168 16169 16170 16171 16172 16173 16174 16175 16176 16177 16178 16179 16180

Sec. 4753.071. A person who is required to meet the supervised professional experience requirement of division (F) of section 4753.06 of the Revised Code shall submit to the board of speech-language pathology and audiology an application for a conditional license. The application shall include a plan for the content of the supervised professional experience on a form the board shall prescribe. The board shall issue the conditional license to the applicant if the applicant meets the requirements of section 4753.06 of the Revised Code, other than the requirement to have obtained the supervised professional experience, and pays to the board the appropriate fee for a conditional license. An applicant may not begin employment until the conditional license has been issued. 16181 16182 16183 16184 16185 16186 16187 16188 16189 16190 16191 16192 16193

A conditional license authorizes an individual to practice speech-language pathology or audiology while completing the supervised professional experience as required by division (F) of section 4753.06 of the Revised Code. A person holding a conditional license may practice speech-language pathology or 16194 16195 16196 16197 16198

audiology while working under the supervision of a person fully licensed in accordance with this chapter. A conditional license is valid for eighteen months unless suspended or revoked pursuant to section 3123.47 or 4753.10 of the Revised Code. 16199 16200 16201 16202

A person holding a conditional license may perform services for which reimbursement will be sought under the medicare program ~~established under Title XVIII of the "Social Security Act," 79 Stat. 286 (1965), 42 U.S.C. 1395, as amended~~, or the medicaid program ~~established under Chapter 5111. of the Revised Code~~ but all requests for reimbursement for such services shall be made by the person who supervises the person performing the services. 16203 16204 16205 16206 16207 16208 16209

Sec. 4755.481. (A) If a physical therapist evaluates and treats a patient without the prescription of, or the referral of the patient by, a person who is licensed to practice medicine and surgery, chiropractic, dentistry, osteopathic medicine and surgery, podiatric medicine and surgery, or nursing as a certified registered nurse anesthetist, clinical nurse specialist, certified nurse-midwife, or certified nurse practitioner, all of the following apply: 16210 16211 16212 16213 16214 16215 16216 16217

(1) The physical therapist shall, upon consent of the patient, inform the patient's physician, chiropractor, dentist, podiatrist, certified registered nurse anesthetist, clinical nurse specialist, certified nurse-midwife, or certified nurse practitioner of the evaluation not later than five business days after the evaluation is made. 16218 16219 16220 16221 16222 16223

(2) If the physical therapist determines, based on reasonable evidence, that no substantial progress has been made with respect to that patient during the thirty-day period immediately following the date of the patient's initial visit with the physical therapist, the physical therapist shall consult with or refer the patient to a licensed physician, chiropractor, dentist, 16224 16225 16226 16227 16228 16229

podiatrist, certified registered nurse anesthetist, clinical nurse specialist, certified nurse-midwife, or certified nurse practitioner, unless either of the following applies: 16230 16231 16232

(a) The evaluation, treatment, or services are being provided for fitness, wellness, or prevention purposes. 16233 16234

(b) The patient previously was diagnosed with chronic, neuromuscular, or developmental conditions and the evaluation, treatment, or services are being provided for problems or symptoms associated with one or more of those previously diagnosed conditions. 16235 16236 16237 16238 16239

(3) If the physical therapist determines that orthotic devices are necessary to treat the patient, the physical therapist shall be limited to the application of the following orthotic devices: 16240 16241 16242 16243

(a) Upper extremity adaptive equipment used to facilitate the activities of daily living; 16244 16245

(b) Finger splints; 16246

(c) Wrist splints; 16247

(d) Prefabricated elastic or fabric abdominal supports with or without metal or plastic reinforcing stays and other prefabricated soft goods requiring minimal fitting; 16248 16249 16250

(e) Nontherapeutic accommodative inlays; 16251

(f) Shoes that are not manufactured or modified for a particular individual; 16252 16253

(g) Prefabricated foot care products; 16254

(h) Custom foot orthotics; 16255

(i) Durable medical equipment. 16256

(4) If, at any time, the physical therapist has reason to believe that the patient has symptoms or conditions that require 16257 16258

treatment or services beyond the scope of practice of a physical 16259
therapist, the physical therapist shall refer the patient to a 16260
licensed health care practitioner acting within the practitioner's 16261
scope of practice. 16262

(B) Nothing in sections 4755.40 to 4755.56 of the Revised 16263
Code shall be construed to require reimbursement under any health 16264
insuring corporation policy, contract, or agreement, any sickness 16265
and accident insurance policy, the ~~medical assistance~~ medicaid 16266
program ~~as defined in section 5111.01 of the Revised Code~~, or the 16267
health partnership program or qualified health plans established 16268
pursuant to sections 4121.44 to 4121.442 of the Revised Code, for 16269
any physical therapy service rendered without the prescription of, 16270
or the referral of the patient by, a licensed physician, 16271
chiropractor, dentist, podiatrist, certified registered nurse 16272
anesthetist, clinical nurse specialist, certified nurse-midwife, 16273
or certified nurse practitioner. 16274

(C) For purposes of this section, "business day" means any 16275
calendar day that is not a Saturday, Sunday, or legal holiday. 16276
"Legal holiday" has the same meaning as in section 1.14 of the 16277
Revised Code. 16278

Sec. 4758.02. (A) Effective two years after the date the 16279
department of alcohol and drug addiction services ceases to 16280
administer its certification and credentialing process under 16281
section 3793.07 of the Revised Code as specified in division 16282
~~(B)~~(A) of that section and except as provided in sections 4758.03 16283
and 4758.04 of the Revised Code, no person shall do any of the 16284
following: 16285

(1) Engage in or represent to the public that the person 16286
engages in chemical dependency counseling for a fee, salary, or 16287
other consideration unless the person holds a valid independent 16288
chemical dependency counselor license, chemical dependency 16289

counselor III license, chemical dependency counselor II license, chemical dependency counselor I certificate, or chemical dependency counselor assistant certificate issued under this chapter; 16290 16291 16292 16293

(2) Use the title "licensed independent chemical dependency counselor," "LICDC," "licensed chemical dependency counselor III," "LCDC III," "licensed chemical dependency counselor II," "LCDC II," "certified chemical dependency counselor I," "CCDC I," "chemical dependency counselor assistant," "CDCA," or any other title or description incorporating the word "chemical dependency counselor" or any other initials used to identify persons acting in those capacities unless currently authorized under this chapter to act in the capacity indicated by the title or initials; 16294 16295 16296 16297 16298 16299 16300 16301 16302

(3) Represent to the public that the person is a registered applicant unless the person holds a valid registered applicant certificate issued under this chapter; 16303 16304 16305

(4) Use the title "certified prevention specialist II," "CPS II," "certified prevention specialist I," "CPS I," "registered applicant," or any other title, description, or initials used to identify persons acting in those capacities unless currently authorized under this chapter to act in the capacity indicated by the title or initials. 16306 16307 16308 16309 16310 16311

(B) Effective six years after ~~the effective date of this section~~ December 23, 2002, no person shall engage in or represent to the public that the person engages in chemical dependency counseling as a chemical dependency counselor I. 16312 16313 16314 16315

Sec. 4758.04. After the date the department of alcohol and drug addiction services ceases to administer its certification and credentialing process under section 3793.07 of the Revised Code as specified in division ~~(B)~~(A) of that section, an individual who holds, on ~~the effective date of this section~~ December 23, 2002, a 16316 16317 16318 16319 16320

valid certificate or credentials that are accepted under section 3793.07 of the Revised Code as authority to practice as a chemical dependency counselor or alcohol and other drug prevention specialist may apply to the chemical dependency professionals board for the board to delay the expiration date of the individual's certificate or credentials. If the board determines that there is good cause for delaying the expiration date, the board may delay the expiration date until a date the board specifies. The date the board specifies shall not be later than the date that is three years after the effective date of the board's initial rules adopted under section 4758.20 of the Revised Code. 16321 16322 16323 16324 16325 16326 16327 16328 16329 16330 16331 16332

An individual who has the expiration date of the individual's certificate or credentials delayed under this section may perform services within the scope, standards, and ethics of the certificate or credentials until the date of the delayed expiration date. 16333 16334 16335 16336 16337

Sec. 4761.01. As used in this chapter: 16338

(A) "Respiratory care" means rendering or offering to render to individuals, groups, organizations, or the public any service involving the evaluation of cardiopulmonary function, the treatment of cardiopulmonary impairment, the assessment of treatment effectiveness, and the care of patients with deficiencies and abnormalities associated with the cardiopulmonary system. The practice of respiratory care includes: 16339 16340 16341 16342 16343 16344 16345

(1) Obtaining, analyzing, testing, measuring, and monitoring blood and gas samples in the determination of cardiopulmonary parameters and related physiologic data, including flows, pressures, and volumes, and the use of equipment employed for this purpose; 16346 16347 16348 16349 16350

(2) Administering, monitoring, recording the results of, and 16351

instructing in the use of medical gases, aerosols, and 16352
bronchopulmonary hygiene techniques, including drainage, 16353
aspiration, and sampling, and applying, maintaining, and 16354
instructing in the use of artificial airways, ventilators, and 16355
other life support equipment employed in the treatment of 16356
cardiopulmonary impairment and provided in collaboration with 16357
other licensed health care professionals responsible for providing 16358
care; 16359

(3) Performing cardiopulmonary resuscitation and respiratory 16360
rehabilitation techniques; 16361

(4) Administering medications for the testing or treatment of 16362
cardiopulmonary impairment. 16363

(B) "Respiratory care professional" means a person who is 16364
licensed under this chapter to practice the full range of 16365
respiratory care services as defined in division (A) of this 16366
section. 16367

(C) "Physician" means an individual authorized under Chapter 16368
4731. of the Revised Code to practice medicine and surgery or 16369
osteopathic medicine and surgery. 16370

(D) "Registered nurse" means an individual licensed under 16371
Chapter 4723. of the Revised Code to engage in the practice of 16372
nursing as a registered nurse. 16373

(E) "Hospital" means a facility that meets the operating 16374
standards of section 3727.02 of the Revised Code. 16375

(F) "Nursing facility" has the same meaning as in section 16376
~~5111.20~~ 5164.01 of the Revised Code. 16377

Sec. 4761.03. The Ohio respiratory care board shall regulate 16378
the practice of respiratory care in this state and the persons to 16379
whom the board issues licenses and limited permits under this 16380
chapter and shall license and register home medical equipment 16381

services providers under Chapter 4752. of the Revised Code. Rules adopted under this chapter that deal with the provision of respiratory care in a hospital, other than rules regulating the issuance of licenses or limited permits, shall be consistent with the conditions for participation under medicare~~, Title XVIII of the "Social Security Act," 79 Stat. 286 (1965), 42 U.S.C.A. 1395, as amended,~~ and with the respiratory care accreditation standards of the joint commission on accreditation of healthcare organizations or the American osteopathic association. 16382 16383 16384 16385 16386 16387 16388 16389 16390

The board shall: 16391

(A) Adopt, and may rescind or amend, rules in accordance with Chapter 119. of the Revised Code to carry out the purposes of this chapter, including rules prescribing: 16392 16393 16394

(1) The form and manner for filing applications for licensure and renewal, limited permits, and limited permit extensions under sections 4761.05 and 4761.06 of the Revised Code; 16395 16396 16397

(2) The form, scoring, and scheduling of examinations and reexaminations for licensure and license renewal; 16398 16399

(3) Standards for the approval of educational programs required to qualify for licensure and continuing education programs required for license renewal; 16400 16401 16402

(4) Continuing education courses and the number of hour requirements necessary for license renewal, in accordance with section 4761.06 of the Revised Code; 16403 16404 16405

(5) Procedures for the issuance and renewal of licenses and limited permits, including the duties that may be fulfilled by the board's executive director and other board employees; 16406 16407 16408

(6) Procedures for the denial, suspension, permanent revocation, refusal to renew, and reinstatement of licenses and limited permits, the conduct of hearings, and the imposition of 16409 16410 16411

fines for engaging in conduct that is grounds for such action and hearings under section 4761.09 of the Revised Code; 16412 16413

(7) Standards of ethical conduct for the practice of respiratory care; 16414 16415

(8) Conditions under which the license renewal fee and continuing education requirements may be waived at the request of a licensee who is not in active practice; 16416 16417 16418

(9) The respiratory care tasks that may be performed by an individual practicing as a polysomnographic technologist pursuant to division (B)(3) of section 4761.10 of the Revised Code; 16419 16420 16421

(10) Procedures for registering out-of-state respiratory care providers authorized to practice in this state under division (A)(4) of section 4761.11 of the Revised Code; 16422 16423 16424

(11) Requirements for criminal records checks of applicants under section 4776.03 of the Revised Code. 16425 16426

(B) Determine the sufficiency of an applicant's qualifications for admission to the licensing examination or a reexamination, and for the issuance or renewal of a license or limited permit; 16427 16428 16429 16430

(C) Determine the respiratory care educational programs that are acceptable for fulfilling the requirements of division (A) of section 4761.04 of the Revised Code; 16431 16432 16433

(D) Schedule, administer, and score the licensing examination or any reexamination for license renewal or reinstatement. The board shall administer the licensing examinations at least twice a year and notify applicants of the time and place of the examinations. 16434 16435 16436 16437 16438

(E) Investigate complaints concerning alleged violations of section 4761.10 of the Revised Code or grounds for the suspension, permanent revocation, or refusal to issue licenses or limited 16439 16440 16441

permits under section 3123.47 or 4761.09 of the Revised Code. The board shall employ investigators who shall, under the direction of the executive director of the board, investigate complaints and make inspections and other inquiries as, in the judgment of the board, are appropriate to enforce sections 3123.41 to 3123.50, 4761.09, and 4761.10 of the Revised Code. Pursuant to an investigation and inspection, the investigators may review and audit records during normal business hours at the place of business of a licensee or person who is the subject of a complaint filed with the board or at any place where the records are kept. 16442 16443 16444 16445 16446 16447 16448 16449 16450 16451

Except when required by court order, the board and its employees shall not disclose confidential information obtained during an investigation or identifying information about any person who files a complaint with the board. 16452 16453 16454 16455

The board may hear testimony in matters relating to the duties imposed upon it and issue subpoenas pursuant to an investigation. The president and secretary of the board may administer oaths. 16456 16457 16458 16459

(F) Conduct hearings, keep records of its proceedings, and do other things as are necessary and proper to carry out and enforce the provisions of this chapter; 16460 16461 16462

(G) Maintain, publish, and make available upon request, for a fee not to exceed the actual cost of printing and mailing: 16463 16464

(1) The requirements for the issuance of licenses and limited permits under this chapter and rules adopted by the board; 16465 16466

(2) A current register of every person licensed to practice respiratory care in this state, to include the addresses of the person's last known place of business and residence, the effective date and identification number of the license, the name and location of the institution that granted the person's degree or certificate of completion of respiratory care educational 16467 16468 16469 16470 16471 16472

requirements, and the date the degree or certificate was issued; 16473

(3) A list of the names and locations of the institutions that each year granted degrees or certificates of completion in respiratory care; 16474 16475 16476

(4) After the administration of each examination, a list of persons who passed the examination. 16477 16478

(H) Submit to the governor and to the general assembly each year a report of all of its official actions during the preceding year, together with any findings and recommendations with regard to the improvement of the profession of respiratory care; 16479 16480 16481 16482

(I) Administer and enforce Chapter 4752. of the Revised Code. 16483

Sec. 4769.01. As used in this chapter: 16484

(A) ~~"Medicare" means the program established by Title XVIII of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended.~~ 16485 16486 16487

~~(B)~~ "Balance billing" means charging or collecting from a medicare beneficiary an amount in excess of the medicare reimbursement rate for medicare-covered services or supplies provided to a medicare beneficiary, except when medicare is the secondary insurer. When medicare is the secondary insurer, the health care practitioner may pursue full reimbursement under the terms and conditions of the primary coverage and, if applicable, the charge allowed under the terms and conditions of the appropriate provider contract, from the primary insurer, but the medicare beneficiary cannot be balance billed above the medicare reimbursement rate for a medicare-covered service or supply. "Balance billing" does not include charging or collecting deductibles or coinsurance required by the program. 16488 16489 16490 16491 16492 16493 16494 16495 16496 16497 16498 16499 16500

~~(C)~~<u>(B)</u> "Health care practitioner" means all of the following: 16501

(1) A dentist or dental hygienist licensed under Chapter 16502

4715. of the Revised Code; 16503

(2) A registered or licensed practical nurse licensed under Chapter 4723. of the Revised Code; 16504 16505

(3) An optometrist licensed under Chapter 4725. of the Revised Code; 16506 16507

(4) A dispensing optician, spectacle dispensing optician, contact lens dispensing optician, or spectacle-contact lens dispensing optician licensed under Chapter 4725. of the Revised Code; 16508 16509 16510 16511

(5) A pharmacist licensed under Chapter 4729. of the Revised Code; 16512 16513

(6) A physician authorized under Chapter 4731. of the Revised Code to practice medicine and surgery, osteopathic medicine and surgery, or podiatry; 16514 16515 16516

(7) A physician assistant authorized under Chapter 4730. of the Revised Code to practice as a physician assistant; 16517 16518

(8) A practitioner of a limited branch of medicine issued a certificate under Chapter 4731. of the Revised Code; 16519 16520

(9) A psychologist licensed under Chapter 4732. of the Revised Code; 16521 16522

(10) A chiropractor licensed under Chapter 4734. of the Revised Code; 16523 16524

(11) A hearing aid dealer or fitter licensed under Chapter 4747. of the Revised Code; 16525 16526

(12) A speech-language pathologist or audiologist licensed under Chapter 4753. of the Revised Code; 16527 16528

(13) An occupational therapist or occupational therapy assistant licensed under Chapter 4755. of the Revised Code; 16529 16530

(14) A physical therapist or physical therapy assistant 16531

licensed under Chapter 4755. of the Revised Code; 16532

(15) A professional clinical counselor, professional counselor, social worker, or independent social worker licensed, or a social work assistant registered, under Chapter 4757. of the Revised Code; 16533 16534 16535 16536

(16) A dietitian licensed under Chapter 4759. of the Revised Code; 16537 16538

(17) A respiratory care professional licensed under Chapter 4761. of the Revised Code; 16539 16540

(18) An emergency medical technician-basic, emergency medical technician-intermediate, or emergency medical technician-paramedic certified under Chapter 4765. of the Revised Code. 16541 16542 16543

Sec. 5101.07. There is hereby created in the state treasury the ODJFS support services federal operating fund. The fund shall consist of federal funds the department of job and family services receives and that the director of job and family services determines are appropriate for deposit into the fund. Money in the fund shall be used to pay the federal share of both of the following: 16544 16545 16546 16547 16548 16549 16550

(A) The department's costs for computer projects; 16551

(B) The operating costs of the parts of the department that provide general support services for the department's work units established under section 5101.06 of the Revised Code. 16552 16553 16554

Sec. 5101.071. There is hereby created in the state treasury the ODJFS support services state operating fund. The fund shall consist of payments made to the fund from other appropriation items by intrastate transfer voucher. Money in the fund shall be used to pay for both of the following: 16555 16556 16557 16558 16559

(A) The department of job and family services' costs for 16560

computer projects; 16561

(B) The operating costs of the parts of the department that provide general support services for the department's work units established under section 5101.06 of the Revised Code. 16562 16563 16564

Sec. 5101.11. ~~This section does not apply to contracts entered into under section 5111.90 or 5111.91 of the Revised Code.~~ 16565 16566

(A) As used in this section: 16567

(1) "Entity" includes an agency, board, commission, or department of the state or a political subdivision of the state; a private, nonprofit entity; a school district; a private school; or a public or private institution of higher education. 16568 16569 16570 16571

(2) "Federal financial participation" means the federal government's share of expenditures made by an entity in implementing a program administered by the department of job and family services. 16572 16573 16574 16575

(B) At the request of any public entity having authority to implement a program administered by the department of job and family services or any private entity under contract with a public entity to implement a program administered by the department, the department may seek to obtain federal financial participation for costs incurred by the entity. Federal financial participation may be sought from programs operated pursuant to Title IV-A~~,~~ and Title IV-E~~, and Title XIX~~ of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C. 301, as amended; the "Food Stamp Act of 1964," 78 Stat. 703, 7 U.S.C. 2011, as amended; and any other statute or regulation under which federal financial participation may be available, except that federal financial participation may be sought only for expenditures made with funds for which federal financial participation is available under federal law. 16576 16577 16578 16579 16580 16581 16582 16583 16584 16585 16586 16587 16588 16589

(C) All funds collected by the department of job and family 16590

services pursuant to division (B) of this section shall be distributed to the entities that incurred the costs, except for any amounts retained by the department pursuant to division (D)(3) of this section. 16591 16592 16593 16594

(D) In distributing federal financial participation pursuant to this section, the department may either enter into an agreement with the entity that is to receive the funds or distribute the funds in accordance with rules adopted under division (F) of this section. If the department decides to enter into an agreement to distribute the funds, the agreement may include terms that do any of the following: 16595 16596 16597 16598 16599 16600 16601

(1) Provide for the whole or partial reimbursement of any cost incurred by the entity in implementing the program; 16602 16603

(2) In the event that federal financial participation is disallowed or otherwise unavailable for any expenditure, require the department of job and family services or the entity, whichever party caused the disallowance or unavailability of federal financial participation, to assume responsibility for the expenditures; 16604 16605 16606 16607 16608 16609

(3) Permit the department to retain not more than five per cent of the amount of the federal financial participation to be distributed to the entity; 16610 16611 16612

(4) Require the public entity to certify the availability of sufficient unencumbered funds to match the federal financial participation it receives under this section; 16613 16614 16615

(5) Establish the length of the agreement, which may be for a fixed or a continuing period of time; 16616 16617

(6) Establish any other requirements determined by the department to be necessary for the efficient administration of the agreement. 16618 16619 16620

(E) An entity that receives federal financial participation 16621
pursuant to this section for a program aiding children and their 16622
families shall establish a process for collaborative planning with 16623
the department of job and family services for the use of the funds 16624
to improve and expand the program. 16625

(F) The director of job and family services shall adopt rules 16626
as necessary to implement this section, including rules for the 16627
distribution of federal financial participation pursuant to this 16628
section. The rules shall be adopted in accordance with Chapter 16629
119. of the Revised Code. The director may adopt or amend any 16630
statewide plan required by the federal government for a program 16631
administered by the department, as necessary to implement this 16632
section. 16633

(G) Federal financial participation received pursuant to this 16634
section shall not be included in any calculation made under 16635
section 5101.16 or 5101.161 of the Revised Code. 16636

Sec. 5101.16. (A) As used in this section and sections 16637
5101.161 and 5101.162 of the Revised Code: 16638

(1) "Disability financial assistance" means the financial 16639
assistance program established under Chapter 5115. of the Revised 16640
Code. 16641

(2) ~~"Disability medical assistance" means the medical~~ 16642
~~assistance program established under Chapter 5115. of the Revised~~ 16643
~~Code.~~ 16644

~~(3)~~ "Food stamps" means the program administered by the 16645
department of job and family services pursuant to section 5101.54 16646
of the Revised Code. 16647

~~(4) "Medicaid" means the medical assistance program~~ 16648
~~established by Chapter 5111. of the Revised Code, excluding~~ 16649
~~transportation services provided under that chapter.~~ 16650

~~(5)~~(3) "Ohio works first" means the program established by Chapter 5107. of the Revised Code. 16651 16652

~~(6)~~(4) "Prevention, retention, and contingency" means the program established by Chapter 5108. of the Revised Code. 16653 16654

~~(7)~~(5) "Public assistance expenditures" means expenditures for all of the following: 16655 16656

(a) Ohio works first; 16657

(b) County administration of Ohio works first; 16658

(c) Prevention, retention, and contingency; 16659

(d) County administration of prevention, retention, and contingency; 16660 16661

(e) Disability financial assistance; 16662

(f) ~~Disability medical assistance;~~ 16663

~~(g)~~ County administration of disability financial assistance; 16664

~~(h) County administration of disability medical assistance;~~ 16665

~~(i)~~(g) County administration of food stamps~~;~~ 16666

~~(j) County administration of medicaid~~. 16667

~~(8)~~(6) "Public medical assistance expenditures" has the same meaning as in section 5160.26 of the Revised Code. 16668 16669

(7) "Title IV-A program" has the same meaning as in section 5101.80 of the Revised Code. 16670 16671

(B) Each board of county commissioners shall pay the county share of public assistance expenditures in accordance with section 5101.161 of the Revised Code. Except as provided in division (C) of this section, a county's share of public assistance expenditures is the sum of all of the following for state fiscal year 1998 and each state fiscal year thereafter: 16672 16673 16674 16675 16676 16677

(1) The amount that is twenty-five per cent of the county's 16678

total expenditures for disability financial assistance ~~and~~ 16679
~~disability medical assistance~~ and county administration of ~~those~~ 16680
~~programs~~ disability financial assistance during the state fiscal 16681
year ending in the previous calendar year that the department of 16682
job and family services determines are allowable. 16683

(2) The amount that is ten per cent, or other percentage 16684
determined under division (D) of this section, of the county's 16685
total expenditures for county administration of food stamps ~~and~~ 16686
~~medicaid~~ during the state fiscal year ending in the previous 16687
calendar year that the department determines are allowable, less 16688
the amount of federal reimbursement credited to the county under 16689
division (E) of this section for the state fiscal year ending in 16690
the previous calendar year; 16691

(3) A percentage of the actual amount of the county share of 16692
program and administrative expenditures during federal fiscal year 16693
1994 for assistance and services, other than child care, provided 16694
under ~~Titles~~ former Title IV-A ~~and IV-F~~ of the "Social Security 16695
Act," 49 Stat. ~~620~~ 627 (1935), 42 U.S.C. ~~301~~ 601, and former Title 16696
IV-F of the "Social Security Act," 102 Stat. 2360 (1988), 42 16697
U.S.C. 681, as those titles existed prior to the enactment of the 16698
"Personal Responsibility and Work Opportunity Reconciliation Act 16699
of 1996," 110 Stat. 2105. The department of job and family 16700
services shall determine the actual amount of the county share 16701
from expenditure reports submitted to the United States department 16702
of health and human services. The percentage shall be the 16703
percentage established in rules adopted under division (F) of this 16704
section. 16705

(C)(1) If a county's share of public assistance expenditures 16706
determined under division (B) of this section and the county's 16707
share of public medical assistance expenditures determined under 16708
division (B) of section 5160.26 of the Revised Code for a state 16709
fiscal year exceeds one hundred ten per cent of the county's share 16710

for those expenditures for the immediately preceding state fiscal 16711
year, the department of job and family services shall reduce the 16712
county's share for expenditures under divisions (B)(1) and (2) of 16713
this section so that the total of the county's share for public 16714
assistance expenditures ~~under division (B) of this section~~ and 16715
public medical assistance expenditures equals one hundred ten per 16716
cent of the county's share of those expenditures for the 16717
immediately preceding state fiscal year. The department of job and 16718
family services shall cooperate with the department of health care 16719
administration for the purpose of making reductions under division 16720
(C)(1) of this section. 16721

(2) A county's share of public assistance expenditures 16722
determined under division (B) of this section may be increased 16723
pursuant to section 5101.163 of the Revised Code and a sanction 16724
under section 5101.24 of the Revised Code. An increase made 16725
pursuant to section 5101.163 of the Revised Code may cause the 16726
county's share to exceed the limit established by division (C)(1) 16727
of this section. 16728

(D)(1) If the per capita tax duplicate of a county is less 16729
than the per capita tax duplicate of the state as a whole and 16730
division (D)(2) of this section does not apply to the county, the 16731
percentage to be used for the purpose of division (B)(2) of this 16732
section is the product of ten multiplied by a fraction of which 16733
the numerator is the per capita tax duplicate of the county and 16734
the denominator is the per capita tax duplicate of the state as a 16735
whole. The department of job and family services shall compute the 16736
per capita tax duplicate for the state and for each county by 16737
dividing the tax duplicate for the most recent available year by 16738
the current estimate of population prepared by the department of 16739
development. 16740

(2) If the percentage of families in a county with an annual 16741
income of less than three thousand dollars is greater than the 16742

percentage of such families in the state and division (D)(1) of this section does not apply to the county, the percentage to be used for the purpose of division (B)(2) of this section is the product of ten multiplied by a fraction of which the numerator is the percentage of families in the state with an annual income of less than three thousand dollars a year and the denominator is the percentage of such families in the county. The department of job and family services shall compute the percentage of families with an annual income of less than three thousand dollars for the state and for each county by multiplying the most recent estimate of such families published by the department of development, by a fraction, the numerator of which is the estimate of average annual personal income published by the bureau of economic analysis of the United States department of commerce for the year on which the census estimate is based and the denominator of which is the most recent such estimate published by the bureau. 16743 16744 16745 16746 16747 16748 16749 16750 16751 16752 16753 16754 16755 16756 16757 16758

(3) If the per capita tax duplicate of a county is less than the per capita tax duplicate of the state as a whole and the percentage of families in the county with an annual income of less than three thousand dollars is greater than the percentage of such families in the state, the percentage to be used for the purpose of division (B)(2) of this section shall be determined as follows: 16759 16760 16761 16762 16763 16764

(a) Multiply ten by the fraction determined under division (D)(1) of this section; 16765 16766

(b) Multiply the product determined under division (D)(3)(a) of this section by the fraction determined under division (D)(2) of this section. 16767 16768 16769

(4) The department of job and family services shall determine, for each county, the percentage to be used for the purpose of division (B)(2) of this section not later than the first day of July of the year preceding the state fiscal year for which the percentage is used. 16770 16771 16772 16773 16774

(E) The department of job and family services shall credit to 16775
a county the amount of federal reimbursement the department 16776
receives from the United States ~~departments~~ department of 16777
agriculture ~~and health and human services~~ for the county's 16778
expenditures for administration of food stamps ~~and medicaid~~ that 16779
the department determines are allowable administrative 16780
expenditures. 16781

(F)(1) The director of job and family services shall adopt 16782
rules in accordance with section 111.15 of the Revised Code to 16783
establish all of the following: 16784

(a) The method the department is to use to change a county's 16785
share of public assistance expenditures determined under division 16786
(B) of this section as provided in division (C) of this section; 16787

(b) The allocation methodology and formula the department 16788
will use to determine the amount of funds to credit to a county 16789
under this section; 16790

(c) The method the department will use to change the payment 16791
of the county share of public assistance expenditures from a 16792
calendar-year basis to a state fiscal year basis; 16793

(d) The percentage to be used for the purpose of division 16794
(B)(3) of this section, which shall, except as provided in section 16795
5101.163 of the Revised Code, meet both of the following 16796
requirements: 16797

(i) The percentage shall not be less than seventy-five per 16798
cent nor more than eighty-two per cent; 16799

(ii) The percentage shall not exceed the percentage that the 16800
state's qualified state expenditures is of the state's historic 16801
state expenditures as those terms are defined in 42 U.S.C. 16802
609(a)(7). 16803

(e) Other procedures and requirements necessary to implement 16804

this section.

(2) The director of job and family services may amend the rule adopted under division (F)(1)(d) of this section to modify the percentage on determination that the amount the general assembly appropriates for Title IV-A programs makes the modification necessary. The rule shall be adopted and amended as if an internal management rule and in consultation with the director of budget and management.

Sec. 5101.162. Subject to available federal funds and appropriations made by the general assembly, the department of job and family services may, at its sole discretion, use available federal funds to reimburse county expenditures for county administration of food stamps ~~or medicaid~~ even though the county expenditures meet or exceed the maximum allowable reimbursement amount established by rules adopted under section 5101.161 of the Revised Code. The director may adopt internal management rules in accordance with section 111.15 of the Revised Code to implement this section.

Sec. 5101.18. ~~(A)~~ When the director of job and family services adopts rules under section 5107.05 regarding income requirements for the Ohio works first program and under section 5115.03 of the Revised Code regarding income and resource requirements for the disability financial assistance program, the director shall determine what payments shall be regarded or disregarded. In making this determination, the director shall consider:

~~(1)~~(A) The source of the payment;

~~(2)~~(B) The amount of the payment;

~~(3)~~(C) The purpose for which the payment was made;

~~(4)~~(D) Whether regarding the payment as income would be in

the public interest; 16835

~~(5)~~<u>(E)</u> Whether treating the payment as income would be 16836
detrimental to any of the programs administered in whole or in 16837
part by the department of job and family services <u>or department of</u> 16838
<u>health care administration</u> and whether such determination would 16839
jeopardize the receipt of any federal grant or payment by the 16840
state or any receipt of aid under Chapter 5107. of the Revised 16841
Code. 16842

~~(B) Any recipient of aid under Title XVI of the "Social~~ 16843
~~Security Act," 49 Stat. 620 (1935), 42 U.S.C. 301, as amended,~~ 16844
~~whose money payment is discontinued as the result of a general~~ 16845
~~increase in old-age, survivors, and disability insurance benefits~~ 16846
~~under such act, shall remain a recipient for the purpose of~~ 16847
~~receiving medical assistance through the medical assistance~~ 16848
~~program established under section 5111.01 of the Revised Code.~~ 16849

Sec. 5101.181. ~~(A) As used in this section and section~~ 16850
~~5101.182 of the Revised Code, "public assistance" includes, in~~ 16851
~~addition to Ohio works first, all of the following:~~ 16852

~~(1) Prevention, retention, and contingency;~~ 16853

~~(2) Medicaid;~~ 16854

~~(3) Disability financial assistance;~~ 16855

~~(4) Disability medical assistance;~~ 16856

~~(5) General assistance provided prior to July 17, 1995, under~~ 16857
~~former Chapter 5113. of the Revised Code.~~ 16858

~~(B)~~ As part of the procedure for the determination of 16859
overpayment to a recipient of public assistance under Chapter 16860
5107., 5108., ~~5111.,~~ or 5115. of the Revised Code, the director of 16861
job and family services shall furnish quarterly the name and 16862
social security number of each individual who receives public 16863
assistance to the director of administrative services, the 16864

administrator of the bureau of workers' compensation, and each of the state's retirement boards. Within fourteen days after receiving the name and social security number of an individual who receives public assistance, the director of administrative services, administrator, or board shall inform the auditor of state as to whether such individual is receiving wages or benefits, the amount of any wages or benefits being received, the social security number, and the address of the individual. The director of administrative services, administrator, boards, and any agent or employee of those officials and boards shall comply with the rules ~~of the director of job and family services~~ adopted under section 5101.30 of the Revised Code restricting the disclosure of information regarding recipients of public assistance. Any person who violates this provision shall thereafter be disqualified from acting as an agent or employee or in any other capacity under appointment or employment of any state board, commission, or agency.

~~(C) The auditor of state may enter into a reciprocal agreement with the director of job and family services or comparable officer of any other state for the exchange of names, current or most recent addresses, or social security numbers of persons receiving public assistance under Title IV-A or under Title XIX of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C. 301, as amended.~~

~~(D)(1) The auditor of state shall retain, for not less than two years, at least one copy of all information received under this section and sections 145.27, 742.41, 3307.20, 3309.22, 4123.27, 5101.182, and 5505.04 of the Revised Code. The auditor shall review the information to determine whether overpayments were made to recipients of public assistance under Chapters 5107., 5108., 5111., and 5115. of the Revised Code. The auditor of state shall initiate action leading to prosecution, where warranted, of~~

~~recipients who received overpayments by forwarding the name of~~ 16897
~~each recipient who received overpayment, together with other~~ 16898
~~pertinent information, to the director of job and family services~~ 16899
~~and the attorney general, to the district director of job and~~ 16900
~~family services of the district through which public assistance~~ 16901
~~was received, and to the county director of job and family~~ 16902
~~services and county prosecutor of the county through which public~~ 16903
~~assistance was received.~~ 16904

~~(2) The auditor of state and the attorney general or their~~ 16905
~~designees may examine any records, whether in computer or printed~~ 16906
~~format, in the possession of the director of job and family~~ 16907
~~services or any county director of job and family services. They~~ 16908
~~shall provide safeguards which restrict access to such records to~~ 16909
~~purposes directly connected with an audit or investigation,~~ 16910
~~prosecution, or criminal or civil proceeding conducted in~~ 16911
~~connection with the administration of the programs and shall~~ 16912
~~comply with the rules of the director of job and family services~~ 16913
~~restricting the disclosure of information regarding recipients of~~ 16914
~~public assistance. Any person who violates this provision shall~~ 16915
~~thereafter be disqualified from acting as an agent or employee or~~ 16916
~~in any other capacity under appointment or employment of any state~~ 16917
~~board, commission, or agency.~~ 16918

~~(3) Costs incurred by the auditor of state in carrying out~~ 16919
~~the auditor of state's duties under this division shall be borne~~ 16920
~~by the auditor of state.~~ 16921

Sec. 5101.182. As part of the procedure for the determination 16922
of overpayment to a recipient of public assistance under Chapter 16923
5107.~~, 5111.,~~ or 5115. of the Revised Code, the director of job 16924
and family services shall semiannually, at times determined 16925
jointly by the auditor of state and the tax commissioner, furnish 16926
to the tax commissioner in computer format the name and social 16927

security number of each individual who receives public assistance. 16928
Within sixty days after receiving the name and social security 16929
number of a recipient of public assistance, the commissioner shall 16930
inform the auditor of state whether the individual filed an Ohio 16931
individual income tax return, separate or joint, as provided by 16932
section 5747.08 of the Revised Code, for either or both of the two 16933
taxable years preceding the year in which the director furnished 16934
the names and social security numbers to the commissioner. If the 16935
individual did so file, at the same time the commissioner shall 16936
also inform the auditor of state of the amount of the federal 16937
adjusted gross income as reported on such returns and of the 16938
addresses on such returns. The commissioner shall also advise the 16939
auditor of state whether such returns were filed on a joint basis, 16940
as provided in section 5747.08 of the Revised Code, in which case 16941
the federal adjusted gross income as reported may be that of the 16942
individual or the individual's spouse. 16943

16944

If the auditor of state determines that further investigation 16945
is needed, the auditor of state may request the commissioner to 16946
determine whether the individual filed income tax returns for any 16947
previous taxable years in which the individual received public 16948
assistance and for which the tax department retains income tax 16949
returns. Within fourteen days of receipt of the request, the 16950
commissioner shall inform the auditor of state whether the 16951
individual filed an individual income tax return for the taxable 16952
years in question, of the amount of the federal adjusted gross 16953
income as reported on such returns, of the addresses on such 16954
returns, and whether the returns were filed on a joint or separate 16955
basis. 16956

If the auditor of state determines that further investigation 16957
is needed of a recipient of public assistance who filed an Ohio 16958
individual income tax return, the auditor of state may request a 16959

certified copy of the Ohio individual income tax return or returns of that person for the taxable years described above, together with any other documents the commissioner has concerning the return or returns. Within fourteen days of receipt of such a request in writing, the commissioner shall forward the returns and documents to the auditor of state.

The director of job and family services, district director of job and family services, county director of job and family services, county prosecutor, attorney general, auditor of state, or any agent or employee of those officials having access to any information or documents furnished by the commissioner pursuant to this section shall not divulge or use any such information except for the purpose of determining overpayment of public assistance, or for an audit, investigation, or prosecution, or in accordance with a proper judicial order. Any person who violates this provision shall thereafter be disqualified from acting as an agent or employee or in any other capacity under appointment or employment of any state or county board, commission, or agency.

Sec. 5101.184. (A) The director of job and family services shall work with the tax commissioner to collect overpayments of assistance under Chapter 5107.~~, 5111.,~~ or 5115., former Chapter 5113., or section 5101.54 of the Revised Code from refunds of state income taxes for taxable year 1992 and thereafter that are payable to the recipients of such overpayments.

Any overpayment of assistance, whether obtained by fraud or misrepresentation, as the result of an error by the recipient or by the agency making the payment, or in any other manner, may be collected under this section. Any reduction under section 5747.12 or 5747.121 of the Revised Code to an income tax refund shall be made before a reduction under this section. No reduction shall be made under this section if the amount of the refund is less than

twenty-five dollars after any reduction under section 5747.12 of the Revised Code. A reduction under this section shall be made before any part of the refund is contributed under section 5747.113 of the Revised Code, or is credited under section 5747.12 of the Revised Code against tax due in any subsequent year. 16991 16992 16993 16994 16995

The director and the tax commissioner, by rules adopted in accordance with Chapter 119. of the Revised Code, shall establish procedures to implement this division. The procedures shall provide for notice to a recipient of assistance and an opportunity for the recipient to be heard before the recipient's income tax refund is reduced. 16996 16997 16998 16999 17000 17001

(B) The director of job and family services may enter into agreements with the federal government to collect overpayments of assistance from refunds of federal income taxes that are payable to recipients of the overpayments. 17002 17003 17004 17005

Sec. 5101.21. (A) As used in sections 5101.21 to ~~5101.212~~ 5101.25 of the Revised Code: 17006 17007

(1) "County grantee" means all of the following: 17008

(a) A board of county commissioners; 17009

(b) A county children services board appointed under section 5153.03 of the Revised Code; 17010 17011

(c) A county elected official that is a child support enforcement agency. 17012 17013

(2) "County subgrant" means a grant that a county grantee awards to another entity. 17014 17015

(3) "County subgrant agreement" means an agreement between a county grantee and another entity under which the county grantee awards the other entity one or more county subgrants. 17016 17017 17018

(4) "Fiscal biennial period" means a two-year period 17019

beginning on the first day of July of an odd-numbered year and ending on the last day of June of the next odd-numbered year. 17020 17021

(5) "Grant" means an award for one or more ODJFS family services duties of federal financial assistance that a federal agency provides in the form of money, or property in lieu of money, to the department of job and family services and that the department awards to a county grantee. "Grant" may include state funds the department awards to a county grantee to match the federal financial assistance. "Grant" does not mean either of the following: 17022 17023 17024 17025 17026 17027 17028 17029

(a) Technical assistance that provides services instead of money; 17030 17031

(b) Other assistance provided in the form of revenue sharing, loans, loan guarantees, interest subsidies, or insurance. 17032 17033

(6) "Grant agreement" means an agreement between the department of job and family services and a county grantee under which the department awards the county grantee one or more grants. 17034 17035 17036

(7) "ODJFS family services duty" means a family services duty associated with a program that the department of job and family services supervises the administration of on the state level. 17037 17038 17039

(B) Effective July 1, 2008, the director of job and family services may award grants to counties only through grant agreements entered into under this section. 17040 17041 17042

(C) The director shall enter into one or more written grant agreements with the county grantees of each county. If a county has multiple county grantees, the director shall jointly enter into the grant agreement with all of the county grantees. The initial grant agreement shall be entered into not later than January 31, 2008, and shall be in effect for fiscal year 2009. Except as provided in rules adopted under this section, subsequent grant agreements shall be entered into before the first day of 17043 17044 17045 17046 17047 17048 17049 17050

each successive fiscal biennial period and shall be in effect for that fiscal biennial period or, in the case of a grant agreement entered into after the first day of a fiscal biennial period and except as provided by section 5101.211 of the Revised Code, for the remainder of the fiscal biennial period. A grant agreement shall do all of the following: 17051 17052 17053 17054 17055 17056

(1) Comply with all of the conditions, requirements, and restrictions applicable to the ODJFS family services duties for which the grants included in the agreement are awarded, including the conditions, requirements, and restrictions established by the department, federal or state law, state plans for receipt of federal financial participation, agreements between the department and a federal agency, and executive orders issued by the governor; 17057 17058 17059 17060 17061 17062 17063

(2) Establish terms and conditions governing the accountability for and use of the grants included in the grant agreement; 17064 17065 17066

(3) Specify both of the following: 17067

(a) The ODJFS family services duties for which the grants included in the agreement are awarded; 17068 17069

(b) The private and government entities designated under section 307.981 of the Revised Code to serve as the county family services agencies performing the ODJFS family services duties; 17070 17071 17072

(4) Provide for the department of job and family services to award the grants included in the agreement in accordance with a methodology for determining the amount of the award established by rules adopted under this section; 17073 17074 17075 17076

(5) Specify the form of the grants which may be a cash draw, reimbursement, property, advance, working capital advance, or other forms specified in rules adopted under this section; 17077 17078 17079

(6) Provide that the grants are subject to the availability 17080

of federal funds and appropriations made by the general assembly; 17081

(7) Specify annual financial, administrative, or other incentive awards, if any, to be provided in accordance with section 5101.23 of the Revised Code; 17082 17083 17084

(8) Include the assurance of each county grantee that the county grantee will do all of the following: 17085 17086

(a) Ensure that the grants included in the agreement are used, and the ODJFS family services duties for which the grants are awarded are performed, in accordance with conditions, requirements, and restrictions applicable to the duties established by the department, a federal or state law, state plans for receipt of federal financial participation, agreements between the department and a federal agency, and executive orders issued by the governor; 17087 17088 17089 17090 17091 17092 17093 17094

(b) Utilize a financial management system and other accountability mechanisms for the grants awarded under the agreement that meet requirements the department establishes; 17095 17096 17097

(c) Do all of the following with regard to a county subgrant: 17098 17099

(i) Award the subgrant through a written county subgrant agreement that requires the entity awarded the county subgrant to comply with all conditions, requirements, and restrictions applicable to the county grantee regarding the grant that the county grantee subgrants to the entity, including the conditions, requirements, and restrictions of this section; 17100 17101 17102 17103 17104 17105

(ii) Monitor the entity that is awarded the subgrant to ensure that the entity uses the subgrant in accordance with conditions, requirements, and restrictions applicable to the ODJFS family services duties for which the subgrant is awarded; 17106 17107 17108 17109

(iii) Take action to recover subgrants that are not used in 17110

accordance with the conditions, requirements, or restrictions 17111
applicable to the ODJFS family services duties for which the 17112
subgrant is awarded. 17113

(d) Promptly reimburse the department the amount that 17114
represents the amount the county grantee is responsible for, 17115
pursuant to action the department takes under division (C) of 17116
section 5101.24 of the Revised Code, of funds the department pays 17117
to any entity because of an adverse audit finding, adverse quality 17118
control finding, final disallowance of federal financial 17119
participation, or other sanction or penalty; 17120

(e) Take prompt corrective action, including paying amounts 17121
resulting from an adverse finding, sanction, or penalty, if the 17122
department, auditor of state, federal agency, or other entity 17123
authorized by federal or state law to determine compliance with 17124
the conditions, requirements, and restrictions applicable to ~~a~~ an 17125
ODJFS family services duty for which a grant included in the 17126
agreement is awarded determines compliance has not been achieved; 17127
17128

(f) Ensure that any matching funds, regardless of the source, 17129
that the county grantee manages are clearly identified and used in 17130
accordance with federal and state laws and the agreement. 17131

(9) Provide for the department taking action pursuant to 17132
division (C) of section 5101.24 of the Revised Code if authorized 17133
by division (B)(1), (2), (3), or (4) of that section; 17134

(10) Provide for timely audits required by federal and state 17135
law and require prompt release of audit findings and prompt action 17136
to correct problems identified in an audit; 17137

(11) Provide for administrative review procedures in 17138
accordance with section 5101.24 of the Revised Code; 17139

(12) Establish the method of amending or terminating the 17140
agreement and an expedited process for correcting terms or 17141

conditions of the agreement that the director and each county grantee agree are erroneous. 17142 17143

(D) A grant agreement does not have to be amended for a county grantee to be required to comply with a new or amended condition, requirement, or restriction for ~~a~~ an ODJFS family services duty established by federal or state law, state plan for receipt of federal financial participation, agreement between the department and a federal agency, or executive order issued by the governor. 17144 17145 17146 17147 17148 17149 17150

(E) The department shall make payments authorized by a grant agreement on vouchers it prepares and may include any funds appropriated or allocated to it for carrying out ODJFS family services duties for which a grant included in the agreement is awarded, including funds for personal services and maintenance. 17151 17152 17153 17154 17155

(F)(1) The director shall adopt rules in accordance with section 111.15 of the Revised Code governing grant agreements. The director shall adopt the rules as if they were internal management rules. Before adopting the rules, the director shall give the public an opportunity to review and comment on the proposed rules. The rules shall establish methodologies to be used to determine the amount of the grants included in the agreements. The rules also shall establish terms and conditions under which an agreement may be entered into after the first day of a fiscal biennial period. The rules may do any or all of the following: 17156 17157 17158 17159 17160 17161 17162 17163 17164 17165

(a) Govern the award of grants included in grant agreements, including the establishment of, and restrictions on, the form of the grants and the distribution of the grants; 17166 17167 17168

(b) Specify allowable uses of the grants included in the agreements; 17169 17170

(c) Establish reporting, cash management, audit, and other requirements the director determines are necessary to provide 17171 17172

accountability for the use of the grants included in the agreements and determine compliance with conditions, requirements, and restrictions established by the department, a federal or state law, state plans for receipt of federal financial participation, agreements between the department and a federal agency, and executive orders issued by the governor. 17173 17174 17175 17176 17177 17178

(2) A requirement of a grant agreement established by a rule adopted under this division is applicable to a grant agreement without having to be restated in the grant agreement. A requirement established by a grant agreement is applicable to the grant agreement without having to be restated in a rule. 17179 17180 17181 17182 17183

Sec. 5101.212. The department of job and family services shall publish in a manner accessible to the public all of the following that concern ODJFS family services duties for which grants included in grant agreements entered into under section 5101.21 of the Revised Code are awarded: state plans for receipt of federal financial participation, agreements between the department and a federal agency, and executive orders issued by the governor. The department may publish the materials electronically or otherwise. 17184 17185 17186 17187 17188 17189 17190 17191 17192

Sec. 5101.214. The director of job and family services may enter into a written agreement with one or more state agencies, as defined in section 117.01 of the Revised Code, and state universities and colleges to assist in the coordination, provision, or enhancement of the ODJFS family services duties of a county family services agency or the workforce development activities of a workforce development agency. The director also may enter into written agreements or contracts with, or issue grants to, private and government entities under which funds are provided for the enhancement or innovation of ODJFS family services duties or workforce development activities on the state 17193 17194 17195 17196 17197 17198 17199 17200 17201 17202 17203

or local level. 17204

The director may adopt internal management rules in accordance with section 111.15 of the Revised Code to implement this section. 17205 17206 17207

Sec. 5101.216. The director of job and family services may enter into one or more written operational agreements with boards of county commissioners to do one or more of the following regarding ODJFS family services duties: 17208 17209 17210 17211

(A) Provide for the director to amend or rescind a rule the director previously adopted; 17212 17213

(B) Provide for the director to modify procedures or establish alternative procedures to accommodate special circumstances in a county; 17214 17215 17216

(C) Provide for the director and board to jointly identify operational problems of mutual concern and develop a joint plan to address the problems; 17217 17218 17219

(D) Establish a framework for the director and board to modify the use of existing resources in a manner that is beneficial to the department of job and family services and the county that the board serves and improves ODJFS family services duties for the recipients of the services. 17220 17221 17222 17223 17224

Sec. 5101.22. The department of job and family services may establish performance and other administrative standards for the administration and outcomes of ODJFS family services duties and determine at intervals the department decides the degree to which a county family services agency complies with a performance or other administrative standard. The department may use statistical sampling, performance audits, case reviews, or other methods it determines necessary and appropriate to determine compliance with performance and administrative standards. 17225 17226 17227 17228 17229 17230 17231 17232 17233

Sec. 5101.221. (A) Except as provided by division (C) of this section, if the department of job and family services determines that a county family services agency has failed to comply with a performance or other administrative standard established under section 5101.22 of the Revised Code or by federal law for the administration or outcome of ~~a~~ an ODJFS family services duty, the department shall require the agency to develop, submit to the department for approval, and comply with a corrective action plan. 17234 17235 17236 17237 17238 17239 17240 17241 17242

(B) If a county family services agency fails to develop, submit to the department, or comply with a corrective action plan under division (A) of this section, or the department disapproves the agency's corrective action plan, the department may require the agency to develop, submit to the department for approval, and comply with a corrective action plan that requires the agency to commit existing resources to the plan. 17243 17244 17245 17246 17247 17248 17249

(C) The department may not require a county family services agency to take action under this section for failure to comply with a performance or other administrative standard established for an incentive awarded by the department. Instead, the department may require a county family services agency that fails to comply with that kind of performance or other administrative standard to take action in accordance with rules adopted by the department governing the standard. 17250 17251 17252 17253 17254 17255 17256 17257

(D) At the request of a county family services agency, the department shall assist the agency with the development of a corrective action plan under this section and provide the agency technical assistance in the implementation of the plan. 17258 17259 17260 17261

Sec. 5101.23. Subject to the availability of funds, the department of job and family services may provide annual 17262 17263

financial, administrative, or other incentive awards to county 17264
family services agencies and workforce development agencies. A 17265
county family services agency or workforce development agency may 17266
spend funds provided as a financial incentive award only for the 17267
purpose for which the funds are appropriated. The department may 17268
adopt internal management rules in accordance with section 111.15 17269
of the Revised Code to establish the amounts of awards, 17270
methodology for distributing the awards, types of awards, and 17271
standards for administration by the department. 17272

There is hereby created in the state treasury the social 17273
services incentive fund. The director of job and family services 17274
may request that the director of budget and management transfer 17275
funds in the Title IV-A reserve fund created under section 5101.82 17276
of the Revised Code and other funds appropriated for ODJFS family 17277
services duties or workforce investment activities into the fund. 17278
If the director of budget and management determines that the funds 17279
identified by the director of job and family services are 17280
available and appropriate for transfer, the director of budget and 17281
management shall make the transfer. Money in the fund shall be 17282
used to provide incentive awards under this section. 17283

Sec. 5101.24. (A) As used in this section, "responsible 17284
county grantee" means whichever county grantee, as defined in 17285
section 5101.21 of the Revised Code, the director of job and 17286
family services determines is appropriate to take action against 17287
under division (C) of this section. 17288

(B) Regardless of whether ~~a~~ an ODJFS family services duty is 17289
performed by a county family services agency, private or 17290
government entity pursuant to a contract entered into under 17291
section 307.982 of the Revised Code or division (C)(2) of section 17292
5153.16 of the Revised Code, or private or government provider of 17293
~~a~~ an ODJFS family service duty, the department of job and family 17294

services may take action under division (C) of this section against the responsible county grantee if the department determines any of the following are the case: 17295 17296 17297

(1) A requirement of a grant agreement entered into under section 5101.21 of the Revised Code that includes a grant for the ODJFS family services duty, including a requirement for grant agreements established by rules adopted under that section, is not complied with; 17298 17299 17300 17301 17302

(2) A county family services agency fails to develop, submit to the department, or comply with a corrective action plan under division (B) of section 5101.221 of the Revised Code, or the department disapproves the agency's corrective action plan developed under division (B) of section 5101.221 of the Revised Code; 17303 17304 17305 17306 17307 17308

(3) A requirement for the ODJFS family services duty established by the department or any of the following is not complied with: a federal or state law, state plan for receipt of federal financial participation, grant agreement between the department and a federal agency, or executive order issued by the governor; 17309 17310 17311 17312 17313 17314

(4) The responsible county grantee is solely or partially responsible, as determined by the director of job and family services, for an adverse audit finding, adverse quality control finding, final disallowance of federal financial participation, or other sanction or penalty regarding the ODJFS family services duty. 17315 17316 17317 17318 17319 17320

(C) The department may take one or more of the following actions against the responsible county grantee when authorized by division (B)(1), (2), (3), or (4) of this section: 17321 17322 17323

(1) Require the responsible county grantee to comply with a corrective action plan pursuant to a time schedule specified by 17324 17325

the department. The corrective action plan shall be established or approved by the department and shall not require a county grantee to commit resources to the plan. 17326 17327 17328

(2) Require the responsible county grantee to comply with a corrective action plan pursuant to a time schedule specified by the department. The corrective action plan shall be established or approved by the department and require a county grantee to commit to the plan existing resources identified by the agency. 17329 17330 17331 17332 17333

(3) Require the responsible county grantee to do one of the following: 17334 17335

(a) Share with the department a final disallowance of federal financial participation or other sanction or penalty; 17336 17337

(b) Reimburse the department the final amount the department pays to the federal government or another entity that represents the amount the responsible county grantee is responsible for of an adverse audit finding, adverse quality control finding, final disallowance of federal financial participation, or other sanction or penalty issued by the federal government, auditor of state, or other entity; 17338 17339 17340 17341 17342 17343 17344

(c) Pay the federal government or another entity the final amount that represents the amount the responsible county grantee is responsible for of an adverse audit finding, adverse quality control finding, final disallowance of federal financial participation, or other sanction or penalty issued by the federal government, auditor of state, or other entity; 17345 17346 17347 17348 17349 17350

(d) Pay the department the final amount that represents the amount the responsible county grantee is responsible for of an adverse audit finding or adverse quality control finding. 17351 17352 17353

(4) Impose an administrative sanction issued by the department against the responsible county grantee. A sanction may be increased if the department has previously taken action against 17354 17355 17356

the responsible entity under this division. 17357

(5) Perform, or contract with a government or private entity 17358
for the entity to perform, the ODJFS family services duty until 17359
the department is satisfied that the responsible county grantee 17360
ensures that the duty will be performed satisfactorily. If the 17361
department performs or contracts with an entity to perform ~~a~~ an 17362
ODJFS family services duty under division (C)(5) of this section, 17363
the department may do either or both of the following: 17364

(a) Spend funds in the county treasury appropriated by the 17365
board of county commissioners for the duty; 17366

(b) Withhold funds allocated or reimbursements due to the 17367
responsible county grantee for the duty and spend the funds for 17368
the duty. 17369

(6) Request that the attorney general bring mandamus 17370
proceedings to compel the responsible county grantee to take or 17371
cease the action that causes division (B)(1), (2), (3), or (4) of 17372
this section to apply. The attorney general shall bring mandamus 17373
proceedings in the Franklin county court of appeals at the 17374
department's request. 17375

(7) If the department takes action under this division 17376
because of division (B)(3) of this section, temporarily withhold 17377
funds allocated or reimbursement due to the responsible county 17378
grantee until the department determines that the responsible 17379
county grantee is in compliance with the requirement. The 17380
department shall release the funds when the department determines 17381
that compliance has been achieved. 17382

(D) If the department proposes to take action against the 17383
responsible county grantee under division (C) of this section, the 17384
department shall notify the responsible county grantee, director 17385
of the appropriate county family services agency, and county 17386
auditor. The notice shall be in writing and specify the action the 17387

department proposes to take. The department shall send the notice by regular United States mail. 17388 17389

Except as provided by division (E) of this section, the responsible county grantee may request an administrative review of a proposed action in accordance with administrative review procedures the department shall establish. The administrative review procedures shall comply with all of the following: 17390 17391 17392 17393 17394

(1) A request for an administrative review shall state specifically all of the following: 17395 17396

(a) The proposed action specified in the notice from the department for which the review is requested; 17397 17398

(b) The reason why the responsible county grantee believes the proposed action is inappropriate; 17399 17400

(c) All facts and legal arguments that the responsible county grantee wants the department to consider; 17401 17402

(d) The name of the person who will serve as the responsible county grantee's representative in the review. 17403 17404

(2) If the department's notice specifies more than one proposed action and the responsible county grantee does not specify all of the proposed actions in its request pursuant to division (D)(1)(a) of this section, the proposed actions not specified in the request shall not be subject to administrative review and the parts of the notice regarding those proposed actions shall be final and binding on the responsible county grantee. 17405 17406 17407 17408 17409 17410 17411 17412

(3) In the case of a proposed action under division (C)(1) of this section, the responsible county grantee shall have fifteen calendar days after the department mails the notice to the responsible county grantee to send a written request to the department for an administrative review. If it receives such a 17413 17414 17415 17416 17417

request within the required time, the department shall postpone taking action under division (C)(1) of this section for fifteen calendar days following the day it receives the request or extended period of time provided for in division (D)(5) of this section to allow a representative of the department and a representative of the responsible county grantee an informal opportunity to resolve any dispute during that fifteen-day or extended period. 17418 17419 17420 17421 17422 17423 17424 17425

(4) In the case of a proposed action under division (C)(2), (3), (4), (5), or (7) of this section, the responsible county grantee shall have thirty calendar days after the department mails the notice to the responsible county grantee to send a written request to the department for an administrative review. If it receives such a request within the required time, the department shall postpone taking action under division (C)(2), (3), (4), (5), or (7) of this section for thirty calendar days following the day it receives the request or extended period of time provided for in division (D)(5) of this section to allow a representative of the department and a representative of the responsible county grantee an informal opportunity to resolve any dispute during that thirty-day or extended period. 17426 17427 17428 17429 17430 17431 17432 17433 17434 17435 17436 17437 17438

(5) If the informal opportunity provided in division (D)(3) or (4) of this section does not result in a written resolution to the dispute within the fifteen- or thirty-day period, the director of job and family services and representative of the responsible county grantee may enter into a written agreement extending the time period for attempting an informal resolution of the dispute under division (D)(3) or (4) of this section. 17439 17440 17441 17442 17443 17444 17445

(6) In the case of a proposed action under division (C)(3) of this section, the responsible county grantee may not include in its request disputes over a finding, final disallowance of federal financial participation, or other sanction or penalty issued by 17446 17447 17448 17449

the federal government, auditor of state, or entity other than the department. 17450 17451

(7) If the responsible county grantee fails to request an administrative review within the required time, the responsible county grantee loses the right to request an administrative review of the proposed actions specified in the notice and the notice becomes final and binding on the responsible county grantee. 17452 17453 17454 17455 17456 17457

(8) If the informal opportunity provided in division (D)(3) or (4) of this section does not result in a written resolution to the dispute within the time provided by division (D)(3), (4), or (5) of this section, the director shall appoint an administrative review panel to conduct the administrative review. The review panel shall consist of department employees and one director or other representative of the type of county family services agency that is responsible for the kind of ODJFS family services duty that is the subject of the dispute and serves a different county than the county served by the responsible county grantee. No individual involved in the department's proposal to take action against the responsible county grantee may serve on the review panel. The review panel shall review the responsible county grantee's request. The review panel may require that the department or responsible county grantee submit additional information and schedule and conduct an informal hearing to obtain testimony or additional evidence. A review of a proposal to take action under division (C)(3) of this section shall be limited solely to the issue of the amount the responsible county grantee shall share with the department, reimburse the department, or pay to the federal government, department, or other entity under division (C)(3) of this section. The review panel is not required to make a stenographic record of its hearing or other proceedings. 17458 17459 17460 17461 17462 17463 17464 17465 17466 17467 17468 17469 17470 17471 17472 17473 17474 17475 17476 17477 17478 17479 17480 17481

(9) After finishing an administrative review, an administrative review panel appointed under division (D)(8) of this section shall submit a written report to the director setting forth its findings of fact, conclusions of law, and recommendations for action. The director may approve, modify, or disapprove the recommendations. If the director modifies or disapproves the recommendations, the director shall state the reasons for the modification or disapproval and the actions to be taken against the responsible county grantee. 17482 17483 17484 17485 17486 17487 17488 17489 17490

(10) The director's approval, modification, or disapproval under division (D)(9) of this section shall be final and binding on the responsible county grantee and shall not be subject to further departmental review. 17491 17492 17493 17494

(E) The responsible county grantee is not entitled to an administrative review under division (D) of this section for any of the following: 17495 17496 17497

(1) An action taken under division (C)(6) of this section; 17498

(2) An action taken under section 5101.242 of the Revised Code; 17499 17500

(3) An action taken under division (C)(3) of this section if the federal government, auditor of state, or entity other than the department has identified the responsible county grantee as being solely or partially responsible for an adverse audit finding, adverse quality control finding, final disallowance of federal financial participation, or other sanction or penalty; 17501 17502 17503 17504 17505 17506

(4) An adjustment to an allocation, cash draw, advance, or reimbursement to a responsible county grantee that the department determines necessary for budgetary reasons; 17507 17508 17509

(5) Withholding of a cash draw or reimbursement due to noncompliance with a reporting requirement established in rules adopted under section 5101.243 of the Revised Code. 17510 17511 17512

(F) This section does not apply to other actions the department takes against the responsible county grantee pursuant to authority granted by another state law unless the other state law requires the department to take the action in accordance with this section. 17513 17514 17515 17516 17517

(G) The director of job and family services may adopt rules in accordance with Chapter 119. of the Revised Code as necessary to implement this section. 17518 17519 17520

Sec. 5101.243. The director of job and family services may adopt rules in accordance with section 111.15 of the Revised Code establishing reporting requirements for ODJFS family services duties and workforce development activities. If the director adopts the rules, the director shall adopt the rules as if they were internal management rules and, before adopting the rules, give the public an opportunity to review and comment on the proposed rules. 17521 17522 17523 17524 17525 17526 17527 17528

Sec. 5101.25. The department of ~~human~~ job and family services, in consultation with county representatives, shall develop annual training goals and model training curriculum regarding ODJFS family services duties for employees of county family services agencies and identify a variety of state funded training opportunities to meet the proposed goals. 17529 17530 17531 17532 17533 17534

Sec. 5101.26. As used in this section and in sections 5101.27 to 5101.30 of the Revised Code: 17535 17536

(A) "County agency" means a county department of job and family services or a public children services agency. 17537 17538

(B) "Fugitive felon" means an individual who is fleeing to avoid prosecution, or custody or confinement after conviction, under the laws of the place from which the individual is fleeing, 17539 17540 17541

for a crime or an attempt to commit a crime that is a felony under 17542
the laws of the place from which the individual is fleeing or, in 17543
the case of New Jersey, a high misdemeanor, regardless of whether 17544
the individual has departed from the individual's usual place of 17545
residence. 17546

(C) "Information" means records as defined in section 149.011 17547
of the Revised Code, any other documents in any format, and data 17548
derived from records and documents that are generated, acquired, 17549
or maintained by the department of job and family services, a 17550
county agency, or an entity performing duties on behalf of the 17551
department or a county agency. 17552

(D) "Law enforcement agency" means the state highway patrol, 17553
an agency that employs peace officers as defined in section 109.71 17554
of the Revised Code, the adult parole authority, a county 17555
department of probation, a prosecuting attorney, the attorney 17556
general, similar agencies of other states, federal law enforcement 17557
agencies, and postal inspectors. "Law enforcement agency" includes 17558
the peace officers and other law enforcement officers employed by 17559
the agency. 17560

(E) "Medical assistance provided under a public assistance 17561
program" means medical assistance provided under the programs 17562
established under ~~sections~~ section 5101.49~~, 5101.50 to 5101.503,~~ 17563
~~5101.51 to 5101.5110, 5101.52 to 5101.529, and 5101.5211 to~~ 17564
~~5101.5216, Chapters 5111. and 5115.,~~ or any other provision of the 17565
Revised Code that the department of job and family services 17566
administers. 17567

(F) "Public assistance" means financial assistance, medical 17568
assistance, or social services provided under a program 17569
administered by the department of job and family services or a 17570
county agency pursuant to Chapter 329., 5101., 5104., 5107., 17571
5108., ~~5111.,~~ or 5115. of the Revised Code or an executive order 17572
issued under section 107.17 of the Revised Code. 17573

(G) "Public assistance recipient" means an applicant for or 17574
recipient or former recipient of public assistance. 17575

Sec. 5101.35. (A) As used in this section: 17576

(1) "Agency" means the following entities that administer a 17577
family services program: 17578

(a) The department of job and family services; 17579

(b) A county department of job and family services; 17580

(c) A public children services agency; 17581

(d) A private or government entity administering, in whole or 17582
in part, a family services program for or on behalf of the 17583
department of job and family services or a county department of 17584
job and family services or public children services agency. 17585

(2) "Appellant" means an applicant, participant, former 17586
participant, recipient, or former recipient of a family services 17587
program who is entitled by federal or state law to a hearing 17588
regarding a decision or order of the agency that administers the 17589
program. 17590

(3) "Family services program" means assistance provided under 17591
a Title IV-A program as defined in section 5101.80 of the Revised 17592
Code or under Chapter 5104.~~, 5111.,~~ or 5115. or section ~~173.35~~ 17593
5160.80, 5101.141, 5101.46, 5101.461, 5101.54, 5153.163, or 17594
5153.165 of the Revised Code, other than assistance provided under 17595
section 5101.46 of the Revised Code by the department of mental 17596
health, the department of mental retardation and developmental 17597
disabilities, a board of alcohol, drug addiction, and mental 17598
health services, or a county board of mental retardation and 17599
developmental disabilities. 17600

(B) Except as provided by ~~divisions~~ division (G) ~~and (H)~~ of 17601
this section, an appellant who appeals under federal or state law 17602
a decision or order of an agency administering a family services 17603

program shall, at the appellant's request, be granted a state hearing by the department of job and family services. This state hearing shall be conducted in accordance with rules adopted under this section. The state hearing shall be recorded, but neither the recording nor a transcript of the recording shall be part of the official record of the proceeding. A state hearing decision is binding upon the agency and department, unless it is reversed or modified on appeal to the director of job and family services or a court of common pleas. 17604 17605 17606 17607 17608 17609 17610 17611 17612

(C) Except as provided by division (G) of this section, an appellant who disagrees with a state hearing decision may make an administrative appeal to the director of job and family services in accordance with rules adopted under this section. This administrative appeal does not require a hearing, but the director or the director's designee shall review the state hearing decision and previous administrative action and may affirm, modify, remand, or reverse the state hearing decision. Any person designated to make an administrative appeal decision on behalf of the director shall have been admitted to the practice of law in this state. An administrative appeal decision is the final decision of the department and is binding upon the department and agency, unless it is reversed or modified on appeal to the court of common pleas. 17613 17614 17615 17616 17617 17618 17619 17620 17621 17622 17623 17624 17625

(D) An agency shall comply with a decision issued pursuant to division (B) or (C) of this section within the time limits established by rules adopted under this section. If a county department of job and family services or a public children services agency fails to comply within these time limits, the department may take action pursuant to section 5101.24 of the Revised Code. If another agency fails to comply within the time limits, the department may force compliance by withholding funds due the agency or imposing another sanction established by rules adopted under this section. 17626 17627 17628 17629 17630 17631 17632 17633 17634 17635

(E) An appellant who disagrees with an administrative appeal decision of the director of job and family services or the director's designee issued under division (C) of this section may appeal from the decision to the court of common pleas pursuant to section 119.12 of the Revised Code. The appeal shall be governed by section 119.12 of the Revised Code except that: 17636 17637 17638 17639 17640 17641

(1) The person may appeal to the court of common pleas of the county in which the person resides, or to the court of common pleas of Franklin county if the person does not reside in this state. 17642 17643 17644 17645

(2) The person may apply to the court for designation as an indigent and, if the court grants this application, the appellant shall not be required to furnish the costs of the appeal. 17646 17647 17648

(3) The appellant shall mail the notice of appeal to the department of job and family services and file notice of appeal with the court within thirty days after the department mails the administrative appeal decision to the appellant. For good cause shown, the court may extend the time for mailing and filing notice of appeal, but such time shall not exceed six months from the date the department mails the administrative appeal decision. Filing notice of appeal with the court shall be the only act necessary to vest jurisdiction in the court. 17649 17650 17651 17652 17653 17654 17655 17656 17657

(4) The department shall be required to file a transcript of the testimony of the state hearing with the court only if the court orders the department to file the transcript. The court shall make such an order only if it finds that the department and the appellant are unable to stipulate to the facts of the case and that the transcript is essential to a determination of the appeal. The department shall file the transcript not later than thirty days after the day such an order is issued. 17658 17659 17660 17661 17662 17663 17664 17665

(F) The department of job and family services shall adopt 17666

rules in accordance with Chapter 119. of the Revised Code to implement this section, including rules governing the following: 17667 17668

(1) State hearings under division (B) of this section. The rules shall include provisions regarding notice of eligibility termination and the opportunity of an appellant appealing a decision or order of a county department of job and family services to request a county conference with the county department before the state hearing is held. 17669 17670 17671 17672 17673 17674

(2) Administrative appeals under division (C) of this section; 17675 17676

(3) Time limits for complying with a decision issued under division (B) or (C) of this section; 17677 17678

(4) Sanctions that may be applied against an agency under division (D) of this section. 17679 17680

(G) The department of job and family services may adopt rules in accordance with Chapter 119. of the Revised Code establishing an appeals process for an appellant who appeals a decision or order regarding a Title IV-A program identified under division (A)(4)(c), (d), (e), or (f) of section 5101.80 of the Revised Code that is different from the appeals process established by this section. The different appeals process may include having a state agency that administers the Title IV-A program pursuant to an interagency agreement entered into under section 5101.801 of the Revised Code administer the appeals process. 17681 17682 17683 17684 17685 17686 17687 17688 17689 17690

(H) ~~If an appellant receiving medicaid through a health insuring corporation that holds a certificate of authority under Chapter 1751. of the Revised Code is appealing a denial of medicaid services based on lack of medical necessity or other clinical issues regarding coverage by the health insuring corporation, the person hearing the appeal may order an independent medical review if that person determines that a review~~ 17691 17692 17693 17694 17695 17696 17697

~~is necessary. The review shall be performed by a health care~~ 17698
~~professional with appropriate clinical expertise in treating the~~ 17699
~~recipient's condition or disease. The department shall pay the~~ 17700
~~costs associated with the review.~~ 17701

~~A review ordered under this division shall be part of the~~ 17702
~~record of the hearing and shall be given appropriate evidentiary~~ 17703
~~consideration by the person hearing the appeal.~~ 17704

~~(I)~~ The requirements of Chapter 119. of the Revised Code 17705
apply to a state hearing or administrative appeal under this 17706
section only to the extent, if any, specifically provided by rules 17707
adopted under this section. 17708

Sec. 5101.36. Any application for public assistance gives a 17709
right of subrogation to the department of job and family services 17710
for any workers' compensation benefits payable to a person who is 17711
subject to a support order, as defined in section 3119.01 of the 17712
Revised Code, on behalf of the applicant, to the extent of any 17713
public assistance payments made on the applicant's behalf. If the 17714
director of job and family services, in consultation with a child 17715
support enforcement agency and the administrator of the bureau of 17716
workers' compensation, determines that a person responsible for 17717
support payments to a recipient of public assistance is receiving 17718
workers' compensation, the director shall notify the administrator 17719
of the amount of the benefit to be paid to the department of job 17720
and family services. 17721

For purposes of this section, "public assistance" means 17722
~~medical assistance provided through the medical assistance program~~ 17723
~~established under section 5111.01 of the Revised Code;~~ Ohio works 17724
first provided under Chapter 5107. of the Revised Code; 17725
prevention, retention, and contingency benefits and services 17726
provided under Chapter 5108. of the Revised Code; or disability 17727
financial assistance provided under Chapter 5115. of the Revised 17728

Code~~; or disability medical assistance provided under Chapter 5115. of the Revised Code~~.

Sec. 5101.47. (A) Except as provided in division (B) of this section, the director of job and family services may accept applications, determine eligibility, redetermine eligibility, and perform related administrative activities for one or more of the following:

(1) ~~The medicaid program established by Chapter 5111. of the Revised Code;~~

~~(2) The children's health insurance program parts I, II, and III provided for under sections 5101.50, 5101.51, and 5101.52 of the Revised Code;~~

~~(3)~~ Publicly funded child care provided under Chapter 5104. of the Revised Code;

~~(4)~~(2) The food stamp program administered by the department of job and family services pursuant to section 5101.54 of the Revised Code;

~~(5)~~(3) Other programs the director determines are supportive of children, adults, or families;

~~(6)~~(4) Other programs regarding which the director determines administrative cost savings and efficiency may be achieved through the department accepting applications, determining eligibility, redetermining eligibility, or performing related administrative activities.

(B) If federal law requires a face-to-face interview to complete an eligibility determination for a program specified in or pursuant to division (A) of this section, the face-to-face interview shall not be conducted by the department of job and family services.

(C) Subject to division (B) of this section, if the director

elects to accept applications, determine eligibility, redetermine 17759
eligibility, and perform related administrative activities for a 17760
program specified in or pursuant to division (A) of this section, 17761
both of the following apply: 17762

(1) An individual seeking services under the program may 17763
apply for the program to the director or to the entity that state 17764
law governing the program authorizes to accept applications for 17765
the program. 17766

(2) The director is subject to federal statutes and 17767
regulations and state statutes and rules that require, permit, or 17768
prohibit an action regarding accepting applications, determining 17769
or redetermining eligibility, and performing related 17770
administrative activities for the program. 17771

(D) The director may adopt rules as necessary to implement 17772
this section. 17773

Sec. 5101.97. (A)(1) Not later than the last day of each July 17774
and January, the department of job and family services shall 17775
complete a report on the characteristics of the individuals who 17776
participate in or receive services through the programs operated 17777
by the department and the outcomes of the individuals' 17778
participation in or receipt of services through the programs. The 17779
reports shall be for the six-month periods ending on the last days 17780
of June and December and shall include information on the 17781
following: 17782

(a) Work activities, developmental activities, and 17783
alternative work activities established under sections 5107.40 to 17784
5107.69 of the Revised Code; 17785

(b) Programs of publicly funded child care, as defined in 17786
section 5104.01 of the Revised Code; 17787

(c) Child support enforcement programs; 17788

~~(d) Births to recipients of the medical assistance program established under Chapter 5111. of the Revised Code~~. 17789 17790

(2) The department shall submit the reports required under division (A)(1) of this section to the speaker and minority leader of the house of representatives, the president and minority leader of the senate, the legislative budget officer, the director of budget and management, and each board of county commissioners. The department shall provide copies of the reports to any person or government entity on request. 17791 17792 17793 17794 17795 17796 17797

In designing the format for the reports, the department shall consult with individuals, organizations, and government entities interested in the programs operated by the department, so that the reports are designed to enable the general assembly and the public to evaluate the effectiveness of the programs and identify any needs that the programs are not meeting. 17798 17799 17800 17801 17802 17803

(B) Whenever the federal government requires that the department submit a report on a program that is operated by the department or is otherwise under the department's jurisdiction, the department shall prepare and submit the report in accordance with the federal requirements applicable to that report. To the extent possible, the department may coordinate the preparation and submission of a particular report with any other report, plan, or other document required to be submitted to the federal government, as well as with any report required to be submitted to the general assembly. The reports required by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104-193) may be submitted as an annual summary. 17804 17805 17806 17807 17808 17809 17810 17811 17812 17813 17814 17815

Sec. 5103.02. As used in sections 5103.03 to 5103.17 of the Revised Code: 17816 17817

(A) "Association" or "institution" includes any incorporated or unincorporated organization, society, association, or agency, 17818 17819

public or private, that receives or cares for children for two or more consecutive weeks; any individual, including the operator of a foster home, who, for hire, gain, or reward, receives or cares for children for two or more consecutive weeks, unless the individual is related to them by blood or marriage; and any individual not in the regular employ of a court, or of an institution or association certified in accordance with section 5103.03 of the Revised Code, who in any manner becomes a party to the placing of children in foster homes, unless the individual is related to such children by blood or marriage, or is the appointed guardian of such children; provided, that any organization, society, association, school, agency, child guidance center, detention or rehabilitation facility, or children's clinic licensed, regulated, approved, operated under the direction of, or otherwise certified by the department of education, a local board of education, the department of youth services, the department of mental health, or the department of mental retardation and developmental disabilities, or any individual who provides care for only a single-family group, placed there by their parents or other relative having custody, shall not be considered as being within the purview of these sections. 17820 17821 17822 17823 17824 17825 17826 17827 17828 17829 17830 17831 17832 17833 17834 17835 17836 17837 17838 17839 17840

(B) "Family foster home" means a foster home that is not a specialized foster home. 17841 17842

(C) "Foster caregiver" means a person holding a valid foster home certificate issued under section 5103.03 of the Revised Code. 17843 17844

(D) "Foster home" means a private residence in which children are received apart from their parents, guardian, or legal custodian, by an individual reimbursed for providing the children nonsecure care, supervision, or training twenty-four hours a day. "Foster home" does not include care provided for a child in the home of a person other than the child's parent, guardian, or legal custodian while the parent, guardian, or legal custodian is 17845 17846 17847 17848 17849 17850 17851

temporarily away. Family foster homes and specialized foster homes 17852
are types of foster homes. 17853

(E) "Medically fragile foster home" means a foster home that 17854
provides specialized medical services designed to meet the needs 17855
of children with intensive health care needs who meet all of the 17856
following criteria: 17857

(1) Under rules adopted by the ~~department~~ director of ~~job and~~ 17858
~~family services~~ health care administration governing payment under 17859
~~Chapter 5111. of the Revised Code~~ the medicaid program for 17860
long-term care services, the children require a skilled level of 17861
care. 17862

(2) The children require the services of a doctor of medicine 17863
or osteopathic medicine at least once a week due to the 17864
instability of their medical conditions. 17865

(3) The children require the services of a registered nurse 17866
on a daily basis. 17867

(4) The children are at risk of institutionalization in a 17868
hospital, skilled nursing facility, or intermediate care facility 17869
for the mentally retarded. 17870

(F) "Recommending agency" means a public children services 17871
agency, private child placing agency, or private noncustodial 17872
agency that recommends that the department of job and family 17873
services take any of the following actions under section 5103.03 17874
of the Revised Code regarding a foster home: 17875

(1) Issue a certificate; 17876

(2) Deny a certificate; 17877

(3) Renew a certificate; 17878

(4) Deny renewal of a certificate; 17879

(5) Revoke a certificate. 17880

(G) "Specialized foster home" means a medically fragile foster home or a treatment foster home. 17881 17882

(H) "Treatment foster home" means a foster home that incorporates special rehabilitative services designed to treat the specific needs of the children received in the foster home and that receives and cares for children who are emotionally or behaviorally disturbed, chemically dependent, mentally retarded, developmentally disabled, or who otherwise have exceptional needs. 17883 17884 17885 17886 17887 17888

Sec. 5107.10. (A) As used in this section: 17889

(1) "Countable income," "gross earned income," and "gross unearned income" have the meanings established in rules adopted under section 5107.05 of the Revised Code. 17890 17891 17892

(2) "Federal poverty guidelines" has the same meaning as in section 5101.46 of the Revised Code, except that references to a person's family in the definition shall be deemed to be references to the person's assistance group. 17893 17894 17895 17896

(3) "Gross income" means gross earned income and gross unearned income. 17897 17898

(4) "Strike" means continuous concerted action in failing to report to duty; willful absence from one's position; or stoppage of work in whole from the full, faithful, and proper performance of the duties of employment, for the purpose of inducing, influencing, or coercing a change in wages, hours, terms, and other conditions of employment. "Strike" does not include a stoppage of work by employees in good faith because of dangerous or unhealthful working conditions at the place of employment that are abnormal to the place of employment. 17899 17900 17901 17902 17903 17904 17905 17906 17907

(B) Under the Ohio works first program, an assistance group shall receive, except as otherwise provided by this chapter, time-limited cash assistance. In the case of an assistance group 17908 17909 17910

that includes a minor head of household or adult, assistance shall be provided in accordance with the self-sufficiency contract entered into under section 5107.14 of the Revised Code. 17911 17912 17913

(C) To be eligible to participate in Ohio works first, an assistance group must meet all of the following requirements: 17914 17915

(1) The assistance group, except as provided in division (E) of this section, must include at least one of the following: 17916 17917

(a) A minor child who, except as provided in section 5107.24 of the Revised Code, resides with a parent, or specified relative caring for the child, or, to the extent permitted by Title IV-A and federal regulations adopted until Title IV-A, resides with a guardian or custodian caring for the child; 17918 17919 17920 17921 17922

(b) A parent residing with and caring for the parent's minor child who receives benefits under the supplemental security income ~~under Title XVI of the "Social Security Act," 86 Stat. 1475 (1972), 42 U.S.C.A. 1383, as amended,~~ program or federal, state, or local adoption assistance; 17923 17924 17925 17926 17927

(c) A specified relative residing with and caring for a minor child who is related to the specified relative in a manner that makes the specified relative a specified relative and receives supplemental security income or federal, state, or local foster care or adoption assistance; 17928 17929 17930 17931 17932

(d) A woman at least six months pregnant. 17933

(2) The assistance group must meet the income requirements established by division (D) of this section. 17934 17935

(3) No member of the assistance group may be involved in a strike. 17936 17937

(4) The assistance group must satisfy the requirements for Ohio works first established by this chapter and sections ~~5101.58, 5101.59, and~~ 5101.83, 5160.37, and 5160.38 of the Revised Code. 17938 17939 17940

(5) The assistance group must meet requirements for Ohio works first established by rules adopted under section 5107.05 of the Revised Code. 17941 17942 17943

(D)(1) Except as provided in division (D)(4) of this section, to determine whether an assistance group is initially eligible to participate in Ohio works first, a county department of job and family services shall do the following: 17944 17945 17946 17947

(a) Determine whether the assistance group's gross income exceeds fifty per cent of the federal poverty guidelines. In making this determination, the county department shall disregard amounts that federal statutes or regulations and sections 5101.17 and 5117.10 of the Revised Code require be disregarded. The assistance group is ineligible to participate in Ohio works first if the assistance group's gross income, less the amounts disregarded, exceeds fifty per cent of the federal poverty guidelines. 17948 17949 17950 17951 17952 17953 17954 17955 17956

(b) If the assistance group's gross income, less the amounts disregarded pursuant to division (D)(1)(a) of this section, does not exceed fifty per cent of the federal poverty guidelines, determine whether the assistance group's countable income is less than the payment standard. The assistance group is ineligible to participate in Ohio works first if the assistance group's countable income equals or exceeds the payment standard. 17957 17958 17959 17960 17961 17962 17963

(2) For the purpose of determining whether an assistance group meets the income requirement established by division (D)(1)(a) of this section, the annual revision that the United States department of health and human services makes to the federal poverty guidelines shall go into effect on the first day of July of the year for which the revision is made. 17964 17965 17966 17967 17968 17969

(3) To determine whether an assistance group participating in Ohio works first continues to be eligible to participate, a county 17970 17971

department of job and family services shall determine whether the assistance group's countable income continues to be less than the payment standard. In making this determination, the county department shall disregard the first two hundred fifty dollars and fifty per cent of the remainder of the assistance group's gross earned income. No amounts shall be disregarded from the assistance group's gross unearned income. The assistance group ceases to be eligible to participate in Ohio works first if its countable income, less the amounts disregarded, equals or exceeds the payment standard. 17972 17973 17974 17975 17976 17977 17978 17979 17980 17981

(4) If an assistance group reapplies to participate in Ohio works first not more than four months after ceasing to participate, a county department of job and family services shall use the income requirement established by division (D)(3) of this section to determine eligibility for resumed participation rather than the income requirement established by division (D)(1) of this section. 17982 17983 17984 17985 17986 17987 17988

(E)(1) An assistance group may continue to participate in Ohio works first even though a public children services agency removes the assistance group's minor children from the assistance group's home due to abuse, neglect, or dependency if the agency does both of the following: 17989 17990 17991 17992 17993

(a) Notifies the county department of job and family services at the time the agency removes the children that it believes the children will be able to return to the assistance group within six months; 17994 17995 17996 17997

(b) Informs the county department at the end of each of the first five months after the agency removes the children that the parent, guardian, custodian, or specified relative of the children is cooperating with the case plans prepared for the children under section 2151.412 of the Revised Code and that the agency is making reasonable efforts to return the children to the assistance group. 17998 17999 18000 18001 18002 18003

(2) An assistance group may continue to participate in Ohio works first pursuant to division (E)(1) of this section for not more than six payment months. This division does not affect the eligibility of an assistance group that includes a woman at least six months pregnant. 18004 18005 18006 18007 18008

Sec. 5107.14. (A) An assistance group is ineligible to participate in Ohio works first unless the following enter into a written self-sufficiency contract with the county department of job and family services not later than thirty days after the assistance group applies for or undergoes a redetermination of eligibility for the program: 18009 18010 18011 18012 18013 18014

(1) Each adult member of the assistance group; 18015

(2) The assistance group's minor head of household unless the minor head of household is participating in the LEAP program. 18016 18017

(B) A self-sufficiency contract shall set forth the rights and responsibilities of the assistance group as applicants for and participants of Ohio works first. Each self-sufficiency contract shall include, based on appraisals conducted under section 5107.41 of the Revised Code and assessments conducted under section 5107.70 of the Revised Code, the following: 18018 18019 18020 18021 18022 18023

(1) The assistance group's plan, developed under section 5107.41 of the Revised Code, to achieve the goal of self sufficiency and personal responsibility through unsubsidized employment within the time limit for participating in Ohio works first established by section 5107.18 of the Revised Code; 18024 18025 18026 18027 18028

(2) Work activities, developmental activities, and alternative work activities to which members of the assistance group are assigned under sections 5107.40 to 5107.69 of the Revised Code; 18029 18030 18031 18032

(3) The responsibility of a caretaker member of the 18033

assistance group to cooperate in establishing a minor child's paternity and establishing, modifying, and enforcing a support order for the child in accordance with section 5107.22 of the Revised Code; 18034 18035 18036 18037

(4) Other responsibilities that members of the assistance group must satisfy to participate in Ohio works first and the consequences for failure or refusal to satisfy the responsibilities; 18038 18039 18040 18041

(5) An agreement that, except as otherwise provided in a waiver issued under section 5107.714 of the Revised Code, the assistance group will comply with the conditions of participating in Ohio works first established by this chapter and sections ~~5101.58, 5101.59, and~~ 5101.83<u>, 5160.37 and 5160.38</u> of the Revised Code; 18042 18043 18044 18045 18046 18047

(6) Assistance and services the county department will provide to the assistance group; 18048 18049

(7) Assistance and services the child support enforcement agency and public children services agency will provide to the assistance group pursuant to a plan of cooperation entered into under section 307.983 of the Revised Code; 18050 18051 18052 18053

(8) Other provisions designed to assist the assistance group in achieving self sufficiency and personal responsibility; 18054 18055

(9) Procedures for assessing whether responsibilities are being satisfied and whether the contract should be amended; 18056 18057

(10) Procedures for amending the contract. 18058

(C) No self-sufficiency contract shall include provisions regarding the LEAP program. 18059 18060

(D) The county department shall provide without charge a copy of the self-sufficiency contract to each assistance group member who signs it. 18061 18062 18063

Sec. 5107.16. (A) If a member of an assistance group fails or 18064
refuses, without good cause, to comply in full with a provision of 18065
a self-sufficiency contract entered into under section 5107.14 of 18066
the Revised Code, a county department of job and family services 18067
shall sanction the assistance group as follows: 18068

(1) For a first failure or refusal, the county department 18069
shall deny or terminate the assistance group's eligibility to 18070
participate in Ohio works first for one payment month; 18071

(2) For a second failure or refusal, the county department 18072
shall deny or terminate the assistance group's eligibility to 18073
participate in Ohio works first for three payment months; 18074

(3) For a third or subsequent failure or refusal, the county 18075
department shall deny or terminate the assistance group's 18076
eligibility to participate in Ohio works first for six payment 18077
months. 18078

(B) The director of job and family services shall establish 18079
standards for the determination of good cause for failure or 18080
refusal to comply in full with a provision of a self-sufficiency 18081
contract in rules adopted under section 5107.05 of the Revised 18082
Code. 18083

(C) After sanctioning an assistance group under division (A) 18084
of this section, a county department of job and family services 18085
shall continue to work with the assistance group. 18086

(D) An adult eligible for the medicaid program pursuant to 18087
division (A)~~(1)(a)~~ of section ~~5111.01~~ 5162.01 of the Revised Code 18088
who is sanctioned under division (A)(3) of this section for a 18089
failure or refusal, without good cause, to comply in full with a 18090
provision of a self-sufficiency contract related to work 18091
responsibilities under sections 5107.40 to 5107.69 of the Revised 18092
Code loses eligibility for the medicaid program unless the adult 18093

is otherwise eligible for the medicaid program pursuant to another division of section ~~5111.01~~ 5162.01 of the Revised Code. 18094 18095

An assistance group that would be participating in Ohio works first if not for a sanction under this section shall continue to be eligible for all of the following: 18096 18097 18098

(1) Publicly funded child care in accordance with division (A)(3) of section 5104.30 of the Revised Code; 18099 18100

(2) Support services in accordance with section 5107.66 of the Revised Code; 18101 18102

(3) To the extent permitted by the "Fair Labor Standards Act of 1938," 52 Stat. 1060, 29 U.S.C. 201, as amended, to participate in work activities, developmental activities, and alternative work activities in accordance with sections 5107.40 to 5107.69 of the Revised Code. 18103 18104 18105 18106 18107

Sec. 5107.20. As used in this section, "support" means child support, spousal support, and support for a spouse or a former spouse. 18108 18109 18110

Participation in Ohio works first constitutes an assignment to the department of job and family services of any rights members of an assistance group have to support from any other person, excluding medical support assigned pursuant to section ~~5101.59~~ 5160.37 of the Revised Code. The rights to support assigned to the department pursuant to this section constitute an obligation of the person who is responsible for providing the support to the state for the amount of cash assistance provided to the assistance group. 18111 18112 18113 18114 18115 18116 18117 18118 18119

The office of child support in the department of job and family services shall collect and distribute support payments owed to Ohio works first participants, whether assigned to the department or unassigned, in accordance with 42 U.S.C. 654 B and 18120 18121 18122 18123

657 and regulations adopted under those statutes, state statutes, 18124
and rules adopted under section 5107.05 of the Revised Code. 18125

Upon implementation of centralized collection and 18126
disbursement under Chapter 3121. of the Revised Code, in 18127
accordance with 42 U.S.C. 654 B and 657 and regulations adopted 18128
under those statutes, the department shall deposit support 18129
payments it receives pursuant to this section into the state 18130
treasury to the credit of the child support collections fund or 18131
the child support administrative fund, both of which are hereby 18132
created. Money credited to the funds shall be used to make cash 18133
assistance payments under Ohio works first. 18134

Sec. 5107.26. (A) As used in this section: 18135

(1) "Transitional child care" means publicly funded child 18136
care provided under division (A)(3) of section 5104.34 of the 18137
Revised Code. 18138

(2) "Transitional medicaid" means the medical assistance 18139
provided under the medicaid program pursuant to section ~~5111.0115~~ 18140
5162.09 of the Revised Code. 18141

(B) Except as provided in division (C) of this section, each 18142
member of an assistance group participating in Ohio works first is 18143
ineligible to participate in the program for six payment months if 18144
a county department of job and family services determines that a 18145
member of the assistance group terminated the member's employment 18146
and each person who, on the day prior to the day a recipient 18147
begins to receive transitional child care or transitional 18148
medicaid, was a member of the recipient's assistance group is 18149
ineligible to participate in Ohio works first for six payment 18150
months if a county department determines that the recipient 18151
terminated the recipient's employment. 18152

(C) No assistance group member shall lose or be denied 18153

eligibility to participate in Ohio works first pursuant to division (B) of this section if the termination of employment was because an assistance group member or recipient of transitional child care or transitional medicaid secured comparable or better employment or the county department of job and family services certifies that the member or recipient terminated the employment with just cause. 18154 18155 18156 18157 18158 18159 18160

Just cause includes the following: 18161

(1) Discrimination by an employer based on age, race, sex, color, handicap, religious beliefs, or national origin; 18162 18163

(2) Work demands or conditions that render continued employment unreasonable, such as working without being paid on schedule; 18164 18165 18166

(3) Employment that has become unsuitable due to any of the following: 18167 18168

(a) The wage is less than the federal minimum wage; 18169

(b) The work is at a site subject to a strike or lockout, unless the strike has been enjoined under section 208 of the "Labor-Management Relations Act," 61 Stat. 155 (1947), 29 U.S.C.A. 178, as amended, an injunction has been issued under section 10 of the "Railway Labor Act," 44 Stat. 586 (1926), 45 U.S.C.A. 160, as amended, or an injunction has been issued under section 4117.16 of the Revised Code; 18170 18171 18172 18173 18174 18175 18176

(c) The documented degree of risk to the member or recipient's health and safety is unreasonable; 18177 18178

(d) The member or recipient is physically or mentally unfit to perform the employment, as documented by medical evidence or by reliable information from other sources. 18179 18180 18181

(4) Documented illness of the member or recipient or of another assistance group member of the member or recipient 18182 18183

requiring the presence of the member or recipient; 18184

(5) A documented household emergency; 18185

(6) Lack of adequate child care for children of the member or 18186
recipient who are under six years of age. 18187

Sec. 5115.02. (A) An individual is not eligible for 18188
disability financial assistance under this chapter if any of the 18189
following apply: 18190

(1) The individual is eligible to participate in the Ohio 18191
works first program established under Chapter 5107. of the Revised 18192
Code; eligible ~~to receive~~ for the supplemental security income 18193
~~provided pursuant to Title XVI of the "Social Security Act," 86~~ 18194
~~Stat. 1475 (1972), 42 U.S.C. 1383, as amended~~ program; or eligible 18195
to participate in or receive assistance through another state or 18196
federal program that provides financial assistance similar to 18197
disability financial assistance, as determined by the director of 18198
job and family services; 18199

(2) The individual is ineligible to participate in the Ohio 18200
works first program because of any of the following: 18201

(a) The time limit established by section 5107.18 of the 18202
Revised Code; 18203

(b) Failure to comply with an application or verification 18204
procedure; 18205

(c) The fraud control provisions of section 5101.83 of the 18206
Revised Code or the fraud control program established pursuant to 18207
45 C.F.R. 235.112, as in effect July 1, 1996; 18208

(d) The self-sufficiency contract provisions of sections 18209
5107.14 and 5107.16 of the Revised Code; 18210

(e) The minor parent provisions of section 5107.24 of the 18211
Revised Code; 18212

(f) The provisions of section 5107.26 of the Revised Code regarding termination of employment without just cause. 18213 18214

(3) The individual, or any of the other individuals included in determining the individual's eligibility, is involved in a strike, as defined in section 5107.10 of the Revised Code; 18215 18216 18217

(4) For the purpose of avoiding consideration of property in determinations of the individual's eligibility for disability financial assistance or a greater amount of assistance, the individual has transferred property during the two years preceding application for or most recent redetermination of eligibility for disability assistance; 18218 18219 18220 18221 18222 18223

(5) The individual is a child and does not live with the child's parents, guardians, or other persons standing in place of parents, unless the child is emancipated by being married, by serving in the armed forces, or by court order; 18224 18225 18226 18227

(6) The individual ~~reside~~ resides in a county home, city infirmary, jail, or public institution; 18228 18229

(7) The individual is a fugitive felon as defined in section 5101.26 of the Revised Code; 18230 18231

(8) The individual is violating a condition of probation, a community control sanction, parole, or a post-release control sanction imposed under federal or state law. 18232 18233 18234

(B)(1) As used in division (B)(2) of this section, "assistance group" has the same meaning as in section 5107.02 of the Revised Code. 18235 18236 18237

(2) Ineligibility under division (A)(2)(c) or (d) of this section applies as follows: 18238 18239

(a) In the case of an individual who is under eighteen years of age, the individual is ineligible only if the individual caused the assistance group to be ineligible to participate in the Ohio 18240 18241 18242

works first program or resides with an individual eighteen years 18243
of age or older who was a member of the same ineligible assistance 18244
group. 18245

(b) In the case of an individual who is eighteen years of age 18246
or older, the individual is ineligible regardless of whether the 18247
individual caused the assistance group to be ineligible to 18248
participate in the Ohio works first program. 18249

Sec. 5115.20. (A) The department of job and family services 18250
shall establish a disability advocacy program and each county 18251
department of job and family services shall establish a disability 18252
advocacy program unit or join with other county departments of job 18253
and family services to establish a joint county disability 18254
advocacy program unit. Through the program the department and 18255
county departments shall cooperate in efforts to assist applicants 18256
for and recipients of assistance under the disability financial 18257
assistance program and the disability medical assistance program, 18258
who might be eligible for benefits under the supplemental security 18259
income ~~benefits under Title XVI of the "Social Security Act," 86~~ 18260
~~Stat. 1475 (1972), 42 U.S.C.A. 1383, as amended~~ program, in 18261
applying for those benefits. The department of health care 18262
administration shall assist the department of job and family 18263
services and county departments with the program. 18264

As part of their disability advocacy programs, the state 18265
department and county departments may enter into contracts for the 18266
services of persons and government entities that in the judgment 18267
of the department or county department have demonstrated expertise 18268
in representing persons seeking supplemental security income 18269
benefits. Each contract shall require the person or entity with 18270
which a department contracts to assess each person referred to it 18271
by the department to determine whether the person appears to be 18272
eligible for supplemental security income benefits, and, if the 18273

person appears to be eligible, assist the person in applying and 18274
represent the person in any proceeding of the social security 18275
administration, including any appeal or reconsideration of a 18276
denial of benefits. The department or county department shall 18277
provide to the person or entity with which it contracts all 18278
records in its possession relevant to the application for 18279
supplemental security income benefits. The department shall 18280
require a county department with relevant records to submit them 18281
to the person or entity. 18282

(B) Each applicant for or recipient of disability financial 18283
assistance ~~or disability medical assistance~~ who, in the judgment 18284
of the department of job and family services or a county 18285
department of job and family services might be eligible for 18286
supplemental security benefits, shall, as a condition of 18287
eligibility for assistance, apply for such benefits if directed to 18288
do so by the department or county department. 18289

(C) ~~With regard to applicants for and recipients of~~ 18290
~~disability financial assistance or disability medical assistance,~~ 18291
~~each county department of job and family services shall do all of~~ 18292
~~the following:~~ 18293

~~(1) Identify applicants and recipients who might be eligible~~ 18294
~~for supplemental security income benefits;~~ 18295

~~(2) Assist applicants and recipients in securing~~ 18296
~~documentation of disabling conditions or refer them for such~~ 18297
~~assistance to a person or government entity with which the~~ 18298
~~department or county department has contracted under division (A)~~ 18299
~~of this section;~~ 18300

~~(3) Inform applicants and recipients of available sources of~~ 18301
~~representation, which may include a person or government entity~~ 18302
~~with which the department or county department has contracted~~ 18303
~~under division (A) of this section, and of their right to~~ 18304

~~represent themselves in reconsiderations and appeals of social security administration decisions that deny them supplemental security income benefits. The county department may require the applicants and recipients, as a condition of eligibility for assistance, to pursue reconsiderations and appeals of social security administration decisions that deny them supplemental security income benefits, and shall assist applicants and recipients as necessary to obtain such benefits or refer them to a person or government entity with which the department or county department has contracted under division (A) of this section~~. 18305 18306 18307 18308 18309 18310 18311 18312 18313 18314

~~(4) Require applicants and recipients who, in the judgment of the county department, are or may be aged, blind, or disabled, to apply for medical assistance under Chapter 5111. of the Revised Code, make determinations when appropriate as to eligibility for medical assistance, and refer their applications when necessary to the disability determination unit established in accordance with division (F) of this section for expedited review;~~ 18315 18316 18317 18318 18319 18320 18321

~~(5) Require each applicant and recipient who in the judgment of the department or the county department might be eligible for supplemental security income benefits, as a condition of eligibility for disability financial assistance or disability medical assistance, to execute a written authorization for the secretary of health and human services to withhold benefits due that individual and pay to the director of job and family services or the director's designee an amount sufficient to reimburse the state and county shares of interim assistance furnished to the individual. For the purposes of division (C)(5) of this section, "benefits" and "interim assistance" have the meanings given in Title XVI of the "Social Security Act."~~ 18322 18323 18324 18325 18326 18327 18328 18329 18330 18331 18332 18333

~~(D)~~ The director of job and family services shall adopt rules in accordance with section 111.15 of the Revised Code for the effective administration of the disability advocacy program. The 18334 18335 18336

rules shall include all of the following: 18337

(1) Methods to be used in collecting information from and 18338
disseminating it to county departments, including the following: 18339

(a) The number of individuals in the county who are disabled 18340
recipients of disability financial assistance or disability 18341
medical assistance; 18342

(b) The final decision made either by the social security 18343
administration or by a court for each application or 18344
reconsideration in which an individual was assisted pursuant to 18345
this section. 18346

(2) The type and process of training to be provided by the 18347
department of job and family services to the employees of the 18348
county department of job and family services who perform duties 18349
under this section and section 329.043 of the Revised Code; 18350

(3) Requirements for the written authorization required by 18351
division ~~(C)(5)~~(E) of ~~this~~ section 329.043 of the Revised Code. 18352

~~(E)~~(D) The department of job and family services shall 18353
provide basic and continuing training to employees of the county 18354
department of job and family services who perform duties under 18355
this section and section 329.043 of the Revised Code. Training 18356
shall include but not be limited to all processes necessary to 18357
obtain federal disability benefits, and methods of advocacy. 18358

~~(F) The department shall establish a disability determination~~ 18359
~~unit and develop guidelines for expediting reviews of applications~~ 18360
~~for medical assistance under Chapter 5111. of the Revised Code for~~ 18361
~~persons who have been referred to the unit under division (C)(4)~~ 18362
~~of this section. The department shall make determinations of~~ 18363
~~eligibility for medical assistance for any such person within the~~ 18364
~~time prescribed by federal regulations.~~ 18365

~~(G)~~(E) The department of job and family services may, under 18366

rules the director of job and family services adopts in accordance 18367
with section 111.15 of the Revised Code, pay a portion of the 18368
federal reimbursement described in division ~~(C)(5)~~(E) of ~~this~~ 18369
section 329.043 of the Revised Code to persons or government 18370
entities that assist or represent assistance recipients in 18371
reconsiderations and appeals of social security administration 18372
decisions denying them supplemental security income benefits. 18373

~~(H)~~(F) The director of job and family services shall conduct 18374
investigations to determine whether disability advocacy programs 18375
are being administered in compliance with the Revised Code and the 18376
rules adopted by the director pursuant to this section. 18377

Sec. 5115.22. (A) If a recipient of disability financial 18378
assistance ~~or disability medical assistance~~, or an individual 18379
whose income and resources are included in determining the 18380
recipient's eligibility for the assistance, becomes possessed of 18381
resources or income in excess of the amount allowed to retain 18382
eligibility, or if other changes occur that affect the recipient's 18383
eligibility or need for assistance, the recipient shall notify the 18384
state or county department of job and family services within the 18385
time limits specified in rules adopted by the director of job and 18386
family services in accordance with section 111.15 of the Revised 18387
Code. Failure of a recipient to report possession of excess 18388
resources or income or a change affecting eligibility or need 18389
within those time limits shall be considered prima-facie evidence 18390
of intent to defraud under section 5115.23 of the Revised Code. 18391

(B) As a condition of eligibility for disability financial 18392
assistance ~~or disability medical assistance~~, and as a means of 18393
preventing or reducing the provision of assistance at public 18394
expense, each applicant for or recipient of the assistance shall 18395
make reasonable efforts to secure support from persons responsible 18396
for the applicant's or recipient's support, and from other 18397

sources, including any federal program designed to provide 18398
assistance to individuals with disabilities. The state or county 18399
department of job and family services may provide assistance to 18400
the applicant or recipient in securing other forms of financial 18401
assistance. 18402

Sec. 5115.23. As used in this section, "erroneous payments" 18403
means disability financial assistance payments ~~or disability~~ 18404
~~medical assistance payments~~ made to persons who are not entitled 18405
to receive them, including payments made as a result of 18406
misrepresentation or fraud, and payments made due to an error by 18407
the recipient or by the county department of job and family 18408
services that made the payment. 18409

The department of job and family services shall adopt rules 18410
in accordance with section 111.15 of the Revised Code specifying 18411
the circumstances under which action is to be taken under this 18412
section to recover erroneous payments. The department, or a county 18413
department of job and family services at the request of the 18414
department, shall take action to recover erroneous payments in the 18415
circumstances specified in the rules. The department or county 18416
department may institute a civil action to recover erroneous 18417
payments. 18418

Whenever disability financial assistance ~~or disability~~ 18419
~~medical assistance~~ has been furnished to a recipient for whose 18420
support another person is responsible, the other person shall, in 18421
addition to the liability otherwise imposed, as a consequence of 18422
failure to support the recipient, be liable for all assistance 18423
furnished the recipient. The value of the assistance so furnished 18424
may be recovered in a civil action brought by the county 18425
department of job and family services. 18426

Each county department of job and family services shall 18427
retain fifty per cent of the erroneous payments it recovers under 18428

this section. The department of job and family services shall 18429
receive the remaining fifty per cent. 18430

Sec. 5117.10. (A) On or before the fifteenth day of January, 18431
the director of development shall pay each applicant determined 18432
eligible for a payment under divisions (A) and (B) of section 18433
5117.07 of the Revised Code one hundred twenty-five dollars. 18434

(B) The director may withhold from any payment to which a 18435
person would otherwise be entitled under division (A) of this 18436
section any amount that the director determines was erroneously 18437
received by such person in a preceding year under this or the 18438
program established under Am. Sub. H.B. 230, as amended by Am. 18439
H.B. 937, Am. Sub. H.B. 1073, Am. Sub. S.B. 493, and Am. Sub. S.B. 18440
523 of the 112th general assembly, provided the director has 18441
employed all other legal methods reasonably available to obtain 18442
reimbursement for the erroneous payment or credit prior to the 18443
commencement of the current program year. 18444

(C) Payments made under this section and credits granted 18445
under section 5117.09 of the Revised Code shall not be considered 18446
income for the purpose of determining eligibility or the level of 18447
benefits or assistance under section 329.042 or Chapters 5107.~~,~~ 18448
~~5111.,~~ and 5115. of the Revised Code; the medicaid program; the 18449
disability medical assistance program; supplemental security 18450
income payments ~~under Title XVI of the "Social Security Act," 49~~ 18451
~~Stat. 620 (1935), 42 U.S.C. 301, as amended~~; or any other program 18452
under which eligibility or the level of benefits or assistance is 18453
based upon need measured by income. 18454

Sec. 5119.04. The department of mental health and any 18455
institutions under its supervision or jurisdiction shall, where 18456
applicable, be in substantial compliance with standards set forth 18457
for psychiatric facilities by the joint commission on 18458

accreditation of healthcare organizations or ~~medical assistance~~ medicaid standards ~~under Title XIX of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C. 301, as amended~~, or other applicable standards, except that the department and any institution under its supervision or jurisdiction shall be in substantial compliance with standards for physical facilities and equipment by July 1, 1989. The requirements of this section do not apply to any facility designated by the director of mental health for use as a psychiatric rehabilitation center.

The requirements of this section are in addition to any other requirements established by the Revised Code and nothing in this section shall be construed to limit any rights, privileges, protections, or immunities which may exist under the constitution and laws of the United States or this state.

Sec. 5119.061. (A) As used in this section, "mentally ill individual" and "specialized services" have the same meanings as in section ~~5111.202~~ 5119.061 of the Revised Code.

(B)(1) Except as provided in division (B)(2) of this section and rules adopted under division (E)(3) of this section, for purposes of section ~~5111.202~~ 5119.061 of the Revised Code, the department of mental health shall determine in accordance with ~~section 1919(e)(7) of the "Social Security Act," 49 Stat. 620 (1935),~~ 42 U.S.C.~~A. 301, as amended,~~ 1396r(e)(7) and regulations adopted under ~~section 1919(f)(8)(A) of that act~~ 42 U.S.C. 1396r(f)(8)(A) whether, because of the individual's physical and mental condition, a mentally ill individual seeking admission to a nursing facility requires the level of services provided by a nursing facility and, if the individual requires that level of services, whether the individual requires specialized services for mental illness. The determination required by this division shall be based on an independent physical and mental evaluation

performed by a person or entity other than the department. 18490

(2) A determination under this division is not required for any of the following: 18491 18492

(a) An individual seeking readmission to a nursing facility after having been transferred from a nursing facility to a hospital for care; 18493 18494 18495

(b) An individual who meets all of the following conditions: 18496

(i) The individual is admitted to the nursing facility directly from a hospital after receiving inpatient care at the hospital; 18497 18498 18499

(ii) The individual requires nursing facility services for the condition for which care in the hospital was received; 18500 18501

(iii) The individual's attending physician has certified, before admission to the nursing facility, that the individual is likely to require less than thirty days of nursing facility services. 18502 18503 18504 18505

(c) An individual transferred from one nursing facility to another nursing facility, with or without an intervening hospital stay. 18506 18507 18508

(C) Except as provided in rules adopted under division (F)(3) of this section, the department of mental health shall review and determine for each resident of a nursing facility who is mentally ill, whether the resident, because of the resident's physical and mental condition, requires the level of services provided by a nursing facility and whether the resident requires specialized services for mental illness. The review and determination shall be conducted in accordance with section 1919(e)(7) of the "Social Security Act" and the regulations adopted under section 1919(f)(8)(A) of the act and based on an independent physical and mental evaluation performed by a person or entity other than the 18509 18510 18511 18512 18513 18514 18515 18516 18517 18518 18519

department. The review and determination shall be completed 18520
promptly after a nursing facility has notified the department that 18521
there has been a significant change in the resident's mental or 18522
physical condition. 18523

(D)(1) In the case of a nursing facility resident who has 18524
continuously resided in a nursing facility for at least thirty 18525
months before the date of a review and determination under 18526
division (C) of this section, if the resident is determined not to 18527
require the level of services provided by a nursing facility, but 18528
is determined to require specialized services for mental illness, 18529
the department, in consultation with the resident's family or 18530
legal representative and care givers, shall do all of the 18531
following: 18532

(a) Inform the resident of the institutional and 18533
noninstitutional alternatives covered under the state <u>medicaid</u> 18534
plan ~~for medical assistance~~; 18535

(b) Offer the resident the choice of remaining in the nursing 18536
facility or receiving covered services in an alternative 18537
institutional or noninstitutional setting; 18538

(c) Clarify the effect on eligibility for services under the 18539
state <u>medicaid</u> plan ~~for medical assistance~~ if the resident chooses 18540
to leave the facility, including its effect on readmission to the 18541
facility; 18542

(d) Provide for or arrange for the provision of specialized 18543
services for the resident's mental illness in the setting chosen 18544
by the resident. 18545

(2) In the case of a nursing facility resident who has 18546
continuously resided in a nursing facility for less than thirty 18547
months before the date of the review and determination under 18548
division (C) of this section, if the resident is determined not to 18549
require the level of services provided by a nursing facility, but 18550

is determined to require specialized services for mental illness, 18551
or if the resident is determined to require neither the level of 18552
services provided by a nursing facility nor specialized services 18553
for mental illness, the department shall act in accordance with 18554
its alternative disposition plan approved by the United States 18555
department of health and human services under section 18556
1919(e)(7)(E) of the "Social Security Act." 18557

(3) In the case of an individual who is determined under 18558
division (B) or (C) of this section to require both the level of 18559
services provided by a nursing facility and specialized services 18560
for mental illness, the department of mental health shall provide 18561
or arrange for the provision of the specialized services needed by 18562
the individual or resident while residing in a nursing facility. 18563

(E) The department of mental health shall adopt rules in 18564
accordance with Chapter 119. of the Revised Code that do all of 18565
the following: 18566

(1) Establish criteria to be used in making the 18567
determinations required by divisions (B) and (C) of this section. 18568
The criteria shall not exceed the criteria established by 18569
regulations adopted by the United States department of health and 18570
human services under section 1919(f)(8)(A) of the "Social Security 18571
Act." 18572

(2) Specify information to be provided by the individual or 18573
nursing facility resident being assessed; 18574

(3) Specify any circumstances, in addition to circumstances 18575
listed in division (B) of this section, under which determinations 18576
under divisions (B) and (C) of this section are not required to be 18577
made. 18578

Sec. 5119.16. As used in this section, "free clinic" has the 18579
same meaning as in section 2305.2341 of the Revised Code. 18580

(A) The department of mental health is hereby designated to 18581
provide certain goods and services for the department of mental 18582
health, the department of mental retardation and developmental 18583
disabilities, the department of rehabilitation and correction, the 18584
department of youth services, and other state, county, or 18585
municipal agencies requesting ~~such~~ those goods and services when 18586
the department of mental health determines that it is in the 18587
public interest, and considers it advisable, to provide ~~these~~ 18588
those goods and services. The department of mental health also may 18589
provide goods and services to agencies operated by the United 18590
States government and to public or private nonprofit agencies, 18591
other than free clinics, that are funded in whole or in part by 18592
the state if the public or private nonprofit agencies are 18593
designated for participation in this program by the director of 18594
mental health for community mental health agencies, the director 18595
of mental retardation and developmental disabilities for community 18596
mental retardation and developmental disabilities agencies, the 18597
director of rehabilitation and correction for community 18598
rehabilitation and correction agencies, or the director of youth 18599
services for community youth services agencies. 18600

Designated community agencies shall receive goods and 18601
services through the department of mental health only in those 18602
cases where the designating state agency certifies that providing 18603
~~such~~ the goods and services to the agency will conserve public 18604
resources to the benefit of the public and where the provision of 18605
~~such~~ the goods and services is considered feasible by the 18606
department of mental health. 18607

(B) The department of mental health may permit free clinics 18608
to purchase certain goods and services to the extent the purchases 18609
fall within the exemption to the Robinson-Patman Act, 15 U.S.C. 13 18610
et seq., applicable to ~~non-profit~~ nonprofit institutions, in 15 18611
U.S.C. 13c, as amended. 18612

(C) The goods and services to be provided by the department of mental health under divisions (A) and (B) of this section may include all of the following: 18613 18614 18615

(1) Procurement, storage, processing, and distribution of food and professional consultation on food operations; 18616 18617

(2) Procurement, storage, and distribution of medical and laboratory supplies, dental supplies, medical records, forms, optical supplies, and sundries, subject to section 5120.135 of the Revised Code; 18618 18619 18620 18621

(3) Procurement, storage, repackaging, distribution, and dispensing of drugs, the provision of professional pharmacy consultation, and drug information services; 18622 18623 18624

(4) Other goods and services as may be agreed to. 18625

(D) ~~The~~ Subject to section 5160.75 of the Revised Code, the department of mental health shall provide the goods and services designated in division (C) of this section to its institutions and to state-operated community-based mental health services. 18626 18627 18628 18629

(E) After consultation with and advice from the director of mental retardation and developmental disabilities, the director of rehabilitation and correction, and the director of youth services and subject to section 5160.75 of the Revised Code, the department of mental health shall provide the goods and services designated in division (C) of this section to the department of mental retardation and developmental disabilities, the department of rehabilitation and correction, and the department of youth services. 18630 18631 18632 18633 18634 18635 18636 18637 18638

(F) The cost of administration of this section shall be determined by the department of mental health and paid by the agencies or free clinics receiving the goods and services to the department for deposit in the state treasury to the credit of the mental health fund, which is hereby created. The fund shall be 18639 18640 18641 18642 18643

used to pay the cost of administration of this section to the department. 18644 18645

(G) If the goods or services designated in division (C) of this section are not provided in a satisfactory manner by the department of mental health to the agencies described in division (A) of this section, the director of mental retardation and developmental disabilities, the director of rehabilitation and correction, the director of youth services, or the managing officer of a department of mental health institution shall attempt to resolve unsatisfactory service with the director of mental health. If, after ~~such~~ the attempt, the provision of goods or services continues to be unsatisfactory, the director or officer shall notify the director of mental health. If, within thirty days of ~~such~~ that notice the department of mental health does not provide the specified goods and services in a satisfactory manner, the director of mental retardation and developmental disabilities, the director of rehabilitation and correction, the director of youth services, or the managing officer of the department of mental health institution shall notify the director of mental health of the director's or managing officer's intent to cease purchasing goods and services from the department. Following a sixty-day cancellation period from the date of ~~such~~ that notice and subject to section 5160.75 of the Revised Code, the department of mental retardation, department of rehabilitation and correction, department of youth services, or the department of mental health institution may obtain the goods and services from a source other than the department of mental health, if the department certifies to the department of administrative services that the requirements of this division have been met. 18646 18647 18648 18649 18650 18651 18652 18653 18654 18655 18656 18657 18658 18659 18660 18661 18662 18663 18664 18665 18666 18667 18668 18669 18670 18671 18672

(H) Whenever a state agency fails to make a payment for goods and services provided under this section within thirty-one days after the date the payment was due, the office of budget and 18673 18674 18675

management may transfer moneys from the state agency to the department of mental health. The amount transferred shall not exceed the amount of overdue payments. Prior to making a transfer under this division, the office of budget and management shall apply any credits the state agency has accumulated in payments for goods and services provided under this section.

(I) Purchases of goods and services under this section are not subject to section 307.86 of the Revised Code.

<u>(J) The department shall not perform any acts described in division (A)(3) of this section for state departments or other state agencies covered by the operation of section 5160.75 of the Revised Code.</u>

Sec. 5119.351. The department of mental health may pay an amount for personal use to each individual residing in a state institution as described in section 5119.02 of the Revised Code who would be eligible for supplemental security income benefits at the reduced rate established by ~~Title XVI of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 1382, as amended~~ <u>the supplemental security income program</u>, if the state <u>medicaid</u> plan ~~for providing medical assistance under section 5111.01 of the Revised Code~~ included reimbursement of services provided in such institutions. The amount paid by the department shall not exceed the reduced supplemental security income benefit rate established by ~~Title XVI of the "Social Security Act~~ <u>the program</u>.~~"~~

Sec. 5119.61. Any provision in this chapter that refers to a board of alcohol, drug addiction, and mental health services also refers to the community mental health board in an alcohol, drug addiction, and mental health service district that has a community mental health board.

The director of mental health with respect to all facilities

and programs established and operated under Chapter 340. of the Revised Code for mentally ill and emotionally disturbed persons, shall do all of the following: 18706 18707 18708

(A) Adopt rules pursuant to Chapter 119. of the Revised Code that may be necessary to carry out the purposes of Chapter 340. and sections 5119.61 to 5119.63 of the Revised Code. 18709 18710 18711

(1) The rules shall include all of the following: 18712

(a) Rules governing a community mental health agency's services under section 340.091 of the Revised Code to an individual referred to the agency under division (C)(2) of section ~~173.35~~ 5160.80 of the Revised Code; 18713 18714 18715 18716

(b) For the purpose of division (A)(16) of section 340.03 of the Revised Code, rules governing the duties of mental health agencies and boards of alcohol, drug addiction, and mental health services under section 3722.18 of the Revised Code regarding referrals of individuals with mental illness or severe mental disability to adult care facilities and effective arrangements for ongoing mental health services for the individuals. The rules shall do at least the following: 18717 18718 18719 18720 18721 18722 18723 18724

(i) Provide for agencies and boards to participate fully in the procedures owners and managers of adult care facilities must follow under division (A)(2) of section 3722.18 of the Revised Code; 18725 18726 18727 18728

(ii) Specify the manner in which boards are accountable for ensuring that ongoing mental health services are effectively arranged for individuals with mental illness or severe mental disability who are referred by the board or mental health agency under contract with the board to an adult care facility. 18729 18730 18731 18732 18733

(c) Rules governing a board of alcohol, drug addiction, and mental health services when making a report to the director of health under section 3722.17 of the Revised Code regarding the 18734 18735 18736

quality of care and services provided by an adult care facility to a person with mental illness or a severe mental disability. 18737 18738

(2) Rules may be adopted to govern the method of paying a community mental health facility, as defined in section ~~5111.023~~ <u>5163.20</u> of the Revised Code, for providing services listed in division (B) of that section. Such rules must be consistent with the contract entered into between the departments of ~~job and family services~~ <u>health care administration</u> and mental health under section ~~5111.91~~ <u>5161.05</u> of the Revised Code and include requirements ensuring appropriate service utilization. 18739 18740 18741 18742 18743 18744 18745 18746

(B) Review and evaluate, and, taking into account the findings and recommendations of the board of alcohol, drug addiction, and mental health services of the district served by the program and the requirements and priorities of the state mental health plan, including the needs of residents of the district now residing in state mental institutions, approve and allocate funds to support community programs, and make recommendations for needed improvements to boards of alcohol, drug addiction, and mental health services; 18747 18748 18749 18750 18751 18752 18753 18754 18755

(C) Withhold state and federal funds for any program, in whole or in part, from a board of alcohol, drug addiction, and mental health services in the event of failure of that program to comply with Chapter 340. or section 5119.61, 5119.611, 5119.612, or 5119.62 of the Revised Code or rules of the department of mental health. The director shall identify the areas of noncompliance and the action necessary to achieve compliance. The director shall offer technical assistance to the board to achieve compliance. The director shall give the board a reasonable time within which to comply or to present its position that it is in compliance. Before withholding funds, a hearing shall be conducted to determine if there are continuing violations and that either assistance is rejected or the board is unable to achieve 18756 18757 18758 18759 18760 18761 18762 18763 18764 18765 18766 18767 18768

compliance. Subsequent to the hearing process, if it is determined that compliance has not been achieved, the director may allocate all or part of the withheld funds to a public or private agency to provide the services not in compliance until the time that there is compliance. The director shall establish rules pursuant to Chapter 119. of the Revised Code to implement this division. 18769 18770 18771 18772 18773 18774

(D) Withhold state or federal funds from a board of alcohol, drug addiction, and mental health services that denies available service on the basis of religion, race, color, creed, sex, national origin, age, disability as defined in section 4112.01 of the Revised Code, developmental disability, or the inability to pay; 18775 18776 18777 18778 18779 18780

(E) Provide consultative services to community mental health agencies with the knowledge and cooperation of the board of alcohol, drug addiction, and mental health services; 18781 18782 18783

(F) Provide to boards of alcohol, drug addiction, and mental health services state or federal funds, in addition to those allocated under section 5119.62 of the Revised Code, for special programs or projects the director considers necessary but for which local funds are not available; 18784 18785 18786 18787 18788

(G) Establish criteria by which a board of alcohol, drug addiction, and mental health services reviews and evaluates the quality, effectiveness, and efficiency of services provided through its community mental health plan. The criteria shall include requirements ensuring appropriate service utilization. The department shall assess a board's evaluation of services and the compliance of each board with this section, Chapter 340. or section 5119.62 of the Revised Code, and other state or federal law and regulations. The department, in cooperation with the board, periodically shall review and evaluate the quality, effectiveness, and efficiency of services provided through each board. The department shall collect information that is necessary 18789 18790 18791 18792 18793 18794 18795 18796 18797 18798 18799 18800

to perform these functions. 18801

(H) Develop and operate a community mental health information system. 18802 18803

Boards of alcohol, drug abuse, and mental health services shall submit information requested by the department in the form and manner prescribed by the department. Information collected by the department shall include, but not be limited to, all of the following: 18804 18805 18806 18807 18808

(1) Information regarding units of services provided in whole or in part under contract with a board, including diagnosis and special needs, demographic information, the number of units of service provided, past treatment, financial status, and service dates in accordance with rules adopted by the department in accordance with Chapter 119. of the Revised Code; 18809 18810 18811 18812 18813 18814

(2) Financial information other than price or price-related data regarding expenditures of boards and community mental health agencies, including units of service provided, budgeted and actual expenses by type, and sources of funds. 18815 18816 18817 18818

Boards shall submit the information specified in division (H)(1) of this section no less frequently than annually for each client, and each time the client's case is opened or closed. The department shall not collect any information for the purpose of identifying by name any person who receives a service through a board of alcohol, drug addiction, and mental health services, except as required by state or federal law to validate appropriate reimbursement. For the purposes of division (H)(1) of this section, the department shall use an identification system that is consistent with applicable nationally recognized standards. 18819 18820 18821 18822 18823 18824 18825 18826 18827 18828

(I) Review each board's community mental health plan submitted pursuant to section 340.03 of the Revised Code and approve or disapprove it in whole or in part. Periodically, in 18829 18830 18831

consultation with representatives of boards and after considering the recommendations of the medical director, the director shall issue criteria for determining when a plan is complete, criteria for plan approval or disapproval, and provisions for conditional approval. The factors that the director considers may include, but are not limited to, the following: 18832 18833 18834 18835 18836 18837

(1) The mental health needs of all persons residing within the board's service district, especially severely mentally disabled children, adolescents, and adults; 18838 18839 18840

(2) The demonstrated quality, effectiveness, efficiency, and cultural relevance of the services provided in each service district, the extent to which any services are duplicative of other available services, and whether the services meet the needs identified above; 18841 18842 18843 18844 18845

(3) The adequacy of the board's accounting for the expenditure of funds. 18846 18847

If the director disapproves all or part of any plan, the director shall provide the board an opportunity to present its position. The director shall inform the board of the reasons for the disapproval and of the criteria that must be met before the plan may be approved. The director shall give the board a reasonable time within which to meet the criteria, and shall offer technical assistance to the board to help it meet the criteria. 18848 18849 18850 18851 18852 18853 18854

If the approval of a plan remains in dispute thirty days prior to the conclusion of the fiscal year in which the board's current plan is scheduled to expire, the board or the director may request that the dispute be submitted to a mutually agreed upon third-party mediator with the cost to be shared by the board and the department. The mediator shall issue to the board and the department recommendations for resolution of the dispute. Prior to the conclusion of the fiscal year in which the current plan is 18855 18856 18857 18858 18859 18860 18861 18862

scheduled to expire, the director, taking into consideration the recommendations of the mediator, shall make a final determination and approve or disapprove the plan, in whole or in part. 18863 18864 18865

Sec. 5120.65. (A) The department of rehabilitation and correction may establish in one or more of the institutions for women operated by the department a prison nursery program under which eligible inmates and children born to them while in the custody of the department may reside together in the institution. If the department establishes a prison nursery program in one or more institutions under this section, sections 5120.651 to 5120.657 of the Revised Code apply regarding the program. If the department establishes a prison nursery program and an inmate participates in the program, neither the inmate's participation in the program nor any provision of sections 5120.65 to 5120.657 of the Revised Code affects, modifies, or interferes with the inmate's custodial rights of the child or establishes legal custody of the child with the department. 18866 18867 18868 18869 18870 18871 18872 18873 18874 18875 18876 18877 18878 18879

(B) As used in sections 5120.651 to 5120.657 of the Revised Code: 18880 18881

(1) "Prison nursery program" means the prison nursery program established by the department of rehabilitation and correction under this section, if one is so established. 18882 18883 18884

(2) "Public assistance" ~~has the same meaning as in section 5101.58 of the Revised Code~~ means all of the following: 18885 18886

(a) Medicaid; 18887

(b) Disability medical assistance; 18888

(c) The Ohio works first program established under Chapter 5107. of the Revised Code; 18889 18890

(d) Disability financial assistance established under Chapter 5115. of the Revised Code. 18891 18892

(3) "Support" means amounts to be paid under a support order. 18893

(4) "Support order" has the same meaning as in section 18894
3119.01 of the Revised Code. 18895

Sec. 5120.652. To participate in the prison nursery program, 18896
each eligible inmate selected by the department shall do all the 18897
following: 18898

(A) Agree in writing to do all the following: 18899

(1) Comply with any program, educational, counseling, and 18900
other requirements established for the program by the department 18901
of rehabilitation and correction; 18902

(2) If eligible, have the child participate in the medicaid 18903
program or a health insurance program; 18904

(3) Accept the normal risks of childrearing; 18905

(4) Abide by any court decisions regarding the allocation of 18906
parental rights and responsibilities with respect to the child. 18907

(B) Assign to the department any rights to support from any 18908
other person, excluding support assigned pursuant to section 18909
5107.20 of the Revised Code and medical support assigned pursuant 18910
to section ~~5101.59~~ 5160.37 of the Revised Code; 18911

(C) Specify with whom the child is to be placed in the event 18912
the inmate's participation in the program is terminated for a 18913
reason other than release from imprisonment. 18914

Sec. 5121.04. (A) The department of mental retardation and 18915
developmental disabilities shall investigate the financial 18916
condition of the residents in institutions, residents whose care 18917
or treatment is being paid for in a private facility or home under 18918
the control of the department, and of the relatives named in 18919
section 5121.06 of the Revised Code as liable for the support of 18920
such residents, in order to determine the ability of any resident 18921

or liable relatives to pay for the support of the resident and to 18922
provide suitable clothing as required by the superintendent of the 18923
institution. 18924

(B) The department shall follow the provisions of this 18925
division in determining the ability to pay of a resident or the 18926
resident's liable relatives and the amount to be charged such 18927
resident or liable relatives. 18928

(1) Subject to divisions (B)(10) and (11) of this section, a 18929
resident without dependents shall be liable for the full 18930
applicable cost. A resident without dependents who has a gross 18931
annual income equal to or exceeding the sum of the full applicable 18932
cost, plus fifty dollars per month, regardless of the source of 18933
such income, shall pay currently the full amount of the applicable 18934
cost; if the resident's gross annual income is less than such sum, 18935
not more than fifty dollars per month shall be kept for personal 18936
use by or on behalf of the resident, except as permitted in the 18937
state medicaid plan ~~for providing medical assistance under Title~~ 18938
~~XIX of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.~~ 18939
~~301, as amended~~, and the balance shall be paid currently on the 18940
resident's support. Subject to divisions (B)(10) and (11) of this 18941
section, the estate of a resident without dependents shall pay 18942
currently any remaining difference between the applicable cost and 18943
the amounts prescribed in this section, or shall execute an 18944
agreement with the department for payment to be made at some 18945
future date under terms suitable to the department. However, no 18946
security interest, mortgage, or lien shall be taken, granted, or 18947
charged against any principal residence of a resident without 18948
dependents under an agreement or otherwise to secure support 18949
payments, and no foreclosure actions shall be taken on security 18950
interests, mortgages, or liens taken, granted, or charged against 18951
principal residences of residents prior to October 7, 1977. 18952

(2) The ability to pay of a resident with dependents, or of a 18953

liable relative of a resident either with or without dependents, 18954
shall be determined in accordance with the resident's or liable 18955
relative's income or other assets, the needs of others who are 18956
dependent on such income and other assets for support, and, if 18957
applicable, divisions (B)(10) and (11) of this section. 18958

For the first thirty days of care and treatment of each 18959
admission, but in no event for more than thirty days in any 18960
calendar year, the resident with dependents or the liable relative 18961
of a resident either with or without dependents shall be charged 18962
an amount equal to the percentage of the average applicable cost 18963
determined in accordance with the schedule of adjusted gross 18964
annual income contained after this paragraph. After such first 18965
thirty days of care and treatment, such resident or such liable 18966
relative shall be charged an amount equal to the percentage of a 18967
base support rate of four dollars per day for residents, as 18968
determined in accordance with the schedule of gross annual income 18969
contained after this paragraph, or in accordance with division 18970
(B)(5) of this section. Beginning January 1, 1978, the department 18971
shall increase the base rate when the consumer price index average 18972
is more than 4.0 for the preceding calendar year by not more than 18973
the average for such calendar year. 18974

Adjusted Gross Annual Income of Resident or Liable Relative (FN a)	Number of Dependents (FN b)								
	1	2	3	4	5	6	7	8 or more	18975–18979
	Rate of Support (In Percentages)								18980
$15,000 or less	--	--	--	--	--	--	--	--	18981
15,001 to 17,500	20	--	--	--	--	--	--	--	18982
17,501 to 20,000	25	20	--	--	--	--	--	--	18983
20,001 to 21,000	30	25	20	--	--	--	--	--	18984
21,001 to 22,000	35	30	25	20	--	--	--	--	18985

22,001 to 23,000	40	35	30	25	20	--	--	--	18986
23,001 to 24,000	45	40	35	30	25	20	--	--	18987
24,001 to 25,000	50	45	40	35	30	25	20	--	18988
25,001 to 26,000	55	50	45	40	35	30	25	20	18989
26,001 to 27,000	60	55	50	45	40	35	30	25	18990
27,001 to 28,000	70	60	55	50	45	40	35	30	18991
28,001 to 30,000	80	70	60	55	50	45	40	35	18992
30,001 to 40,000	90	80	70	60	55	50	45	40	18993
40,001 and over	100	90	80	70	60	55	50	45	18994

Footnote a. The resident or relative shall furnish a copy of the resident's or relative's federal income tax return as evidence of gross annual income. 18995 18996 18997

Footnote b. The number of dependents includes the liable relative but excludes a resident in an institution. "Dependent" includes any person who receives more than half the person's support from the resident or the resident's liable relative. 18998 18999 19000 19001

(3) A resident or liable relative having medical, funeral, or related expenses in excess of four per cent of the adjusted gross annual income, which expenses were not covered by insurance, may adjust such gross annual income by reducing the adjusted gross annual income by the full amount of such expenses. Proof of such expenses satisfactory to the department must be furnished. 19002 19003 19004 19005 19006 19007

(4) Additional dependencies may be claimed if: 19008

(a) The liable relative is blind; 19009

(b) The liable relative is over sixty-five; 19010

(c) A child is a college student with expenses in excess of fifty dollars per month; 19011 19012

(d) The services of a housekeeper, costing in excess of fifty dollars per month, are required if the person who normally keeps house for minor children is the resident. 19013 19014 19015

(5) If with respect to any resident with dependents there is chargeable under division (B)(2) of this section less than fifty per cent of the applicable cost or, if the base support rate was used, less than fifty per cent of the amount determined by use of the base support rate, and if with respect to such resident there is a liable relative who has an estate having a value in excess of fifteen thousand dollars or if such resident has a dependent and an estate having a value in excess of fifteen thousand dollars, there shall be paid with respect to such resident a total of fifty per cent of the applicable cost or the base support rate amount, as the case may be, on a current basis or there shall be executed with respect to such resident an agreement with the department for payment to be made at some future date under terms suitable to the department. 19016 19017 19018 19019 19020 19021 19022 19023 19024 19025 19026 19027 19028 19029

(6) When a person has been a resident for fifteen years and the support charges for which a relative is liable have been paid for the fifteen-year period, the liable relative shall be relieved of any further support charges. 19030 19031 19032 19033

(7) The department shall accept voluntary payments from residents or liable relatives whose incomes are below the minimum shown in the schedule set forth in this division. The department also shall accept voluntary payments in excess of required amounts from both liable and nonliable relatives. 19034 19035 19036 19037 19038

(8) If a resident is covered by an insurance policy, or other contract that provides for payment of expenses for care and treatment for mental retardation or other developmental disability at or from an institution or facility (including a community service unit under the jurisdiction of the department), the other provisions of this section, except divisions (B)(8), (10), and (11) of this section, and of section 5121.01 of the Revised Code shall be suspended to the extent that such insurance policy or other contract is in force, and such resident shall be charged the 19039 19040 19041 19042 19043 19044 19045 19046 19047

full amount of the applicable cost. Any insurance carrier or other third party payor providing coverage for such care and treatment shall pay for this support obligation in an amount equal to the lesser of either the applicable cost or the benefits provided under the policy or other contract. Whether or not an insured, owner of, or other person having an interest in such policy or other contract is liable for support payments under other provisions of this chapter, the insured, policy owner, or other person shall assign payment directly to the department of all assignable benefits under the policy or other contract and shall pay over to the department, within ten days of receipt, all insurance or other benefits received as reimbursement or payment for expenses incurred by the resident or for any other reason. If the insured, policy owner, or other person refuses to assign such payment to the department or refuses to pay such received reimbursements or payments over to the department within ten days of receipt, the insured's, policy owners', or other person's total liability for the services equals the applicable statutory liability for payment for the services as determined under other provisions of this chapter, plus the amounts payable under the terms of the policy or other contract. In no event shall this total liability exceed the full amount of the applicable cost. Upon its request, the department is entitled to a court order that compels the insured, owner of, or other person having an interest in the policy or other contract to comply with the assignment requirements of this division or that itself serves as a legally sufficient assignment in compliance with such requirements. Notwithstanding section 5123.89 of the Revised Code and any other law relating to confidentiality of records, the managing officer of the institution or facility where a person is or has been a resident shall disclose pertinent medical information concerning the resident to the insurance carrier or other third party payor in question, in order to effect collection from the carrier or

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payor of the state's claim for care and treatment under this division. For such disclosure, the managing officer is not subject to any civil or criminal liability. 19081 19082 19083

(9) The rate to be charged for pre-admission care, after-care, day-care, or routine consultation and treatment services shall be based upon the ability of the resident or the resident's liable relatives to pay. When it is determined by the department that a charge shall be made, such charge shall be computed as provided in divisions (B)(1) and (2) of this section. 19084 19085 19086 19087 19088 19089

(10) If a resident with or without dependents is the beneficiary of a trust created pursuant to section 1339.51 of the Revised Code, then, notwithstanding any contrary provision of this chapter or of a rule adopted pursuant to this chapter, divisions (C) and (D) of that section shall apply in determining the assets or resources of the resident, the resident's estate, the settlor, or the settlor's estate and to claims arising under this chapter against the resident, the resident's estate, the settlor, or the settlor's estate. 19090 19091 19092 19093 19094 19095 19096 19097 19098

(11) If the department waives the liability of an individual and the individual's liable relatives pursuant to section 5123.194 of the Revised Code, the liability of the individual and relative ceases in accordance with the waiver's terms. 19099 19100 19101 19102

(C) The department may enter into agreements with a resident or a liable relative for support payments to be made in the future. However, no security interest, mortgage, or lien shall be taken, granted, or charged against any principal family residence of a resident with dependents or a liable relative under an agreement or otherwise to secure support payments, and no foreclosure actions shall be taken on security interests, mortgages or liens taken, granted, or charged against principal residences of residents or liable relatives prior to October 7, 1977. 19103 19104 19105 19106 19107 19108 19109 19110 19111 19112

(D) The department shall make all investigations and determinations required by this section within ninety days after a resident is admitted to an institution under the department's control and immediately shall notify by mail the persons liable of the amount to be charged. 19113 19114 19115 19116 19117

(E) All actions to enforce the collection of payments agreed upon or charged by the department shall be commenced within six years after the date of default of an agreement to pay support charges or the date such payment becomes delinquent. If a payment is made pursuant to an agreement which is in default, a new six-year period for actions to enforce the collection of payments under such agreement shall be computed from the date of such payment. For purposes of this division an agreement is in default or a payment is delinquent if a payment is not made within thirty days after it is incurred or a payment, pursuant to an agreement, is not made within thirty days after the date specified for such payment. In all actions to enforce the collection of payment for the liability for support, every court of record shall receive into evidence the proof of claim made by the state together with all debts and credits, and it shall be prima-facie evidence of the facts contained in it. 19118 19119 19120 19121 19122 19123 19124 19125 19126 19127 19128 19129 19130 19131 19132 19133

Sec. 5123.01. As used in this chapter: 19134

(A) "Chief medical officer" means the licensed physician appointed by the managing officer of an institution for the mentally retarded with the approval of the director of mental retardation and developmental disabilities to provide medical treatment for residents of the institution. 19135 19136 19137 19138 19139

(B) "Chief program director" means a person with special training and experience in the diagnosis and management of the mentally retarded, certified according to division (C) of this section in at least one of the designated fields, and appointed by 19140 19141 19142 19143

the managing officer of an institution for the mentally retarded 19144
with the approval of the director to provide habilitation and care 19145
for residents of the institution. 19146

(C) "Comprehensive evaluation" means a study, including a 19147
sequence of observations and examinations, of a person leading to 19148
conclusions and recommendations formulated jointly, with 19149
dissenting opinions if any, by a group of persons with special 19150
training and experience in the diagnosis and management of persons 19151
with mental retardation or a developmental disability, which group 19152
shall include individuals who are professionally qualified in the 19153
fields of medicine, psychology, and social work, together with 19154
such other specialists as the individual case may require. 19155

(D) "Education" means the process of formal training and 19156
instruction to facilitate the intellectual and emotional 19157
development of residents. 19158

(E) "Habilitation" means the process by which the staff of 19159
the institution assists the resident in acquiring and maintaining 19160
those life skills that enable the resident to cope more 19161
effectively with the demands of the resident's own person and of 19162
the resident's environment and in raising the level of the 19163
resident's physical, mental, social, and vocational efficiency. 19164
Habilitation includes but is not limited to programs of formal, 19165
structured education and training. 19166

(F) "Health officer" means any public health physician, 19167
public health nurse, or other person authorized or designated by a 19168
city or general health district. 19169

(G) "Home and community-based services" means medicaid-funded 19170
home and community-based services specified in division (B)(1) of 19171
section ~~5111.87~~ 5163.65 of the Revised Code provided under the 19172
medicaid waiver components the department of mental retardation 19173
and developmental disabilities administers pursuant to section 19174

~~5111.871~~ <u>5163.651</u> of the Revised Code. 19175

(H) "Indigent person" means a person who is unable, without substantial financial hardship, to provide for the payment of an attorney and for other necessary expenses of legal representation, including expert testimony. 19176 19177 19178 19179

(I) "Institution" means a public or private facility, or a part of a public or private facility, that is licensed by the appropriate state department and is equipped to provide residential habilitation, care, and treatment for the mentally retarded. 19180 19181 19182 19183 19184

(J) "Licensed physician" means a person who holds a valid certificate issued under Chapter 4731. of the Revised Code authorizing the person to practice medicine and surgery or osteopathic medicine and surgery, or a medical officer of the government of the United States while in the performance of the officer's official duties. 19185 19186 19187 19188 19189 19190

(K) "Managing officer" means a person who is appointed by the director of mental retardation and developmental disabilities to be in executive control of an institution for the mentally retarded under the jurisdiction of the department. 19191 19192 19193 19194

(L) ~~"Medicaid" has the same meaning as in section 5111.01 of the Revised Code.~~ 19195 19196

~~(M)~~ "Medicaid case management services" means case management services provided to an individual with mental retardation or other developmental disability that the state medicaid plan requires. 19197 19198 19199 19200

~~(N)~~<u>(M)</u> "Mentally retarded person" means a person having significantly subaverage general intellectual functioning existing concurrently with deficiencies in adaptive behavior, manifested during the developmental period. 19201 19202 19203 19204

~~(O)~~(N) "Mentally retarded person subject to institutionalization by court order" means a person eighteen years of age or older who is at least moderately mentally retarded and in relation to whom, because of the person's retardation, either of the following conditions exist: 19205 19206 19207 19208 19209

(1) The person represents a very substantial risk of physical impairment or injury to self as manifested by evidence that the person is unable to provide for and is not providing for the person's most basic physical needs and that provision for those needs is not available in the community; 19210 19211 19212 19213 19214

(2) The person needs and is susceptible to significant habilitation in an institution. 19215 19216

~~(P)~~(O) "A person who is at least moderately mentally retarded" means a person who is found, following a comprehensive evaluation, to be impaired in adaptive behavior to a moderate degree and to be functioning at the moderate level of intellectual functioning in accordance with standard measurements as recorded in the most current revision of the manual of terminology and classification in mental retardation published by the American association on mental retardation. 19217 19218 19219 19220 19221 19222 19223 19224

~~(Q)~~(P) As used in this division, "substantial functional limitation," "developmental delay," and "established risk" have the meanings established pursuant to section 5123.011 of the Revised Code. 19225 19226 19227 19228

"Developmental disability" means a severe, chronic disability that is characterized by all of the following: 19229 19230

(1) It is attributable to a mental or physical impairment or a combination of mental and physical impairments, other than a mental or physical impairment solely caused by mental illness as defined in division (A) of section 5122.01 of the Revised Code. 19231 19232 19233 19234

(2) It is manifested before age twenty-two. 19235

(3) It is likely to continue indefinitely. 19236

(4) It results in one of the following: 19237

(a) In the case of a person under three years of age, at 19238
least one developmental delay or an established risk; 19239

(b) In the case of a person at least three years of age but 19240
under six years of age, at least two developmental delays or an 19241
established risk; 19242

(c) In the case of a person six years of age or older, a 19243
substantial functional limitation in at least three of the 19244
following areas of major life activity, as appropriate for the 19245
person's age: self-care, receptive and expressive language, 19246
learning, mobility, self-direction, capacity for independent 19247
living, and, if the person is at least sixteen years of age, 19248
capacity for economic self-sufficiency. 19249

(5) It causes the person to need a combination and sequence 19250
of special, interdisciplinary, or other type of care, treatment, 19251
or provision of services for an extended period of time that is 19252
individually planned and coordinated for the person. 19253

~~(R)~~(Q) "Developmentally disabled person" means a person with 19254
a developmental disability. 19255

~~(S)~~(R) "State institution" means an institution that is 19256
tax-supported and under the jurisdiction of the department. 19257

~~(T)~~(S) "Residence" and "legal residence" have the same 19258
meaning as "legal settlement," which is acquired by residing in 19259
Ohio for a period of one year without receiving general assistance 19260
prior to July 17, 1995, under former Chapter 5113. of the Revised 19261
Code, financial assistance under Chapter 5115. of the Revised 19262
Code, or assistance from a private agency that maintains records 19263
of assistance given. A person having a legal settlement in the 19264
state shall be considered as having legal settlement in the 19265

assistance area in which the person resides. No adult person coming into this state and having a spouse or minor children residing in another state shall obtain a legal settlement in this state as long as the spouse or minor children are receiving public assistance, care, or support at the expense of the other state or its subdivisions. For the purpose of determining the legal settlement of a person who is living in a public or private institution or in a home subject to licensing by the department of job and family services, the department of mental health, or the department of mental retardation and developmental disabilities, the residence of the person shall be considered as though the person were residing in the county in which the person was living prior to the person's entrance into the institution or home. Settlement once acquired shall continue until a person has been continuously absent from Ohio for a period of one year or has acquired a legal residence in another state. A woman who marries a man with legal settlement in any county immediately acquires the settlement of her husband. The legal settlement of a minor is that of the parents, surviving parent, sole parent, parent who is designated the residential parent and legal custodian by a court, other adult having permanent custody awarded by a court, or guardian of the person of the minor, provided that: 19266 19267 19268 19269 19270 19271 19272 19273 19274 19275 19276 19277 19278 19279 19280 19281 19282 19283 19284 19285 19286 19287

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(1) A minor female who marries shall be considered to have the legal settlement of her husband and, in the case of death of her husband or divorce, she shall not thereby lose her legal settlement obtained by the marriage. 19289 19290 19291 19292

(2) A minor male who marries, establishes a home, and who has resided in this state for one year without receiving general assistance prior to July 17, 1995, under former Chapter 5113. of the Revised Code, financial assistance under Chapter 5115. of the Revised Code, or assistance from a private agency that maintains 19293 19294 19295 19296 19297

records of assistance given shall be considered to have obtained a legal settlement in this state. 19298 19299

(3) The legal settlement of a child under eighteen years of age who is in the care or custody of a public or private child caring agency shall not change if the legal settlement of the parent changes until after the child has been in the home of the parent for a period of one year. 19300 19301 19302 19303 19304

No person, adult or minor, may establish a legal settlement in this state for the purpose of gaining admission to any state institution. 19305 19306 19307

~~(U)~~(T)(1) "Resident" means, subject to division (R)(2) of this section, a person who is admitted either voluntarily or involuntarily to an institution or other facility pursuant to section 2945.39, 2945.40, 2945.401, or 2945.402 of the Revised Code subsequent to a finding of not guilty by reason of insanity or incompetence to stand trial or under this chapter who is under observation or receiving habilitation and care in an institution. 19308 19309 19310 19311 19312 19313 19314

(2) "Resident" does not include a person admitted to an institution or other facility under section 2945.39, 2945.40, 2945.401, or 2945.402 of the Revised Code to the extent that the reference in this chapter to resident, or the context in which the reference occurs, is in conflict with any provision of sections 2945.37 to 2945.402 of the Revised Code. 19315 19316 19317 19318 19319 19320

~~(V)~~(U) "Respondent" means the person whose detention, commitment, or continued commitment is being sought in any proceeding under this chapter. 19321 19322 19323

~~(W)~~(V) "Working day" and "court day" mean Monday, Tuesday, Wednesday, Thursday, and Friday, except when such day is a legal holiday. 19324 19325 19326

~~(X)~~(W) "Prosecutor" means the prosecuting attorney, village solicitor, city director of law, or similar chief legal officer 19327 19328

who prosecuted a criminal case in which a person was found not guilty by reason of insanity, who would have had the authority to prosecute a criminal case against a person if the person had not been found incompetent to stand trial, or who prosecuted a case in which a person was found guilty.

~~(Y)~~(X) "Court" means the probate division of the court of common pleas.

~~(Z)~~(Y) "Supported living" has the same meaning as in section 5126.01 of the Revised Code.

Sec. 5123.021. (A) As used in this section, "mentally retarded individual" and "specialized services" have the same meanings as in section ~~5111.202~~ 5164.45 of the Revised Code.

(B)(1) Except as provided in division (B)(2) of this section and rules adopted under division (E)(3) of this section, for purposes of section ~~5111.202~~ 5164.41 of the Revised Code, the department of mental retardation and developmental disabilities shall determine in accordance with ~~section 1919(e)(7) of the "Social Security Act," 49 Stat. 620 (1935),~~ 42 U.S.C.~~A. 301, as amended,~~ 1396r(e)(7) and regulations adopted under ~~section 1919(f)(8)(A) of that act~~ 42 U.S.C. 1396r(f)(8)(A) whether, because of the individual's physical and mental condition, a mentally retarded individual seeking admission to a nursing facility requires the level of services provided by a nursing facility and, if the individual requires that level of services, whether the individual requires specialized services for mental retardation.

(2) A determination under this division is not required for any of the following:

(a) An individual seeking readmission to a nursing facility after having been transferred from a nursing facility to a

hospital for care; 19359

(b) An individual who meets all of the following conditions: 19360

(i) The individual is admitted to the nursing facility directly from a hospital after receiving inpatient care at the hospital; 19361 19362 19363

(ii) The individual requires nursing facility services for the condition for which the individual received care in the hospital; 19364 19365 19366

(iii) The individual's attending physician has certified, before admission to the nursing facility, that the individual is likely to require less than thirty days of nursing facility services. 19367 19368 19369 19370

(c) An individual transferred from one nursing facility to another nursing facility, with or without an intervening hospital stay. 19371 19372 19373

(C) Except as provided in rules adopted under division (F)(3) of this section, the department of mental retardation and developmental disabilities shall review and determine, for each resident of a nursing facility who is mentally retarded, whether the resident, because of the resident's physical and mental condition, requires the level of services provided by a nursing facility and whether the resident requires specialized services for mental retardation. The review and determination shall be conducted in accordance with section 1919(e)(7) of the "Social Security Act" and the regulations adopted under section 1919(f)(8)(A) of the act. The review and determination shall be completed promptly after a nursing facility has notified the department that there has been a significant change in the resident's mental or physical condition. 19374 19375 19376 19377 19378 19379 19380 19381 19382 19383 19384 19385 19386 19387

(D)(1) In the case of a nursing facility resident who has continuously resided in a nursing facility for at least thirty 19388 19389

months before the date of a review and determination under 19390
division (C) of this section, if the resident is determined not to 19391
require the level of services provided by a nursing facility, but 19392
is determined to require specialized services for mental 19393
retardation, the department, in consultation with the resident's 19394
family or legal representative and care givers, shall do all of 19395
the following: 19396

(a) Inform the resident of the institutional and 19397
noninstitutional alternatives covered under the state <u>medicaid</u> 19398
plan ~~for medical assistance~~; 19399

(b) Offer the resident the choice of remaining in the nursing 19400
facility or receiving covered services in an alternative 19401
institutional or noninstitutional setting; 19402

(c) Clarify the effect on eligibility for services under the 19403
state <u>medicaid</u> plan ~~for medical assistance~~ if the resident chooses 19404
to leave the facility, including its effect on readmission to the 19405
facility; 19406

(d) Provide for or arrange for the provision of specialized 19407
services for the resident's mental retardation in the setting 19408
chosen by the resident. 19409

(2) In the case of a nursing facility resident who has 19410
continuously resided in a nursing facility for less than thirty 19411
months before the date of the review and determination under 19412
division (C) of this section, if the resident is determined not to 19413
require the level of services provided by a nursing facility, but 19414
is determined to require specialized services for mental 19415
retardation, or if the resident is determined to require neither 19416
the level of services provided by a nursing facility nor 19417
specialized services for mental retardation, the department shall 19418
act in accordance with its alternative disposition plan approved 19419
by the United States department of health and human services under 19420

section 1919(e)(7)(E) of the "Social Security Act." 19421

(3) In the case of an individual who is determined under division (B) or (C) of this section to require both the level of services provided by a nursing facility and specialized services for mental retardation, the department of mental retardation and developmental disabilities shall provide or arrange for the provision of the specialized services needed by the individual or resident while residing in a nursing facility. 19422 19423 19424 19425 19426 19427 19428

(E) The department of mental retardation and developmental disabilities shall adopt rules in accordance with Chapter 119. of the Revised Code that do all of the following: 19429 19430 19431

(1) Establish criteria to be used in making the determinations required by divisions (B) and (C) of this section. The criteria shall not exceed the criteria established by regulations adopted by the United States department of health and human services under section 1919(f)(8)(A) of the "Social Security Act." 19432 19433 19434 19435 19436 19437

(2) Specify information to be provided by the individual or nursing facility resident being assessed; 19438 19439

(3) Specify any circumstances, in addition to circumstances listed in division (B) of this section, under which determinations under divisions (B) and (C) of this section are not required to be made. 19440 19441 19442 19443

Sec. 5123.0412. (A) The department of mental retardation and developmental disabilities shall charge each county board of mental retardation and developmental disabilities an annual fee equal to one and one-half per cent of the total value of all medicaid paid claims for home and community-based services provided during the year to an individual eligible for services from the county board. No county board shall pass the cost of a 19444 19445 19446 19447 19448 19449 19450

fee charged to the county board under this section on to another 19451
provider of these services. 19452

(B) The fees collected under this section shall be deposited 19453
into the ODMR/DD administration and oversight fund and the ~~ODJFS~~ 19454
ODHCA administration and oversight fund, both of which are hereby 19455
created in the state treasury. The portion of the fees to be 19456
deposited into the ODMR/DD administration and oversight fund and 19457
the portion of the fees to be deposited into the ~~ODJFS~~ ODHCA 19458
administration and oversight fund shall be the portion specified 19459
in an interagency agreement entered into under division (C) of 19460
this section. The department of mental retardation and 19461
developmental disabilities shall use the money in the ODMR/DD 19462
administration and oversight fund and the department of ~~job and~~ 19463
~~family services~~ health care administration shall use the money in 19464
the ~~ODJFS~~ ODHCA administration and oversight fund for both of the 19465
following purposes: 19466

(1) The administrative and oversight costs of medicaid case 19467
management services and home and community-based services. The 19468
administrative and oversight costs shall include costs for staff, 19469
systems, and other resources the departments need and dedicate 19470
solely to the following duties associated with the services: 19471

(a) Eligibility determinations; 19472

(b) Training; 19473

(c) Fiscal management; 19474

(d) Claims processing; 19475

(e) Quality assurance oversight; 19476

(f) Other duties the departments identify. 19477

(2) Providing technical support to county boards' local 19478
administrative authority under section 5126.055 of the Revised 19479
Code for the services. 19480

(C) The departments of mental retardation and developmental disabilities and ~~job and family services~~ health care administration shall enter into an interagency agreement to do both of the following: 19481 19482 19483 19484

(1) Specify which portion of the fees collected under this section is to be deposited into the ODMR/DD administration and oversight fund and which portion is to be deposited into the ~~ODJFS~~ ODHCA administration and oversight fund; 19485 19486 19487 19488

(2) Provide for the departments to coordinate the staff whose costs are paid for with money in the ODMR/DD administration and oversight fund and the ~~ODJFS~~ ODHCA administration and oversight fund. 19489 19490 19491 19492

(D) The departments shall submit an annual report to the director of budget and management certifying how the departments spent the money in the ODMR/DD administration and oversight fund and the ~~ODJFS~~ ODHCA administration and oversight fund for the purposes specified in division (B) of this section. 19493 19494 19495 19496 19497

Sec. 5123.0417. (A) Using funds available under section ~~5112.371~~ 5166.481 of the Revised Code, the director of mental retardation and developmental disabilities shall establish one or more programs for individuals under twenty-one years of age who have intensive behavioral needs, including such individuals with a primary diagnosis of autism spectrum disorder. The programs may include one or more medicaid waiver components that the director administers pursuant to section ~~5111.871~~ 5163.651 of the Revised Code. The programs may do one or more of the following: 19498 19499 19500 19501 19502 19503 19504 19505 19506

(1) Establish models that incorporate elements common to effective intervention programs and evidence-based practices in services for children with intensive behavioral needs; 19507 19508 19509

(2) Design a template for individualized education plans and 19510

individual service plans that provide consistent intervention programs and evidence-based practices for the care and treatment of children with intensive behavioral needs; 19511 19512 19513

(3) Disseminate best practice guidelines for use by families of children with intensive behavioral needs and professionals working with such families; 19514 19515 19516

(4) Develop a transition planning model for effectively mainstreaming school-age children with intensive behavioral needs to their public school district; 19517 19518 19519

(5) Contribute to the field of early and effective identification and intervention programs for children with intensive behavioral needs by providing financial support for scholarly research and publication of clinical findings. 19520 19521 19522 19523

(B) The director of mental retardation and developmental disabilities shall collaborate with the director of ~~job and family services~~ health care administration and consult with the executive director of the Ohio center for autism and low incidence and university-based programs that specialize in services for individuals with developmental disabilities when establishing programs under this section. 19524 19525 19526 19527 19528 19529 19530

Sec. 5123.171. As used in this section, "respite care" means appropriate, short-term, temporary care provided to a mentally retarded or developmentally disabled person to sustain the family structure or to meet planned or emergency needs of the family. 19531 19532 19533 19534

The department of mental retardation and developmental disabilities shall provide respite care services to persons with mental retardation or a developmental disability for the purpose of promoting self-sufficiency and normalization, preventing or reducing inappropriate institutional care, and furthering the unity of the family by enabling the family to meet the special 19535 19536 19537 19538 19539 19540

needs of a mentally retarded or developmentally disabled person. 19541

In order to be eligible for respite care services under this section, the mentally retarded or developmentally disabled person must be in need of habilitation services as defined in section 5126.01 of the Revised Code. 19542 19543 19544 19545

Respite care may be provided in a facility licensed under section 5123.19 of the Revised Code or certified as an intermediate care facility for the mentally retarded under ~~Title XIX of~~ the ~~"Social Security Act," 49 Stat. 620 (1935), 42 U.S.C. 301, as amended,~~ medicaid program or certified as a respite care home under section 5126.05 of the Revised Code. 19546 19547 19548 19549 19550 19551

The department shall develop a system for locating vacant beds that are available for respite care and for making information on vacant beds available to users of respite care services. Facilities certified as intermediate care facilities for the mentally retarded and facilities holding contracts with the department for the provision of residential services under section 5123.18 of the Revised Code shall report vacant beds to the department but shall not be required to accept respite care clients. 19552 19553 19554 19555 19556 19557 19558 19559 19560

The director of mental retardation and developmental disabilities shall adopt, and may amend or rescind, rules in accordance with Chapter 119. of the Revised Code for both of the following: 19561 19562 19563 19564

(A) Certification by county boards of mental retardation and developmental disabilities of respite care homes; 19565 19566

(B) Provision of respite care services authorized by this section. Rules adopted under this division shall establish all of the following: 19567 19568 19569

(1) A formula for distributing funds appropriated for respite care services; 19570 19571

(2) Standards for supervision, training and quality control in the provision of respite care services; 19572 19573

(3) Eligibility criteria for emergency respite care services. 19574

Sec. 5123.181. The director of mental retardation and developmental disabilities and the director of job and family services health care administration shall, in concert with each other, eliminate all double billings and double payments for services on behalf of persons with mental retardation or another developmental disability in intermediate care facilities. The department of mental retardation and developmental disabilities may enter into contracts with providers of services for the purpose of making payments to the providers for services rendered to eligible clients who are persons with mental retardation or a developmental disability over and above the services authorized and paid under Chapter 5111. of the Revised Code medicaid program. Payments authorized under this section and section 5123.18 of the Revised Code shall not be subject to audit findings pursuant to Chapter 5111. of under the Revised Code medicaid program, unless an audit determines that payment was made to the provider for services that were not rendered in accordance with the provisions of the provider agreement entered into with the department of job and family services health care administration or the department of mental retardation and developmental disabilities pursuant to this section. 19575 19576 19577 19578 19579 19580 19581 19582 19583 19584 19585 19586 19587 19588 19589 19590 19591 19592 19593 19594 19595

Sec. 5123.19. (A) As used in this section and in sections 5123.191, 5123.194, 5123.196, 5123.198, and 5123.20 of the Revised Code: 19596 19597 19598

(1)(a) "Residential facility" means a home or facility in which a mentally retarded or developmentally disabled person resides, except the home of a relative or legal guardian in which 19599 19600 19601

a mentally retarded or developmentally disabled person resides, a 19602
respite care home certified under section 5126.05 of the Revised 19603
Code, a county home or district home operated pursuant to Chapter 19604
5155. of the Revised Code, or a dwelling in which the only 19605
mentally retarded or developmentally disabled residents are in an 19606
independent living arrangement or are being provided supported 19607
living. 19608

(b) "Intermediate care facility for the mentally retarded" 19609
means a residential facility that is considered an intermediate 19610
care facility for the mentally retarded for the purposes of 19611
~~Chapter 5111. of~~ the ~~Revised Code~~ medicaid program. 19612

(2) "Political subdivision" means a municipal corporation, 19613
county, or township. 19614

(3) "Independent living arrangement" means an arrangement in 19615
which a mentally retarded or developmentally disabled person 19616
resides in an individualized setting chosen by the person or the 19617
person's guardian, which is not dedicated principally to the 19618
provision of residential services for mentally retarded or 19619
developmentally disabled persons, and for which no financial 19620
support is received for rendering such service from any 19621
governmental agency by a provider of residential services. 19622

(4) "Licensee" means the person or government agency that has 19623
applied for a license to operate a residential facility and to 19624
which the license was issued under this section. 19625

(5) "Related party" has the same meaning as in section 19626
5123.16 of the Revised Code except that "provider" as used in the 19627
definition of "related party" means a person or government entity 19628
that held or applied for a license to operate a residential 19629
facility, rather than a person or government entity certified to 19630
provide supported living. 19631

(B) Every person or government agency desiring to operate a 19632

residential facility shall apply for licensure of the facility to the director of mental retardation and developmental disabilities unless the residential facility is subject to section 3721.02, 3722.04, 5103.03, or 5119.20 of the Revised Code. Notwithstanding Chapter 3721. of the Revised Code, a nursing home that is certified as an intermediate care facility for the mentally retarded ~~under Title XIX of~~ for the ~~"Social Security Act," 79 Stat. 286 (1965), 42 U.S.C.A. 1396, as amended,~~ medicaid program shall apply for licensure of the portion of the home that is certified as an intermediate care facility for the mentally retarded. 19633 19634 19635 19636 19637 19638 19639 19640 19641 19642 19643

(C) Subject to section 5123.196 of the Revised Code, the director of mental retardation and developmental disabilities shall license the operation of residential facilities. An initial license shall be issued for a period that does not exceed one year, unless the director denies the license under division (D) of this section. A license shall be renewed for a period that does not exceed three years, unless the director refuses to renew the license under division (D) of this section. The director, when issuing or renewing a license, shall specify the period for which the license is being issued or renewed. A license remains valid for the length of the licensing period specified by the director, unless the license is terminated, revoked, or voluntarily surrendered. 19644 19645 19646 19647 19648 19649 19650 19651 19652 19653 19654 19655 19656

(D) If it is determined that an applicant or licensee is not in compliance with a provision of this chapter that applies to residential facilities or the rules adopted under such a provision, the director may deny issuance of a license, refuse to renew a license, terminate a license, revoke a license, issue an order for the suspension of admissions to a facility, issue an order for the placement of a monitor at a facility, issue an order for the immediate removal of residents, or take any other action 19657 19658 19659 19660 19661 19662 19663 19664

the director considers necessary consistent with the director's authority under this chapter regarding residential facilities. In the director's selection and administration of the sanction to be imposed, all of the following apply: 19665 19666 19667 19668

(1) The director may deny, refuse to renew, or revoke a license, if the director determines that the applicant or licensee has demonstrated a pattern of serious noncompliance or that a violation creates a substantial risk to the health and safety of residents of a residential facility. 19669 19670 19671 19672 19673

(2) The director may terminate a license if more than twelve consecutive months have elapsed since the residential facility was last occupied by a resident or a notice required by division (K) of this section is not given. 19674 19675 19676 19677

(3) The director may issue an order for the suspension of admissions to a facility for any violation that may result in sanctions under division (D)(1) of this section and for any other violation specified in rules adopted under division (H)(2) of this section. If the suspension of admissions is imposed for a violation that may result in sanctions under division (D)(1) of this section, the director may impose the suspension before providing an opportunity for an adjudication under Chapter 119. of the Revised Code. The director shall lift an order for the suspension of admissions when the director determines that the violation that formed the basis for the order has been corrected. 19678 19679 19680 19681 19682 19683 19684 19685 19686 19687 19688

(4) The director may order the placement of a monitor at a residential facility for any violation specified in rules adopted under division (H)(2) of this section. The director shall lift the order when the director determines that the violation that formed the basis for the order has been corrected. 19689 19690 19691 19692 19693

(5) If the director determines that two or more residential facilities owned or operated by the same person or government 19694 19695

entity are not being operated in compliance with a provision of this chapter that applies to residential facilities or the rules adopted under such a provision, and the director's findings are based on the same or a substantially similar action, practice, circumstance, or incident that creates a substantial risk to the health and safety of the residents, the director shall conduct a survey as soon as practicable at each residential facility owned or operated by that person or government entity. The director may take any action authorized by this section with respect to any facility found to be operating in violation of a provision of this chapter that applies to residential facilities or the rules adopted under such a provision. 19696 19697 19698 19699 19700 19701 19702 19703 19704 19705 19706 19707

(6) When the director initiates license revocation proceedings, no opportunity for submitting a plan of correction shall be given. The director shall notify the licensee by letter of the initiation of the proceedings. The letter shall list the deficiencies of the residential facility and inform the licensee that no plan of correction will be accepted. The director shall also send a copy of the letter to the county board of mental retardation and developmental disabilities. The county board shall send a copy of the letter to each of the following: 19708 19709 19710 19711 19712 19713 19714 19715 19716

(a) Each resident who receives services from the licensee; 19717

(b) The guardian of each resident who receives services from the licensee if the resident has a guardian; 19718 19719

(c) The parent or guardian of each resident who receives services from the licensee if the resident is a minor. 19720 19721

(7) Pursuant to rules which shall be adopted in accordance with Chapter 119. of the Revised Code, the director may order the immediate removal of residents from a residential facility whenever conditions at the facility present an immediate danger of physical or psychological harm to the residents. 19722 19723 19724 19725 19726

(8) In determining whether a residential facility is being operated in compliance with a provision of this chapter that applies to residential facilities or the rules adopted under such a provision, or whether conditions at a residential facility present an immediate danger of physical or psychological harm to the residents, the director may rely on information obtained by a county board of mental retardation and developmental disabilities or other governmental agencies. 19727 19728 19729 19730 19731 19732 19733 19734

(9) In proceedings initiated to deny, refuse to renew, or revoke licenses, the director may deny, refuse to renew, or revoke a license regardless of whether some or all of the deficiencies that prompted the proceedings have been corrected at the time of the hearing. 19735 19736 19737 19738 19739

(E) The director shall establish a program under which public notification may be made when the director has initiated license revocation proceedings or has issued an order for the suspension of admissions, placement of a monitor, or removal of residents. The director shall adopt rules in accordance with Chapter 119. of the Revised Code to implement this division. The rules shall establish the procedures by which the public notification will be made and specify the circumstances for which the notification must be made. The rules shall require that public notification be made if the director has taken action against the facility in the eighteen-month period immediately preceding the director's latest action against the facility and the latest action is being taken for the same or a substantially similar violation of a provision of this chapter that applies to residential facilities or the rules adopted under such a provision. The rules shall specify a method for removing or amending the public notification if the director's action is found to have been unjustified or the violation at the residential facility has been corrected. 19740 19741 19742 19743 19744 19745 19746 19747 19748 19749 19750 19751 19752 19753 19754 19755 19756 19757

(F)(1) Except as provided in division (F)(2) of this section, 19758

appeals from proceedings initiated to impose a sanction under division (D) of this section shall be conducted in accordance with Chapter 119. of the Revised Code. 19759 19760 19761

(2) Appeals from proceedings initiated to order the suspension of admissions to a facility shall be conducted in accordance with Chapter 119. of the Revised Code, unless the order was issued before providing an opportunity for an adjudication, in which case all of the following apply: 19762 19763 19764 19765 19766

(a) The licensee may request a hearing not later than ten days after receiving the notice specified in section 119.07 of the Revised Code. 19767 19768 19769

(b) If a timely request for a hearing that includes the licensee's current address is made, the hearing shall commence not later than thirty days after the department receives the request. 19770 19771 19772

(c) After commencing, the hearing shall continue uninterrupted, except for Saturdays, Sundays, and legal holidays, unless other interruptions are agreed to by the licensee and the director. 19773 19774 19775 19776

(d) If the hearing is conducted by a hearing examiner, the hearing examiner shall file a report and recommendations not later than ten days after the last of the following: 19777 19778 19779

(i) The close of the hearing; 19780

(ii) If a transcript of the proceedings is ordered, the hearing examiner receives the transcript; 19781 19782

(iii) If post-hearing briefs are timely filed, the hearing examiner receives the briefs. 19783 19784

(e) A copy of the written report and recommendation of the hearing examiner shall be sent, by certified mail, to the licensee and the licensee's attorney, if applicable, not later than five days after the report is filed. 19785 19786 19787 19788

(f) Not later than five days after the hearing examiner files the report and recommendations, the licensee may file objections to the report and recommendations. 19789 19790 19791

(g) Not later than fifteen days after the hearing examiner files the report and recommendations, the director shall issue an order approving, modifying, or disapproving the report and recommendations. 19792 19793 19794 19795

(h) Notwithstanding the pendency of the hearing, the director shall lift the order for the suspension of admissions when the director determines that the violation that formed the basis for the order has been corrected. 19796 19797 19798 19799

(G) Neither a person or government agency whose application for a license to operate a residential facility is denied nor a related party of the person or government agency may apply for a license to operate a residential facility before the date that is one year after the date of the denial. Neither a licensee whose residential facility license is revoked nor a related party of the licensee may apply for a residential facility license before the date that is five years after the date of the revocation. 19800 19801 19802 19803 19804 19805 19806 19807

(H) In accordance with Chapter 119. of the Revised Code, the director shall adopt and may amend and rescind rules for licensing and regulating the operation of residential facilities, including intermediate care facilities for the mentally retarded. The rules for intermediate care facilities for the mentally retarded may differ from those for other residential facilities. The rules shall establish and specify the following: 19808 19809 19810 19811 19812 19813 19814

(1) Procedures and criteria for issuing and renewing licenses, including procedures and criteria for determining the length of the licensing period that the director must specify for each license when it is issued or renewed; 19815 19816 19817 19818

(2) Procedures and criteria for denying, refusing to renew, 19819

terminating, and revoking licenses and for ordering the suspension of admissions to a facility, placement of a monitor at a facility, and the immediate removal of residents from a facility; 19820 19821 19822

(3) Fees for issuing and renewing licenses, which shall be deposited into the program fee fund created under section 5123.033 of the Revised Code; 19823 19824 19825

(4) Procedures for surveying residential facilities; 19826

(5) Requirements for the training of residential facility personnel; 19827 19828

(6) Classifications for the various types of residential facilities; 19829 19830

(7) Certification procedures for licensees and management contractors that the director determines are necessary to ensure that they have the skills and qualifications to properly operate or manage residential facilities; 19831 19832 19833 19834

(8) The maximum number of persons who may be served in a particular type of residential facility; 19835 19836

(9) Uniform procedures for admission of persons to and transfers and discharges of persons from residential facilities; 19837 19838

(10) Other standards for the operation of residential facilities and the services provided at residential facilities; 19839 19840

(11) Procedures for waiving any provision of any rule adopted under this section. 19841 19842

(I) Before issuing a license, the director of the department or the director's designee shall conduct a survey of the residential facility for which application is made. The director or the director's designee shall conduct a survey of each licensed residential facility at least once during the period the license is valid and may conduct additional inspections as needed. A survey includes but is not limited to an on-site examination and 19843 19844 19845 19846 19847 19848 19849

evaluation of the residential facility, its personnel, and the services provided there. 19850 19851

In conducting surveys, the director or the director's designee shall be given access to the residential facility; all records, accounts, and any other documents related to the operation of the facility; the licensee; the residents of the facility; and all persons acting on behalf of, under the control of, or in connection with the licensee. The licensee and all persons on behalf of, under the control of, or in connection with the licensee shall cooperate with the director or the director's designee in conducting the survey. 19852 19853 19854 19855 19856 19857 19858 19859 19860

Following each survey, unless the director initiates a license revocation proceeding, the director or the director's designee shall provide the licensee with a report listing any deficiencies, specifying a timetable within which the licensee shall submit a plan of correction describing how the deficiencies will be corrected, and, when appropriate, specifying a timetable within which the licensee must correct the deficiencies. After a plan of correction is submitted, the director or the director's designee shall approve or disapprove the plan. A copy of the report and any approved plan of correction shall be provided to any person who requests it. 19861 19862 19863 19864 19865 19866 19867 19868 19869 19870 19871

The director shall initiate disciplinary action against any department employee who notifies or causes the notification to any unauthorized person of an unannounced survey of a residential facility by an authorized representative of the department. 19872 19873 19874 19875

(J) In addition to any other information which may be required of applicants for a license pursuant to this section, the director shall require each applicant to provide a copy of an approved plan for a proposed residential facility pursuant to section 5123.042 of the Revised Code. This division does not apply to renewal of a license. 19876 19877 19878 19879 19880 19881

(K) A licensee shall notify the owner of the building in which the licensee's residential facility is located of any significant change in the identity of the licensee or management contractor before the effective date of the change if the licensee is not the owner of the building. 19882 19883 19884 19885 19886

Pursuant to rules which shall be adopted in accordance with Chapter 119. of the Revised Code, the director may require notification to the department of any significant change in the ownership of a residential facility or in the identity of the licensee or management contractor. If the director determines that a significant change of ownership is proposed, the director shall consider the proposed change to be an application for development by a new operator pursuant to section 5123.042 of the Revised Code and shall advise the applicant within sixty days of the notification that the current license shall continue in effect or a new license will be required pursuant to this section. If the director requires a new license, the director shall permit the facility to continue to operate under the current license until the new license is issued, unless the current license is revoked, refused to be renewed, or terminated in accordance with Chapter 119. of the Revised Code. 19887 19888 19889 19890 19891 19892 19893 19894 19895 19896 19897 19898 19899 19900 19901 19902

(L) A county board of mental retardation and developmental disabilities, the legal rights service, and any interested person may file complaints alleging violations of statute or department rule relating to residential facilities with the department. All complaints shall be in writing and shall state the facts constituting the basis of the allegation. The department shall not reveal the source of any complaint unless the complainant agrees in writing to waive the right to confidentiality or until so ordered by a court of competent jurisdiction. 19903 19904 19905 19906 19907 19908 19909 19910 19911

The department shall adopt rules in accordance with Chapter 119. of the Revised Code establishing procedures for the receipt, 19912 19913

referral, investigation, and disposition of complaints filed with the department under this division. 19914 19915

(M) The department shall establish procedures for the notification of interested parties of the transfer or interim care of residents from residential facilities that are closing or are losing their license. 19916 19917 19918 19919

(N) Before issuing a license under this section to a residential facility that will accommodate at any time more than one mentally retarded or developmentally disabled individual, the director shall, by first class mail, notify the following: 19920 19921 19922 19923

(1) If the facility will be located in a municipal corporation, the clerk of the legislative authority of the municipal corporation; 19924 19925 19926

(2) If the facility will be located in unincorporated territory, the clerk of the appropriate board of county commissioners and the fiscal officer of the appropriate board of township trustees. 19927 19928 19929 19930

The director shall not issue the license for ten days after mailing the notice, excluding Saturdays, Sundays, and legal holidays, in order to give the notified local officials time in which to comment on the proposed issuance. 19931 19932 19933 19934

Any legislative authority of a municipal corporation, board of county commissioners, or board of township trustees that receives notice under this division of the proposed issuance of a license for a residential facility may comment on it in writing to the director within ten days after the director mailed the notice, excluding Saturdays, Sundays, and legal holidays. If the director receives written comments from any notified officials within the specified time, the director shall make written findings concerning the comments and the director's decision on the issuance of the license. If the director does not receive written 19935 19936 19937 19938 19939 19940 19941 19942 19943 19944

comments from any notified local officials within the specified time, the director shall continue the process for issuance of the license. 19945 19946 19947

(O) Any person may operate a licensed residential facility that provides room and board, personal care, habilitation services, and supervision in a family setting for at least six but not more than eight persons with mental retardation or a developmental disability as a permitted use in any residential district or zone, including any single-family residential district or zone, of any political subdivision. These residential facilities may be required to comply with area, height, yard, and architectural compatibility requirements that are uniformly imposed upon all single-family residences within the district or zone. 19948 19949 19950 19951 19952 19953 19954 19955 19956 19957 19958

(P) Any person may operate a licensed residential facility that provides room and board, personal care, habilitation services, and supervision in a family setting for at least nine but not more than sixteen persons with mental retardation or a developmental disability as a permitted use in any multiple-family residential district or zone of any political subdivision, except that a political subdivision that has enacted a zoning ordinance or resolution establishing planned unit development districts may exclude these residential facilities from those districts, and a political subdivision that has enacted a zoning ordinance or resolution may regulate these residential facilities in multiple-family residential districts or zones as a conditionally permitted use or special exception, in either case, under reasonable and specific standards and conditions set out in the zoning ordinance or resolution to: 19959 19960 19961 19962 19963 19964 19965 19966 19967 19968 19969 19970 19971 19972 19973

(1) Require the architectural design and site layout of the residential facility and the location, nature, and height of any walls, screens, and fences to be compatible with adjoining land 19974 19975 19976

uses and the residential character of the neighborhood; 19977

(2) Require compliance with yard, parking, and sign regulation; 19978 19979

(3) Limit excessive concentration of these residential facilities. 19980 19981

(Q) This section does not prohibit a political subdivision from applying to residential facilities nondiscriminatory regulations requiring compliance with health, fire, and safety regulations and building standards and regulations. 19982 19983 19984 19985

(R) Divisions (O) and (P) of this section are not applicable to municipal corporations that had in effect on June 15, 1977, an ordinance specifically permitting in residential zones licensed residential facilities by means of permitted uses, conditional uses, or special exception, so long as such ordinance remains in effect without any substantive modification. 19986 19987 19988 19989 19990 19991

(S)(1) The director may issue an interim license to operate a residential facility to an applicant for a license under this section if either of the following is the case: 19992 19993 19994

(a) The director determines that an emergency exists requiring immediate placement of persons in a residential facility, that insufficient licensed beds are available, and that the residential facility is likely to receive a permanent license under this section within thirty days after issuance of the interim license. 19995 19996 19997 19998 19999 20000

(b) The director determines that the issuance of an interim license is necessary to meet a temporary need for a residential facility. 20001 20002 20003

(2) To be eligible to receive an interim license, an applicant must meet the same criteria that must be met to receive a permanent license under this section, except for any differing 20004 20005 20006

procedures and time frames that may apply to issuance of a permanent license. 20007 20008

(3) An interim license shall be valid for thirty days and may be renewed by the director for a period not to exceed one hundred fifty days. 20009 20010 20011

(4) The director shall adopt rules in accordance with Chapter 119. of the Revised Code as the director considers necessary to administer the issuance of interim licenses. 20012 20013 20014

(T) Notwithstanding rules adopted pursuant to this section establishing the maximum number of persons who may be served in a particular type of residential facility, a residential facility shall be permitted to serve the same number of persons being served by the facility on the effective date of the rules or the number of persons for which the facility is authorized pursuant to a current application for a certificate of need with a letter of support from the department of mental retardation and developmental disabilities and which is in the review process prior to April 4, 1986. 20015 20016 20017 20018 20019 20020 20021 20022 20023 20024

(U) The director or the director's designee may enter at any time, for purposes of investigation, any home, facility, or other structure that has been reported to the director or that the director has reasonable cause to believe is being operated as a residential facility without a license issued under this section. 20025 20026 20027 20028 20029

The director may petition the court of common pleas of the county in which an unlicensed residential facility is located for an order enjoining the person or governmental agency operating the facility from continuing to operate without a license. The court may grant the injunction on a showing that the person or governmental agency named in the petition is operating a residential facility without a license. The court may grant the injunction, regardless of whether the residential facility meets 20030 20031 20032 20033 20034 20035 20036 20037

the requirements for receiving a license under this section. 20038

Sec. 5123.192. Notwithstanding section 5123.19 of the Revised Code, any nursing home that on June 30, 1987, contained beds that the department of health had certified prior to June 30, 1987, as intermediate care facility for the mentally retarded beds under ~~Title XIX of~~ the ~~"Social Security Act," 49 Stat. 620 (1935), 42 U.S.C. 301, as amended,~~ medicaid program or any nursing home that on June 30, 1987, had an application pending before the department to convert intermediate care facility beds to intermediate care facility for the mentally retarded beds, shall not be required to apply for licensure under section 5123.19 of the Revised Code, shall be subject to the requirements for licensure as a nursing home and all other requirements of Chapter 3721. of the Revised Code and any rules adopted under that chapter, and shall be subject to sections 3702.51 to 3702.62 of the Revised Code and any rules adopted under those sections, unless either of the following applies: 20039 20040 20041 20042 20043 20044 20045 20046 20047 20048 20049 20050 20051 20052 20053 20054

(A) The nursing home's certification or provider agreement as an intermediate care facility for the mentally retarded is subject to a final order of nonrenewal or termination with respect to which all appeal rights have been exhausted and the facility intends to apply for recertification; 20055 20056 20057 20058 20059

(B) The nursing home intends to increase its number of beds certified as intermediate care facility for the mentally retarded beds. In such a case, the nursing home shall be required to apply for licensure of the additional beds under section 5123.19 of the Revised Code. 20060 20061 20062 20063 20064

Sec. 5123.198. (A) As used in this section, "date of the commitment" means the date that an individual specified in division (B) of this section begins to reside in a state-operated 20065 20066 20067

intermediate care facility for the mentally retarded after being committed to the facility pursuant to sections 5123.71 to 5123.76 of the Revised Code. 20068 20069 20070

(B) Except as provided in division (C) of this section, whenever a resident of a residential facility is committed to a state-operated intermediate care facility for the mentally retarded pursuant to sections 5123.71 to 5123.76 of the Revised Code, the department of mental retardation and developmental disabilities, pursuant to an adjudication order issued in accordance with Chapter 119. of the Revised Code, shall reduce by one the number of residents for which the facility in which the resident resided is licensed. 20071 20072 20073 20074 20075 20076 20077 20078 20079

(C) The department shall not reduce under division (B) of this section the number of residents for which a residential facility is licensed if any of the following are the case: 20080 20081 20082

(1) The resident of the residential facility who is committed to a state-operated intermediate care facility for the mentally retarded resided in the residential facility because of the closure, on or after June 26, 2003, of another state-operated intermediate care facility for the mentally retarded; 20083 20084 20085 20086 20087

(2) The residential facility admits within ninety days of the date of the commitment an individual who resides on the date of the commitment in a state-operated intermediate care facility for the mentally retarded or another residential facility; 20088 20089 20090 20091

(3) The department fails to do either of the following within ninety days of the date of the commitment: 20092 20093

(a) Identify an individual to whom all of the following applies: 20094 20095

(i) Resides on the date of the commitment in a state-operated intermediate care facility for the mentally retarded or another residential facility; 20096 20097 20098

(ii) Has indicated to the department an interest in relocating to the residential facility or has a parent or guardian who has indicated to the department an interest for the individual to relocate to the residential facility; 20099 20100 20101 20102

(iii) The department determines the individual has needs that the residential facility can meet. 20103 20104

(b) Provide the residential facility with information about the individual identified under division (C)(2)(a) of this section that the residential facility needs in order to determine whether the facility can meet the individual's needs. 20105 20106 20107 20108

(4) If the department completes the actions specified in divisions (C)(3)(a) and (b) of this section not later than ninety days after the date of the commitment and except as provided in division (D) of this section, the residential facility does all of the following not later than ninety days after the date of the commitment: 20109 20110 20111 20112 20113 20114

(a) Evaluates the information provided by the department; 20115

(b) Assesses the identified individual's needs; 20116

(c) Determines that the residential facility cannot meet the identified individual's needs. 20117 20118

(5) If the department completes the actions specified in divisions (C)(3)(a) and (b) of this section not later than ninety days after the date of the commitment and the residential facility determines that the residential facility can meet the identified individual's needs, the individual, or a parent or guardian of the individual, refuses placement in the residential facility. 20119 20120 20121 20122 20123 20124

(D) The department may reduce under division (B) of this section the number of residents for which a residential facility is licensed even though the residential facility completes the actions specified in division (C)(4) of this section not later 20125 20126 20127 20128

than ninety days after the date of the commitment if all of the following are the case: 20129 20130

(1) The department disagrees with the residential facility's determination that the residential facility cannot meet the identified individual's needs. 20131 20132 20133

(2) The department issues a written decision pursuant to the uniform procedures for admissions, transfers, and discharges established by rules adopted under division (H)(9) of section 5123.19 of the Revised Code that the residential facility should admit the identified individual. 20134 20135 20136 20137 20138

(3) After the department issues the written decision specified in division (D)(2) of this section, the residential facility refuses to admit the identified individual. 20139 20140 20141

(E) A residential facility that admits, refuses to admit, transfers, or discharges a resident under this section shall comply with the uniform procedures for admissions, transfers, and discharges established by rules adopted under division (H)(9) of section 5123.19 of the Revised Code. 20142 20143 20144 20145 20146

(F) The department of mental retardation and developmental disabilities may notify the department of ~~job and family services~~ health care administration of any reduction under this section in the number of residents for which a residential facility that is an intermediate care facility for the mentally retarded is licensed. On receiving the notice, the department of ~~job and family services~~ health care administration may transfer to the department of mental retardation and developmental disabilities the savings in the nonfederal share of medicaid expenditures for each fiscal year after the year of the commitment to be used for costs of the resident's care in the state-operated intermediate care facility for the mentally retarded. In determining the amount saved, the department of ~~job and family services~~ health care 20147 20148 20149 20150 20151 20152 20153 20154 20155 20156 20157 20158 20159

administration shall consider medicaid payments for the remaining 20160
residents of the facility in which the resident resided. 20161

Sec. 5123.211. (A) As used in this section, "residential 20162
services" has the same meaning as in section 5126.01 of the 20163
Revised Code. 20164

(B) The department of mental retardation and developmental 20165
disabilities shall provide or arrange provision of residential 20166
services for each person who, on or after July 1, 1989, ceases to 20167
be a resident of a state institution because of closure of the 20168
institution or a reduction in the institution's population by 20169
forty per cent or more within a period of one year. The services 20170
shall be provided in the county in which the person chooses to 20171
reside and shall consist of one of the following as determined 20172
appropriate by the department in consultation with the county 20173
board of mental retardation and developmental disabilities of the 20174
county in which the services are to be provided: 20175

(1) Residential services provided pursuant to section 5123.18 20176
of the Revised Code; 20177

(2) Residential services for which reimbursement is made 20178
under the ~~medical assistance~~ medicaid program ~~established under~~ 20179
~~section 5111.01 of the Revised Code~~; 20180

(3) Residential services provided in a manner or setting 20181
approved by the director of mental retardation and developmental 20182
disabilities. 20183

(C) Not less than six months prior to closing a state 20184
institution or reducing a state institution's population by forty 20185
per cent or more within a period of one year, the department shall 20186
identify those counties in which individuals leaving the 20187
institution have chosen to reside and notify the county boards of 20188
mental retardation and developmental disabilities in those 20189

counties of the need to develop the services specified in division (B) of this section. The notice shall specify the number of individuals requiring services who plan to reside in the county and indicate the amount of funds the department will use to provide or arrange services for those individuals. 20190 20191 20192 20193 20194

(D) In each county in which one or more persons receive residential services pursuant to division (B) of this section, the department shall provide or arrange provision of residential services, or shall distribute moneys to the county board of mental retardation and developmental disabilities to provide or arrange provision of residential services, for an equal number of persons with mental retardation or developmental disabilities in that county who the county board has determined need residential services but are not receiving them. 20195 20196 20197 20198 20199 20200 20201 20202 20203

Sec. 5123.71. (A)(1) Proceedings for the involuntary institutionalization of a person pursuant to sections 5123.71 to 5123.76 of the Revised Code shall be commenced by the filing of an affidavit with the probate division of the court of common pleas of the county where the person resides or where the person is institutionalized, in the manner and form prescribed by the department of mental retardation and developmental disabilities either on information or actual knowledge, whichever is determined to be proper by the court. The affidavit may be filed only by a person who has custody of the individual as a parent, guardian, or service provider or by a person acting on behalf of the department or a county board of mental retardation and developmental disabilities. This section does not apply regarding the institutionalization of a person pursuant to section 2945.39, 2945.40, 2945.401, or 2945.402 of the Revised Code. 20204 20205 20206 20207 20208 20209 20210 20211 20212 20213 20214 20215 20216 20217 20218

The affidavit shall contain an allegation setting forth the specific category or categories under division ~~(O)~~(N) of section 20219 20220

5123.01 of the Revised Code upon which the commencement of proceedings is based and a statement of the factual ground for the belief that the person is a mentally retarded person subject to institutionalization by court order. Except as provided in division (A)(2) of this section, the affidavit shall be accompanied by both of the following: 20221 20222 20223 20224 20225 20226

(a) A comprehensive evaluation report prepared by the person's evaluation team that includes a statement by the members of the team certifying that they have performed a comprehensive evaluation of the person and that they are of the opinion that the person is a mentally retarded person subject to institutionalization by court order; 20227 20228 20229 20230 20231 20232

(b) An assessment report prepared by the county board of mental retardation and developmental disabilities under section 5123.711 of the Revised Code specifying that the individual is in need of services on an emergency or priority basis. 20233 20234 20235 20236

(2) In lieu of the comprehensive evaluation report, the affidavit may be accompanied by a written and sworn statement that the person or the guardian of a person adjudicated incompetent has refused to allow a comprehensive evaluation and county board assessment and assessment reports. Immediately after accepting an affidavit that is not accompanied by the reports of a comprehensive evaluation and county board assessment, the court shall cause a comprehensive evaluation and county board assessment of the person named in the affidavit to be performed. The evaluation shall be conducted in the least restrictive environment possible and the assessment shall be conducted in the same manner as assessments conducted under section 5123.711 of the Revised Code. The evaluation and assessment must be completed before a probable cause hearing or full hearing may be held under section 5123.75 or 5123.76 of the Revised Code. 20237 20238 20239 20240 20241 20242 20243 20244 20245 20246 20247 20248 20249 20250 20251

A written report of the evaluation team's findings and the 20252

county board's assessment shall be filed with the court. The reports shall, consistent with the rules of evidence, be accepted as probative evidence in any proceeding under section 5123.75 or 5123.76 of the Revised Code. If the counsel for the person who is evaluated or assessed is known, the court shall send to the counsel a copy of the reports as soon as possible after they are filed and prior to any proceedings under section 5123.75 or 5123.76 of the Revised Code. 20253 20254 20255 20256 20257 20258 20259 20260

(B) Any person who is involuntarily detained in an institution or otherwise is in custody under this chapter shall be informed of the right to do the following: 20261 20262 20263

(1) Immediately make a reasonable number of telephone calls or use other reasonable means to contact an attorney, a physician, or both, to contact any other person or persons to secure representation by counsel, or to obtain medical assistance, and be provided assistance in making calls if the assistance is needed and requested; 20264 20265 20266 20267 20268 20269

(2) Retain counsel and have independent expert evaluation and, if the person is an indigent person, be represented by court-appointed counsel and have independent expert evaluation at court expense; 20270 20271 20272 20273

(3) Upon request, have a hearing to determine whether there is probable cause to believe that the person is a mentally retarded person subject to institutionalization by court order. 20274 20275 20276

(C) No person who is being treated by spiritual means through prayer alone in accordance with a recognized religious method of healing may be ordered detained or involuntarily committed unless the court has determined that the person represents a very substantial risk of self-impairment, self-injury, or impairment or injury to others. 20277 20278 20279 20280 20281 20282

Sec. 5123.76. (A) The full hearing shall be conducted in a manner consistent with the procedures outlined in this chapter and with due process of law. The hearing shall be held by a judge of the probate division or, upon transfer by the judge of the probate division, by another judge of the court of common pleas, or a referee designated by the judge of the probate division. Any referee designated by the judge of the probate division must be an attorney. 20283 20284 20285 20286 20287 20288 20289 20290

(1) The following shall be made available to counsel for the respondent: 20291 20292

(a) All relevant documents, information, and evidence in the custody or control of the state or prosecutor; 20293 20294

(b) All relevant documents, information, and evidence in the custody or control of the institution, facility, or program in which the respondent currently is held or in which the respondent has been held pursuant to these proceedings; 20295 20296 20297 20298

(c) With the consent of the respondent, all relevant documents, information, and evidence in the custody or control of any institution or person other than the state. 20299 20300 20301

(2) The respondent has the right to be represented by counsel of the respondent's choice and has the right to attend the hearing except if unusual circumstances of compelling medical necessity exist that render the respondent unable to attend and the respondent has not expressed a desire to attend. 20302 20303 20304 20305 20306

(3) If the respondent is not represented by counsel and the court determines that the conditions specified in division (A)(2) of this section justify the respondent's absence and the right to counsel has not been validly waived, the court shall appoint counsel forthwith to represent the respondent at the hearing, reserving the right to tax costs of appointed counsel to the 20307 20308 20309 20310 20311 20312

respondent unless it is shown that the respondent is indigent. If the court appoints counsel, or if the court determines that the evidence relevant to the respondent's absence does not justify the absence, the court shall continue the case. 20313 20314 20315 20316

(4) The respondent shall be informed of the right to retain counsel, to have independent expert evaluation, and, if an indigent person, to be represented by court appointed counsel and have expert independent evaluation at court expense. 20317 20318 20319 20320

(5) The hearing may be closed to the public unless counsel for the respondent requests that the hearing be open to the public. 20321 20322 20323

(6) Unless objected to by the respondent, the respondent's counsel, or the designee of the director of mental retardation and developmental disabilities, the court, for good cause shown, may admit persons having a legitimate interest in the proceedings. 20324 20325 20326 20327

(7) The affiant under section 5123.71 of the Revised Code shall be subject to subpoena by either party. 20328 20329

(8) The court shall examine the sufficiency of all documents filed and shall inform the respondent, if present, and the respondent's counsel of the nature of the content of the documents and the reason for which the respondent is being held or for which the respondent's placement is being sought. 20330 20331 20332 20333 20334

(9) The court shall receive only relevant, competent, and material evidence. 20335 20336

(10) The designee of the director shall present the evidence for the state. In proceedings under this chapter, the attorney general shall present the comprehensive evaluation, assessment, diagnosis, prognosis, record of habilitation and care, if any, and less restrictive habilitation plans, if any. The attorney general does not have a similar presentation responsibility in connection with a person who has been found not guilty by reason of insanity 20337 20338 20339 20340 20341 20342 20343

and who is the subject of a hearing under section 2945.40 of the Revised Code to determine whether the person is a mentally retarded person subject to institutionalization by court order. 20344 20345 20346

(11) The respondent has the right to testify and the respondent or the respondent's counsel has the right to subpoena witnesses and documents and to present and cross-examine witnesses. 20347 20348 20349 20350

(12) The respondent shall not be compelled to testify and shall be so advised by the court. 20351 20352

(13) On motion of the respondent or the respondent's counsel for good cause shown, or upon the court's own motion, the court may order a continuance of the hearing. 20353 20354 20355

(14) To an extent not inconsistent with this chapter, the Rules of Civil Procedure shall be applicable. 20356 20357

(B) Unless, upon completion of the hearing, the court finds by clear and convincing evidence that the respondent named in the affidavit is a mentally retarded person subject to institutionalization by court order, it shall order the respondent's discharge forthwith. 20358 20359 20360 20361 20362

(C) If, upon completion of the hearing, the court finds by clear and convincing evidence that the respondent is a mentally retarded person subject to institutionalization by court order, the court may order the respondent's discharge or order the respondent, for a period not to exceed ninety days, to any of the following: 20363 20364 20365 20366 20367 20368

(1) A public institution, provided that commitment of the respondent to the institution will not cause the institution to exceed its licensed capacity determined in accordance with section 5123.19 of the Revised Code and provided that such a placement is indicated by the comprehensive evaluation report filed pursuant to section 5123.71 of the Revised Code; 20369 20370 20371 20372 20373 20374

(2) A private institution; 20375

(3) A county mental retardation program; 20376

(4) Receive private habilitation and care; 20377

(5) Any other suitable facility, program, or the care of any person consistent with the comprehensive evaluation, assessment, diagnosis, prognosis, and habilitation needs of the respondent. 20378 20379 20380

(D) Any order made pursuant to division (C)(2), (4), or (5) of this section shall be conditional upon the receipt by the court of consent by the facility, program, or person to accept the respondent. 20381 20382 20383 20384

(E) In determining the place to which, or the person with whom, the respondent is to be committed, the court shall consider the comprehensive evaluation, assessment, diagnosis, and projected habilitation plan for the respondent, and shall order the implementation of the least restrictive alternative available and consistent with habilitation goals. 20385 20386 20387 20388 20389 20390

(F) If, at any time it is determined by the director of the facility or program to which, or the person to whom, the respondent is committed that the respondent could be equally well habilitated in a less restrictive environment that is available, the following shall occur: 20391 20392 20393 20394 20395

(1) The respondent shall be released by the director of the facility or program or by the person forthwith and referred to the court together with a report of the findings and recommendations of the facility, program, or person. 20396 20397 20398 20399

(2) The director of the facility or program or the person shall notify the respondent's counsel and the designee of the director of mental retardation and developmental disabilities. 20400 20401 20402

(3) The court shall dismiss the case or order placement in the less restrictive environment. 20403 20404

(G)(1) Except as provided in divisions (G)(2) and (3) of this section, any person who has been committed under this section may apply at any time during the ninety-day period for voluntary admission to an institution under section 5123.69 of the Revised Code. Upon admission of a voluntary resident, the managing officer immediately shall notify the court, the respondent's counsel, and the designee of the director in writing of that fact by mail or otherwise, and, upon receipt of the notice, the court shall dismiss the case. 20405 20406 20407 20408 20409 20410 20411 20412 20413

(2) A person who is found incompetent to stand trial or not guilty by reason of insanity and who is committed pursuant to section 2945.39, 2945.40, 2945.401, or 2945.402 of the Revised Code shall not be voluntarily admitted to an institution pursuant to division (G)(1) of this section until after the termination of the commitment, as described in division (J) of section 2945.401 of the Revised Code. 20414 20415 20416 20417 20418 20419 20420

(H) If, at the end of any commitment period, the respondent has not already been discharged or has not requested voluntary admission status, the director of the facility or program, or the person to whose care the respondent has been committed, shall discharge the respondent forthwith, unless at least ten days before the expiration of that period the designee of the director of mental retardation and developmental disabilities or the prosecutor files an application with the court requesting continued commitment. 20421 20422 20423 20424 20425 20426 20427 20428 20429

(1) An application for continued commitment shall include a written report containing a current comprehensive evaluation and assessment, a diagnosis, a prognosis, an account of progress and past habilitation, and a description of alternative habilitation settings and plans, including a habilitation setting that is the least restrictive setting consistent with the need for habilitation. A copy of the application shall be provided to 20430 20431 20432 20433 20434 20435 20436

respondent's counsel. The requirements for notice under section 20437
5123.73 of the Revised Code and the provisions of divisions (A) to 20438
(E) of this section apply to all hearings on such applications. 20439

(2) A hearing on the first application for continued 20440
commitment shall be held at the expiration of the first ninety-day 20441
period. The hearing shall be mandatory and may not be waived. 20442

(3) Subsequent periods of commitment not to exceed one 20443
hundred eighty days each may be ordered by the court if the 20444
designee of the director of mental retardation and developmental 20445
disabilities files an application for continued commitment, after 20446
a hearing is held on the application or without a hearing if no 20447
hearing is requested and no hearing required under division (H)(4) 20448
of this section is waived. Upon the application of a person 20449
involuntarily committed under this section, supported by an 20450
affidavit of a licensed physician alleging that the person is no 20451
longer a mentally retarded person subject to institutionalization 20452
by court order, the court for good cause shown may hold a full 20453
hearing on the person's continued commitment prior to the 20454
expiration of any subsequent period of commitment set by the 20455
court. 20456

(4) A mandatory hearing shall be held at least every two 20457
years after the initial commitment. 20458

(5) If the court, after a hearing upon a request to continue 20459
commitment, finds that the respondent is a mentally retarded 20460
person subject to institutionalization by court order, the court 20461
may make an order pursuant to divisions (C), (D), and (E) of this 20462
section. 20463

(I) Notwithstanding the provisions of division (H) of this 20464
section, no person who is found to be a mentally retarded person 20465
subject to institutionalization by court order pursuant to 20466
division ~~(O)~~(N)(2) of section 5123.01 of the Revised Code shall be 20467

held under involuntary commitment for more than five years. 20468

(J) The managing officer admitting a person pursuant to a judicial proceeding, within ten working days of the admission, shall make a report of the admission to the department. 20469 20470 20471

Sec. 5126.01. As used in this chapter: 20472

(A) As used in this division, "adult" means an individual who is eighteen years of age or over and not enrolled in a program or service under Chapter 3323. of the Revised Code and an individual sixteen or seventeen years of age who is eligible for adult services under rules adopted by the director of mental retardation and developmental disabilities pursuant to Chapter 119. of the Revised Code. 20473 20474 20475 20476 20477 20478 20479

(1) "Adult services" means services provided to an adult outside the home, except when they are provided within the home according to an individual's assessed needs and identified in an individual service plan, that support learning and assistance in the area of self-care, sensory and motor development, socialization, daily living skills, communication, community living, social skills, or vocational skills. 20480 20481 20482 20483 20484 20485 20486

(2) "Adult services" includes all of the following: 20487

(a) Adult day habilitation services; 20488

(b) Adult day care; 20489

(c) Prevocational services; 20490

(d) Sheltered employment; 20491

(e) Educational experiences and training obtained through entities and activities that are not expressly intended for individuals with mental retardation and developmental disabilities, including trade schools, vocational or technical schools, adult education, job exploration and sampling, unpaid 20492 20493 20494 20495 20496

work experience in the community, volunteer activities, and spectator sports; 20497 20498

(f) Community employment services and supported employment services. 20499 20500

(B)(1) "Adult day habilitation services" means adult services that do the following: 20501 20502

(a) Provide access to and participation in typical activities and functions of community life that are desired and chosen by the general population, including such activities and functions as opportunities to experience and participate in community exploration, companionship with friends and peers, leisure activities, hobbies, maintaining family contacts, community events, and activities where individuals without disabilities are involved; 20503 20504 20505 20506 20507 20508 20509 20510

(b) Provide supports or a combination of training and supports that afford an individual a wide variety of opportunities to facilitate and build relationships and social supports in the community. 20511 20512 20513 20514

(2) "Adult day habilitation services" includes all of the following: 20515 20516

(a) Personal care services needed to ensure an individual's ability to experience and participate in vocational services, educational services, community activities, and any other adult day habilitation services; 20517 20518 20519 20520

(b) Skilled services provided while receiving adult day habilitation services, including such skilled services as behavior management intervention, occupational therapy, speech and language therapy, physical therapy, and nursing services; 20521 20522 20523 20524

(c) Training and education in self-determination designed to help the individual do one or more of the following: develop 20525 20526

self-advocacy skills, exercise the individual's civil rights, acquire skills that enable the individual to exercise control and responsibility over the services received, and acquire skills that enable the individual to become more independent, integrated, or productive in the community; 20527 20528 20529 20530 20531

(d) Recreational and leisure activities identified in the individual's service plan as therapeutic in nature or assistive in developing or maintaining social supports; 20532 20533 20534

(e) Counseling and assistance provided to obtain housing, including such counseling as identifying options for either rental or purchase, identifying financial resources, assessing needs for environmental modifications, locating housing, and planning for ongoing management and maintenance of the housing selected; 20535 20536 20537 20538 20539

(f) Transportation necessary to access adult day habilitation services; 20540 20541

(g) Habilitation management, as described in section 5126.14 of the Revised Code. 20542 20543

(3) "Adult day habilitation services" does not include activities that are components of the provision of residential services, family support services, or supported living services. 20544 20545 20546

(C) "Appointing authority" means the following: 20547

(1) In the case of a member of a county board of mental retardation and developmental disabilities appointed by, or to be appointed by, a board of county commissioners, the board of county commissioners; 20548 20549 20550 20551

(2) In the case of a member of a county board appointed by, or to be appointed by, a senior probate judge, the senior probate judge. 20552 20553 20554

(D) "Community employment services" or "supported employment services" means job training and other services related to 20555 20556

employment outside a sheltered workshop. "Community employment services" or "supported employment services" include all of the following: 20557 20558 20559

(1) Job training resulting in the attainment of competitive work, supported work in a typical work environment, or self-employment; 20560 20561 20562

(2) Supervised work experience through an employer paid to provide the supervised work experience; 20563 20564

(3) Ongoing work in a competitive work environment at a wage commensurate with workers without disabilities; 20565 20566

(4) Ongoing supervision by an employer paid to provide the supervision. 20567 20568

(E) As used in this division, "substantial functional limitation," "developmental delay," and "established risk" have the meanings established pursuant to section 5123.011 of the Revised Code. 20569 20570 20571 20572

"Developmental disability" means a severe, chronic disability that is characterized by all of the following: 20573 20574

(1) It is attributable to a mental or physical impairment or a combination of mental and physical impairments, other than a mental or physical impairment solely caused by mental illness as defined in division (A) of section 5122.01 of the Revised Code; 20575 20576 20577 20578

(2) It is manifested before age twenty-two; 20579

(3) It is likely to continue indefinitely; 20580

(4) It results in one of the following: 20581

(a) In the case of a person under age three, at least one developmental delay or an established risk; 20582 20583

(b) In the case of a person at least age three but under age six, at least two developmental delays or an established risk; 20584 20585

(c) In the case of a person age six or older, a substantial functional limitation in at least three of the following areas of major life activity, as appropriate for the person's age: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and, if the person is at least age sixteen, capacity for economic self-sufficiency. 20586 20587 20588 20589 20590 20591 20592

(5) It causes the person to need a combination and sequence of special, interdisciplinary, or other type of care, treatment, or provision of services for an extended period of time that is individually planned and coordinated for the person. 20593 20594 20595 20596

(F) "Early childhood services" means a planned program of habilitation designed to meet the needs of individuals with mental retardation or other developmental disabilities who have not attained compulsory school age. 20597 20598 20599 20600

(G)(1) "Environmental modifications" means the physical adaptations to an individual's home, specified in the individual's service plan, that are necessary to ensure the individual's health, safety, and welfare or that enable the individual to function with greater independence in the home, and without which the individual would require institutionalization. 20601 20602 20603 20604 20605 20606

(2) "Environmental modifications" includes such adaptations as installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, and installation of specialized electric and plumbing systems necessary to accommodate the individual's medical equipment and supplies. 20607 20608 20609 20610 20611

(3) "Environmental modifications" does not include physical adaptations or improvements to the home that are of general utility or not of direct medical or remedial benefit to the individual, including such adaptations or improvements as carpeting, roof repair, and central air conditioning. 20612 20613 20614 20615 20616

(H) "Family support services" means the services provided under a family support services program operated under section 5126.11 of the Revised Code. 20617 20618 20619

(I) "Habilitation" means the process by which the staff of the facility or agency assists an individual with mental retardation or other developmental disability in acquiring and maintaining those life skills that enable the individual to cope more effectively with the demands of the individual's own person and environment, and in raising the level of the individual's personal, physical, mental, social, and vocational efficiency. Habilitation includes, but is not limited to, programs of formal, structured education and training. 20620 20621 20622 20623 20624 20625 20626 20627 20628

(J) "Home and community-based services" means medicaid-funded home and community-based services specified in division (B)(1) of section ~~5111.87~~ 5163.65 of the Revised Code and provided under the medicaid waiver components the department of mental retardation and developmental disabilities administers pursuant to section ~~5111.871~~ 5163.651 of the Revised Code. 20629 20630 20631 20632 20633 20634

(K) "Immediate family" means parents, grandparents, brothers, sisters, spouses, sons, daughters, aunts, uncles, mothers-in-law, fathers-in-law, brothers-in-law, sisters-in-law, sons-in-law, and daughters-in-law. 20635 20636 20637 20638

(L) ~~"Medicaid" has the same meaning as in section 5111.01 of the Revised Code.~~ 20639 20640

~~(M)~~ "Medicaid case management services" means case management services provided to an individual with mental retardation or other developmental disability that the state medicaid plan requires. 20641 20642 20643 20644

~~(N)~~(M) "Mental retardation" means a mental impairment manifested during the developmental period characterized by significantly subaverage general intellectual functioning existing 20645 20646 20647

concurrently with deficiencies in the effectiveness or degree with which an individual meets the standards of personal independence and social responsibility expected of the individual's age and cultural group. 20648 20649 20650 20651

~~(O)~~(N) "Residential services" means services to individuals with mental retardation or other developmental disabilities to provide housing, food, clothing, habilitation, staff support, and related support services necessary for the health, safety, and welfare of the individuals and the advancement of their quality of life. "Residential services" includes program management, as described in section 5126.14 of the Revised Code. 20652 20653 20654 20655 20656 20657 20658

~~(P)~~(O) "Resources" means available capital and other assets, including moneys received from the federal, state, and local governments, private grants, and donations; appropriately qualified personnel; and appropriate capital facilities and equipment. 20659 20660 20661 20662 20663

~~(Q)~~(P) "Senior probate judge" means the current probate judge of a county who has served as probate judge of that county longer than any of the other current probate judges of that county. If a county has only one probate judge, "senior probate judge" means that probate judge. 20664 20665 20666 20667 20668

~~(R)~~(Q) "Service and support administration" means the duties performed by a service and support administrator pursuant to section 5126.15 of the Revised Code. 20669 20670 20671

~~(S)~~(R)(1) "Specialized medical, adaptive, and assistive equipment, supplies, and supports" means equipment, supplies, and supports that enable an individual to increase the ability to perform activities of daily living or to perceive, control, or communicate within the environment. 20672 20673 20674 20675 20676

(2) "Specialized medical, adaptive, and assistive equipment, supplies, and supports" includes the following: 20677 20678

(a) Eating utensils, adaptive feeding dishes, plate guards, mylatex straps, hand splints, reaches, feeder seats, adjustable pointer sticks, interpreter services, telecommunication devices for the deaf, computerized communications boards, other communication devices, support animals, veterinary care for support animals, adaptive beds, supine boards, prone boards, wedges, sand bags, sidelayers, bolsters, adaptive electrical switches, hand-held shower heads, air conditioners, humidifiers, emergency response systems, folding shopping carts, vehicle lifts, vehicle hand controls, other adaptations of vehicles for accessibility, and repair of the equipment received. 20679 20680 20681 20682 20683 20684 20685 20686 20687 20688 20689

(b) Nondisposable items not covered by medicaid that are intended to assist an individual in activities of daily living or instrumental activities of daily living. 20690 20691 20692

~~(T)~~(S) "Supportive home services" means a range of services to families of individuals with mental retardation or other developmental disabilities to develop and maintain increased acceptance and understanding of such persons, increased ability of family members to teach the person, better coordination between school and home, skills in performing specific therapeutic and management techniques, and ability to cope with specific situations. 20693 20694 20695 20696 20697 20698 20699 20700

~~(U)~~(T)(1) "Supported living" means services provided for as long as twenty-four hours a day to an individual with mental retardation or other developmental disability through any public or private resources, including moneys from the individual, that enhance the individual's reputation in community life and advance the individual's quality of life by doing the following: 20701 20702 20703 20704 20705 20706

(a) Providing the support necessary to enable an individual to live in a residence of the individual's choice, with any number of individuals who are not disabled, or with not more than three individuals with mental retardation and developmental disabilities 20707 20708 20709 20710

unless the individuals are related by blood or marriage; 20711

(b) Encouraging the individual's participation in the community; 20712 20713

(c) Promoting the individual's rights and autonomy; 20714

(d) Assisting the individual in acquiring, retaining, and improving the skills and competence necessary to live successfully in the individual's residence. 20715 20716 20717

(2) "Supported living" includes the provision of all of the following: 20718 20719

(a) Housing, food, clothing, habilitation, staff support, professional services, and any related support services necessary to ensure the health, safety, and welfare of the individual receiving the services; 20720 20721 20722 20723

(b) A combination of lifelong or extended-duration supervision, training, and other services essential to daily living, including assessment and evaluation and assistance with the cost of training materials, transportation, fees, and supplies; 20724 20725 20726 20727 20728

(c) Personal care services and homemaker services; 20729

(d) Household maintenance that does not include modifications to the physical structure of the residence; 20730 20731

(e) Respite care services; 20732

(f) Program management, as described in section 5126.14 of the Revised Code. 20733 20734

Sec. 5126.042. (A) As used in this section: 20735

(1) "Emergency" means any situation that creates for an individual with mental retardation or developmental disabilities a risk of substantial self-harm or substantial harm to others if action is not taken within thirty days. An "emergency" may include 20736 20737 20738 20739

one or more of the following situations: 20740

(a) Loss of present residence for any reason, including legal 20741
action; 20742

(b) Loss of present caretaker for any reason, including 20743
serious illness of the caretaker, change in the caretaker's 20744
status, or inability of the caretaker to perform effectively for 20745
the individual; 20746

(c) Abuse, neglect, or exploitation of the individual; 20747

(d) Health and safety conditions that pose a serious risk to 20748
the individual or others of immediate harm or death; 20749

(e) Change in the emotional or physical condition of the 20750
individual that necessitates substantial accommodation that cannot 20751
be reasonably provided by the individual's existing caretaker. 20752

(2) "Service substitution list" means a service substitution 20753
list established by a county board of mental retardation and 20754
developmental disabilities before ~~the effective date of this~~ 20755
~~amendment~~ September 1, 2008, pursuant to division (B) of this 20756
section as this section existed on the day immediately before ~~the~~ 20757
~~effective date of this amendment~~ September 1, 2008. 20758

(B) If a county board of mental retardation and developmental 20759
disabilities determines that available resources are not 20760
sufficient to meet the needs of all individuals who request 20761
programs and services and may be offered the programs and 20762
services, it shall establish waiting lists for services. The board 20763
may establish priorities for making placements on its waiting 20764
lists according to an individual's emergency status and shall 20765
establish priorities in accordance with divisions (D) and (E) of 20766
this section. 20767

The individuals who may be placed on a waiting list include 20768
individuals with a need for services on an emergency basis and 20769

individuals who have requested services for which resources are not available. 20770 20771

An individual placed on a county board's service substitution list before ~~the effective date of this amendment~~ September 1, 2008, for the purpose of obtaining home and community-based services shall be deemed to have been placed on the county board's waiting list for home and community-based services on the date the individual made a request to the county board that the individual receive home and community-based services instead of the services the individual received at the time the request for home and community-based services was made to the county board. 20772 20773 20774 20775 20776 20777 20778 20779 20780

(C) A county board shall establish a separate waiting list for each of the following categories of services, and may establish separate waiting lists within the waiting lists: 20781 20782 20783

(1) Early childhood services; 20784

(2) Educational programs for preschool and school age children; 20785 20786

(3) Adult services; 20787

(4) Service and support administration; 20788

(5) Residential services and supported living; 20789

(6) Transportation services; 20790

(7) Other services determined necessary and appropriate for persons with mental retardation or a developmental disability according to their individual habilitation or service plans; 20791 20792 20793

(8) Family support services provided under section 5126.11 of the Revised Code. 20794 20795

(D) Except as provided in division (G) of this section, a county board shall do, as priorities, all of the following in accordance with the assessment component, approved under section 5123.046 of the Revised Code, of the county board's plan developed 20796 20797 20798 20799

under section 5126.054 of the Revised Code: 20800

(1) For the purpose of obtaining additional federal medicaid funds for home and community-based services and medicaid case management services, do both of the following: 20801 20802 20803

(a) Give an individual who is eligible for home and community-based services and meets both of the following requirements priority over any other individual on a waiting list established under division (C) of this section for home and community-based services that include supported living, residential services, or family support services: 20804 20805 20806 20807 20808 20809

(i) Is twenty-two years of age or older; 20810

(ii) Receives supported living or family support services. 20811

(b) Give an individual who is eligible for home and community-based services and meets both of the following requirements priority over any other individual on a waiting list established under division (C) of this section for home and community-based services that include adult services: 20812 20813 20814 20815 20816

(i) Resides in the individual's own home or the home of the individual's family and will continue to reside in that home after enrollment in home and community-based services; 20817 20818 20819

(ii) Receives adult services from the county board. 20820

(2) As federal medicaid funds become available pursuant to division (D)(1) of this section, give an individual who is eligible for home and community-based services and meets any of the following requirements priority for such services over any other individual on a waiting list established under division (C) of this section: 20821 20822 20823 20824 20825 20826

(a) Does not receive residential services or supported living, either needs services in the individual's current living arrangement or will need services in a new living arrangement, and 20827 20828 20829

has a primary caregiver who is sixty years of age or older; 20830

(b) Is less than twenty-two years of age and has at least one of the following service needs that are unusual in scope or intensity: 20831 20832 20833

(i) Severe behavior problems for which a behavior support plan is needed; 20834 20835

(ii) An emotional disorder for which anti-psychotic medication is needed; 20836 20837

(iii) A medical condition that leaves the individual dependent on life-support medical technology; 20838 20839

(iv) A condition affecting multiple body systems for which a combination of specialized medical, psychological, educational, or habilitation services are needed; 20840 20841 20842

(v) A condition the county board determines to be comparable in severity to any condition described in divisions (D)(2)(b)(i) to (iv) of this section and places the individual at significant risk of institutionalization. 20843 20844 20845 20846

(c) Is twenty-two years of age or older, does not receive residential services or supported living, and is determined by the county board to have intensive needs for home and community-based services on an in-home or out-of-home basis. 20847 20848 20849 20850

(E) Except as provided in division (G) of this section and for a number of years and beginning on a date specified in rules adopted under division (K) of this section, a county board shall give an individual who is eligible for home and community-based services, resides in a nursing facility, and chooses to move to another setting with the help of home and community-based services, priority over any other individual on a waiting list established under division (C) of this section for home and community-based services who does not meet these criteria. 20851 20852 20853 20854 20855 20856 20857 20858 20859

(F) If two or more individuals on a waiting list established under division (C) of this section for home and community-based services have priority for the services pursuant to division (D)(1) or (2) or (E) of this section, a county board may use criteria specified in rules adopted under division (K)(2) of this section in determining the order in which the individuals with priority will be offered the services. Otherwise, the county board shall offer the home and community-based services to such individuals in the order they are placed on the waiting list. 20860 20861 20862 20863 20864 20865 20866 20867 20868

(G) No individual may receive priority for services pursuant to division (D) or (E) of this section over an individual placed on a waiting list established under division (C) of this section on an emergency status. 20869 20870 20871 20872

(H) Prior to establishing any waiting list under this section, a county board shall develop and implement a policy for waiting lists that complies with this section and rules adopted under division (K) of this section. 20873 20874 20875 20876

Prior to placing an individual on a waiting list, the county board shall assess the service needs of the individual in accordance with all applicable state and federal laws. The county board shall place the individual on the appropriate waiting list and may place the individual on more than one waiting list. The county board shall notify the individual of the individual's placement and position on each waiting list on which the individual is placed. 20877 20878 20879 20880 20881 20882 20883 20884

At least annually, the county board shall reassess the service needs of each individual on a waiting list. If it determines that an individual no longer needs a program or service, the county board shall remove the individual from the waiting list. If it determines that an individual needs a program or service other than the one for which the individual is on the waiting list, the county board shall provide the program or 20885 20886 20887 20888 20889 20890 20891

service to the individual or place the individual on a waiting 20892
list for the program or service in accordance with the board's 20893
policy for waiting lists. 20894

When a program or service for which there is a waiting list 20895
becomes available, the county board shall reassess the service 20896
needs of the individual next scheduled on the waiting list to 20897
receive that program or service. If the reassessment demonstrates 20898
that the individual continues to need the program or service, the 20899
board shall offer the program or service to the individual. If it 20900
determines that an individual no longer needs a program or 20901
service, the county board shall remove the individual from the 20902
waiting list. If it determines that an individual needs a program 20903
or service other than the one for which the individual is on the 20904
waiting list, the county board shall provide the program or 20905
service to the individual or place the individual on a waiting 20906
list for the program or service in accordance with the board's 20907
policy for waiting lists. The county board shall notify the 20908
individual of the individual's placement and position on the 20909
waiting list on which the individual is placed. 20910

(I) A child subject to a determination made pursuant to 20911
section 121.38 of the Revised Code who requires the home and 20912
community-based services provided through a medicaid component 20913
that the department of mental retardation and developmental 20914
disabilities administers under section ~~5111.871~~ 5163.651 of the 20915
Revised Code shall receive services through that medicaid 20916
component. For all other services, a child subject to a 20917
determination made pursuant to section 121.38 of the Revised Code 20918
shall be treated as an emergency by the county boards and shall 20919
not be subject to a waiting list. 20920

(J) Not later than the fifteenth day of March of each 20921
even-numbered year, each county board shall prepare and submit to 20922
the director of mental retardation and developmental disabilities 20923

its recommendations for the funding of services for individuals with mental retardation and developmental disabilities and its proposals for reducing the waiting lists for services. 20924 20925 20926

(K)(1) The department of mental retardation and developmental disabilities shall adopt rules in accordance with Chapter 119. of the Revised Code governing waiting lists established under this section. The rules shall include procedures to be followed to ensure that the due process rights of individuals placed on waiting lists are not violated. 20927 20928 20929 20930 20931 20932

(2) As part of the rules adopted under this division, the department shall adopt rules establishing criteria a county board may use under division (F) of this section in determining the order in which individuals with priority for home and community-based services will be offered the services. The rules shall also specify conditions under which a county board, when there is no individual with priority for home and community-based services pursuant to division (D)(1) or (2) or (E) of this section available and appropriate for the services, may offer the services to an individual on a waiting list for the services but not given such priority for the services. 20933 20934 20935 20936 20937 20938 20939 20940 20941 20942 20943

(3) As part of the rules adopted under this division, the department shall adopt rules specifying both of the following for the priority category established under division (E) of this section: 20944 20945 20946 20947

(a) The number of years, which shall not exceed five, that the priority category will be in effect; 20948 20949

(b) The date that the priority category is to go into effect. 20950

(L) The following shall take precedence over the applicable provisions of this section: 20951 20952

(1) Medicaid rules and regulations; 20953

(2) Any specific requirements that may be contained within a medicaid state plan amendment or waiver program that a county board has authority to administer or with respect to which it has authority to provide services, programs, or supports. 20954 20955 20956 20957

Sec. 5126.046. (A) Each county board of mental retardation and developmental disabilities that has medicaid local administrative authority under division (A) of section 5126.055 of the Revised Code for habilitation, vocational, or community employment services provided as part of home and community-based services shall create a list of all persons and government entities eligible to provide such habilitation, vocational, or community employment services. If the county board chooses and is eligible to provide such habilitation, vocational, or community employment services, the county board shall include itself on the list. The county board shall make the list available to each individual with mental retardation or other developmental disability who resides in the county and is eligible for such habilitation, vocational, or community employment services. The county board shall also make the list available to such individuals' families. 20958 20959 20960 20961 20962 20963 20964 20965 20966 20967 20968 20969 20970 20971 20972 20973

An individual with mental retardation or other developmental disability who is eligible for habilitation, vocational, or community employment services may choose the provider of the services. 20974 20975 20976 20977

(B) Each month, the department of mental retardation and developmental disabilities shall create a list of all persons and government entities eligible to provide residential services and supported living. The department shall include on the list all residential facilities licensed under section 5123.19 of the Revised Code and all supported living providers certified under section 5123.161 of the Revised Code. The department shall 20978 20979 20980 20981 20982 20983 20984

distribute the monthly lists to county boards that have local 20985
administrative authority under division (A) of section 5126.055 of 20986
the Revised Code for residential services and supported living 20987
provided as part of home and community-based services. A county 20988
board that receives a list shall make it available to each 20989
individual with mental retardation or other developmental 20990
disability who resides in the county and is eligible for such 20991
residential services or supported living. The county board shall 20992
also make the list available to the families of those individuals. 20993
20994

An individual who is eligible for residential services or 20995
supported living may choose the provider of the residential 20996
services or supported living. 20997

(C) If a county board that has medicaid local administrative 20998
authority under division (A) of section 5126.055 of the Revised 20999
Code for home and community-based services violates the right 21000
established by this section of an individual to choose a provider 21001
that is qualified and willing to provide services to the 21002
individual, the individual shall receive timely notice that the 21003
individual may request a hearing under section ~~5101.35~~ 5160.34 of 21004
the Revised Code. 21005

(D) The departments of mental retardation and developmental 21006
disabilities and ~~job and family services~~ health care 21007
administration shall adopt rules in accordance with Chapter 119. 21008
of the Revised Code governing the implementation of this section. 21009
The rules shall include procedures for individuals to choose their 21010
service providers. The rules shall not be limited by a provider 21011
selection system established under section 5126.42 of the Revised 21012
Code, including any pool of providers created pursuant to a 21013
provider selection system. 21014

Sec. 5126.054. (A) Each county board of mental retardation 21015

and developmental disabilities shall, by resolution, develop a three-calendar year plan that includes the following three components: 21016 21017 21018

(1) An assessment component that includes all of the following: 21019 21020

(a) The number of individuals with mental retardation or other developmental disability residing in the county who need the level of care provided by an intermediate care facility for the mentally retarded, may seek home and community-based services, are given priority for the services pursuant to division (D) of section 5126.042 of the Revised Code; the service needs of those individuals; and the projected annualized cost for services; 21021 21022 21023 21024 21025 21026 21027

(b) The source of funds available to the county board to pay the nonfederal share of medicaid expenditures that the county board is required by sections 5126.059 and 5126.0510 of the Revised Code to pay; 21028 21029 21030 21031

(c) Any other applicable information or conditions that the department of mental retardation and developmental disabilities requires as a condition of approving the component under section 5123.046 of the Revised Code. 21032 21033 21034 21035

(2) (A preliminary implementation component that specifies the number of individuals to be provided, during the first year that the plan is in effect, home and community-based services pursuant to the priority given to them under divisions (D)(1) and (2) of section 5126.042 of the Revised Code and the types of home and community-based services the individuals are to receive; 21036 21037 21038 21039 21040 21041

(3) A component that provides for the implementation of medicaid case management services and home and community-based services for individuals who begin to receive the services on or after the date the plan is approved under section 5123.046 of the Revised Code. A county board shall include all of the following in 21042 21043 21044 21045 21046

the component: 21047

(a) If the department of mental retardation and developmental disabilities or department of ~~job and family services~~ health care administration requires, an agreement to pay the nonfederal share of medicaid expenditures that the county board is required by sections 5126.059 and 5126.0510 of the Revised Code to pay; 21048 21049 21050 21051 21052

(b) How the services are to be phased in over the period the plan covers, including how the county board will serve individuals on a waiting list established under division (C) of section 5126.042 who are given priority status under division (D)(1) of that section; 21053 21054 21055 21056 21057

(c) Any agreement or commitment regarding the county board's funding of home and community-based services that the county board has with the department at the time the county board develops the component; 21058 21059 21060 21061

(d) Assurances adequate to the department that the county board will comply with all of the following requirements: 21062 21063

(i) To provide the types of home and community-based services specified in the preliminary implementation component required by division (A)(2) of this section to at least the number of individuals specified in that component; 21064 21065 21066 21067

(ii) To use any additional funds the county board receives for the services to improve the county board's resource capabilities for supporting such services available in the county at the time the component is developed and to expand the services to accommodate the unmet need for those services in the county; 21068 21069 21070 21071 21072

(iii) To employ a business manager who is either a new employee who has earned at least a bachelor's degree in business administration or a current employee who has the equivalent experience of a bachelor's degree in business administration. If the county board will employ a new employee, the county board 21073 21074 21075 21076 21077

shall include in the component a timeline for employing the employee. 21078 21079

(iv) To employ or contract with a medicaid services manager who is either a new employee who has earned at least a bachelor's degree or a current employee who has the equivalent experience of a bachelor's degree. If the county board will employ a new employee, the county board shall include in the component a timeline for employing the employee. Two or three county boards that have a combined total enrollment in county board services not exceeding one thousand individuals as determined pursuant to certifications made under division (B) of section 5126.12 of the Revised Code may satisfy this requirement by sharing the services of a medicaid services manager or using the services of a medicaid services manager employed by or under contract with a regional council that the county boards establish under section 5126.13 of the Revised Code. 21080 21081 21082 21083 21084 21085 21086 21087 21088 21089 21090 21091 21092 21093

(e) Programmatic and financial accountability measures and projected outcomes expected from the implementation of the plan; 21094 21095

(f) Any other applicable information or conditions that the department requires as a condition of approving the component under section 5123.046 of the Revised Code. 21096 21097 21098

(B) A county board whose plan developed under division (A) of this section is approved by the department under section 5123.046 of the Revised Code shall update and renew the plan in accordance with a schedule the department shall develop. 21099 21100 21101 21102

Sec. 5126.055. (A) Except as provided in section 5126.056 of the Revised Code, a county board of mental retardation and developmental disabilities has medicaid local administrative authority to, and shall, do all of the following for an individual with mental retardation or other developmental disability who resides in the county that the county board serves and seeks or 21103 21104 21105 21106 21107 21108

receives home and community-based services: 21109

(1) Perform assessments and evaluations of the individual. As 21110
part of the assessment and evaluation process, the county board 21111
shall do all of the following: 21112

(a) Make a recommendation to the department of mental 21113
retardation and developmental disabilities on whether the 21114
department should approve or deny the individual's application for 21115
the services, including on the basis of whether the individual 21116
needs the level of care an intermediate care facility for the 21117
mentally retarded provides; 21118

(b) If the individual's application is denied because of the 21119
county board's recommendation and the individual requests a 21120
hearing under section ~~5101.35~~ 5160.34 of the Revised Code, 21121
present, with the department of mental retardation and 21122
developmental disabilities or department of ~~job and family~~ 21123
~~services~~ health care administration, whichever denies the 21124
application, the reasons for the recommendation and denial at the 21125
hearing; 21126

(c) If the individual's application is approved, recommend to 21127
the departments of mental retardation and developmental 21128
disabilities and ~~job and family services~~ health care 21129
administration the services that should be included in the 21130
individual's individualized service plan and, if either department 21131
approves, reduces, denies, or terminates a service included in the 21132
individual's individualized service plan under section ~~5111.871~~ 21133
5163.651 of the Revised Code because of the county board's 21134
recommendation, present, with the department that made the 21135
approval, reduction, denial, or termination, the reasons for the 21136
recommendation and approval, reduction, denial, or termination at 21137
a hearing under section ~~5101.35~~ 5160.34 of the Revised Code. 21138

(2) In accordance with the rules adopted under section 21139

5126.046 of the Revised Code, perform the county board's duties under that section regarding assisting the individual's right to choose a qualified and willing provider of the services and, at a hearing under section 5101.35 of the Revised Code, present evidence of the process for appropriate assistance in choosing providers; 21140 21141 21142 21143 21144 21145

(3) If the county board is certified under section 5123.161 of the Revised Code to provide the services and agrees to provide the services to the individual and the individual chooses the county board to provide the services, furnish, in accordance with the county board's medicaid provider agreement and for the authorized reimbursement rate, the services the individual requires; 21146 21147 21148 21149 21150 21151 21152

(4) Monitor the services provided to the individual and ensure the individual's health, safety, and welfare. The monitoring shall include quality assurance activities. If the county board provides the services, the department of mental retardation and developmental disabilities shall also monitor the services. 21153 21154 21155 21156 21157 21158

(5) Develop, with the individual and the provider of the individual's services, an effective individualized service plan that includes coordination of services, recommend that the departments of mental retardation and developmental disabilities and ~~job and family services~~ <u>health care administration</u> approve the plan, and implement the plan unless either department disapproves it; 21159 21160 21161 21162 21163 21164 21165

(6) Have an investigative agent conduct investigations under section 5126.313 of the Revised Code that concern the individual; 21166 21167

(7) Have a service and support administrator perform the duties under division (B)(9) of section 5126.15 of the Revised Code that concern the individual. 21168 21169 21170

(B) A county board shall perform its medicaid local administrative authority under this section in accordance with all of the following: 21171 21172 21173

(1) The county board's plan that the department of mental retardation and developmental disabilities approves under section 5123.046 of the Revised Code; 21174 21175 21176

(2) All applicable federal and state laws; 21177

(3) All applicable policies of the departments of mental retardation and developmental disabilities and ~~job and family services~~ health care administration and the United States department of health and human services; 21178 21179 21180 21181

(4) The department of ~~job and family services'~~ health care administration's supervision under its authority under section ~~5111.01~~ 5161.01 of the Revised Code to act as the single state medicaid agency; 21182 21183 21184 21185

(5) The department of mental retardation and developmental disabilities' oversight. 21186 21187

(C) The departments of mental retardation and developmental disabilities and ~~job and family services~~ health care administration shall communicate with and provide training to county boards regarding medicaid local administrative authority granted by this section. The communication and training shall include issues regarding audit protocols and other standards established by the United States department of health and human services that the departments determine appropriate for communication and training. County boards shall participate in the training. The departments shall assess the county board's compliance against uniform standards that the departments shall establish. 21188 21189 21190 21191 21192 21193 21194 21195 21196 21197 21198 21199

(D) A county board may not delegate its medicaid local administrative authority granted under this section but may 21200 21201

contract with a person or government entity, including a council 21202
of governments, for assistance with its medicaid local 21203
administrative authority. A county board that enters into such a 21204
contract shall notify the director of mental retardation and 21205
developmental disabilities. The notice shall include the tasks and 21206
responsibilities that the contract gives to the person or 21207
government entity. The person or government entity shall comply in 21208
full with all requirements to which the county board is subject 21209
regarding the person or government entity's tasks and 21210
responsibilities under the contract. The county board remains 21211
ultimately responsible for the tasks and responsibilities. 21212

(E) A county board that has medicaid local administrative 21213
authority under this section shall, through the departments of 21214
mental retardation and developmental disabilities and ~~job and~~ 21215
~~family services~~ health care administration, reply to, and 21216
cooperate in arranging compliance with, a program or fiscal audit 21217
or program violation exception that a state or federal audit or 21218
review discovers. The department of ~~job and family services~~ health 21219
care administration shall timely notify the department of mental 21220
retardation and developmental disabilities and the county board of 21221
any adverse findings. After receiving the notice, the county 21222
board, in conjunction with the department of mental retardation 21223
and developmental disabilities, shall cooperate fully with the 21224
department of ~~job and family services~~ health care administration 21225
and timely prepare and send to the department a written plan of 21226
correction or response to the adverse findings. The county board 21227
is liable for any adverse findings that result from an action it 21228
takes or fails to take in its implementation of medicaid local 21229
administrative authority. 21230

(F) If the department of mental retardation and developmental 21231
disabilities or department of ~~job and family services~~ health care 21232
administration determines that a county board's implementation of 21233

its medicaid local administrative authority under this section is deficient, the department that makes the determination shall require that county board do the following: 21234 21235 21236

(1) If the deficiency affects the health, safety, or welfare of an individual with mental retardation or other developmental disability, correct the deficiency within twenty-four hours; 21237 21238 21239

(2) If the deficiency does not affect the health, safety, or welfare of an individual with mental retardation or other developmental disability, receive technical assistance from the department or submit a plan of correction to the department that is acceptable to the department within sixty days and correct the deficiency within the time required by the plan of correction. 21240 21241 21242 21243 21244 21245

Sec. 5126.0512. (A) As used in this section, "medicaid waiver component" means a medicaid waiver component as defined in section ~~5111.85~~ <u>5163.50</u> of the Revised Code under which home and community-based services are provided. 21246 21247 21248 21249

(B) Effective July 1, 2007, each county board of mental retardation and developmental disabilities shall ensure, for each medicaid waiver component, that the number of individuals eligible under section 5126.041 of the Revised Code for services from the county board who are enrolled in a medicaid waiver component is no less than the sum of the following: 21250 21251 21252 21253 21254 21255

(1) The number of individuals eligible for services from the county board who are enrolled in the medicaid waiver component on June 30, 2007; 21256 21257 21258

(2) The number of medicaid waiver component slots the county board requested before July 1, 2007, that were assigned to the county board before that date but in which no individual was enrolled before that date. 21259 21260 21261 21262

(C) An individual enrolled in a medicaid waiver component 21263

after March 1, 2007, due to an emergency reserve capacity waiver assignment shall not be counted in determining the number of individuals a county board must ensure under division (B) of this section are enrolled in a medicaid waiver component. 21264 21265 21266 21267

(D) An individual who is enrolled in a medicaid waiver component to comply with the terms of the consent order filed March 5, 2007, in *Martin v. Strickland*, Case No. 89-CV-00362, in the United States district court for the southern district of Ohio, eastern division, shall be excluded in determining whether a county board has complied with division (B) of this section. 21268 21269 21270 21271 21272 21273

(E) A county board shall make as many requests for individuals to be enrolled in a medicaid waiver component as necessary for the county board to comply with division (B) of this section. 21274 21275 21276 21277

Sec. 5126.082. (A) In addition to the rules adopted under division (A)(2) of section 5126.08 of the Revised Code establishing standards to be followed by county boards of mental retardation and developmental disabilities in administering, providing, arranging, and operating programs and services and in addition to the board accreditation system established under section 5126.081 of the Revised Code, the director of mental retardation and developmental disabilities shall adopt rules in accordance with Chapter 119. of the Revised Code establishing standards for promoting and advancing the quality of life of individuals with mental retardation and developmental disabilities receiving any of the following: 21278 21279 21280 21281 21282 21283 21284 21285 21286 21287 21288 21289

(1) Early childhood services pursuant to section 5126.05 of the Revised Code for children under age three; 21290 21291

(2) Adult services pursuant to section 5126.05 and division (B) of section 5126.051 of the Revised Code for individuals age sixteen or older; 21292 21293 21294

(3) Family support services pursuant to section 5126.11 of the Revised Code. 21295 21296

(B) The rules adopted under this section shall specify the actions county boards of mental retardation and developmental disabilities and the agencies with which they contract should take to do the following: 21297 21298 21299 21300

(1) Offer individuals with mental retardation and developmental disabilities, and their families when appropriate, choices in programs and services that are centered on the needs and desires of those individuals; 21301 21302 21303 21304

(2) Maintain infants with their families whenever possible by collaborating with other agencies that provide services to infants and their families and taking other appropriate actions; 21305 21306 21307

(3) Provide families that have children with mental retardation and developmental disabilities under age eighteen residing in their homes the resources necessary to allow the children to remain in their homes; 21308 21309 21310 21311

(4) Create and implement community employment services based on the needs and desires of adults with mental retardation and developmental disabilities; 21312 21313 21314

(5) Create, in collaboration with other agencies, transportation systems that provide safe and accessible transportation within the county to individuals with disabilities; 21315 21316 21317

(6) Provide services that allow individuals with disabilities to be integrated into the community by engaging in educational, vocational, and recreational activities with individuals who do not have disabilities; 21318 21319 21320 21321

(7) Provide age-appropriate retirement services for individuals age sixty-five and older with mental retardation and developmental disabilities; 21322 21323 21324

(8) Establish residential services and supported living for individuals with mental retardation and developmental disabilities in accordance with their needs. 21325 21326 21327

(C) To assist in funding programs and services that meet the standards established under this section, each county board of mental retardation and developmental disabilities shall make a good faith effort to acquire available federal funds, including reimbursements under ~~Title XIX of~~ the ~~"Social Security Act," 79 Stat. 286 (1965), 42 U.S.C.A. 1396, as amended~~ medicaid program. 21328 21329 21330 21331 21332 21333

(D) Each county board of mental retardation and developmental disabilities shall work toward full compliance with the standards established under this section, based on its available resources. Funds received under this chapter shall be used to comply with the standards. Annually, each board shall conduct a self audit to evaluate the board's progress in complying fully with the standards. 21334 21335 21336 21337 21338 21339 21340

(E) The department shall complete a program quality review of each county board of mental retardation and developmental disabilities to determine the extent to which the board has complied with the standards. The review shall be conducted in conjunction with the comprehensive accreditation review of the board that is conducted under section 5126.081 of the Revised Code. 21341 21342 21343 21344 21345 21346 21347

Notwithstanding any provision of this chapter or Chapter 5123. of the Revised Code requiring the department to distribute funds to county boards of mental retardation and developmental disabilities, the department may withhold funds from a board if it finds that the board is not in substantial compliance with the standards established under this section. 21348 21349 21350 21351 21352 21353

(F) When the standards for accreditation from the commission on accreditation of rehabilitation facilities, or another 21354 21355

accrediting agency, meet or exceed the standards established under 21356
this section, the director may accept accreditation from the 21357
commission or other agency as evidence that the board is in 21358
compliance with all or part of the standards established under 21359
this section. Programs and services accredited by the commission 21360
or agency are exempt from the program quality reviews required by 21361
division (E) of this section. 21362

Sec. 5126.12. (A) As used in this section: 21363

(1) "Approved school age class" means a class operated by a 21364
county board of mental retardation and developmental disabilities 21365
and funded by the department of education under section 3317.20 of 21366
the Revised Code. 21367

(2) "Approved preschool unit" means a class or unit operated 21368
by a county board of mental retardation and developmental 21369
disabilities and approved under division (B) of section 3317.05 of 21370
the Revised Code. 21371

(3) "Active treatment" means a continuous treatment program, 21372
which includes aggressive, consistent implementation of a program 21373
of specialized and generic training, treatment, health services, 21374
and related services, that is directed toward the acquisition of 21375
behaviors necessary for an individual with mental retardation or 21376
other developmental disability to function with as much 21377
self-determination and independence as possible and toward the 21378
prevention of deceleration, regression, or loss of current optimal 21379
functional status. 21380

(4) "Eligible for active treatment" means that an individual 21381
with mental retardation or other developmental disability resides 21382
in an intermediate care facility for the mentally retarded 21383
certified ~~under Title XIX of the "Social Security Act," 79 Stat.~~ 21384
~~286 (1965), 42 U.S.C. 1396, as amended~~ for the medicaid program; 21385
resides in a state institution operated by the department of 21386

mental retardation and developmental disabilities; or is enrolled in home and community-based services. 21387 21388

(5) "Traditional adult services" means vocational and nonvocational activities conducted within a sheltered workshop or adult activity center or supportive home services. 21389 21390 21391

(B) Each county board of mental retardation and developmental disabilities shall certify to the director of mental retardation and developmental disabilities all of the following: 21392 21393 21394

(1) On or before the fifteenth day of October, the average daily membership for the first full week of programs and services during October receiving: 21395 21396 21397

(a) Early childhood services provided pursuant to section 5126.05 of the Revised Code for children who are less than three years of age on the thirtieth day of September of the academic year; 21398 21399 21400 21401

(b) Special education for children with disabilities in approved school age classes; 21402 21403

(c) Adult services for persons sixteen years of age and older operated pursuant to section 5126.05 and division (B) of section 5126.051 of the Revised Code. Separate counts shall be made for the following: 21404 21405 21406 21407

(i) Persons enrolled in traditional adult services who are eligible for but not enrolled in active treatment; 21408 21409

(ii) Persons enrolled in traditional adult services who are eligible for and enrolled in active treatment; 21410 21411

(iii) Persons enrolled in traditional adult services but who are not eligible for active treatment; 21412 21413

(iv) Persons participating in community employment services. To be counted as participating in community employment services, a person must have spent an average of no less than ten hours per 21414 21415 21416

week in that employment during the preceding six months. 21417

(d) Other programs in the county for individuals with mental retardation and developmental disabilities that have been approved for payment of subsidy by the department of mental retardation and developmental disabilities. 21418 21419 21420 21421

The membership in each such program and service in the county shall be reported on forms prescribed by the department of mental retardation and developmental disabilities. 21422 21423 21424

The department of mental retardation and developmental disabilities shall adopt rules defining full-time equivalent enrollees and for determining the average daily membership therefrom, except that certification of average daily membership in approved school age classes shall be in accordance with rules adopted by the state board of education. The average daily membership figure shall be determined by dividing the amount representing the sum of the number of enrollees in each program or service in the week for which the certification is made by the number of days the program or service was offered in that week. No enrollee may be counted in average daily membership for more than one program or service. 21425 21426 21427 21428 21429 21430 21431 21432 21433 21434 21435 21436

(2) By the fifteenth day of December, the number of children enrolled in approved preschool units on the first day of December; 21437 21438

(3) On or before the thirtieth day of April, an itemized report of all income and operating expenditures for the immediately preceding calendar year, in the format specified by the department of mental retardation and developmental disabilities; 21439 21440 21441 21442 21443

(4) That each required certification and report is in accordance with rules established by the department of mental retardation and developmental disabilities and the state board of education for the operation and subsidization of the programs and 21444 21445 21446 21447

services. 21448

Sec. 5160.01. As used in the Revised Code: 21449

"Children's buy-in program" means the program established under sections 5167.35 to 5167.40 of the Revised Code. 21450 21451

"Children's health insurance program" means the program authorized by Title XXI of the Social Security Act of 1935 and sections 5167.01 to 5167.32 of the Revised Code. 21452 21453 21454

"Disability medical assistance program" and "disability medical assistance" mean the program authorized by Chapter 5168. of the Revised Code. 21455 21456 21457

"Medicaid program" and "medicaid" mean the medical assistance program created by Title XIX of the Social Security Act of 1935 and Chapters 5161., 5162., 5163., 5164., 5165., and 5166. of the Revised Code. 21458 21459 21460 21461

"Medicare program" and "medicare" mean the health insurance program created by Title XVIII of the Social Security Act of 1935. 21462 21463

"Ohio's best Rx program" means the program established under Chapter 5169. of the Revised Code. 21464 21465

"Supplemental security income program," "SSI program," "supplemental security income," and "SSI" mean the program providing benefits to qualified aged, blind, and disabled individuals created by Title XVI of the Social Security Act of 1935. 21466 21467 21468 21469 21470

"Residential state supplement program" means the program administered pursuant to section 5160.80 of the Revised Code. 21471 21472

Sec. 5160.02. As used in this chapter: 21473

(A) "ODHCA family services duty" means a family services duty associated with an ODHCA program. 21474 21475

(B) "ODHCA program" means all of the following: 21476

(1) The children's buy-in program; 21477

(2) The children's health insurance program; 21478

(3) The disability medical assistance program; 21479

(4) The medicaid program; 21480

(5) The Ohio's best Rx program; 21481

(6) The residential state supplement program; 21482

(7) Any other program that state law permits or requires the department of health care administration to administer. 21483 21484

Sec. 5160.03. The director of health care administration shall do all of the following as necessary for the department's efficient administration: 21485 21486 21487

(A) Organize the department of health care administration, including creating administrative subunits; 21488 21489

(B) Appoint employees and prescribe their titles and duties, including chiefs of administrative subunits; 21490 21491

(C) Establish procedures for conducting the business of the department, including procedures for the custody, use, and preservation of records, papers, documents, and property. 21492 21493 21494

Sec. ~~5111.084~~ 5160.04. There is hereby established the pharmacy and therapeutics committee of the department of ~~job and family services~~ health care administration. The committee shall consist of ten members and shall be appointed by the director of ~~job and family services~~ health care administration. The membership of the committee shall include: 21495 21496 21497 21498 21499 21500

(A) Three pharmacists licensed under Chapter 4729. of the Revised Code; 21501 21502

(B) Two doctors of medicine and two doctors of osteopathy who hold certificates issued under Chapter 4731. of the Revised Code; 21503 21504 21505

(C) A registered nurse licensed under Chapter 4723. of the Revised Code; 21506 21507

(D) A pharmacologist who has a doctoral degree; 21508

(E) A psychiatrist who holds a certificate issued under Chapter 4731. of the Revised Code and specializes in psychiatry. 21509 21510

The committee shall elect one of its members as chairperson. 21511

Sec. 5160.05. If the director of health care administration determines that a position with the department of health care administration can best be filled in accordance with division (A)(2) of section 124.30 of the Revised Code or without regard to a residency requirement established by a rule adopted by the director of administrative services, the director of health care administration shall provide the director of administrative services certification of the determination. 21512 21513 21514 21515 21516 21517 21518 21519

Sec. 5160.06. The director of health care administration may require any of the employees of the department of health care administration who may be charged with custody or control of any public money or property or who is required to give bond, to give a bond, properly conditioned, in a sum to be fixed by the director which when approved by the director, shall be filed in the office of the secretary of state. The cost of such bonds, when approved by the director, shall be paid from funds available for the department. The bonds required or authorized by this section may, in the discretion of the director, be individual, schedule, or blanket bonds. 21520 21521 21522 21523 21524 21525 21526 21527 21528 21529 21530

Sec. 5160.08. The director of health care administration may 21531

acquire by purchase, lease, or otherwise such real and personal 21532
property rights in the name of the state as are necessary for the 21533
purposes of the department of health care administration. The 21534
director, with the approval of the governor and the attorney 21535
general, may sell, lease, or exchange portions of real and 21536
personal property of the department when the sale, lease, or 21537
exchange is advantageous to the state. Money received from such 21538
sales, leases, or exchanges shall be credited to the general 21539
revenue fund. 21540

Sec. 5160.10. There is hereby created in the state treasury 21541
the ODHCA support services federal operating fund. The fund shall 21542
consist of federal funds the department of health care 21543
administration receives and that the director of health care 21544
administration determines are appropriate for deposit into the 21545
fund. Money in the fund shall be used to pay the federal share of 21546
both of the following: 21547

(A) The department's costs for computer projects; 21548

(B) The operating costs of the parts of the department that 21549
provide general support services for the department's 21550
administrative subunits. 21551

Sec. 5160.101. There is hereby created in the state treasury 21552
the ODHCA support services state operating fund. The fund shall 21553
consist of payments made to the fund from other appropriation 21554
items by intrastate transfer voucher. Money in the fund shall be 21555
used to pay for both of the following: 21556

(A) The department of health care administration's costs for 21557
computer projects; 21558

(B) The operating costs of the parts of the department that 21559
provide general support services for the department's 21560
administrative subunits. 21561

Sec. 5160.12. The director of health care administration may expend funds appropriated or available to the department of health care administration from any person or government entity. For purposes of this section, the director may enter into contracts with persons and government entities and make grants to persons and government entities. To the extent permitted by federal law, the director may advance funds to a grantee when necessary for the grantee to perform duties under the grant as specified by the director. 21562 21563 21564 21565 21566 21567 21568 21569 21570

Sec. 5160.13. (A) As used in this section: 21571

(1) "Entity" includes an agency, board, commission, or department of the state or a political subdivision of the state; a private, nonprofit entity; a school district; a private school; or a public or private institution of higher education. 21572 21573 21574 21575

(2) "Federal financial participation" means the federal government's share of expenditures made by an entity in implementing an ODHCA program. 21576 21577 21578

(B) This section does not apply to contracts entered into under section 5161.05 or 5161.10 of the Revised Code. 21579 21580

(C) At the request of any public entity having authority to implement an ODHCA program or any private entity under contract with a public entity to implement an ODHCA program, the department may seek to obtain federal financial participation for costs incurred by the entity. Federal financial participation may be sought only for expenditures made with funds for which federal financial participation is available under federal law. 21581 21582 21583 21584 21585 21586 21587

(D) All funds collected by the department pursuant to this section shall be distributed to the entities that incurred the costs, except for any amounts retained by the department pursuant to division (E)(3) of this section. 21588 21589 21590 21591

(E) In distributing federal financial participation pursuant to this section, the department may either enter into an agreement with the entity that is to receive the funds or distribute the funds in accordance with rules adopted under division (F) of this section. If the department decides to enter into an agreement to distribute the funds, the agreement may include terms that do any of the following: 21592 21593 21594 21595 21596 21597 21598

(1) Provide for the whole or partial reimbursement of any cost incurred by the entity in implementing the program; 21599 21600

(2) In the event that federal financial participation is disallowed or otherwise unavailable for any expenditure, require the department or the entity, whichever party caused the disallowance or unavailability of federal financial participation, to assume responsibility for the expenditures; 21601 21602 21603 21604 21605

(3) Permit the department to retain not more than five per cent of the amount of the federal financial participation to be distributed to the entity; 21606 21607 21608

(4) Require the public entity to certify the availability of sufficient unencumbered funds to match the federal financial participation it receives under this section; 21609 21610 21611

(5) Establish the length of the agreement, which may be for a fixed or a continuing period of time; 21612 21613

(6) Establish any other requirements determined by the department to be necessary for the efficient administration of the agreement. 21614 21615 21616

(F) The director of health care administration shall adopt rules as necessary to implement this section, including rules for the distribution of federal financial participation pursuant to this section. The rules shall be adopted in accordance with Chapter 119. of the Revised Code. The director may amend the state medicaid plan or state child health plan as necessary to implement 21617 21618 21619 21620 21621 21622

this section. 21623

(G) Federal financial participation received pursuant to this section shall not be included in any calculation made under sections 5160.26 and 5160.261 of the Revised Code. 21624 21625 21626

Sec. 5160.15. (A) As used in sections 5160.15 to 5160.152 of the Revised Code: 21627 21628

(1) "County subgrant" means a grant that a board of county commissioners awards to another entity. 21629 21630

(2) "County subgrant agreement" means an agreement between a board of county commissioners and another entity under which the board awards the other entity one or more county subgrants. 21631 21632 21633

(3) "Fiscal biennial period" means a two-year period beginning on the first day of July of an odd-numbered year and ending on the last day of June of the next odd-numbered year. 21634 21635 21636

(4) "Grant" means an award for one or more ODHCA family services duties of federal financial assistance that a federal agency provides in the form of money, or property in lieu of money, to the department of health care administration and that the department awards to a board of county commissioners. "Grant" may include state funds the department awards to a board of county commissioners to match the federal financial assistance. "Grant" does not mean either of the following: 21637 21638 21639 21640 21641 21642 21643 21644

(a) Technical assistance that provides services instead of money; 21645 21646

(b) Other assistance provided in the form of revenue sharing, loans, loan guarantees, interest subsidies, or insurance. 21647 21648

(5) "Grant agreement" means an agreement between the department of health care administration and a board of county commissioners under which the department awards the board one or more grants. 21649 21650 21651 21652

(B) Effective July 1, 2009, the director of health care administration may award grants to counties only through grant agreements entered into under this section. 21653 21654 21655

(C) The director shall enter into one or more written grant agreements with the board of county commissioners of each county. Except as provided in rules adopted under this section, grant agreements shall be entered into before the first day of each fiscal biennial period and shall be in effect for that fiscal biennial period or, in the case of a grant agreement entered into after the first day of a fiscal biennial period and except as provided by section 5160.151 of the Revised Code, for the remainder of the fiscal biennial period. A grant agreement shall do all of the following: 21656 21657 21658 21659 21660 21661 21662 21663 21664 21665

(1) Comply with all of the conditions, requirements, and restrictions applicable to the ODHCA family services duties for which the grants included in the agreement are awarded, including the conditions, requirements, and restrictions established by the department, federal or state law, state plans for receipt of federal financial participation, agreements between the department and a federal agency, and executive orders issued by the governor; 21666 21667 21668 21669 21670 21671 21672

(2) Establish terms and conditions governing the accountability for and use of the grants included in the grant agreement; 21673 21674 21675

(3) Specify both of the following: 21676

(a) The ODHCA family services duties for which the grants included in the agreement are awarded; 21677 21678

(b) The private and government entities designated under section 307.981 of the Revised Code to serve as the county family services agencies performing the ODHCA family services duties. 21679 21680 21681

(4) Provide for the department of health care administration to award the grants included in the agreement in accordance with a 21682 21683

methodology for determining the amount of the award established by rules adopted under this section; 21684 21685

(5) Specify the form of the grants which may be a cash draw, reimbursement, property, advance, working capital advance, or other forms specified in rules adopted under this section; 21686 21687 21688

(6) Provide that the grants are subject to the availability of federal funds and appropriations made by the general assembly; 21689 21690

(7) Specify annual financial, administrative, or other incentive awards, if any, to be provided in accordance with section 5160.20 of the Revised Code; 21691 21692 21693

(8) Include the assurance of each board of county commissioners that the board will do all of the following: 21694 21695

(a) Ensure that the grants included in the agreement are used, and the ODHCA family services duties for which the grants are awarded are performed, in accordance with conditions, requirements, and restrictions applicable to the duties established by the department, a federal or state law, state plans for receipt of federal financial participation, agreements between the department and a federal agency, and executive orders issued by the governor; 21696 21697 21698 21699 21700 21701 21702 21703

(b) Utilize a financial management system and other accountability mechanisms for the grants awarded under the agreement that meet requirements the department establishes; 21704 21705 21706

(c) Do all of the following with regard to a county subgrant: 21707

(i) Award the subgrant through a written county subgrant agreement that requires the entity awarded the county subgrant to comply with all conditions, requirements, and restrictions applicable to the board of county commissioners regarding the grant that the board subgrants to the entity, including the conditions, requirements, and restrictions of this section; 21708 21709 21710 21711 21712 21713

(ii) Monitor the entity that is awarded the subgrant to ensure that the entity uses the subgrant in accordance with conditions, requirements, and restrictions applicable to the ODHCA family services duties for which the subgrant is awarded; 21714 21715 21716 21717

(iii) Take action to recover subgrants that are not used in accordance with the conditions, requirements, or restrictions applicable to the ODHCA family services duties for which the subgrant is awarded. 21718 21719 21720 21721

(d) Promptly reimburse the department the amount that represents the amount the board of county commissioners is responsible for, pursuant to action the department takes under division (B) of section 5160.21 of the Revised Code, of funds the department pays to any entity because of an adverse audit finding, adverse quality control finding, final disallowance of federal financial participation, or other sanction or penalty; 21722 21723 21724 21725 21726 21727 21728

(e) Take prompt corrective action, including paying amounts resulting from an adverse finding, sanction, or penalty, if the department, auditor of state, federal agency, or other entity authorized by federal or state law to determine compliance with the conditions, requirements, and restrictions applicable to an ODHCA family services duty for which a grant included in the agreement is awarded determines compliance has not been achieved; 21729 21730 21731 21732 21733 21734 21735

(f) Ensure that any matching funds, regardless of the source, that the board of county commissioners manages are clearly identified and used in accordance with federal and state laws and the agreement. 21736 21737 21738 21739

(9) Provide for the department taking action pursuant to division (B) of section 5160.21 of the Revised Code if authorized by division (A)(1), (2), (3), or (4) of that section; 21740 21741 21742

(10) Provide for timely audits required by federal and state law and require prompt release of audit findings and prompt action 21743 21744

to correct problems identified in an audit; 21745

(11) Provide for administrative review procedures in accordance with section 5160.21 of the Revised Code; 21746 21747

(12) Establish the method of amending or terminating the agreement and an expedited process for correcting terms or conditions of the agreement that the director and the board of county commissioners agree are erroneous. 21748 21749 21750 21751

(D) A grant agreement does not have to be amended for a board of county commissioners to be required to comply with a new or amended condition, requirement, or restriction for an ODHCA family services duty established by federal or state law, state plan for receipt of federal financial participation, agreement between the department and a federal agency, or executive order issued by the governor. 21752 21753 21754 21755 21756 21757 21758

(E) The department shall make payments authorized by a grant agreement on vouchers it prepares and may include any funds appropriated or allocated to it for carrying out ODHCA family services duties for which a grant included in the agreement is awarded, including funds for personal services and maintenance. 21759 21760 21761 21762 21763

(F)(1) The director shall adopt rules in accordance with section 111.15 of the Revised Code governing grant agreements. The director shall adopt the rules as if they were internal management rules. Before adopting the rules, the director shall give the public an opportunity to review and comment on the proposed rules. The rules shall establish methodologies to be used to determine the amount of the grants included in the agreements. The rules also shall establish terms and conditions under which an agreement may be entered into after the first day of a fiscal biennial period. The rules may do any or all of the following: 21764 21765 21766 21767 21768 21769 21770 21771 21772 21773

(a) Govern the award of grants included in grant agreements, including the establishment of, and restrictions on, the form of 21774 21775

the grants and the distribution of the grants; 21776

(b) Specify allowable uses of the grants included in the agreements; 21777 21778

(c) Establish reporting, cash management, audit, and other requirements the director determines are necessary to provide accountability for the use of the grants included in the agreements and determine compliance with conditions, requirements, and restrictions established by the department, a federal or state law, state plans for receipt of federal financial participation, agreements between the department and a federal agency, and executive orders issued by the governor. 21779 21780 21781 21782 21783 21784 21785 21786

(2) A requirement of a grant agreement established by a rule adopted under this division is applicable to a grant agreement without having to be restated in the grant agreement. A requirement established by a grant agreement is applicable to the grant agreement without having to be restated in a rule. 21787 21788 21789 21790 21791

Sec. 5160.151. The director of health care administration may provide for a grant agreement entered into under section 5160.15 of the Revised Code to have a retroactive effective date of the first day of July of an odd-numbered year if both of the following are the case: 21792 21793 21794 21795 21796

(A) The agreement is entered into after that date and before the last day of that July. 21797 21798

(B) The board of county commissioners requests the retroactive effective date and provides the director good cause satisfactory to the director for the reason the agreement was not entered into on or before the first day of that July. 21799 21800 21801 21802

Sec. 5160.152. The department of health care administration shall publish in a manner accessible to the public all of the following that concern ODHCA family services duties for which 21803 21804 21805

grants included in grant agreements entered into under section 5160.15 of the Revised Code are awarded: state plans for receipt of federal financial participation, agreements between the department and a federal agency, and executive orders issued by the governor. The department may publish the materials electronically or otherwise. 21806 21807 21808 21809 21810 21811

Sec. 5160.17. The director of health care administration may enter into a written agreement with one or more state agencies, as defined in section 117.01 of the Revised Code, and state universities and colleges to assist in the coordination, provision, or enhancement of ODHCA family services duties. The director also may enter into written agreements or contracts with, or issue grants to, private and government entities under which funds are provided for the enhancement or innovation of ODHCA family services duties on the state or local level. 21812 21813 21814 21815 21816 21817 21818 21819 21820

The director may adopt internal management rules in accordance with section 111.15 of the Revised Code to implement this section. 21821 21822 21823

Sec. 5160.18. The director of health care administration may enter into one or more written operational agreements with boards of county commissioners to do one or more of the following regarding ODHCA family services duties: 21824 21825 21826 21827

(A) Provide for the director to amend or rescind a rule the director previously adopted; 21828 21829

(B) Provide for the director to modify procedures or establish alternative procedures to accommodate special circumstances in a county; 21830 21831 21832

(C) Provide for the director and board to jointly identify operational problems of mutual concern and develop a joint plan to 21833 21834

address the problems; 21835

(D) Establish a framework for the director and board to modify the use of existing resources in a manner that is beneficial to the department of health care administration and the county that the board serves and improves ODHCA family services duties for the recipients of the services. 21836 21837 21838 21839 21840

Sec. 5160.19. The department of health care administration may establish performance and other administrative standards for the administration and outcomes of ODHCA family services duties and determine at intervals the department decides the degree to which a county department of job and family services complies with a performance or other administrative standard. The department may use statistical sampling, performance audits, case reviews, or other methods it determines necessary and appropriate to determine compliance with performance and administrative standards. 21841 21842 21843 21844 21845 21846 21847 21848 21849

Sec. 5160.191. (A) Except as provided by division (C) of this section, if the department of health care administration determines that a county department of job and family services has failed to comply with a performance or other administrative standard established under section 5160.19 of the Revised Code or by federal law for the administration or outcome of an ODHCA family services duty, the department shall require the county department to develop, submit to the department for approval, and comply with a corrective action plan. 21850 21851 21852 21853 21854 21855 21856 21857 21858

(B) If a county department fails to develop, submit to the department, or comply with a corrective action plan under division (A) of this section, or the department disapproves the county department's corrective action plan, the department may require the county department to develop, submit to the department for approval, and comply with a corrective action plan that requires 21859 21860 21861 21862 21863 21864

the county department to commit existing resources to the plan. 21865

(C) The department may not require a county department to take action under this section for failure to comply with a performance or other administrative standard established for an incentive awarded by the department. Instead, the department may require a county department that fails to comply with that kind of performance or other administrative standard to take action in accordance with rules adopted by the department governing the standard. 21866 21867 21868 21869 21870 21871 21872 21873

(D) At the request of a county department, the department shall assist the county department with the development of a corrective action plan under this section and provide the county department technical assistance in the implementation of the plan. 21874 21875 21876 21877

Sec. 5160.192. The director of health care administration may adopt rules in accordance with section 111.15 of the Revised Code to implement sections 5160.19 to 5160.192 of the Revised Code. If the director adopts the rules, the director shall adopt the rules as if they were internal management rules. 21878 21879 21880 21881 21882

Sec. 5160.20. Subject to the availability of funds, the department of health care administration may provide annual financial, administrative, or other incentive awards to county departments of job and family services. A county department may spend funds provided as a financial incentive award only for the purpose for which the funds are appropriated. The department may adopt internal management rules in accordance with section 111.15 of the Revised Code to establish the amounts of awards, methodology for distributing the awards, types of awards, and standards for administration by the department. 21883 21884 21885 21886 21887 21888 21889 21890 21891 21892

There is hereby created in the state treasury the medicaid local incentive fund. The director of health care administration 21893 21894

may request that the director of budget and management transfer funds appropriated for ODHCA family services duties into the fund. If the director of budget and management determines that the funds identified by the director of health care administration are available and appropriate for transfer, the director of budget and management shall make the transfer. Money in the fund shall be used to provide incentive awards under this section. 21895 21896 21897 21898 21899 21900 21901

Sec. 5160.21. (A) Regardless of whether an ODHCA family services duty is performed by a county department of job and family services, private or government entity pursuant to a contract entered into under section 307.982 of the Revised Code, or private or government provider of an ODHCA family service duty, the department of health care administration may take action under division (B) of this section against a board of county commissioners if the department determines any of the following are the case: 21902 21903 21904 21905 21906 21907 21908 21909 21910

(1) A requirement of a grant agreement entered into under section 5160.15 of the Revised Code that includes a grant for the ODHCA family services duty, including a requirement for grant agreements established by rules adopted under that section, is not complied with; 21911 21912 21913 21914 21915

(2) A county department fails to develop, submit to the department, or comply with a corrective action plan under division (B) of section 5160.191 of the Revised Code, or the department disapproves the county department's corrective action plan developed under division (B) of section 5160.191 of the Revised Code; 21916 21917 21918 21919 21920 21921

(3) A requirement for the ODHCA family services duty established by the department or any of the following is not complied with: a federal or state law, state plan for receipt of federal financial participation, grant agreement between the 21922 21923 21924 21925

department and a federal agency, or executive order issued by the governor; 21926 21927

(4) The board of county commissioners is solely or partially responsible, as determined by the director of health care administration, for an adverse audit finding, adverse quality control finding, final disallowance of federal financial participation, or other sanction or penalty regarding the ODHCA family services duty. 21928 21929 21930 21931 21932 21933

(B) The department may take one or more of the following actions against a board of county commissioners when authorized by division (A)(1), (2), (3), or (4) of this section: 21934 21935 21936

(1) Require the board to comply with a corrective action plan pursuant to a time schedule specified by the department. The corrective action plan shall be established or approved by the department and shall not require the board to commit resources to the plan. 21937 21938 21939 21940 21941

(2) Require the board to comply with a corrective action plan pursuant to a time schedule specified by the department. The corrective action plan shall be established or approved by the department and require the board to commit to the plan existing resources identified by the agency. 21942 21943 21944 21945 21946

(3) Require the board to do one of the following: 21947

(a) Share with the department a final disallowance of federal financial participation or other sanction or penalty; 21948 21949

(b) Reimburse the department the final amount the department pays to the federal government or another entity that represents the amount the board is responsible for of an adverse audit finding, adverse quality control finding, final disallowance of federal financial participation, or other sanction or penalty issued by the federal government, auditor of state, or other entity; 21950 21951 21952 21953 21954 21955 21956

(c) Pay the federal government or another entity the final amount that represents the amount the board is responsible for of an adverse audit finding, adverse quality control finding, final disallowance of federal financial participation, or other sanction or penalty issued by the federal government, auditor of state, or other entity; 21957 21958 21959 21960 21961 21962

(d) Pay the department the final amount that represents the amount the board is responsible for of an adverse audit finding or adverse quality control finding. 21963 21964 21965

(4) Impose an administrative sanction issued by the department against the board. A sanction may be increased if the department has previously taken action against the board under this division. 21966 21967 21968 21969

(5) Perform, or contract with a government or private entity for the entity to perform, the ODHCA family services duty until the department is satisfied that the board ensures that the duty will be performed satisfactorily. If the department performs or contracts with an entity to perform an ODHCA family services duty under division (B)(5) of this section, the department may do either or both of the following: 21970 21971 21972 21973 21974 21975 21976

(a) Spend funds in the county treasury appropriated by the board for the duty; 21977 21978

(b) Withhold funds allocated or reimbursements due to the board for the duty and spend the funds for the duty. 21979 21980

(6) Request that the attorney general bring mandamus proceedings to compel the board to take or cease the action that causes division (A)(1), (2), (3), or (4) of this section to apply. The attorney general shall bring mandamus proceedings in the Franklin county court of appeals at the department's request. 21981 21982 21983 21984 21985

(7) If the department takes action under this division because of division (A)(3) of this section, temporarily withhold 21986 21987

funds allocated or reimbursement due to the board until the department determines that the board is in compliance with the requirement. The department shall release the funds when the department determines that compliance has been achieved. 21988 21989 21990 21991

(C) If the department proposes to take action against a board of county commissioners under division (B) of this section, the department shall notify the board, director of the county department of job and family services, and county auditor. The notice shall be in writing and specify the action the department proposes to take. The department shall send the notice by regular United States mail. 21992 21993 21994 21995 21996 21997 21998

Except as provided in division (D) of this section, the board may request an administrative review of a proposed action in accordance with administrative review procedures the department shall establish. The administrative review procedures shall comply with all of the following: 21999 22000 22001 22002 22003

(1) A request for an administrative review shall state specifically all of the following: 22004 22005

(a) The proposed action specified in the notice from the department for which the review is requested; 22006 22007

(b) The reason why the board believes the proposed action is inappropriate; 22008 22009

(c) All facts and legal arguments that the board wants the department to consider; 22010 22011

(d) The name of the person who will serve as the board's representative in the review. 22012 22013

(2) If the department's notice specifies more than one proposed action and the board does not specify all of the proposed actions in its request pursuant to division (C)(1)(a) of this section, the proposed actions not specified in the request shall 22014 22015 22016 22017

not be subject to administrative review and the parts of the notice regarding those proposed actions shall be final and binding on the board. 22018 22019 22020

(3) In the case of a proposed action under division (B)(1) of this section, the board shall have fifteen calendar days after the department mails the notice to the board to send a written request to the department for an administrative review. If it receives such a request within the required time, the department shall postpone taking action under division (B)(1) of this section for fifteen calendar days following the day it receives the request or for the extended period of time provided for in division (C)(5) of this section to allow a representative of the department and a representative of the board an informal opportunity to resolve any dispute during that fifteen-day or extended period. 22021 22022 22023 22024 22025 22026 22027 22028 22029 22030 22031

(4) In the case of a proposed action under division (B)(2), (3), (4), (5), or (7) of this section, the board shall have thirty calendar days after the department mails the notice to the board to send a written request to the department for an administrative review. If it receives such a request within the required time, the department shall postpone taking action under division (B)(2), (3), (4), (5), or (7) of this section for thirty calendar days following the day it receives the request or for the extended period of time provided for in division (C)(5) of this section to allow a representative of the department and a representative of the board an informal opportunity to resolve any dispute during that thirty-day or extended period. 22032 22033 22034 22035 22036 22037 22038 22039 22040 22041 22042 22043

(5) If the informal opportunity provided in division (C)(3) or (4) of this section does not result in a written resolution to the dispute within the fifteen- or thirty-day period, the director of health care administration and representative of the board may enter into a written agreement extending the time period for attempting an informal resolution of the dispute under division 22044 22045 22046 22047 22048 22049

(C)(3) or (4) of this section. 22050

(6) In the case of a proposed action under division (B)(3) of this section, the board may not include in its request disputes over a finding, final disallowance of federal financial participation, or other sanction or penalty issued by the federal government, auditor of state, or entity other than the department. 22051 22052 22053 22054 22055

(7) If the board fails to request an administrative review within the required time, the board loses the right to request an administrative review of the proposed actions specified in the notice and the notice becomes final and binding on the board. 22056 22057 22058 22059

(8) If the informal opportunity provided in division (C)(3) or (4) of this section does not result in a written resolution to the dispute within the time provided by division (C)(3), (4), or (5) of this section, the director shall appoint an administrative review panel to conduct the administrative review. The review panel shall consist of department employees and one county director of job and family services or other representative of a county department of job and family services from a different county than the county served by the board. No individual involved in the department's proposal to take action against the board may serve on the review panel. The review panel shall review the board's request. The review panel may require that the department or board submit additional information and schedule and conduct an informal hearing to obtain testimony or additional evidence. A review of a proposal to take action under division (B)(3) of this section shall be limited solely to the issue of the amount the board shall share with the department, reimburse the department, or pay to the federal government, department, or other entity under division (B)(3) of this section. The review panel is not required to make a stenographic record of its hearing or other proceedings. 22060 22061 22062 22063 22064 22065 22066 22067 22068 22069 22070 22071 22072 22073 22074 22075 22076 22077 22078 22079 22080

(9) After finishing an administrative review, an 22081

administrative review panel appointed under division (C)(8) of this section shall submit a written report to the director setting forth its findings of fact, conclusions of law, and recommendations for action. The director may approve, modify, or disapprove the recommendations. If the director modifies or disapproves the recommendations, the director shall state the reasons for the modification or disapproval and the actions to be taken against the board. 22082 22083 22084 22085 22086 22087 22088 22089

(10) The director's approval, modification, or disapproval under division (C)(9) of this section shall be final and binding on the board and shall not be subject to further departmental review. 22090 22091 22092 22093

(D) A board of county commissioners is not entitled to an administrative review under division (C) of this section for any of the following: 22094 22095 22096

(1) An action taken under division (B)(6) of this section; 22097

(2) An action taken under section 5160.211 of the Revised Code; 22098 22099

(3) An action taken under division (B)(3) of this section if the federal government, auditor of state, or entity other than the department has identified the board as being solely or partially responsible for an adverse audit finding, adverse quality control finding, final disallowance of federal financial participation, or other sanction or penalty; 22100 22101 22102 22103 22104 22105

(4) An adjustment to an allocation, cash draw, advance, or reimbursement to the board that the department determines necessary for budgetary reasons; 22106 22107 22108

(5) Withholding of a cash draw or reimbursement due to noncompliance with a reporting requirement established in rules adopted under section 5160.22 of the Revised Code. 22109 22110 22111

(E) This section does not apply to other actions the department takes against a board of county commissioners pursuant to authority granted by another state law unless the other state law requires the department to take the action in accordance with this section. 22112 22113 22114 22115 22116

(F) The director of health care administration may adopt rules in accordance with Chapter 119. of the Revised Code as necessary to implement this section. 22117 22118 22119

Sec. 5160.211. The department of health care administration may certify a claim to the attorney general under section 131.02 of the Revised Code for the attorney general to take action under that section against a board of county commissioners to recover any funds that the department determines the board owes the department for actions taken under division (B)(2), (3), (4), or (5) of section 5160.21 of the Revised Code. 22120 22121 22122 22123 22124 22125 22126

Sec. 5160.22. The director of health care administration may adopt rules in accordance with section 111.15 of the Revised Code establishing reporting requirements for ODHCA family services duties. If the director adopts the rules, the director shall adopt the rules as if they were internal management rules and, before adopting the rules, give the public an opportunity to review and comment on the proposed rules. 22127 22128 22129 22130 22131 22132 22133

Sec. 5160.23. If the department of health care administration determines that a grant awarded to a board of county commissioners in a grant agreement entered into under section 5160.15 of the Revised Code, an allocation, advance, or reimbursement the department makes to a county department of job and family services, or a cash draw a county department of job and family services makes exceeds the allowable amount for the grant, allocation, advance, reimbursement, or cash draw, the department 22134 22135 22136 22137 22138 22139 22140 22141

may adjust, offset, withhold, or reduce an allocation, cash draw, advance, reimbursement, or other financial assistance to the board or county department as necessary to recover the amount of the excess grant, allocation, advance, reimbursement, or cash draw. The department is not required to make the adjustment, offset, withholding, or reduction in accordance with section 5160.21 of the Revised Code. 22142 22143 22144 22145 22146 22147 22148

The director of health care administration may adopt rules under section 111.15 of the Revised Code as necessary to implement this section. The director shall adopt the rules as if they were internal management rules. 22149 22150 22151 22152

Sec. 5160.24. The department of health care administration, in consultation with county representatives, shall develop annual training goals and model training curriculum regarding ODHCA family services duties for employees of county departments of job and family services and identify a variety of state funded training opportunities to meet the proposed goals. 22153 22154 22155 22156 22157 22158

Sec. 5160.26. (A) As used in sections 5160.26 to 5160.262 of the Revised Code: 22159 22160

"Disability medical assistance expenditures" means expenditures for the disability medical assistance program and county administration of the disability medical assistance program. 22161 22162 22163 22164

"Medicaid expenditures" means expenditures for county administration of the medicaid program. "Medicaid expenditures" does not include expenditures for transportation services provided under the medicaid program. 22165 22166 22167 22168

"Public assistance expenditures" has the same meaning as in section 5101.16 of the Revised Code. 22169 22170

"Public medical assistance expenditures" means disability 22171

medical assistance expenditures and medicaid expenditures. 22172

(B) Except as provided in division (C) of this section, a county's share of public medical assistance expenditures is the sum of the following for each state fiscal year: 22173 22174 22175

(1) The amount that is twenty-five per cent of the county's total disability medical assistance expenditures during the state fiscal year ending in the previous calendar year that the department of health care administration determines are allowable; 22176 22177 22178 22179

(2) The amount that is ten per cent, or other percentage determined under division (D) of this section, of the county's total medicaid expenditures during the state fiscal year ending in the previous calendar year that the department of health care administration determines are allowable, less the amount of federal reimbursement credited to the county under division (E) of this section for the state fiscal year ending in the previous calendar year. 22180 22181 22182 22183 22184 22185 22186 22187

(C)(1) If a county's share of public medical assistance expenditures determined under division (B) of this section and the county's share of public assistance expenditures determined under division (B) of section 5101.16 of the Revised Code for a state fiscal year exceeds one hundred ten per cent of the county's share for those expenditures for the immediately preceding state fiscal year, the department of health care administration shall reduce the county's share for public medical assistance expenditures so that the total of the county's share for public medical assistance expenditures and public assistance expenditures equals one hundred ten per cent of the county's share of those expenditures for the immediately preceding state fiscal year. The department of health care administration shall cooperate with the department of job and family services for the purpose of making reductions under division (C)(1) of this section. 22188 22189 22190 22191 22192 22193 22194 22195 22196 22197 22198 22199 22200 22201 22202

(2) A county's share of public medical assistance expenditures determined under division (B) of this section may be increased pursuant to a sanction under section 5160.21 of the Revised Code. 22203 22204 22205 22206

(D)(1) If the per capita tax duplicate of a county is less than the per capita tax duplicate of the state as a whole and division (D)(2) of this section does not apply to the county, the percentage to be used for the purpose of division (B)(2) of this section is the product of ten multiplied by a fraction of which the numerator is the per capita tax duplicate of the county and the denominator is the per capita tax duplicate of the state as a whole. The department of health care administration shall compute the per capita tax duplicate for the state and for each county by dividing the tax duplicate for the most recent available year by the current estimate of population prepared by the department of development. 22207 22208 22209 22210 22211 22212 22213 22214 22215 22216 22217 22218

(2) If the percentage of families in a county with an annual income of less than three thousand dollars is greater than the percentage of such families in the state and division (D)(1) of this section does not apply to the county, the percentage to be used for the purpose of division (B)(2) of this section is the product of ten multiplied by a fraction of which the numerator is the percentage of families in the state with an annual income of less than three thousand dollars a year and the denominator is the percentage of such families in the county. The department of health care administration shall compute the percentage of families with an annual income of less than three thousand dollars for the state and for each county by multiplying the most recent estimate of such families published by the department of development, by a fraction, the numerator of which is the estimate of average annual personal income published by the bureau of economic analysis of the United States department of commerce for 22219 22220 22221 22222 22223 22224 22225 22226 22227 22228 22229 22230 22231 22232 22233 22234

the year on which the census estimate is based and the denominator of which is the most recent such estimate published by the bureau. 22235 22236

(3) If the per capita tax duplicate of a county is less than the per capita tax duplicate of the state as a whole and the percentage of families in the county with an annual income of less than three thousand dollars is greater than the percentage of such families in the state, the percentage to be used for the purpose of division (B)(2) of this section shall be determined as follows: 22237 22238 22239 22240 22241 22242

(a) Multiply ten by the fraction determined under division (D)(1) of this section; 22243 22244

(b) Multiply the product determined under division (D)(3)(a) of this section by the fraction determined under division (D)(2) of this section. 22245 22246 22247

(4) The department of health care administration shall determine, for each county, the percentage to be used for the purpose of division (B)(2) of this section not later than the first day of July of the year preceding the state fiscal year for which the percentage is used. 22248 22249 22250 22251 22252

(E) The department of health care administration shall credit to a county the amount of federal reimbursement the department receives from the United States department of health and human services for the county's medicaid expenditures that the department determines are allowable administrative expenditures. 22253 22254 22255 22256 22257

(F) The director of health care administration shall adopt rules in accordance with section 111.15 of the Revised Code to establish all of the following: 22258 22259 22260

(1) The method the department of health care administration is to use to change a county's share of public medical assistance expenditures determined under division (B) of this section as provided in division (C) of this section; 22261 22262 22263 22264

(2) The allocation methodology and formula the department will use to determine the amount of funds to credit to a county under this section; 22265 22266 22267

(3) The method the department will use to change the payment of the county share of public medical assistance expenditures from a calendar-year basis to a state fiscal year basis; 22268 22269 22270

(4) Other procedures and requirements necessary to implement this section. 22271 22272

Sec. 5160.261. Prior to the sixteenth day of May annually, the department of health care administration shall certify to the board of county commissioners of each county the amount estimated by the department to be needed in the following state fiscal year to meet the county share, as determined under section 5160.26 of the Revised Code, of public medical assistance expenditures. Each January, the board shall appropriate the amount certified by the department and an additional five per cent of that amount. Each June, the board may reappropriate, for any purpose the board determines to be appropriate, the amount appropriated in January that exceeds the total of the amount certified by the department for the last six months of the current state fiscal year and the first six months of the following state fiscal year. 22273 22274 22275 22276 22277 22278 22279 22280 22281 22282 22283 22284 22285

Before the fifteenth day of each payment period the director of health care administration establishes by rule, the department of health care administration shall pay a county the estimated state and federal share of the county's public medical assistance expenditures for that payment period increased or decreased by the amount the department underpaid or overpaid the county for the most recent payment period that the department knows an underpayment or overpayment was made. 22286 22287 22288 22289 22290 22291 22292 22293

If the department establishes a maximum amount that it will reimburse a county for public medical assistance expenditures and 22294 22295

a county spends more for public medical assistance expenditures than is reimbursable, the department shall not pay the county a state or, except as provided in section 5160.262 of the Revised Code, a federal share for the amount of the expenditure that exceeds the maximum allowable reimbursement amount. County expenditures that exceed the maximum allowable reimbursement amount shall not be credited to a county's share of public medical assistance expenditures under section 5160.26 of the Revised Code. The department also shall not pay a county a state or, except as provided in section 5160.262 of the Revised Code, a federal share for an administrative expenditure that is not allowed by the department. 22296 22297 22298 22299 22300 22301 22302 22303 22304 22305 22306 22307

A county shall deposit all funds appropriated by a board of county commissioners and received from the department under this section in a special fund in the county treasury known as the public assistance fund. A county shall make payments for public medical assistance expenditures from the public assistance fund. 22308 22309 22310 22311 22312

The attorney general shall bring mandamus proceedings in the Franklin county court of appeals against any board of county commissioners that fails to make appropriations or deposits into the public assistance fund required by this section. 22313 22314 22315 22316

The director shall adopt internal management rules in accordance with section 111.15 of the Revised Code to do all of the following: 22317 22318 22319

(A) Establish the method by which the department is to make payments to counties under this section; 22320 22321

(B) Establish procedures for payment by counties of the county share of public medical assistance expenditures; 22322 22323

(C) Establish payment periods for paying a county its estimated state and federal share of public medical assistance expenditures; 22324 22325 22326

(D) Allow county departments of job and family services to use the public assistance fund for other purposes and programs similar to the disability medical assistance program and medicaid program. 22327 22328 22329 22330

The director may adopt internal management rules in accordance with section 111.15 of the Revised Code to establish a maximum amount that it will reimburse a county for public medical assistance expenditures. 22331 22332 22333 22334

Sec. 5160.262. Subject to available federal funds and appropriations made by the general assembly, the department of health care administration may, at its sole discretion, use available federal funds to reimburse a county for medicaid expenditures even though the county's medicaid expenditures meet or exceed the maximum allowable reimbursement amount established by rules adopted under section 5160.261 of the Revised Code. The director may adopt internal management rules in accordance with section 111.15 of the Revised Code to implement this section. 22335 22336 22337 22338 22339 22340 22341 22342 22343

Sec. 5160.28. The department of health care administration may make any investigations that are necessary in the performance of its duties, and to that end the department shall have the same power as a judge of a county court to administer oaths and to enforce the attendance and testimony of witnesses and the production of books or papers. 22344 22345 22346 22347 22348 22349

The department shall keep a record of its investigations stating the time, place, charges or subject, witnesses summoned and examined, and their conclusions. 22350 22351 22352

Witnesses shall be paid the fees and mileage provided for under section 119.094 of the Revised Code. 22353 22354

Sec. 5160.29. Any judge of any division of the court of 22355

common pleas, upon application of the department of health care administration, may compel the attendance of witnesses, the production of books or papers, and the giving of testimony before the department, by a judgment for contempt or otherwise, in the same manner as in cases before those courts. 22356 22357 22358 22359 22360

Sec. 5160.30. The department of health care administration may appoint and commission any competent officer, employee, agency, or person to serve as a special agent, investigator, or representative to perform a designated duty for and in behalf of the department. Specific credentials shall be given by the department to each person so designated, and each credential shall state: 22361 22362 22363 22364 22365 22366 22367

(A) The person's name; 22368

(B) Agency with which such person is connected; 22369

(C) Purpose of appointment; 22370

(D) Date of expiration of appointment, if appropriate; 22371

(E) Such information as the department considers proper. 22372

Sec. 5160.32. (A) Subject to division (B) of this section, the director of health care administration may accept applications, determine eligibility, redetermine eligibility, and perform related administrative activities for one or more of the following: 22373 22374 22375 22376 22377

(1) The medicaid program; 22378

(2) The children's health insurance program; 22379

(3) The children's buy-in program; 22380

(4) Other programs regarding which the director determines administrative cost savings and efficiency may be achieved through the department accepting applications, determining eligibility, 22381 22382 22383

redetermining eligibility, or performing related administrative activities. 22384 22385

(B) If federal law requires a face-to-face interview to complete an eligibility determination for a program, the face-to-face interview shall not be conducted by the department of health care administration. 22386 22387 22388 22389

(C) Subject to division (B) of this section, if the director elects to accept applications, determine eligibility, redetermine eligibility, and perform related administrative activities for a program under this section, both of the following apply: 22390 22391 22392 22393

(1) An individual seeking services under the program may apply for the program to the director or to the entity that state law governing the program authorizes to accept applications for the program. 22394 22395 22396 22397

(2) The director is subject to federal statutes and regulations and state statutes and rules that require, permit, or prohibit an action regarding accepting applications, determining or redetermining eligibility, and performing related administrative activities for the program. 22398 22399 22400 22401 22402

(D) The director may adopt rules as necessary to implement this section. 22403 22404

Sec. 5160.34. (A) As used in this section: 22405

(1) "Agency" means the following entities that administer an ODHCA program: 22406 22407

(a) The department of health care administration; 22408

(b) A county department of job and family services; 22409

(c) A private or government entity administering, in whole or in part, an ODHCA program for or on behalf of the department of health care administration or a county department of job and 22410 22411 22412

family services. 22413

(2) "Appellant" means an applicant, participant, former participant, recipient, or former recipient of an ODHCA program who is entitled by federal or state law to a hearing regarding a decision or order of the agency that administers the program. 22414 22415 22416 22417

(3) "ODHCA program" means the disability medical assistance program, the medicaid program, and residential state supplement program. 22418 22419 22420

(B) Except as provided by division (F) of this section, an appellant who appeals under federal or state law a decision or order of an agency administering an ODHCA program shall, at the appellant's request, be granted a state hearing by the department of health care administration. This state hearing shall be conducted in accordance with rules adopted under this section. The state hearing shall be recorded, but neither the recording nor a transcript of the recording shall be part of the official record of the proceeding. A state hearing decision is binding upon the agency and department, unless it is reversed or modified on appeal to the director of health care administration or a court of common pleas. 22421 22422 22423 22424 22425 22426 22427 22428 22429 22430 22431 22432

(C) An appellant who disagrees with a state hearing decision may make an administrative appeal to the director of health care administration in accordance with rules adopted under this section. This administrative appeal does not require a hearing, but the director or the director's designee shall review the state hearing decision and previous administrative action and may affirm, modify, remand, or reverse the state hearing decision. Any person designated to make an administrative appeal decision on behalf of the director shall have been admitted to the practice of law in this state. An administrative appeal decision is the final decision of the department and is binding upon the department and agency, unless it is reversed or modified on appeal to the court 22433 22434 22435 22436 22437 22438 22439 22440 22441 22442 22443 22444

of common pleas. 22445

(D) An agency shall comply with a decision issued pursuant to division (B) or (C) of this section within the time limits established by rules adopted under this section. If a county department of job and family services fails to comply within these time limits, the department may take action pursuant to section 5160.21 of the Revised Code. If another agency fails to comply within the time limits, the department may force compliance by withholding funds due the agency or imposing another sanction established by rules adopted under this section. 22446 22447 22448 22449 22450 22451 22452 22453 22454

(E) An appellant who disagrees with an administrative appeal decision of the director of health care administration or the director's designee issued under division (C) of this section may appeal from the decision to the court of common pleas pursuant to section 119.12 of the Revised Code. The appeal shall be governed by section 119.12 of the Revised Code except that: 22455 22456 22457 22458 22459 22460

(1) The person may appeal to the court of common pleas of the county in which the person resides, or to the court of common pleas of Franklin county if the person does not reside in this state. 22461 22462 22463 22464

(2) The person may apply to the court for designation as an indigent and, if the court grants this application, the appellant shall not be required to furnish the costs of the appeal. 22465 22466 22467

(3) The appellant shall mail the notice of appeal to the department of health care administration and file notice of appeal with the court within thirty days after the department mails the administrative appeal decision to the appellant. For good cause shown, the court may extend the time for mailing and filing notice of appeal, but such time shall not exceed six months from the date the department mails the administrative appeal decision. Filing notice of appeal with the court shall be the only act necessary to 22468 22469 22470 22471 22472 22473 22474 22475

vest jurisdiction in the court. 22476

(4) The department shall be required to file a transcript of the testimony of the state hearing with the court only if the court orders the department to file the transcript. The court shall make such an order only if it finds that the department and the appellant are unable to stipulate to the facts of the case and that the transcript is essential to a determination of the appeal. The department shall file the transcript not later than thirty days after the day such an order is issued. 22477 22478 22479 22480 22481 22482 22483 22484

(F) If an appellant receiving medicaid through a health insuring corporation that holds a certificate of authority under Chapter 1751. of the Revised Code is appealing a denial of medicaid services based on lack of medical necessity or other clinical issues regarding coverage by the health insuring corporation, the person hearing the appeal may order an independent medical review if that person determines that a review is necessary. The review shall be performed by a health care professional with appropriate clinical expertise in treating the recipient's condition or disease. The department shall pay the costs associated with the review. 22485 22486 22487 22488 22489 22490 22491 22492 22493 22494 22495

A review ordered under this division shall be part of the record of the hearing and shall be given appropriate evidentiary consideration by the person hearing the appeal. 22496 22497 22498

(G) The director of health care administration shall adopt rules in accordance with Chapter 119. of the Revised Code to implement this section, including rules governing the following: 22499 22500 22501

(1) State hearings under division (B) of this section. The rules shall include provisions regarding notice of eligibility termination and the opportunity of an appellant appealing a decision or order of a county department of job and family services to request a county conference with the county department 22502 22503 22504 22505 22506

before the state hearing is held. 22507

(2) Administrative appeals under division (C) of this section; 22508 22509

(3) Time limits for complying with a decision issued under division (B) or (C) of this section; 22510 22511

(4) Sanctions that may be applied against an agency under division (D) of this section. 22512 22513

(H) The requirements of Chapter 119. of the Revised Code apply to a state hearing or administrative appeal under this section only to the extent, if any, specifically provided by rules adopted under this section. 22514 22515 22516 22517

Sec. 5160.341. The department of health care administration may employ or contract with hearing officers to draft and recommend state hearing decisions under division (B) of section 5160.34 of the Revised Code. The department may employ or contract with hearing authorities to issue state hearing decisions under division (B) of section 5160.34 of the Revised Code. Except in the case of an individual who was employed by or under contract with the department of job and family services to perform the duties of a hearing authority under division (B) of section 5101.35 of the Revised Code before July 1, 2000, an individual performing the duties of a hearing authority shall have been admitted to the practice of law in this state. 22518 22519 22520 22521 22522 22523 22524 22525 22526 22527 22528 22529

Sec. ~~5101.571~~ 5160.36. As used in sections ~~5101.571~~ 5160.36 to ~~5101.591~~ 5160.41 of the Revised Code: 22530 22531

(A) "Information" means all of the following: 22532

(1) An individual's name, address, date of birth, and social security number; 22533 22534

(2) The group or plan number, or other identifier, assigned 22535

by a third party to a policy held by an individual or a plan in 22536
which the individual participates and the nature of the coverage; 22537

(3) Any other data the director of ~~job and family services~~ 22538
health care administration specifies in rules adopted under 22539
section ~~5101.591~~ 5160.41 of the Revised Code. 22540

(B) "Medical assistance" means medical items or services 22541
provided under any of the following: 22542

(1) Medicaid~~, as defined in section 5111.01 of the Revised~~ 22543
~~Code~~; 22544

(2) The children's health insurance program ~~part I, part II,~~ 22545
~~and part III established under sections 5101.50 to 5101.529 of the~~ 22546
~~Revised Code~~; 22547

(3) The disability medical assistance program ~~established~~ 22548
~~under Chapter 5115. of the Revised Code~~; 22549

(4) The children's buy-in program ~~established under sections~~ 22550
~~5101.5211 to 5101.5216 of the Revised Code~~. 22551

(C) "Medical support" means support specified as support for 22552
the purpose of medical care by order of a court or administrative 22553
agency. 22554

(D) "Public assistance" means medical assistance or 22555
assistance under the Ohio works first program established under 22556
Chapter 5107. of the Revised Code. 22557

(E)(1) Subject to division (E)(2) of this section, and except 22558
as provided in division (E)(3) of this section, "third party" 22559
means all of the following: 22560

(a) A person authorized to engage in the business of sickness 22561
and accident insurance under Title XXXIX of the Revised Code; 22562

(b) A person or governmental entity providing coverage for 22563
medical services or items to individuals on a self-insurance 22564
basis; 22565

(c) A health insuring corporation as defined in section 1751.01 of the Revised Code; 22566 22567

(d) A group health plan as defined in 29 U.S.C. 1167; 22568

(e) A service benefit plan as referenced in 42 U.S.C. 1396a(a)(25); 22569 22570

(f) A managed care organization; 22571

(g) A pharmacy benefit manager; 22572

(h) A third party administrator; 22573

(i) Any other person or governmental entity that is, by law, contract, or agreement, responsible for the payment or processing of a claim for a medical item or service for a public assistance recipient or participant. 22574 22575 22576 22577

(2) Except when otherwise provided by 42 U.S.C. 1395y(b), a person or governmental entity listed in division (E)(1) of this section is a third party even if the person or governmental entity limits or excludes payments for a medical item or service in the case of a public assistance recipient. 22578 22579 22580 22581 22582

(3) "Third party" does not include the program for medically handicapped children established under section 3701.023 of the Revised Code. 22583 22584 22585

Sec. ~~5101.59~~ 5160.37. (A) The application for, or acceptance of, public assistance constitutes an automatic assignment of certain rights to the department of ~~job and family services~~ health care administration. This assignment includes the rights of the applicant, recipient, or participant and also the rights of any other member of the assistance group for whom the applicant, recipient, or participant can legally make an assignment. 22586 22587 22588 22589 22590 22591 22592

(B) Pursuant to this section, the applicant, recipient, or participant assigns to the department any rights to medical 22593 22594

support available to the applicant, recipient, or participant or for other members of the assistance group under an order of a court or administrative agency, and any rights to payments by a liable third party for the cost of medical assistance paid on behalf of a public assistance recipient or participant. The recipient or participant shall cooperate with the department in obtaining such payments. 22595 22596 22597 22598 22599 22600 22601

Medicare benefits shall not be assigned pursuant to this section. Benefits assigned to the department by operation of this section are directly reimbursable to the department by liable third parties. 22602 22603 22604 22605

(C) Refusal by the applicant, recipient, or participant to cooperate in obtaining medical assistance paid for self or any other member of the assistance group renders the applicant, recipient, or participant ineligible for public assistance, unless cooperation is waived by the department. Eligibility shall continue for any individual who cannot legally assign the individual's own rights and who would have been eligible for public assistance but for the refusal to assign the individual's rights or to cooperate as required by this section by another person legally able to assign the individual's rights. 22606 22607 22608 22609 22610 22611 22612 22613 22614 22615

(D) If the applicant, recipient, or participant or any member of the assistance group becomes ineligible for public assistance, the department shall restore to the applicant, recipient, participant, or member of the assistance group any future rights to benefits assigned under this section. 22616 22617 22618 22619 22620

(E) The rights of assignment given to the department under this section do not include rights to support assigned under section 5107.20 or 5115.07 of the Revised Code. 22621 22622 22623

Sec. ~~5101.58~~ 5160.38. (A) The acceptance of public assistance gives an automatic right of recovery to the department of ~~job and~~ 22624 22625

~~family services~~ health care administration and a county department of job and family services against the liability of a third party for the cost of medical assistance paid on behalf of the public assistance recipient or participant. When an action or claim is brought against a third party by a public assistance recipient or participant, any payment, settlement or compromise of the action or claim, or any court award or judgment, is subject to the recovery right of the department of ~~job and family services~~ health care administration or county department of job and family services. Except in the case of a recipient or participant who receives medical assistance through a managed care organization, the department's or county department's claim shall not exceed the amount of medical assistance paid by a department on behalf of the recipient or participant. A payment, settlement, compromise, judgment, or award that excludes the cost of medical assistance paid for by a department shall not preclude a department from enforcing its rights under this section.

(B) In the case of a recipient or participant who receives medical assistance through a managed care organization, the amount of the department's or county department's claim shall be the amount the managed care organization pays for medical assistance rendered to the recipient or participant, even if that amount is more than the amount a department pays to the managed care organization for the recipient's or participant's medical assistance.

(C) A recipient or participant, and the recipient's or participant's attorney, if any, shall cooperate with the departments. In furtherance of this requirement, the recipient or participant, or the recipient's or participant's attorney, if any, shall, not later than thirty days after initiating informal recovery activity or filing a legal recovery action against a

third party, provide written notice of the activity or action to the appropriate department or departments as follows: 22658 22659

(1) To only the department of ~~job and family services~~ health care administration when medical assistance under medicaid or the children's buy-in program has been paid; 22660 22661 22662

(2) To the department of ~~job and family services~~ health care administration and the appropriate county department of job and family services when medical assistance under the disability medical assistance program has been paid. 22663 22664 22665 22666

(D) The written notice that must be given under division (C) of this section shall disclose the identity and address of any third party against whom the recipient or participant has or may have a right of recovery. 22667 22668 22669 22670

(E) No settlement, compromise, judgment, or award or any recovery in any action or claim by a recipient or participant where the departments have a right of recovery shall be made final without first giving the appropriate departments written notice as described in division (C) of this section and a reasonable opportunity to perfect their rights of recovery. If the departments are not given the appropriate written notice, the recipient or participant and, if there is one, the recipient's or participant's attorney, are liable to reimburse the departments for the recovery received to the extent of medical payments made by the departments. 22671 22672 22673 22674 22675 22676 22677 22678 22679 22680 22681

(F) The departments shall be permitted to enforce their recovery rights against the third party even though they accepted prior payments in discharge of their rights under this section if, at the time the departments received such payments, they were not aware that additional medical expenses had been incurred but had not yet been paid by the departments. The third party becomes liable to the department of ~~job and family services~~ health care 22682 22683 22684 22685 22686 22687 22688

administration or county department of job and family services as soon as the third party is notified in writing of the valid claims for recovery under this section. 22689 22690 22691

(G)(1) Subject to division (G)(2) of this section, the right of recovery of a department does not apply to that portion of any judgment, award, settlement, or compromise of a claim, to the extent of attorneys' fees, costs, or other expenses incurred by a recipient or participant in securing the judgment, award, settlement, or compromise, or to the extent of medical, surgical, and hospital expenses paid by such recipient or participant from the recipient's or participant's own resources. 22692 22693 22694 22695 22696 22697 22698 22699

(2) Reasonable attorneys' fees, not to exceed one-third of the total judgment, award, settlement, or compromise, plus costs and other expenses incurred by the recipient or participant in securing the judgment, award, settlement, or compromise, shall first be deducted from the total judgment, award, settlement, or compromise. After fees, costs, and other expenses are deducted from the total judgment, award, settlement, or compromise, the department of ~~job and family services~~ health care administration or appropriate county department of job and family services shall receive no less than one-half of the remaining amount, or the actual amount of medical assistance paid, whichever is less. 22700 22701 22702 22703 22704 22705 22706 22707 22708 22709 22710

(H) A right of recovery created by this section may be enforced separately or jointly by the department of ~~job and family services~~ health care administration or the appropriate county department of job and family services. To enforce their recovery rights, the departments may do any of the following: 22711 22712 22713 22714 22715

(1) Intervene or join in any action or proceeding brought by the recipient or participant or on the recipient's or participant's behalf against any third party who may be liable for the cost of medical assistance paid; 22716 22717 22718 22719

(2) Institute and pursue legal proceedings against any third party who may be liable for the cost of medical assistance paid;

(3) Initiate legal proceedings in conjunction with any injured, diseased, or disabled recipient or participant or the recipient's or participant's attorney or representative.

(I) A recipient or participant shall not assess attorney fees, costs, or other expenses against the department of ~~job and family services~~ health care administration or a county department of job and family services when the department or county department enforces its right of recovery created by this section.

(J) The right of recovery given to the department under this section does not include rights to support from any other person assigned to the state under sections 5107.20 and 5115.07 of the Revised Code, but includes payments made by a third party under contract with a person having a duty to support.

Sec. ~~5111.121~~ 5160.39. (A) ~~As used in this section, "third party" has the same meaning as in section 5101.571 of the Revised Code.~~

~~(B)~~ In addition to the authority granted under section ~~5101.59~~ 5160.37 of the Revised Code, the department of ~~job and family services~~ health care administration may, to the extent necessary to reimburse its costs, garnish the wages, salary, or other employment income of, and withhold amounts from state tax refunds to, any person to whom both of the following apply:

(1) The person is required by a court or administrative order to provide coverage of the cost of health care services to a child eligible for ~~medical assistance under this chapter~~ the medicaid program.

(2) The person has received payment from a third party for

the costs of such services but has not used the payment to 22750
reimburse either the other parent or guardian of the child or the 22751
provider of the services. 22752

~~(C)~~(B) Claims for current and past due child support shall 22753
take priority over claims under division ~~(B)~~(A) of this section. 22754

Sec. ~~5101.572~~ 5160.40. (A) A third party shall cooperate with 22755
the department of ~~job and family services~~ health care 22756
administration in identifying individuals for the purpose of 22757
establishing third party liability ~~pursuant to Title XIX of the~~ 22758
~~Social Security Act, as amended~~ for the medicaid program. 22759

(B) In furtherance of the requirement in division (A) of this 22760
section and to allow the department to determine any period that 22761
the individual or the individual's spouse or dependent may have 22762
been covered by the third party and the nature of the coverage, a 22763
third party shall provide, as the department so chooses, 22764
information or access to information, or both, in the third 22765
party's electronic data system on the department's request and in 22766
accordance with division (C) of this section. 22767

(C)(1) If the department chooses to receive information 22768
directly, the third party shall provide the information under all 22769
of the following circumstances: 22770

(a) In a medium, format, and manner prescribed by the 22771
director of ~~job and family services~~ health care administration in 22772
rules adopted under section ~~5101.591~~ 5160.41 of the Revised Code; 22773

(b) Free of charge; 22774

(c) Not later than the end of the thirtieth day after the 22775
department makes its request, unless a different time is agreed to 22776
by the director in writing. 22777

(2) If the department chooses to receive access to 22778
information, the third party shall provide access by a method 22779

prescribed by the director of ~~job and family services~~ <u>health care administration</u> in rules adopted under section ~~5101.591~~ <u>5160.41</u> of the Revised Code. In facilitating access, the department may enter into a trading partner agreement with the third party to permit the exchange of information via "ASC X 12N 270/271 Health Care Eligibility Benefit Inquiry and Response" transactions. 22780 22781 22782 22783 22784 22785

(D) All of the following apply with respect to information provided by a third party to the department under this section: 22786 22787

(1) The information is confidential and not a public record under section 149.43 of the Revised Code. 22788 22789

(2) The release of information to the department is not to be considered a violation of any right of confidentiality or contract that the third party may have with covered persons including, but not limited to, contractees, beneficiaries, heirs, assignees, and subscribers. 22790 22791 22792 22793 22794

(3) The third party is immune from any liability that it may otherwise incur through its release of information to the department. 22795 22796 22797

The department of ~~job and family services~~ <u>health care administration</u> shall limit its use of information gained from third parties to purposes directly connected with the administration of the medicaid program and the child support program authorized by Title IV-D of the "Social Security Act." 22798 22799 22800 22801 22802

(E) No third party shall disclose to other parties or make use of any information regarding recipients of aid under Chapter 5107. ~~or 5111.~~ of the Revised Code <u>or the medicaid program</u> that it obtains from the department, except in the manner provided for by the director of ~~job and family services~~ <u>health care administration</u> in administrative rules. 22803 22804 22805 22806 22807 22808

<u>(F) The department of health care administration may enter into an interagency agreement with the department of job and</u> 22809 22810

family services as necessary to implement this section as regards recipients of assistance under Chapter 5107. of the Revised Code and the child support program authorized by Title IV-D of the "Social Security Act."

Sec. ~~5101.573~~ 5160.401. (A) Subject to divisions (B) and (C) of this section, a third party shall do all of the following:

(1) Accept the department of ~~job and family services'~~ health care administration's right of recovery under section ~~5101.58~~ 5160.38 of the Revised Code and the assignment of rights to the department that are described in section ~~5101.59~~ 5160.38 of the Revised Code.

(2) Respond to an inquiry by the department regarding a claim for payment of a medical item or service that was submitted to the third party not later than three years after the date of the provision of such medical item or service;

(3) Pay a claim described in division (A)(2) of this section;

(4) Not deny a claim submitted by the department solely on the basis of the date of submission of the claim, type or format of the claim form, or a failure by the medical assistance recipient who is the subject of the claim to present proper documentation of coverage at the time of service, if both of the following are true:

(a) The claim was submitted by the department not later than three years after the date of the provision of the medical item or service;

(b) An action by the department to enforce its right of recovery under section ~~5101.58~~ 5160.38 of the Revised Code on the claim was commenced not later than six years after the department's submission of the claim.

(B) For purposes of the requirements in division (A) of this

section, a third party shall treat a managed care organization as the department for a claim in which both of the following are true: 22841 22842 22843

(1) The individual who is the subject of the claim received a medical item or service through a managed care organization that has entered into a contract with the department of ~~job and family services~~ <u>health care administration</u> under section ~~5111.16~~ <u>5165.03</u> of the Revised Code; 22844 22845 22846 22847 22848

(2) The department has assigned its right of recovery for the claim to the managed care organization. 22849 22850

(C) The time limitations associated with the requirements in divisions (A)(2) and (A)(4) of this section apply only to submissions of claims to, and payments of claims by, a health insurer to which 42 U.S.C. 1396a(a)(25)(I) applies. 22851 22852 22853 22854

Sec. ~~5101.574~~ <u>5160.402</u>. No third party shall consider whether an individual is eligible for or receives medical assistance when either of the following applies: 22855 22856 22857

(A) The individual seeks to obtain a policy or enroll in a plan or program operated or administered by the third party; 22858 22859

(B) The individual, or a person or governmental entity on the individual's behalf, seeks payment for a medical item or service provided to the individual. 22860 22861 22862

Sec. ~~5101.575~~ <u>5160.403</u>. (A) If a third party violates section ~~5101.572~~ <u>5160.40</u>, ~~5101.573~~ <u>5160.401</u>, or ~~5101.574~~ <u>5160.402</u> of the Revised Code, a governmental entity that is responsible for issuing a license, certificate of authority, registration, or approval that authorizes the third party to do business in this state may impose a fine against the third party or deny, revoke, or terminate the third party's license, certificate, registration, or approval to do business in this state. The governmental entity 22863 22864 22865 22866 22867 22868 22869 22870

shall determine which sanction is to be imposed. All actions to impose the sanction shall be taken in accordance with Chapter 119. of the Revised Code.

(B) In addition to the sanctions that may be imposed under division (A) of this section for a violation of section ~~5101.572~~ 5160.40, ~~5101.573~~ 5160.401, or ~~5101.574~~ 5160.402 of the Revised Code, the attorney general may petition a court of common pleas to enjoin the violation.

Sec. ~~5101.591~~ 5160.41. (A) Except as provided in division (B) of this section, the director of ~~job and family services~~ health care administration may adopt rules in accordance with Chapter 119. of the Revised Code to implement sections ~~5101.571~~ 5160.36 to ~~5101.59~~ 5160.41 of the Revised Code, including rules that specify what constitutes cooperating with efforts to obtain support or payments, or medical assistance payments, and when cooperation may be waived.

(B) The department shall adopt rules in accordance with Chapter 119. of the Revised Code to do all of the following:

(1) For purposes of the definition of "information" in division (A) of section ~~5101.571~~ 5160.36 of the Revised Code, any data other than the data specified in that division that should be included in the definition.

(2) For purposes of division (C)(1)(a) of section ~~5101.572~~ 5160.40 of the Revised Code, the medium, format, and manner in which a third party must provide information to the department.

(3) For purposes of division (C)(2) of section ~~5101.572~~ 5160.40 of the Revised Code, the method by which a third party must provide the department with access to information.

Sec. 5160.42. Any application for the medicaid program or disability medical assistance program gives a right of subrogation

to the department of health care administration for any workers' compensation benefits payable to a person who is subject to a support order, as defined in section 3119.01 of the Revised Code, on behalf of the applicant, to the extent of any payments made on the applicant's behalf under the medicaid program or disability medical assistance program. If the director of health care administration, in consultation with a child support enforcement agency and the administrator of the bureau of workers' compensation, determines that a person responsible for support payments to a medicaid recipient or disability medical assistance recipient is receiving workers' compensation, the director shall notify the administrator of the amount of the benefit to be paid to the department of health care administration. 22901 22902 22903 22904 22905 22906 22907 22908 22909 22910 22911 22912 22913

Sec. 5160.43. As used in sections 5160.43 to 5160.46 of the Revised Code, "public medical assistance program" means the disability medical assistance program and medicaid program. 22914 22915 22916

As part of the procedure for the determination of whether benefits were incorrectly paid on behalf of public medical assistance program recipients, the director of health care administration shall furnish quarterly the name and social security number of each public medical assistance program recipient to the director of administrative services, the administrator of the bureau of workers' compensation, and each of the state's retirement boards. Within fourteen days after receiving the name and social security number of a public medical assistance program recipient, the director of administrative services, administrator, or board shall inform the auditor of state as to whether the recipient is receiving wages or benefits, the amount of any wages or benefits being received, the social security number, and the address of the recipient. The director of administrative services, administrator, boards, and any agent or employee of those officials and boards shall comply with the rules 22917 22918 22919 22920 22921 22922 22923 22924 22925 22926 22927 22928 22929 22930 22931 22932

adopted under section 5160.65 of the Revised Code restricting the disclosure of information regarding public medical assistance program recipients. Any person who violates this provision shall thereafter be disqualified from acting as an agent or employee or in any other capacity under appointment or employment of any state board, commission, or agency. 22933 22934 22935 22936 22937 22938

Sec. 5160.44. As part of the procedure for the determination of whether benefits were incorrectly paid on behalf of a public medical assistance program recipient, the director of health care administration shall semiannually, at times determined jointly by the auditor of state and the tax commissioner, furnish to the tax commissioner in computer format the name and social security number of each public medical assistance program recipient. Within sixty days after receiving the name and social security number of a public medical assistance program recipient, the commissioner shall inform the auditor of state whether the recipient filed an Ohio individual income tax return, separate or joint, as provided by section 5747.08 of the Revised Code, for either or both of the two taxable years preceding the year in which the director furnished the names and social security numbers to the commissioner. If the recipient did so file, at the same time the commissioner shall also inform the auditor of state of the amount of the federal adjusted gross income as reported on such returns and of the addresses on such returns. The commissioner shall also advise the auditor of state whether such returns were filed on a joint basis, as provided in section 5747.08 of the Revised Code, in which case the federal adjusted gross income as reported may be that of the recipient or the recipient's spouse. 22939 22940 22941 22942 22943 22944 22945 22946 22947 22948 22949 22950 22951 22952 22953 22954 22955 22956 22957 22958 22959 22960

If the auditor of state determines that further investigation is needed, the auditor of state may ask the commissioner to determine whether the public medical assistance program recipient filed income tax returns for any previous taxable years in which 22961 22962 22963 22964

the recipient received medical assistance under a public medical assistance program and for which the tax department retains income tax returns. Within fourteen days of receipt of the request, the commissioner shall inform the auditor of state whether the recipient filed an individual income tax return for the taxable years in question, of the amount of the federal adjusted gross income as reported on such returns, of the addresses on such returns, and whether the returns were filed on a joint or separate basis. 22965 22966 22967 22968 22969 22970 22971 22972 22973

If the auditor of state determines that further investigation is needed of a public medical assistance program recipient who filed an Ohio individual income tax return, the auditor of state may request a certified copy of the Ohio individual income tax return or returns of that person for the taxable years described above, together with any other documents the commissioner has concerning the return or returns. Within fourteen days of receipt of such a request in writing, the commissioner shall forward the returns and documents to the auditor of state. 22974 22975 22976 22977 22978 22979 22980 22981 22982

The director of health care administration, county director of job and family services, county prosecutor, attorney general, auditor of state, or any agent or employee of those officials having access to any information or documents furnished by the commissioner pursuant to this section shall not divulge or use any such information except for the purpose of determining whether benefits were incorrectly paid on behalf of a public medical assistance program recipient, or for an audit, investigation, or prosecution, or in accordance with a proper judicial order. Any person who violates this provision shall thereafter be disqualified from acting as an agent or employee or in any other capacity under appointment or employment of any state or county board, commission, or agency. 22983 22984 22985 22986 22987 22988 22989 22990 22991 22992 22993 22994 22995

Sec. 5160.45. The director of health care administration shall work with the tax commissioner to recover benefits incorrectly paid on behalf of public medical assistance program recipients from refunds of state income taxes that are payable to the recipients. Any benefit incorrectly paid, because of fraud or misrepresentation, as the result of an error by the recipient or by the agency making the payment, or for any other reason, may be collected under this section. Any reduction under section 5747.12 or 5747.121 of the Revised Code to an income tax refund shall be made before a reduction under this section. No reduction shall be made under this section if the amount of the refund is less than twenty-five dollars after any reduction under section 5747.12 of the Revised Code. A reduction under this section shall be made before any part of the refund is contributed under section 5747.113 of the Revised Code or is credited under section 5747.12 of the Revised Code against tax due in any subsequent year. 22996 22997 22998 22999 23000 23001 23002 23003 23004 23005 23006 23007 23008 23009 23010 23011

The director and the tax commissioner, by rules adopted in accordance with Chapter 119. of the Revised Code, shall establish procedures to implement this section. The procedures shall provide for notice to a public medical assistance program recipient and an opportunity for the recipient to be heard before the recipient's income tax refund is reduced. 23012 23013 23014 23015 23016 23017

Sec. 5160.46. The director of health care administration may enter into agreements with the federal government to recover benefits incorrectly paid on behalf of public medical assistance program recipients from refunds of federal income taxes that are payable to the recipients. 23018 23019 23020 23021 23022

Sec. 5160.50. As used in sections 5160.50 to 5160.65 of the Revised Code: 23023 23024

"Community control sanction" has the same meaning as in 23025

section 2929.01 of the Revised Code. 23026

"Fugitive felon" means an individual who is fleeing to avoid prosecution, or custody or confinement after conviction, under the laws of the place from which the individual is fleeing, for a crime or an attempt to commit a crime that is a felony under the laws of the place from which the individual is fleeing or, in the case of New Jersey, a high misdemeanor, regardless of whether the individual has departed from the individual's usual place of residence. 23027 23028 23029 23030 23031 23032 23033 23034

"Information" means records as defined in section 149.011 of the Revised Code, any other documents in any format, and data derived from records and documents that are generated, acquired, or maintained by the department of health care administration, a county department of job and family services, or an entity performing duties on behalf of the department or a county department. 23035 23036 23037 23038 23039 23040 23041

"Law enforcement agency" means the state highway patrol, an agency that employs peace officers as defined in section 109.71 of the Revised Code, the adult parole authority, a county department of probation, a prosecuting attorney, the attorney general, similar agencies of other states, federal law enforcement agencies, and postal inspectors. "Law enforcement agency" includes the peace officers and other law enforcement officers employed by the agency. 23042 23043 23044 23045 23046 23047 23048 23049

"Medical assistance provided under a government-funded program" means medical assistance provided under the medicaid program, children's health insurance program, children's buy-in program, disability medical assistance program, or any other program established under the Revised Code that the department of health care administration administers. 23050 23051 23052 23053 23054 23055

"Post-release control sanction" has the same meaning as in 23056

section 2967.01 of the Revised Code. 23057

"Public medical assistance program" means the children's health insurance program, children's buy-in program, disability medical assistance program, and medicaid program. 23058 23059 23060

"Public medical assistance program recipient" means an applicant for, or recipient or former recipient of, a public medical assistance program. 23061 23062 23063

Sec. 5160.51. Except as permitted by sections 5160.52 to 5160.64 of the Revised Code or the rules adopted under section 5160.65 of the Revised Code or required by federal law, no person or government entity shall solicit, disclose, receive, use, or knowingly permit, or participate in the use of any information regarding a public medical assistance program recipient for any purpose not directly connected with the administration of the public medical assistance program. 23064 23065 23066 23067 23068 23069 23070 23071

Sec. 5160.52. To the extent permitted by federal law, the department of health care administration and county departments of job and family services shall release information regarding a public medical assistance program recipient for purposes directly connected to the administration of the public medical assistance program to a government entity responsible for administering the public medical assistance program. 23072 23073 23074 23075 23076 23077 23078

Sec. 5160.53. To the extent permitted by federal law, the department of health care administration and county departments of job and family services shall provide information regarding a public medical assistance program recipient to a law enforcement agency for the purpose of any investigation, prosecution, or criminal or civil proceeding relating to the administration of the public medical assistance program. 23079 23080 23081 23082 23083 23084 23085

Sec. 5160.54. (A) To the extent permitted by federal law and section 1347.08 of the Revised Code, the department of health care administration and county departments of job and family services shall provide access to information regarding a public medical assistance program recipient to all of the following: 23086 23087 23088 23089 23090

(1) The recipient; 23091

(2) The authorized representative; 23092

(3) The legal guardian of the recipient; 23093

(4) The attorney of the recipient, if the attorney has written authorization that complies with section 5160.57 of the Revised Code from the recipient. 23094 23095 23096

(B) The director of health care administration may adopt rules defining "authorized representative" for the purpose of this section. 23097 23098 23099

Sec. 5160.55. (A) To the extent permitted by federal law and subject to division (C) of this section, the department of health care administration and county departments of job and family services may release information regarding a public medical assistance program recipient as follows: 23100 23101 23102 23103 23104

(1) For purposes directly connected to the administration of a state, federal, or federally assisted program that provides cash or in-kind assistance or services directly to individuals, to a government entity responsible for administering the program; 23105 23106 23107 23108

(2) For the purpose of protecting children, to a government entity responsible for administering a children's protective services program; 23109 23110 23111

(3) Subject to division (B) of this section, to any person or government entity to whom the recipient authorizes to receive the information by providing the department or county department 23112 23113 23114

voluntary, written authorization that complies with section 5160.57 of the Revised Code. 23115 23116

(B) The department and a county department shall release information pursuant to division (A)(3) of this section only in accordance with the public medical assistance program recipient's authorization. The department or county department shall provide, at no cost, a copy of each written authorization to the individual who signed it. 23117 23118 23119 23120 23121 23122

(C) Neither the department nor a county department may release information under this section concerning a public medical assistance program recipient's receipt of medical assistance provided under a government-funded program unless all of the following conditions are met: 23123 23124 23125 23126 23127

(1) The release of information is for purposes directly connected to the administration of or provision of medical assistance provided under a government-funded program; 23128 23129 23130

(2) The information is released to persons or government entities that are subject to standards of confidentiality and safeguarding information substantially comparable to those established for medical assistance provided under a government-funded program; 23131 23132 23133 23134 23135

(3) The department or county department has obtained an authorization consistent with section 5160.57 of the Revised Code. 23136 23137

Sec. 5160.56. Information concerning the receipt of medical assistance provided under a government-funded program may be released only if the release complies with the more restrictive of the following: 23138 23139 23140 23141

(A) Sections 5160.52 to 5160.55 of the Revised Code and rules adopted under section 5160.65 of the Revised Code; 23142 23143

(B) The Health Insurance Portability and Accountability Act 23144

of 1996, 110 Stat. 1955, 42 U.S.C. 1320d, et seq., as amended, and regulations adopted by the United States department of health and human services to implement the act. 23145 23146 23147

Sec. 5160.57. (A) For the purposes of sections 5160.54 and 5160.55 of the Revised Code, an authorization shall be made on a form that uses language understandable to the average person and contains all of the following: 23148 23149 23150 23151

(1) A description of the information to be used or disclosed that identifies the information in a specific and meaningful fashion; 23152 23153 23154

(2) The name or other specific identification of the person or class of persons authorized to make the requested use or disclosure; 23155 23156 23157

(3) The name or other specific identification of the person or governmental entity to which the information may be released; 23158 23159

(4) A description of each purpose of the requested use or disclosure of the information; 23160 23161

(5) The date on which the authorization expires or an event related either to the individual who is the subject of the request or to the purposes of the requested use or disclosure, the occurrence of which will cause the authorization to expire; 23162 23163 23164 23165

(6) A statement that the information used or disclosed pursuant to the authorization may be disclosed by the recipient of the information and may no longer be protected from disclosure; 23166 23167 23168

(7) The signature of the individual or the individual's authorized representative and the date on which the authorization was signed; 23169 23170 23171

(8) If signed by an authorized representative, a description of the representative's authority to act for the individual; 23172 23173

(9) A statement of the individual or authorized representative's right to prospectively revoke the written authorization in writing, along with one of the following: 23174 23175 23176

(a) A description of how the individual or authorized representative may revoke the authorization; 23177 23178

(b) If the department of health care administration's privacy notice contains a description of how the individual or authorized representative may revoke the authorization, a reference to that privacy notice. 23179 23180 23181 23182

(10) A statement that treatment, payment, enrollment, or eligibility for a public medical assistance program cannot be conditioned on signing the authorization unless the authorization is necessary for determining eligibility for the program. 23183 23184 23185 23186

(B) When an individual requests information pursuant to section 5160.54 or 5160.55 of the Revised Code regarding the individual's receipt of a public medical assistance program and does not wish to provide a statement of purpose, the statement "at request of the individual" is a sufficient description for purposes of division (A)(4) of this section. 23187 23188 23189 23190 23191 23192

Sec. 5160.58. If cost savings are indicated in the report that the director of job and family services submitted to the general assembly under section 5101.272 of the Revised Code, the department of health care administration shall enter into any necessary agreements with the United States department of health and human services and neighboring states to join and participate as an active member in the public assistance reporting information system. The department may disclose information regarding a public medical assistance program recipient to the extent necessary to participate as an active member in the public assistance reporting information system. 23193 23194 23195 23196 23197 23198 23199 23200 23201 23202 23203

Sec. 5160.59. On request of the department of health care administration or a county department of job and family services, a law enforcement agency shall provide information regarding public medical assistance program recipients to enable the department or county department to determine, for eligibility purposes, whether a recipient or a member of a recipient's assistance group is a fugitive felon or violating a condition of probation, a community control sanction, parole, or a post-release control sanction imposed under state or federal law. 23204 23205 23206 23207 23208 23209 23210 23211 23212

A county department may enter into a written agreement with a local law enforcement agency establishing procedures concerning access to information and providing for compliance with this section. 23213 23214 23215 23216

The auditor of state shall prepare an annual report on the outcome of the agreements required by this section. The report shall include the number of fugitive felons, probation and parole violators, and violators of community control sanctions and post-release control sanctions apprehended during the immediately preceding year as a result of the exchange of information pursuant to this section. The auditor of state shall file the report with the governor, the president and minority leader of the senate, and the speaker and minority leader of the house of representatives. The department, county departments, and law enforcement agencies shall cooperate with the auditor of state's office in gathering the information needed for the report. 23217 23218 23219 23220 23221 23222 23223 23224 23225 23226 23227 23228

Sec. 5160.60. To the extent permitted by federal law, the department of health care administration and county departments of job and family services shall provide information, except information directly related to the receipt of medical assistance or medical services, regarding disability medical assistance program recipients to law enforcement agencies on request for the 23229 23230 23231 23232 23233 23234

purposes of investigations, prosecutions, and criminal and civil proceedings that are within the scope of the law enforcement agencies' official duties. 23235 23236 23237

Sec. 5160.61. Information about a public medical assistance program recipient shall be exchanged, obtained, or shared under sections 5160.59 and 5160.60 of the Revised Code only if the department of health care administration, county department of job and family services, or law enforcement agency requesting the information gives sufficient information to specifically identify the recipient. In addition to the recipient's name, identifying information may include the recipient's current or last known address, social security number, other identifying number, age, gender, physical characteristics, any information specified in an agreement entered into under section 5160.59 of the Revised Code, or any information considered appropriate by the department or county department. 23238 23239 23240 23241 23242 23243 23244 23245 23246 23247 23248 23249 23250

Sec. 5160.62. The department of health care administration and its officers and employees are not liable in damages in a civil action for any injury, death, or loss to person or property that allegedly arises from the release of information in accordance with sections 5160.59 and 5160.60 of the Revised Code. This section does not affect any immunity or defense that the department and its officers and employees may be entitled to under another section of the Revised Code or the common law of this state, including section 9.86 of the Revised Code. 23251 23252 23253 23254 23255 23256 23257 23258 23259

Sec. 5160.63. As used in this section, "employee" has the same meaning as in division (B) of section 2744.01 of the Revised Code. 23260 23261 23262

County departments of job and family services and their employees are not liable in damages in a civil action for any 23263 23264

injury, death, or loss to person or property that allegedly arises from the release of information in accordance with sections 5160.59 and 5160.60 of the Revised Code. This section does not affect any immunity or defense that the county departments and their employees may be entitled to under another section of the Revised Code or the common law of this state, including section 2744.02 and division (A)(6) of section 2744.03 of the Revised Code. 23265 23266 23267 23268 23269 23270 23271 23272

Sec. 5160.64. To the extent permitted by federal law, the department of health care administration and county departments of job and family services shall provide access to information to the auditor of state acting pursuant to Chapter 117. or sections 117.54, 117.55, 117.56, 5160.43, and 5160.44 of the Revised Code and to any other government entity authorized by federal law to conduct an audit of or similar activity involving a public medical assistance program. 23273 23274 23275 23276 23277 23278 23279 23280

Sec. 5160.65. The director of health care administration shall adopt rules in accordance with Chapter 119. of the Revised Code implementing sections 5160.50 to 5160.64 of the Revised Code and governing the custody, use, and preservation of the information generated or received by the department of health care administration, county departments of job and family services, other state and county entities, contractors, grantees, private entities, or officials participating in the administration of a public medical assistance program. The rules shall specify conditions and procedures for the release of information. The rules shall comply with applicable federal statutes and regulations. To the extent permitted by federal law: 23281 23282 23283 23284 23285 23286 23287 23288 23289 23290 23291 23292

(A) The rules may permit providers of services or assistance under a public medical assistance program limited access to information that is essential for the providers to render services 23293 23294 23295

or assistance or to bill for services or assistance rendered. The 23296
department of aging, when investigating a complaint under section 23297
173.20 of the Revised Code, shall be granted any limited access 23298
permitted in the rules pursuant to division (A) of this section. 23299

(B) The rules may permit a contractor, grantee, or other 23300
state or county entity limited access to information that is 23301
essential for the contractor, grantee, or entity to perform 23302
administrative or other duties on behalf of the department or 23303
county department. A contractor, grantee, or entity given access 23304
to information pursuant to division (B) of this section is bound 23305
by the director's rules, and disclosure of the information by the 23306
contractor, grantee, or entity in a manner not authorized by the 23307
rules is a violation of section 5160.51 of the Revised Code. 23308

Sec. 5160.66. Whenever names, addresses, or other information 23309
relating to public medical assistance program recipients is held 23310
by any agency other than the department of health care 23311
administration or a county department of job and family services, 23312
that other agency shall adopt rules consistent with sections 23313
5160.50 to 5160.65 of the Revised Code to prevent the publication 23314
or disclosure of names, lists, or other information concerning 23315
those recipients. 23316

Sec. ~~5101.31~~ 5160.67. Any record, data, pricing information, 23317
or other information regarding a drug rebate agreement or a 23318
supplemental drug rebate agreement for the medicaid program 23319
~~established under Chapter 5111. of the Revised Code~~ or the 23320
disability medical assistance program ~~established under section~~ 23321
~~5115.10 of the Revised Code~~ that the department of ~~job and family~~ 23322
~~services~~ health care administration receives from a pharmaceutical 23323
manufacturer or creates pursuant to negotiation of the agreement 23324
is not a public record under section 149.43 of the Revised Code 23325
and shall be treated by the department as confidential 23326

information. 23327

Sec. 5160.70. Not later than the last day of each July and January, the department of health care administration shall complete a report on the characteristics of the individuals who receive services through the programs operated by the department and the outcomes of the individuals' receipt of the services. The reports shall be for the six-month periods ending on the last days of June and December and shall include information regarding births to medicaid recipients. 23328 23329 23330 23331 23332 23333 23334 23335

The department shall submit the reports to the speaker and minority leader of the house of representatives, the president and minority leader of the senate, the legislative budget officer, the director of budget and management, and each board of county commissioners. The department shall provide copies of the reports to any person or government entity on request. 23336 23337 23338 23339 23340 23341

In designing the format for the reports, the department shall consult with individuals, organizations, and government entities interested in the programs operated by the department, so that the reports are designed to enable the general assembly and the public to evaluate the effectiveness of the programs and identify any needs that the programs are not meeting. 23342 23343 23344 23345 23346 23347

Sec. 5160.71. Whenever the federal government requires that the department of health care administration submit a report on a program that is operated by the department or is otherwise under the department's jurisdiction, the department shall prepare and submit the report in accordance with the federal requirements applicable to that report. To the extent possible, the department may coordinate the preparation and submission of a particular report with any other report, plan, or other document required to be submitted to the federal government, as well as with any report 23348 23349 23350 23351 23352 23353 23354 23355 23356

required to be submitted to the general assembly.

Sec. 5160.75. The department of health care administration shall create within the department the central pharmaceutical purchasing office. The office shall purchase, store, repackage, distribute, and dispense all drugs, pharmaceutical products, and related items needed by the departments of health, job and family services, mental health, mental retardation and developmental disabilities, rehabilitation and correction, and youth services and other state agencies for which the department of administrative services purchases supplies under section 125.05 of the Revised Code. The office also shall provide professional pharmacy consultation and drug information services to those departments and other state agencies.

Notwithstanding section 125.05 of the Revised Code, purchases of drugs, pharmaceutical products, and related items under this section need not be purchased through the department of administrative services.

Sec. ~~173.35~~ 5160.80. (A) As used in this section, "PASSPORT administrative agency" means an entity under contract with the department of aging to provide administrative services regarding the PASSPORT program created under section 173.40 of the Revised Code.

(B) The department of ~~aging~~ health care administration shall administer the residential state supplement program under which the state supplements the ~~supplemental security income~~ payments received by aged, blind, or disabled adults under ~~Title XVI of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A., as amended~~ the supplemental security income program. Residential state supplement payments shall be used for the provision of accommodations, supervision, and personal care services to

supplemental security income recipients who the department determines are at risk of needing institutional care. 23387 23388

(C) For an individual to be eligible for residential state supplement payments, all of the following must be the case: 23389 23390

(1) Except as provided by division (G) of this section, the individual must reside in one of the following: 23391 23392

(a) An adult foster home certified under section 173.36 of the Revised Code; 23393 23394

(b) A home or facility, other than a nursing home or nursing home unit of a home for the aging, licensed by the department of health under Chapter 3721. or 3722. of the Revised Code and certified in accordance with standards established by the director of aging under division (D)(2) of this section; 23395 23396 23397 23398 23399

(c) A community alternative home licensed under section 3724.03 of the Revised Code and certified in accordance with standards established by the director of aging under division (D)(2) of this section; 23400 23401 23402 23403

(d) A residential facility as defined in division (A)(1)(d)(ii) of section 5119.22 of the Revised Code licensed by the department of mental health and certified in accordance with standards established by the director of aging under division (D)(2) of this section; 23404 23405 23406 23407 23408

(e) An apartment or room used to provide community mental health housing services certified by the department of mental health under section 5119.611 of the Revised Code and approved by a board of alcohol, drug addiction, and mental health services under division (A)(14) of section 340.03 of the Revised Code and certified in accordance with standards established by the director of aging under division (D)(2) of this section. 23409 23410 23411 23412 23413 23414 23415

(2) Effective July 1, 2000, a PASSPORT administrative agency 23416

must have determined that the environment in which the individual 23417
will be living while receiving the payments is appropriate for the 23418
individual's needs. If the individual is eligible for supplemental 23419
security income payments or social security disability insurance 23420
benefits because of a mental disability, the PASSPORT 23421
administrative agency shall refer the individual to a community 23422
mental health agency for the community mental health agency to 23423
issue in accordance with section 340.091 of the Revised Code a 23424
recommendation on whether the PASSPORT administrative agency 23425
should determine that the environment in which the individual will 23426
be living while receiving the payments is appropriate for the 23427
individual's needs. Division (C)(2) of this section does not apply 23428
to an individual receiving residential state supplement payments 23429
on June 30, 2000, until the individual's first eligibility 23430
redetermination after that date. 23431

(3) The individual satisfies all eligibility requirements 23432
established by rules adopted under division (D) of this section. 23433

(D)(1) The ~~directors~~ director of ~~aging and job and family~~ 23434
~~services~~ health care administration shall adopt rules in 23435
accordance with section 111.15 of the Revised Code as necessary to 23436
implement the residential state supplement program. 23437

To the extent permitted by Title XVI of the "Social Security 23438
Act~~,~~ of 1935" and any other provision of federal law, the director 23439
of ~~job and family services~~ health care administration shall adopt 23440
rules establishing standards for adjusting the eligibility 23441
requirements concerning the level of impairment a person must have 23442
so that the amount appropriated for the program by the general 23443
assembly is adequate for the number of eligible individuals. The 23444
rules shall not limit the eligibility of disabled persons solely 23445
on a basis classifying disabilities as physical or mental. The 23446
director of ~~job and family services~~ health care administration 23447
also shall adopt rules that establish eligibility standards for 23448

aged, blind, or disabled individuals who reside in one of the 23449
homes or facilities specified in division (C)(1) of this section 23450
but who, because of their income, do not receive supplemental 23451
security income payments. The rules may provide that these 23452
individuals may include individuals who receive other types of 23453
benefits, including, social security disability insurance benefits 23454
provided under Title II of the "Social Security Act~~,~~ of 1935" ~~49~~ 23455
~~Stat. 620 (1935), 42 U.S.C.A. 401, as amended~~. Notwithstanding 23456
division (B) of this section, such payments may be made if funds 23457
are available for them. 23458

The director of ~~aging~~ health care administration shall adopt 23459
rules establishing the method to be used to determine the amount 23460
an eligible individual will receive under the program. The amount 23461
the general assembly appropriates for the program shall be a 23462
factor included in the method that department establishes. 23463

(2) The director of aging shall adopt rules in accordance 23464
with Chapter 119. of the Revised Code establishing standards for 23465
certification of living facilities described in division (C)(1) of 23466
this section. 23467

The directors of aging and mental health shall enter into an 23468
agreement to certify facilities that apply for certification and 23469
meet the standards established by the director of aging under this 23470
division. 23471

(E) The county department of job and family services of the 23472
county in which an applicant for the residential state supplement 23473
program resides shall determine whether the applicant meets income 23474
and resource requirements for the program. 23475

(F) The department of ~~aging~~ health care administration shall 23476
maintain a waiting list of any individuals eligible for payments 23477
under this section but not receiving them because moneys 23478
appropriated to the department for the purposes of this section 23479

are insufficient to make payments to all eligible individuals. An individual may apply to be placed on the waiting list even though the individual does not reside in one of the homes or facilities specified in division (C)(1) of this section at the time of application. The director of ~~aging~~ health care administration, by rules adopted in accordance with Chapter 119. of the Revised Code, shall specify procedures and requirements for placing an individual on the waiting list and priorities for the order in which individuals placed on the waiting list are to begin to receive residential state supplement payments. The rules specifying priorities may give priority to individuals placed on the waiting list on or after July 1, 2006, who receive supplemental security income benefits ~~under Title XVI of the "Social Security Act," 86 Stat. 1475 (1972), 42 U.S.C. 1381, as amended~~. The rules shall not affect the place on the waiting list of any person who was on the list on July 1, 2006. The rules specifying priorities may also set additional priorities based on living arrangement, such as whether an individual resides in a facility listed in division (C)(1) of this section or has been admitted to a nursing facility.

(G) An individual in a licensed or certified living arrangement receiving state supplementation on November 15, 1990, under former section 5101.531 of the Revised Code shall not become ineligible for payments under this section solely by reason of the individual's living arrangement as long as the individual remains in the living arrangement in which the individual resided on November 15, 1990.

(H) The department of ~~aging~~ health care administration shall notify each person denied approval for payments under this section of the person's right to a hearing. On request, the hearing shall be provided ~~by the department of job and family services~~ in accordance with section ~~5101.35~~ 5160.34 of the Revised Code.

Sec. ~~173.351~~ 5160.81. (A) As used in this section: 23512

"Area agency on aging" has the same meaning as in section 173.14 of the Revised Code. 23513 23514

"Long-term care consultation program" means the program the department of aging is required to develop under section 173.42 of the Revised Code. 23515 23516 23517

"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. 23518 23519 23520 23521 23522

"Nursing facility" has the same meaning as in section ~~5111.20~~ 5164.01 of the Revised Code. 23523 23524

~~"Residential state supplement program" means the program administered pursuant to section 173.35 of the Revised Code.~~ 23525 23526

(B) Each month, each area agency on aging shall determine whether individuals who reside in the area that the area agency on aging serves and are on a waiting list for the residential state supplement program have been admitted to a nursing facility. If an area agency on aging determines that 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 residential state supplement program is appropriate for the individual and whether the individual would rather participate in the program than continue residing in the nursing facility. If the administrator determines that the residential state supplement program is appropriate for the individual and the individual would rather participate in the program than continue residing in the nursing 23527 23528 23529 23530 23531 23532 23533 23534 23535 23536 23537 23538 23539 23540 23541

facility, the administrator shall so notify the department of ~~aging~~ health care administration. On receipt of the notice from the administrator, the department of ~~aging~~ health care administration shall approve the individual's enrollment in the residential state supplement program in accordance with the priorities specified in rules adopted under division (F) of section ~~173.35~~ 5160.80 of the Revised Code. Each quarter, the department of ~~aging~~ health care administration shall certify to the director of budget and management the estimated increase in costs of the residential state supplement program resulting from enrollment of individuals in the program pursuant to this section. 23542 23543 23544 23545 23546 23547 23548 23549 23550 23551 23552 23553

(C) Not later than the last day of each calendar year, the director of ~~aging~~ health care administration shall submit to the general assembly a report regarding the number of individuals enrolled in the residential state supplement program pursuant to this section and the costs incurred and savings achieved as a result of the enrollments. 23554 23555 23556 23557 23558 23559

Sec. 5160.99. Whoever violates section 5160.51 of the Revised Code is guilty of a misdemeanor of the first degree. 23560 23561

Sec. 5161.01. The department of health care administration shall act as the single state agency to supervise the administration of the medicaid program. As the single state agency, the department shall comply with 42 C.F.R. 431.10(e). The department's rules governing medicaid are binding on other agencies that administer components of the medicaid program. No agency may establish, by rule or otherwise, a policy governing medicaid that is inconsistent with a medicaid policy established, in rule or otherwise, by the director of health care administration. 23562 23563 23564 23565 23566 23567 23568 23569 23570 23571

Sec. ~~5111.102~~ 5161.011. As used in this section, "state 23572
agency" has the same meaning as in section 9.23 of the Revised 23573
Code. 23574

No provision of Title LI of the Revised Code or any other law 23575
of this state that incorporates any provision of federal ~~Medicaid~~ 23576
medicaid law, Title XIX of the Social Security Act, 79 Stat. 286 23577
(1965), 42 U.S.C. 1396, or that may be construed as requiring the 23578
state, a state agency, or any state official or employee to comply 23579
with that federal provision, shall be construed as creating a 23580
cause of action to enforce such state law beyond the causes of 23581
action available under federal law for enforcement of the 23582
provision of federal law. 23583

Sec. ~~5111.98~~ 5161.02. (A) The director of ~~job and family~~ 23584
~~services~~ health care administration may do all of the following as 23585
necessary for the department of ~~job and family services~~ health 23586
care administration to fulfill the duties it has, as the single 23587
state agency for the medicaid program, under the "Medicare 23588
Prescription Drug, Improvement, and Modernization Act of 2003" 23589
Pub. L. No. 108-173, 117 Stat. 2066: 23590

(1) Adopt rules; 23591

(2) Assign duties to county departments of job and family 23592
services; 23593

(3) Make payments to the United States department of health 23594
and human services from appropriations made to the department of 23595
~~job and family services~~ health care administration for this 23596
purpose. 23597

(B) Rules adopted under division (A)(1) of this section shall 23598
be adopted as follows: 23599

(1) If the rules concern the department's duties regarding 23600
service providers, in accordance with Chapter 119. of the Revised 23601

Code; 23602

(2) If the rules concern the department's duties concerning 23603
individuals' eligibility for services, in accordance with section 23604
111.15 of the Revised Code; 23605

(3) If the rules concern the department's duties concerning 23606
financial and operational matters between the department and 23607
county departments of job and family services, in accordance with 23608
section 111.15 of the Revised Code as if the rules were internal 23609
management rules. 23610

Sec. 5161.03. The director of health care administration 23611
shall prepare and submit to the United States secretary of health 23612
and human services both of the following as necessary to 23613
accomplish the requirements of state law governing the medicaid 23614
program: 23615

(A) A state medicaid plan. 23616

(B) Amendments to the state medicaid plan. 23617

Sec. ~~5111.91~~ 5161.05. The department of ~~job and family~~ 23618
~~services~~ health care administration may enter into contracts with 23619
one or more other state agencies or political subdivisions to have 23620
the state agency or political subdivision administer one or more 23621
components of the medicaid program, or one or more aspects of a 23622
component, under the department's supervision. A state agency or 23623
political subdivision that enters into such a contract shall 23624
comply with the terms of the contract and any rules the director 23625
of ~~job and family services~~ health care administration has adopted 23626
governing the component, or aspect of the component, that the 23627
state agency or political subdivision is to administer, including 23628
any rules establishing review, audit, and corrective action plan 23629
requirements. A contract with a state agency shall be in the form 23630
of an interagency agreement. The interagency agreement shall 23631

include a requirement for the state agency to submit an annual 23632
financing plan to the department. 23633

A state agency or political subdivision that enters into a 23634
contract with the department under this section shall reimburse 23635
the department for the nonfederal share of the cost to the 23636
department of performing, or contracting for the performance of, a 23637
fiscal audit of the component of the medicaid program, or aspect 23638
of the component, that the state agency or political subdivision 23639
administers if rules governing the component, or aspect of the 23640
component, require that a fiscal audit be conducted. 23641

There is hereby created in the state treasury the medicaid 23642
administrative reimbursement fund. The department shall use money 23643
in the fund to pay for the nonfederal share of the cost of a 23644
fiscal audit for which a state agency or political subdivision is 23645
required by this section to reimburse the department. The 23646
department shall deposit the reimbursements into the fund. 23647

Sec. ~~5111.911~~ 5161.06. Any contract the department of ~~job and~~ 23648
~~family services~~ health care administration enters into with the 23649
department of mental health or department of alcohol and drug 23650
addiction services under section ~~5111.91~~ 5161.05 of the Revised 23651
Code is subject to the approval of the director of budget and 23652
management and shall require or specify all of the following: 23653

(A) In the case of a contract with the department of mental 23654
health, that section ~~5111.912~~ 5161.07 of the Revised Code be 23655
complied with; 23656

(B) In the case of a contract with the department of alcohol 23657
and drug addiction services, that section ~~5111.913~~ 5161.08 of the 23658
Revised Code be complied with; 23659

(C) How providers will be paid for providing the services; 23660

(D) The department of mental health's or department of 23661

alcohol and drug addiction services' responsibilities for 23662
reimbursing providers, including program oversight and quality 23663
assurance. 23664

Sec. ~~5111.912~~ 5161.07. If the department of ~~job and family~~ 23665
~~services~~ health care administration enters into a contract with 23666
the department of mental health under section ~~5111.91~~ 5161.05 of 23667
the Revised Code, the department of mental health and boards of 23668
alcohol, drug addiction, and mental health services shall pay the 23669
nonfederal share of any medicaid payment to a provider for 23670
services under the component, or aspect of the component, the 23671
department of mental health administers. 23672

Sec. ~~5111.913~~ 5161.08. If the department of ~~job and family~~ 23673
~~services~~ health care administration enters into a contract with 23674
the department of alcohol and drug addiction services under 23675
section ~~5111.91~~ 5161.05 of the Revised Code, the department of 23676
alcohol and drug addiction services and boards of alcohol, drug 23677
addiction, and mental health services shall pay the nonfederal 23678
share of any medicaid payment to a provider for services under the 23679
component, or aspect of the component, the department of alcohol 23680
and drug addiction services administers. 23681

Sec. ~~5111.90~~ 5161.10. (A) As used in sections ~~5111.90~~ 5161.10 23682
to ~~5111.93~~ 5161.13 of the Revised Code: 23683

(1) "Political subdivision" means a municipal corporation, 23684
township, county, school district, or other body corporate and 23685
politic responsible for governmental activities only in a 23686
geographical area smaller than that of the state. 23687

(2) "State agency" means every organized body, office, or 23688
agency, other than the department of ~~job and family services~~ 23689
health care administration, established by the laws of the state 23690
for the exercise of any function of state government. 23691

(B) To the extent permitted by Title XIX of the "Social 23692
Security Act~~,~~ of 1935" ~~79 Stat. 286 (1965), 42 U.S.C.A. 1396, as~~ 23693
~~amended,~~ and regulations adopted under that title, the department 23694
of ~~job and family services~~ health care administration may enter 23695
into contracts with political subdivisions to use funds of the 23696
political subdivision to pay the nonfederal share of expenditures 23697
under the medicaid program. The determination and provision of 23698
federal financial reimbursement to a subdivision entering into a 23699
contract under this section shall be determined by the department, 23700
subject to section ~~5111.92~~ 5161.12 of the Revised Code, approval 23701
by the United States secretary of health and human services, and 23702
the availability of federal financial participation. 23703

Sec. ~~5111.92~~ 5161.12. (A)(1) Except as provided in division 23704
(B) of this section, if a state agency or political subdivision 23705
administers one or more components of the medicaid program that 23706
the United States department of health and human services 23707
approved, and for which federal financial participation was 23708
initially obtained, prior to January 1, 2002, or administers one 23709
or more aspects of such a component, the department of ~~job and~~ 23710
~~family services~~ health care administration may retain or collect 23711
not more than ten per cent of the federal financial participation 23712
the state agency or political subdivision obtains through an 23713
approved, administrative claim regarding the component or aspect 23714
of the component. If the department retains or collects a 23715
percentage of such federal financial participation, the percentage 23716
the department retains or collects shall be specified in a 23717
contract the department enters into with the state agency or 23718
political subdivision under section ~~5111.91~~ 5161.05 of the Revised 23719
Code. 23720

(2) Except as provided in division (B) of this section, if a 23721
state agency or political subdivision administers one or more 23722
components of the medicaid program that the United States 23723

department of health and human services approved on or after January 1, 2002, or administers one or more aspects of such a component, the department of ~~job and family services~~ health care administration shall retain or collect not less than three and not more than ten per cent of the federal financial participation the state agency or political subdivision obtains through an approved, administrative claim regarding the component or aspect of the component. The percentage the department retains or collects shall be specified in a contract the department enters into with the state agency or political subdivision under section ~~5111.91~~ 5161.05 of the Revised Code.

(B) The department of ~~job and family services~~ health care administration may retain or collect a percentage of federal financial participation under divisions (A)(1) and (2) of this section only to the extent permitted by federal statutes and regulations.

(C) All amounts the department retains or collects under this section shall be deposited into the health care services administration fund created under section ~~5111.94~~ 5161.15 of the Revised Code.

Sec. ~~5111.93~~ 5161.13. The department of ~~job and family services~~ health care administration may retain or collect a percentage of the federal financial participation included in a supplemental medicaid payment to one or more medicaid providers owned or operated by a state agency or political subdivision that brings the payment to such provider or providers to the upper payment limit established by 42 C.F.R. 447.272. If the department retains or collects a percentage of that federal financial participation, the department shall adopt a rule under Chapter 119. of the Revised Code specifying the percentage the department is to retain or collect. All amounts the department retains or

collects under this section shall be deposited into the health care services administration fund created under section ~~5111.94~~ 5161.15 of the Revised Code. 23755 23756 23757

Sec. ~~5111.94~~ 5161.15. (A) As used in this section, "vendor offset" means a reduction of a medicaid payment to a medicaid provider to correct a previous, incorrect medicaid payment to that provider. 23758 23759 23760 23761

(B) There is hereby created in the state treasury the health care services administration fund. Except as provided in division (C) of this section, all the following shall be deposited into the fund: 23762 23763 23764 23765

(1) Amounts deposited into the fund pursuant to sections ~~5111.92~~ 5161.12 and ~~5111.93~~ 5161.13 of the Revised Code; 23766 23767

(2) The amount of the state share of all money the department of ~~job and family services~~ health care administration, in fiscal year 2003 and each fiscal year thereafter, recovers pursuant to a tort action under the department's right of recovery under section ~~5101.58~~ 5160.38 of the Revised Code that exceeds the state share of all money the department, in fiscal year 2002, recovers pursuant to a tort action under that right of recovery; 23768 23769 23770 23771 23772 23773 23774

(3) Subject to division (D) of this section, the amount of the state share of all money the department of ~~job and family services~~ health care administration, in fiscal year 2003 and each fiscal year thereafter, recovers through audits of medicaid providers that exceeds the state share of all money the department, in fiscal year 2002, recovers through such audits; 23775 23776 23777 23778 23779 23780

(4) Amounts from assessments on hospitals under section ~~5112.06~~ 5166.05 of the Revised Code and intergovernmental transfers by governmental hospitals under section ~~5112.07~~ 5166.06 of the Revised Code that are deposited into the fund in accordance 23781 23782 23783 23784

with the law; 23785

(5) Amounts that the department of education pays to the 23786
department of ~~job and family services~~ health care administration, 23787
if any, pursuant to an interagency agreement entered into under 23788
section ~~5111.713~~ 5163.303 of the Revised Code. 23789

(C) No funds shall be deposited into the health care services 23790
administration fund in violation of federal statutes or 23791
regulations. 23792

(D) In determining under division (B)(3) of this section the 23793
amount of money the department, in a fiscal year, recovers through 23794
audits of medicaid providers, the amount recovered in the form of 23795
vendor offset shall be excluded. 23796

(E) The director of ~~job and family services~~ health care 23797
administration shall use funds available in the health care 23798
services administration fund to pay for costs associated with the 23799
administration of the medicaid program. 23800

Sec. ~~5111.941~~ 5161.16. (A) The medicaid revenue and 23801
collections fund is hereby created in the state treasury. Except 23802
as otherwise provided by statute or as authorized by the 23803
controlling board, both of the following shall be credited to the 23804
fund: 23805

(1) The nonfederal share of all medicaid-related revenues, 23806
collections, and recoveries; 23807

(2) The monthly premiums charged under the children's buy-in 23808
program pursuant to section ~~5101.5213~~ 5167.37 of the Revised Code. 23809

(B) The department of ~~job and family services~~ health care 23810
administration shall use money credited to the medicaid revenue 23811
and collections fund to pay for medicaid services and contracts 23812
and the children's buy-in program ~~established under sections~~ 23813
~~5101.5211 to 5101.5216 of the Revised Code~~. 23814

Sec. ~~5111.942~~ 5161.17. (A) The prescription drug rebates fund is hereby created in the state treasury. Both of the following shall be credited to the fund: 23815 23816 23817

(1) The ~~non-federal~~ nonfederal share of all rebates paid by drug manufacturers to the department of ~~job and family services~~ health care administration in accordance with a rebate agreement required by 42 U.S.C.A. 1396r-8; 23818 23819 23820 23821

(2) The ~~non-federal~~ nonfederal share of all supplemental rebates paid by drug manufacturers to the department of ~~job and family services~~ health care administration in accordance with the supplemental drug rebate program established under section ~~5111.081~~ 5163.26 of the Revised Code. 23822 23823 23824 23825 23826

(B) The department of ~~job and family services~~ health care administration shall use money credited to the prescription drug rebates fund to pay for medicaid services and contracts. 23827 23828 23829

Sec. ~~5111.943~~ 5161.18. (A) The health care - federal fund is hereby created in the state treasury. All of the following shall be credited to the fund: 23830 23831 23832

(1) Funds that division (B) of section ~~5112.18~~ 5166.12 of the Revised Code requires be credited to the fund; 23833 23834

(2) The federal share of all rebates paid by drug manufacturers to the department of ~~job and family services~~ health care administration in accordance with a rebate agreement required by 42 U.S.C. 1396r-8; 23835 23836 23837 23838

(3) The federal share of all supplemental rebates paid by drug manufacturers to the department of ~~job and family services~~ health care administration in accordance with the supplemental drug rebate program established under section ~~5111.081~~ 5163.26 of the Revised Code; 23839 23840 23841 23842 23843

(4) Except as otherwise provided by statute or as authorized by the controlling board, the federal share of all other medicaid-related revenues, collections, and recoveries.

(B) All money credited to the health care - federal fund pursuant to division (B) of section ~~5112.18~~ 5166.12 of the Revised Code shall be used solely for distributing funds to hospitals under section ~~5112.08~~ 5166.07 of the Revised Code. The department of ~~job and family services~~ health care administration shall use all other money credited to the fund to pay for other medicaid services and contracts.

Sec. ~~5111.915~~ 5161.25. (A) The department of ~~job and family services~~ health care administration shall enter into an agreement with the department of administrative services for the department of administrative services to contract through competitive selection pursuant to section 125.07 of the Revised Code with a vendor to perform an assessment of the data collection and data warehouse functions of the medicaid data warehouse system, including the ability to link the data sets of all agencies serving medicaid recipients.

The assessment of the data system shall include functions related to fraud and abuse detection, program management and budgeting, and performance measurement capabilities of all agencies serving medicaid recipients, including the departments of aging, alcohol and drug addiction services, health, ~~job and family services~~ health care administration, mental health, and mental retardation and developmental disabilities.

The department of administrative services shall enter into this contract within thirty days after ~~the effective date of this section~~ September 29, 2005. The contract shall require the vendor to complete the assessment within ninety days after ~~the effective date of this section~~ September 29, 2005.

A qualified vendor with whom the department of administrative services contracts to assess the data system shall also assist the medicaid agencies in the definition of the requirements for an enhanced data system or a new data system and assist the department of administrative services in the preparation of a request for proposal to enhance or develop a data system.

(B) Based on the assessment performed pursuant to division (A) of this section, the department of administrative services shall seek a qualified vendor through competitive selection pursuant to section 125.07 of the Revised Code to develop or enhance a data collection and data warehouse system for the department of ~~job and family services~~ health care administration and all agencies serving medicaid recipients.

Within ninety days after ~~the effective date of this section~~ September 29, 2005, the department of ~~job and family services~~ health care administration shall seek enhanced federal funding for ninety per cent of the funds required to establish or enhance the data system. The department of administrative services shall not award a contract for establishing or enhancing the data system until the department of ~~job and family services~~ health care administration receives approval from the secretary of the United States department of health and human services for the ninety per cent federal match.

Sec. ~~5111.10~~ 5161.30. The director of ~~job and family services~~ health care administration may conduct reviews of the medicaid program. The reviews may include physical inspections of records and sites where medicaid-funded services are provided and interviews of providers and recipients of the services. If the director determines pursuant to a review that a person or government entity has violated a rule governing the medicaid program, the director may establish a corrective action plan for

the violator and impose fiscal, administrative, or both types of 23906
sanctions on the violator in accordance with rules governing the 23907
medicaid program. 23908

Sec. ~~5111.09~~ 5161.32. On or before the first day of January 23909
of each year, the department of ~~job and family services~~ health 23910
care administration shall submit to the speaker and minority 23911
leader of the house of representatives and the president and 23912
minority leader of the senate, and shall make available to the 23913
public, a report on the effectiveness of ~~the Ohio works first~~ 23914
~~program established under Chapter 5107. of the Revised Code and~~ 23915
the ~~medical assistance~~ medicaid program ~~established under this~~ 23916
~~chapter~~ in meeting the health care needs of low-income pregnant 23917
women, infants, and children. The report shall include: the 23918
estimated number of persons eligible for health care services to 23919
pregnant women, infants, and children under the programs; the 23920
actual number of eligible persons served; the number of prenatal, 23921
postpartum, and child health visits; a report on birth outcomes, 23922
including a comparison of low-birthweight births and infant 23923
mortality rates of program participants with the general female 23924
child-bearing and infant population in this state; and a 23925
comparison of the prenatal, delivery, and child health costs of 23926
the programs with such costs of similar programs in other states, 23927
where available. 23928

Sec. ~~5111.091~~ 5161.33. Not later than the first day of each 23929
calendar quarter, the director of ~~job and family services~~ health 23930
care administration shall submit a report to the president and 23931
minority leader of the senate, speaker and minority leader of the 23932
house of representatives, and the chairpersons of the committees 23933
of the senate and house of representatives that hear bills making 23934
biennial appropriations on the establishment and implementation of 23935
programs designed to control the increase of the cost of the 23936

medicaid program, increase the efficiency of the medicaid program, 23937
and promote better health outcomes. 23938

The report shall include information regarding all of the 23939
following: 23940

(A) Provider network management; 23941

(B) Electronic claims submission and payment systems; 23942

(C) Limited provider contracts and payments based on 23943
performance; 23944

(D) Efforts to enforce third party liability; 23945

(E) Implementation of the medicaid information technology 23946
system; 23947

(F) Expansion of the medicaid data warehouse and decision 23948
support system; 23949

(G) Development of infrastructure policies for electronic 23950
health records and e-prescribing. 23951

Sec. ~~5111.01~~ 5162.01. ~~As used in this chapter, "medical~~ 23952
~~assistance program" or "medicaid" means the program that is~~ 23953
~~authorized by this chapter and provided by the department of job~~ 23954
~~and family services under this chapter, Title XIX of the "Social~~ 23955
~~Security Act," 79 Stat. 286 (1965), 42 U.S.C.A. 1396, as amended,~~ 23956
~~and the waivers of Title XIX requirements granted to the~~ 23957
~~department by the centers for medicare and medicaid services of~~ 23958
~~the United States department of health and human services.~~ 23959

~~The department of job and family services shall act as the~~ 23960
~~single state agency to supervise the administration of the~~ 23961
~~medicaid program. As the single state agency, the department shall~~ 23962
~~comply with 42 C.F.R. 431.10(e). The department's rules governing~~ 23963
~~medicaid are binding on other agencies that administer components~~ 23964
~~of the medicaid program. No agency may establish, by rule or~~ 23965

~~otherwise, a policy governing medicaid that is inconsistent with a medicaid policy established, in rule or otherwise, by the director of job and family services.~~

~~(A)~~ The department of ~~job and family services~~ health care administration may provide medical assistance under the medicaid program as long as federal funds are provided for such assistance, to the following:

~~(1)~~(A) Families with children that meet ~~either of the following conditions:~~

~~(a) The family meets~~ the income, resource, and family composition requirements in effect on July 16, 1996, for the former aid to dependent children program as those requirements were established by Chapter 5107. of the Revised Code, federal waivers granted pursuant to requests made under former section 5101.09 of the Revised Code, and rules adopted ~~by the department~~ for that former program or any changes the department makes to those requirements in accordance with ~~paragraph (a)(2) of section 114 of the "Personal Responsibility and Work Opportunity Reconciliation Act of 1996," 110 Stat. 2177,~~ 42 U.S.C.~~A.~~ 1396u-1~~,~~ for the purpose of implementing section ~~5111.019~~ 5126.05 of the Revised Code. An adult loses eligibility for medicaid under division (A)~~(1)(a)~~ of this section pursuant to division (D) of section 5107.16 of the Revised Code.

~~(b) The family does not meet the requirements specified in division (A)(1)(a) of this section but is eligible for medicaid pursuant to section 5101.18 of the Revised Code.~~

~~(2)~~(B) Aged, blind, and disabled persons who meet either of the following conditions:

~~(a)~~(1) Receive federal ~~aid~~ benefits under ~~Title XVI of the "Social Security Act,"~~ the supplemental security income program or are eligible for but are not receiving ~~such aid~~ SSI benefits,

provided that the income from all other sources for individuals 23997
with independent living arrangements shall not exceed one hundred 23998
seventy-five dollars per month. The income standards hereby 23999
established shall be adjusted annually at the rate that is used by 24000
the United States department of health and human services to 24001
adjust the amounts payable under ~~Title XVI~~ the SSI program. 24002

~~(b)~~(2) Do not receive ~~aid under Title XVI~~ supplemental 24003
security income benefits, but meet any of the following criteria: 24004

~~(i)~~(a) Would be eligible ~~to receive such aid~~ for SSI 24005
benefits, except that their income, other than that excluded from 24006
consideration as income ~~under Title XVI~~ for the SSI program, 24007
exceeds the maximum under division ~~(A)(2)(a)~~(B)(1) of this 24008
section, and incurred expenses for medical care, as determined 24009
under federal regulations applicable to section 209(b) of the 24010
"Social Security Amendments of 1972," 86 Stat. 1381, 42 U.S.C.A. 24011
1396a(f), as amended, equal or exceed the amount by which their 24012
income exceeds the maximum under division ~~(A)(2)(a)~~(B)(1) of this 24013
section; 24014

~~(ii)~~(b) Received aid for the aged, aid to the blind, or aid 24015
for the permanently and totally disabled prior to January 1, 1974, 24016
and continue to meet all the same eligibility requirements; 24017

~~(iii) Are eligible for medicaid pursuant to section 5101.18~~ 24018
~~of the Revised Code~~ (c) Lost eligibility for SSI benefits due to a 24019
general increase in old-age, survivors, and disability insurance 24020
benefits under Title II of the Social Security Act of 1935. 24021

~~(3)~~(C) Persons to whom federal law requires, as a condition 24022
of state participation in the medicaid program, that medicaid be 24023
provided; 24024

~~(4)~~(D) Persons under age twenty-one who meet the income 24025
requirements for the Ohio works first program established under 24026
Chapter 5107. of the Revised Code but do not meet other 24027

eligibility requirements for the program. The director shall adopt rules in accordance with Chapter 119. of the Revised Code specifying which Ohio works first requirements shall be waived for the purpose of providing medicaid eligibility under division (A)(4) of this section. 24028 24029 24030 24031 24032

~~(B) If sufficient funds are appropriated for the medicaid program, the department may provide medical assistance under the medicaid program to persons in groups designated by federal law as groups to which a state, at its option, may provide medical assistance under the medicaid program.~~ 24033 24034 24035 24036 24037

~~(C) The department may expand eligibility for the medicaid program to include individuals under age nineteen with family incomes at or below one hundred fifty per cent of the federal poverty guidelines, except that the eligibility expansion shall not occur unless the department receives the approval of the federal government. The department may implement the eligibility expansion authorized under this division on any date selected by the department, but not sooner than January 1, 1998.~~ 24038 24039 24040 24041 24042 24043 24044 24045

~~(D) In addition to any other authority or requirement to adopt rules under this chapter, the director may adopt rules in accordance with section 111.15 of the Revised Code as the director considers necessary to establish standards, procedures, and other requirements regarding the provision of medical assistance under the medicaid program. The rules may establish requirements to be followed in applying for medicaid, making determinations of eligibility for medicaid, and verifying eligibility for medicaid. The rules may include special conditions as the department determines appropriate for making applications, determining eligibility, and verifying eligibility for any medical assistance that the department may provide under the medicaid program pursuant to division (C) of this section and section 5111.014 or 5111.019 of the Revised Code.~~ 24046 24047 24048 24049 24050 24051 24052 24053 24054 24055 24056 24057 24058 24059

Sec. 5162.02. If funds are appropriated for such purpose by 24060
the general assembly, the department of health care administration 24061
may expand eligibility for the medicaid program to persons in 24062
groups designated by federal law as groups to which a state, at 24063
its option, may provide medical assistance under the medicaid 24064
program. 24065

Sec. 5162.03. The department of health care administration 24066
may expand eligibility for the medicaid program to individuals 24067
under nineteen years of age with family incomes at or below one 24068
hundred fifty per cent of the federal poverty guidelines, except 24069
that the eligibility expansion shall not occur unless the 24070
department receives the approval of the United States department 24071
of health and human services. The department may implement the 24072
eligibility expansion authorized by this section on any date 24073
selected by the department. 24074

Sec. ~~5111.014~~ 5162.04. (A) The director of ~~job and family~~ 24075
~~services~~ health care administration shall submit to the United 24076
States secretary of health and human services an amendment to the 24077
state medicaid plan to make an individual who meets all of the 24078
following requirements eligible for medicaid: 24079

(1) The individual is pregnant; 24080

(2) The individual's family income does not exceed two 24081
hundred per cent of the federal poverty guidelines; 24082

(3) The individual satisfies all relevant requirements 24083
established by rules adopted under ~~division (D) of~~ section ~~5111.01~~ 24084
5162.20 of the Revised Code. 24085

(B) If approved by the United States secretary of health and 24086
human services, the director of ~~job and family services~~ health 24087
care administration shall implement the medicaid plan amendment 24088

submitted under division (A) of this section as soon as possible after receipt of notice of the approval, but not sooner than January 1, 2008. 24089 24090 24091

Sec. ~~5111.019~~ 5162.05. The director of ~~job and family services~~ health care administration shall submit to the United States secretary of health and human services an amendment to the state medicaid plan to make an individual eligible for medicaid who meets all of the following requirements: 24092 24093 24094 24095 24096

(A) The individual is the parent of a child under nineteen years of age and resides with the child; 24097 24098

(B) The individual's family income does not exceed ninety per cent of the federal poverty guidelines; 24099 24100

(C) The individual is not otherwise eligible for medicaid; 24101

(D) The individual satisfies all relevant requirements established by rules adopted under ~~division (D) of~~ section ~~5111.01~~ 5162.20 of the Revised Code. 24102 24103 24104

Sec. ~~5111.0111~~ 5162.06. (A) The director of ~~job and family services~~ health care administration shall submit to the United States secretary of health and human services an amendment to the state medicaid plan to implement 42 U.S.C. 1396a (a)(10)(A)(ii)(XVII) to make an individual who meets all of the following requirements eligible for medicaid: 24105 24106 24107 24108 24109 24110

(1) The individual is under twenty-one years of age; 24111

(2) The individual was in foster care under the responsibility of the state on the individual's eighteenth birthday; 24112 24113 24114

(3) Foster care maintenance payments or independent living services were furnished under a program funded under Title IV-E of the Social Security Act of 1935 on the individual's behalf before 24115 24116 24117

the individual attained eighteen years of age; 24118

(4) The individual meets all other applicable eligibility requirements established in rules adopted under section ~~5111.011~~ 5162.20 of the Revised Code. 24119 24120 24121

(B) If approved by the United States secretary of health and human services, the director of ~~job and family services~~ health care administration shall implement the medicaid plan amendment submitted under this section beginning January 1, 2008. 24122 24123 24124 24125

Sec. ~~5111.0113~~ 5162.07. Children who are in the temporary or permanent custody of a certified public or private nonprofit agency or institution or in adoptions subsidized under division (B) of section 5153.163 of the Revised Code are eligible for ~~medical assistance through~~ the medicaid program ~~established under section 5111.01 of the Revised Code~~. 24126 24127 24128 24129 24130 24131

Sec. ~~5111.0110~~ 5162.08. (A) The director of ~~job and family services~~ health care administration shall submit to the United States secretary of health and human services an amendment to the state medicaid plan to implement the "Breast and Cervical Cancer Prevention and Treatment Act of 2000," 114 Stat. 1381, 42 U.S.C.A. 1396a, as amended, to provide medical assistance to women who meet all of the following requirements: 24132 24133 24134 24135 24136 24137 24138

(1) Are under age sixty-five; 24139

(2) Are not otherwise eligible for medicaid; 24140

(3) Have been screened for breast and cervical cancer under the centers for disease control and prevention breast and cervical cancer early detection program established under 42 U.S.C.A. 300k in accordance with 42 U.S.C.A. 300n; 24141 24142 24143 24144

(4) Need treatment for breast or cervical cancer; 24145

(5) Are not otherwise covered under creditable coverage, as 24146

defined in 42 U.S.C.A. 300gg(c). 24147

(B) If the United States secretary of health and human 24148
services approves the state medicaid plan amendment submitted 24149
under division (A) of this section, the director of ~~job and family~~ 24150
~~services~~ health care administration shall implement the amendment. 24151
The medical assistance provided under the amendment shall be 24152
limited to medical assistance provided during the period in which 24153
a woman who meets the requirements of division (A) of this section 24154
requires treatment for breast or cervical cancer. 24155

Sec. ~~5111.0115~~ 5162.09. (A) The department of ~~job and family~~ 24156
~~services~~ health care administration may provide medical assistance 24157
under the medicaid program, as long as federal funds are provided 24158
for such assistance, to each former participant of the Ohio works 24159
first program established under Chapter 5107. of the Revised Code 24160
who meets all of the following requirements: 24161

(1) Is ineligible to participate in Ohio works first solely 24162
as a result of increased income due to employment; 24163

(2) Is not covered by, and does not have access to, medical 24164
insurance coverage through the employer with benefits comparable 24165
to those provided under this section, as determined in accordance 24166
with rules adopted by the director of ~~job and family services~~ 24167
health care administration under division (B) of this section; 24168

(3) Meets any other requirement established by rule adopted 24169
under division (B) of this section. 24170

(B) The director of ~~job and family services~~ health care 24171
administration shall adopt such rules under Chapter 119. of the 24172
Revised Code as are necessary to implement and administer the 24173
~~medical assistance~~ medicaid program under this section. 24174

(C) A person seeking to participate in ~~a program of medical~~ 24175
~~assistance under~~ the medicaid program pursuant to this section 24176

shall apply to the county department of job and family services in the county in which the applicant resides. The application shall be made on a form prescribed by the department of ~~job and family services~~ health care administration and furnished by the county department. 24177 24178 24179 24180 24181

(D) If the county department of job and family services determines that a person is eligible to receive ~~medical assistance~~ medicaid under this section, the department shall provide assistance, to the same extent and in the same manner as ~~medical assistance~~ medicaid is provided to a person eligible for ~~medical assistance~~ medicaid pursuant to division (A)~~(1)(a)~~ of section ~~5111.01~~ 5162.01 of the Revised Code, for no longer than twelve months, beginning the month after the date the participant's eligibility for Ohio works first is terminated. 24182 24183 24184 24185 24186 24187 24188 24189 24190

Sec. ~~5111.70~~ 5162.10. (A) As used in sections ~~5111.70~~ 5162.10 to ~~5111.7011~~ 5162.1011 of the Revised Code: 24191 24192

"Applicant" means an individual who applies to participate in the medicaid buy-in for workers with disabilities program. 24193 24194

"Earned income" has the meaning established by rules adopted under section ~~5111.708~~ 5162.108 of the Revised Code. 24195 24196

"Employed individual with a medically improved disability" has the same meaning as in 42 U.S.C. 1396d(v). 24197 24198

"Family" means an applicant or participant and the spouse and dependent children of the applicant or participant. If an applicant or participant is under eighteen years of age, "family" also means the parents of the applicant or participant. 24199 24200 24201 24202

"Federal poverty guidelines" has the same meaning as in section 5101.46 of the Revised Code. 24203 24204

"Health insurance" has the meaning established by rules adopted under section ~~5111.708~~ 5162.108 of the Revised Code. 24205 24206

"Income" means earned income and unearned income.

"Participant" means an individual who has been determined eligible for the medicaid buy-in for workers with disabilities program and is participating in the program.

"Resources" has the meaning established by rules adopted under section ~~5111.708~~ 5162.108 of the Revised Code.

"Spouse" has the meaning established in rules adopted under section ~~5111.708~~ 5162.108 of the Revised Code.

~~"Supplemental security income program" means the program established under Title XVI of the "Social Security Act," 86 Stat. 1329 (1972), 42 U.S.C. 1381, as amended.~~

"Medicaid buy-in for workers with disabilities program" means the component of the medicaid program established under sections ~~5111.70~~ 5162.10 to ~~5111.7011~~ 5162.1011 of the Revised Code.

"Unearned income" has the meaning established by rules adopted under section ~~5111.708~~ 5162.108 of the Revised Code.

(B) Not later than one hundred eighty days after ~~the effective date of this section~~ September 29, 2007, the director of ~~job and family services~~ health care administration shall submit to the United States secretary of health and human services an amendment to the state medicaid plan and any federal waiver necessary to establish the medicaid buy-in for workers with disabilities program in accordance with 42 U.S.C. 1396a(a)(10)(A)(ii)(XV) and (XVI) and sections ~~5111.70~~ 5162.10 to ~~5111.7011~~ 5162.1011 of the Revised Code. The director shall implement sections ~~5111.701~~ 5162.101 to ~~5111.7011~~ 5162.1011 of the Revised Code if the amendment and, if needed, federal waiver are approved.

Sec. ~~5111.701~~ 5162.101. Under the medicaid buy-in for workers

with disabilities program, an individual who does all of the following in accordance with rules adopted under section ~~5111.708~~ 5162.108 of the Revised Code qualifies for medical assistance under the medicaid program:

(A) Applies for the medicaid buy-in for workers with disabilities program;

(B) Provides satisfactory evidence of all of the following:

(1) That the individual is at least sixteen years of age and under sixty-five years of age;

(2) Except as provided in section ~~5111.706~~ 5162.106 of the Revised Code, that one of the following applies to the individual:

(a) The individual is considered disabled for the purpose of the supplemental security income program, regardless of whether the individual receives supplemental security income benefits, and the individual has earnings from employment.

(b) The individual is an employed individual with a medically improved disability.

(3) That the value of the individual's resources, less amounts disregarded pursuant to rules adopted under section ~~5111.708~~ 5162.108 of the Revised Code, does not exceed the amount provided for by section ~~5111.702~~ 5162.102 of the Revised Code;

(4) That the individual's income, less amounts disregarded pursuant to section ~~5111.703~~ 5162.103 of the Revised Code, does not exceed two hundred fifty per cent of the federal poverty guidelines;

(5) That the individual meets the additional eligibility requirements for the medicaid buy-in for workers with disabilities program that ~~the director of job and family services establishes~~ are established in rules adopted under section ~~5111.708~~ 5162.108

of the Revised Code.

(C) To the extent required by section ~~5111.704~~ 5162.104 of the Revised Code, pays the premium established under that section.

Sec. ~~5111.702~~ 5162.102. (A) Except as provided in division (B) of this section, the maximum value of resources, less amounts disregarded pursuant to rules adopted under section ~~5111.708~~ 5162.108 of the Revised Code, that an individual may have without the individual exceeding the resource eligibility limit for the medicaid buy-in for workers with disabilities program shall not exceed ten thousand dollars.

(B) Each calendar year, the director of ~~job and family services~~ health care administration shall adjust the resource eligibility limit specified in division (A) of this section by the change in the consumer price index for all items for all urban consumers for the previous calendar year, as published by the United States bureau of labor statistics. The annual adjustment shall go into effect on the earliest date possible.

Sec. ~~5111.703~~ 5162.103. For the purpose of determining whether an individual is within the income eligibility limit for the medicaid buy-in for workers with disabilities program, all of the following apply:

(A) Twenty thousand dollars of the individual's earned income shall be disregarded.

(B) No amount that the individual's employer pays to obtain health insurance for one or more members of the individual's family, including any amount of a premium established under section ~~5111.704~~ 5162.104 of the Revised Code that the employer pays, shall be treated as the individual's income.

(C) Any other amounts, if any, specified in rules adopted

under section ~~5111.708~~ 5162.108 of the Revised Code shall be disregarded from the individual's earned income, unearned income, or both.

Sec. ~~5111.704~~ 5162.104. An individual whose income exceeds one hundred fifty per cent of the federal poverty guidelines shall pay an annual premium as a condition of qualifying for the medicaid buy-in for workers with disabilities program. The amount of the premium shall be determined as follows:

(A) Subtract one hundred fifty per cent of the federal poverty guidelines, as applicable for a family size equal to the size of the individual's family, from the amount of the income of the individual's family;

(B) Subtract an amount specified in rules adopted under section ~~5111.708~~ 5162.108 of the Revised Code from the difference determined under division (A) of this section;

(C) Multiply the difference determined under division (B) of this section by one tenth.

Sec. ~~5111.705~~ 5162.105. No individual shall be denied eligibility for the medicaid buy-in for workers with disabilities program on the basis that the individual receives services under a home and community-based services medicaid waiver component as defined in section ~~5111.851~~ 5163.51 of the Revised Code.

Sec. ~~5111.706~~ 5162.106. An individual participating in the medicaid buy-in for workers with disabilities program may continue to participate in the program for up to six months even though the individual ceases to have earnings from employment or to be an employed individual with a medically improved disability due to ceasing to be employed if the individual continues to meet all other eligibility requirements for the program.

Sec. ~~5111.707~~ 5162.107. If the United States secretary of 24326
health and human services requires that a provision in the 24327
amendment to the state medicaid plan or the federal waiver request 24328
submitted under section ~~5111.70~~ 5162.10 of the Revised Code be 24329
changed or removed in order for the secretary to approve the 24330
amendment or waiver or to avoid an extended delay in the 24331
secretary's approval, the director of ~~job and family services~~ 24332
health care administration shall make the change or removal. The 24333
change or removal may cause the medicaid buy-in for workers with 24334
disabilities program to include a provision that is inconsistent 24335
with sections ~~5111.70~~ 5162.10 to ~~5111.706~~ 5162.106 of the Revised 24336
Code. Such a change or removal shall be made only to the extent 24337
necessary to obtain the United States secretary's approval or 24338
avoid an extended delay in the secretary's approval and shall be 24339
reflected in rules adopted under section ~~5111.708~~ 5162.108 of the 24340
Revised Code. 24341

Sec. ~~5111.708~~ 5162.108. (A) The director of ~~job and family~~ 24342
~~services~~ health care administration, after consulting with the 24343
medicaid buy-in advisory council, shall adopt rules in accordance 24344
with Chapter 119. of the Revised Code as necessary to implement 24345
the medicaid buy-in for workers with disabilities program. The 24346
rules shall do all of the following: 24347

(1) Specify assets, asset values, and amounts to be 24348
disregarded in determining asset and income eligibility limits for 24349
the program; 24350

(2) Establish meanings for the terms "earned income," "health 24351
insurance," "resources," "spouse," and "unearned income"; 24352

(3) Establish additional eligibility requirements for the 24353
program that must be established for the United States secretary 24354
of health and human services to approve the program; 24355

(4) For the purpose of division (B) of section ~~5111.704~~ 5162.104 of the Revised Code, specify an amount to be subtracted from the difference determined under division (A) of that section. 24356 24357 24358 24359

(B) The director, after consulting with the medicaid buy-in advisory council, may adopt rules in accordance with Chapter 119. of the Revised Code to specify amounts to be disregarded from an individual's earned income, unearned income, or both under division (C) of section ~~5111.703~~ 5162.103 of the Revised Code for the purpose of determining whether the individual is within the income eligibility limit for the medicaid buy-in for workers with disabilities program. 24360 24361 24362 24363 24364 24365 24366 24367

Sec. ~~5111.709~~ 5162.109. (A) There is hereby created the medicaid buy-in advisory council. The council shall consist of all of the following: 24368 24369 24370

(1) The following voting members: 24371

(a) The executive director of assistive technology of Ohio or the executive director's designee; 24372 24373

(b) The director of the axis center for public awareness of people with disabilities or the director's designee; 24374 24375

(c) The executive director of the cerebral palsy association of Ohio or the executive director's designee; 24376 24377

(d) The chief executive officer of Ohio advocates for mental health or the chief executive officer's designee; 24378 24379

(e) The state director of the Ohio chapter of AARP or the state director's designee; 24380 24381

(f) The director of the Ohio developmental disabilities council created under section 5123.35 of the Revised Code or the director's designee; 24382 24383 24384

(g) The executive director of the governor's council on people with disabilities created under section 3303.41 of the Revised Code or the executive director's designee; 24385 24386 24387

(h) The administrator of the legal rights service created under section 5123.60 of the Revised Code or the administrator's designee; 24388 24389 24390

(i) The chairperson of the Ohio Olmstead task force or the chairperson's designee; 24391 24392

(j) The executive director of the Ohio statewide independent living council or the executive director's designee; 24393 24394

(k) The president of the Ohio chapter of the national multiple sclerosis society or the president's designee; 24395 24396

(l) The executive director of the arc of Ohio or the executive director's designee; 24397 24398

(m) The executive director of the commission on minority health or the executive director's designee; 24399 24400

(n) The executive director of the brain injury association of Ohio or the executive director's designee; 24401 24402

(o) The executive officer of any other advocacy organization who volunteers to serve on the council, or such an executive officer's designee, if the other voting members, at a meeting called by the chairperson elected under division (C) of this section, determine it is appropriate for the advocacy organization to be represented on the council; 24403 24404 24405 24406 24407 24408

(p) One or more participants who volunteer to serve on the council and are selected by the other voting members at a meeting the chairperson calls after the medicaid buy-in for workers with disabilities program is implemented. 24409 24410 24411 24412

(2) The following non-voting members: 24413

(a) The director of ~~job and family services~~ health care 24414

administration or the director's designee; 24415

(b) The administrator of the rehabilitation services commission or the administrator's designee; 24416 24417

(c) The director of alcohol and drug addiction services or the director's designee; 24418 24419

(d) The director of mental retardation and developmental disabilities or the director's designee; 24420 24421

(e) The director of mental health or the director's designee; 24422

(f) The executive officer of any other government entity, or the executive officer's designee, if the voting members, at a meeting called by the chairperson, determine it is appropriate for the government entity to be represented on the council. 24423 24424 24425 24426

(B) All members of the medicaid buy-in advisory council shall serve without compensation or reimbursement, except as serving on the council is considered part of their usual job duties. 24427 24428 24429

(C) The voting members of the medicaid buy-in advisory council shall elect one of the members of the council to serve as the council's chairperson for a two-year term. The chairperson may be re-elected to successive terms. 24430 24431 24432 24433

(D) The department of ~~job and family services~~ health care administration shall provide the Ohio medicaid buy-in advisory council with accommodations for the council to hold its meetings and shall provide the council with other administrative assistance the council needs to perform its duties. 24434 24435 24436 24437 24438

Sec. ~~5111.7010~~ 5162.1010. The director of ~~job and family services~~ health care administration or the director's designee shall consult with the medicaid buy-in advisory council before adopting, amending, or rescinding any rules under section ~~5111.708~~ 5162.108 of the Revised Code governing the medicaid buy-in for workers with disabilities program. 24439 24440 24441 24442 24443 24444

The director or designee shall meet at least quarterly with the council to discuss the program. At the meetings, the council may provide the director or designee with suggestions for improving the program and the director or designee shall provide the council with all of the following information: 24445 24446 24447 24448 24449

(A) The number of individuals who participated in the program the previous calendar quarter; 24450 24451

(B) The cost of the program the previous calendar quarter; 24452

(C) The amount of revenue generated the previous quarter by premiums that participants pay under section ~~5111.704~~ 5162.104 of the Revised Code; 24453 24454 24455

(D) The average amount of earned income of participants' families; 24456 24457

(E) The average amount of time participants have participated in the program; 24458 24459

(F) The types of other health insurance participants have been able to obtain. 24460 24461

Sec. ~~5111.7011~~ 5162.1011. Not less than once each year, the director of ~~job and family services~~ health care administration shall submit a report on the medicaid buy-in for workers with disabilities program to the governor, speaker and minority leader of the house of representatives, president and minority leader of the senate, and chairpersons of the house and senate committees to which the biennial operating budget bill is referred. The report shall include all of the following information: 24462 24463 24464 24465 24466 24467 24468 24469

(A) The number of individuals who participated in the medicaid buy-in for workers with disabilities program; 24470 24471

(B) The cost of the program; 24472

(C) The amount of revenue generated by premiums that 24473

participants pay under section ~~5111.704~~ 5162.104 of the Revised Code; 24474 24475

(D) The average amount of earned income of participants' families; 24476 24477

(E) The average amount of time participants have participated in the program; 24478 24479

(F) The types of other health insurance participants have been able to obtain. 24480 24481

Sec. ~~5111.013~~ 5162.15. (A) The provision of ~~medical assistance~~ medicaid to pregnant women and young children who are eligible for ~~medical assistance~~ medicaid under division ~~(A)(3)~~(C) of section ~~5111.01~~ 5162.01 of the Revised Code, but who are not otherwise eligible for ~~medical assistance~~ medicaid under that section, shall be known as the healthy start program. 24482 24483 24484 24485 24486 24487

(B) The department of ~~job and family services~~ health care administration shall do all of the following with regard to the application procedures for the healthy start program: 24488 24489 24490

(1) Establish a short application form for the program that requires the applicant to provide no more information than is necessary for making determinations of eligibility for the healthy start program, except that the form may require applicants to provide their social security numbers. The form shall include a statement, which must be signed by the applicant, indicating that she does not choose at the time of making application for the program to apply for assistance provided under any other program administered by the department and that she understands that she is permitted at any other time to apply at the county department of job and family services of the county in which she resides for any other assistance administered by the department or department of job and family services. 24491 24492 24493 24494 24495 24496 24497 24498 24499 24500 24501 24502 24503

(2) To the extent permitted by federal law, do one or both of the following: 24504 24505

(a) Distribute the application form for the program to each public or private entity that serves as a women, infants, and children clinic or as a child and family health clinic and to each administrative body for such clinics and train employees of each such agency or entity to provide applicants assistance in completing the form; 24506 24507 24508 24509 24510 24511

(b) In cooperation with the department of health, develop arrangements under which employees of county departments of job and family services are stationed at public or private agencies or entities selected by the department of ~~job and family services~~ health care administration that serve as women, infants, and children clinics; child and family health clinics; or administrative bodies for such clinics for the purpose both of assisting applicants for the program in completing the application form and of making determinations at that location of eligibility for the program. 24512 24513 24514 24515 24516 24517 24518 24519 24520 24521

(3) Establish performance standards by which a county department of job and family services' level of enrollment of persons potentially eligible for the program can be measured, and establish acceptable levels of enrollment for each county department. 24522 24523 24524 24525 24526

(4) Direct any county department of job and family services whose rate of enrollment of potentially eligible enrollees in the program is below acceptable levels established under division (B)(3) of this section to implement corrective action. Corrective action may include but is not limited to any one or more of the following to the extent permitted by federal law: 24527 24528 24529 24530 24531 24532

(a) Establishing formal referral and outreach methods with local health departments and local entities receiving funding 24533 24534

through the bureau of maternal and child health; 24535

(b) Designating a specialized intake unit within the county department for healthy start applicants; 24536 24537

(c) Establishing abbreviated timeliness requirements to shorten the time between receipt of an application and the scheduling of an initial application interview; 24538 24539 24540

(d) Establishing a system for telephone scheduling of intake interviews for applicants; 24541 24542

(e) Establishing procedures to minimize the time an applicant must spend in completing the application and eligibility determination process, including permitting applicants to complete the process at times other than the regular business hours of the county department and at locations other than the offices of the county department. 24543 24544 24545 24546 24547 24548

(C) To the extent permitted by federal law, local funds, whether from public or private sources, expended by a county department for administration of the healthy start program shall be considered to have been expended by the state for the purpose of determining the extent to which the state has complied with any federal requirement that the state provide funds to match federal funds for ~~medical assistance~~ medicaid, except that this division shall not affect the amount of funds the county is entitled to receive under section ~~5101.16, 5101.161,~~ 5160.26 or ~~5111.012~~ 5160.261 of the Revised Code. 24549 24550 24551 24552 24553 24554 24555 24556 24557 24558

(D) The director of ~~job and family services~~ health care administration shall do one or both of the following: 24559 24560

(1) To the extent that federal funds are provided for such assistance, adopt a plan for granting presumptive eligibility for pregnant women applying for healthy start; 24561 24562 24563

(2) To the extent permitted by federal medicaid regulations, 24564

adopt a plan for making same-day determinations of eligibility for pregnant women applying for healthy start. 24565 24566

(E) A county department of job and family services that maintains offices at more than one location shall accept applications for the healthy start program at all of those locations. 24567 24568 24569 24570

(F) The director of ~~job and family services~~ health care administration shall adopt rules in accordance with section 111.15 of the Revised Code as necessary to implement this section. 24571 24572 24573

Sec. ~~5111.016~~ 5162.16. (A) As used in this section, "healthcheck" has the same meaning as in section 3313.714 of the Revised Code. 24574 24575 24576

(B) The department of ~~job and family services~~ health care administration shall adopt rules in accordance with Chapter 119. of the Revised Code establishing a combination of written and oral methods designed to provide information about healthcheck to all persons eligible for the program or their parents or guardians. The department shall ensure that its methods of providing information are effective. The methods shall comply with federal law and regulations. 24577 24578 24579 24580 24581 24582 24583 24584

Each county department of job and family services or other entity that distributes or accepts applications for ~~medical assistance~~ medicaid shall prominently display a notice that complies with the rules adopted under this division. 24585 24586 24587 24588

Sec. 5162.17. The department of health care administration shall establish a disability determination unit and develop guidelines for expediting reviews of applications for the medicaid program for persons who have been referred to the unit under division (D) of section 329.043 of the Revised Code. The department shall make determinations of eligibility for medicaid 24589 24590 24591 24592 24593 24594

for any such person within the time prescribed by federal regulations. 24595 24596

Sec. ~~5111.0119~~ 5162.18. (A)(1) As used in this section, subject to division (A)(2) of this section, "state or local correctional facility" means any of the following: 24597 24598 24599

(a) A "state correctional institution," as defined in section 2967.01 of the Revised Code; 24600 24601

(b) A "local correctional facility," as defined in section 2903.13 of the Revised Code; 24602 24603

(c) A correctional facility that is privately operated and managed pursuant to section 9.06 of the Revised Code. 24604 24605

(2) "State or local correctional facility" does not include any facility operated directly by or at the direction of the department of youth services. 24606 24607 24608

(B) If a person who is confined in a state or local correctional facility was a medicaid recipient immediately prior to being confined in the facility, all of the following apply: 24609 24610 24611

(1) The person's eligibility for medicaid while so confined shall be suspended due to the confinement. 24612 24613

(2) No medicaid payment shall be made for any care, services, or supplies provided to the person during the suspension described in division (B)(1) of this section. 24614 24615 24616

(3) The suspension described in division (B)(1) of this section shall end upon the release of the person from the confinement. 24617 24618 24619

(4) Except as provided in division (C) of this section, the person shall not be required to reapply or undergo a redetermination of eligibility for medicaid when the suspension described in division (B)(1) of this section ends. 24620 24621 24622 24623

(C) A person may be disenrolled from medicaid any time after the suspension described in division (B)(1) of this section ends if the person is no longer eligible for medicaid. A person may be required to undergo a redetermination of eligibility for medicaid any time after the suspension described in division (B)(1) of this section ends if it is time or past time for the person's eligibility redetermination or the person's circumstances have changed in a manner warranting a redetermination.

(D) The department of ~~job and family services~~ health care administration shall take the steps necessary to begin implementation of this section not later than September 1, 2009.

Sec. ~~5111.011~~ 5162.20. (A) The director of ~~job and family services~~ health care administration shall adopt rules establishing eligibility requirements for the medicaid program. The rules shall be adopted pursuant to section 111.15 of the Revised Code and shall be consistent with federal and state law. The rules shall include rules that do all of the following:

(1) Establish requirements to be followed in applying for medicaid, making determinations of eligibility for medicaid, and verifying eligibility for medicaid;

(2) Establish standards consistent with federal law for allocating income and resources as income and resources of the spouse, children, parents, or stepparents of a recipient of or applicant for medicaid;

~~(2)~~(3) Define the term "resources" as used in division (A)~~(1)~~(2) of this section;

~~(3)~~(4) Specify the number of months that is to be used for the purpose of the term "look-back date" used in section ~~5111.0116~~ 5162.21 of the Revised Code;

~~(4)~~(5) Establish processes to be used to determine both of

the following: 24654

(a) The date an institutionalized individual's ineligibility 24655
for services under section ~~5111.0116~~ 5162.21 of the Revised Code 24656
is to begin; 24657

(b) The number of months an institutionalized individual's 24658
ineligibility for such services is to continue. 24659

~~(5)~~(6) Establish exceptions to the period of ineligibility 24660
that an institutionalized individual would otherwise be subject to 24661
under section ~~5111.0116~~ 5162.21 of the Revised Code; 24662

~~(6)~~(7) Define the term "other medicaid-funded long-term care 24663
services" as used in sections ~~5111.0117~~ 5162.22 and ~~5111.0118~~ 24664
5162.23 of the Revised Code; 24665

~~(7)~~(8) For the purpose of division (C)(2)(c) of section 24666
~~5111.0117~~ 5162.22 of the Revised Code, establish the process to 24667
determine whether the child of an aged, blind, or disabled 24668
individual is financially dependent on the individual for housing. 24669

(B) Notwithstanding any provision of state law, including 24670
statutes, administrative rules, common law, and court rules, 24671
regarding real or personal property or domestic relations, the 24672
standards established under rules adopted under division (A)~~(1)~~(2) 24673
of this section shall be used to determine eligibility for 24674
medicaid. 24675

Sec. ~~5111.0116~~ 5162.21. (A) As used in this section: 24676

(1) "Assets" include all of an individual's income and 24677
resources and those of the individual's spouse, including any 24678
income or resources the individual or spouse is entitled to but 24679
does not receive because of action by any of the following: 24680

(a) The individual or spouse; 24681

(b) A person or government entity, including a court or 24682

administrative agency, with legal authority to act in place of or on behalf of the individual or spouse; 24683 24684

(c) A person or government entity, including a court or administrative agency, acting at the direction or on the request of the individual or spouse. 24685 24686 24687

(2) "Home and community-based services" means home and community-based services furnished under a medicaid waiver granted by the United States secretary of health and human services under 42 U.S.C. 1396n(c) or (d). 24688 24689 24690 24691

(3) "Institutionalized individual" means a resident of a nursing facility, an inpatient in a medical institution for whom a payment is made based on a level of care provided in a nursing facility, or an individual described in 42 U.S.C. 1396a(a)(10)(A)(ii)(VI). 24692 24693 24694 24695 24696

(4) "Look-back date" means the date that is a number of months specified in rules adopted under section ~~5111.011~~ 5162.20 of the Revised Code immediately before either of the following: 24697 24698 24699

(a) The date an individual becomes an institutionalized individual if the individual is eligible for medicaid on that date; 24700 24701 24702

(b) The date an individual applies for medicaid while an institutionalized individual. 24703 24704

(5) "Nursing facility" has the same meaning as in section ~~5111.20~~ 5164.01 of the Revised Code. 24705 24706

(6) "Nursing facility equivalent services" means services that are covered by the medicaid program, equivalent to nursing facility services, provided by an institution that provides the same level of care as a nursing facility, and provided to an inpatient of the institution who is a medicaid recipient eligible for medicaid-covered nursing facility equivalent services. 24707 24708 24709 24710 24711 24712

(7) "Nursing facility services" means nursing facility services covered by the medicaid program that a nursing facility provides to a resident of the nursing facility who is a medicaid recipient eligible for medicaid-covered nursing facility services. 24713 24714 24715 24716

(B) Except as provided in rules adopted under section ~~5111.011~~ 5162.20 of the Revised Code, an institutionalized individual is ineligible for nursing facility services, nursing facility equivalent services, and home and community-based services if the individual or individual's spouse disposes of assets for less than fair market value on or after the look-back date. The institutionalized individual's ineligibility shall begin on a date determined in accordance with rules adopted under section ~~5111.011~~ 5162.20 of the Revised Code and shall continue for a number of months determined in accordance with such rules. 24717 24718 24719 24720 24721 24722 24723 24724 24725 24726

(C) To secure compliance with this section, the director of ~~job and family services~~ health care administration may require an individual, as a condition of initial or continued eligibility for medicaid, to provide documentation of the individual's assets up to five years before the date the individual becomes an institutionalized individual if the individual is eligible for medicaid on that date or the date the individual applies for medicaid while an institutionalized individual. Documentation may include tax returns, records from financial institutions, and real property records. 24727 24728 24729 24730 24731 24732 24733 24734 24735 24736

Sec. ~~5111.0117~~ 5162.22. (A) As used in this section and section ~~5111.0118~~ 5162.23 of the Revised Code: 24737 24738

(1) "ICF/MR services" means intermediate care facility for the mentally retarded services covered by the medicaid program that an intermediate care facility for the mentally retarded provides to a resident of the facility who is a medicaid recipient eligible for medicaid-covered intermediate care facility for the 24739 24740 24741 24742 24743

mentally retarded services. 24744

(2) "Intermediate care facility for the mentally retarded" has the same meaning as in section ~~5111.20~~ <u>5164.01</u> of the Revised Code. 24745 24746 24747

(3) "Nursing facility" has the same meaning as in section ~~5111.20~~ <u>5164.01</u> of the Revised Code. 24748 24749

(4) "Nursing facility services" means nursing facility services covered by the medicaid program that a nursing facility provides to a resident of the nursing facility who is a medicaid recipient eligible for medicaid-covered nursing facility services. 24750 24751 24752 24753

(5) "Other medicaid-funded long-term care services" has the meaning specified in rules adopted under section ~~5111.011~~ <u>5162.20</u> of the Revised Code. 24754 24755 24756

(B) Except as provided by division (C) of this section and for the purpose of determining whether an aged, blind, or disabled individual is eligible for nursing facility services, ICF/MR services, or other medicaid-funded long-term care services, the director of ~~job and family services~~ <u>health care administration</u> may consider an aged, blind, or disabled individual's real property to not be the individual's homestead or principal place of residence once the individual has resided in a nursing facility, intermediate care facility for the mentally retarded, or other medical institution for at least thirteen months. 24757 24758 24759 24760 24761 24762 24763 24764 24765 24766

(C) Division (B) of this section does not apply to an individual if any of the following reside in the individual's real property that, because of this division, continues to be considered the individual's homestead or principal place of residence: 24767 24768 24769 24770 24771

(1) The individual's spouse; 24772

(2) The individual's child if any of the following apply: 24773

(a) The child is under twenty-one years of age. 24774

(b) The child is considered blind or disabled under 42 U.S.C. 1382c. 24775 24776

(c) The child is financially dependent on the individual for housing as determined in accordance with rules adopted under section ~~5111.011~~ 5162.20 of the Revised Code. 24777 24778 24779

(3) The individual's sibling if the sibling has a verified equity interest in the real property and resided in the real property for at least one year immediately before the date the individual was admitted to the nursing facility, intermediate care facility for the mentally retarded, or other medical institution. 24780 24781 24782 24783 24784

Sec. ~~5111.0118~~ 5162.23. (A) Except as otherwise provided by this section, no individual shall qualify for nursing facility services or other medicaid-funded long-term care services if the individual's equity interest in the individual's home exceeds five hundred thousand dollars. The director of ~~job and family services~~ health care administration shall increase this amount effective January 1, 2011, and the first day of each year thereafter, by the percentage increase in the consumer price index for all urban consumers (all items; United States city average), rounded to the nearest one thousand dollars. 24785 24786 24787 24788 24789 24790 24791 24792 24793 24794

(B) This section does not apply to an individual if either of the following applies: 24795 24796

(1) Either of the following lawfully reside in the individual's home: 24797 24798

(a) The individual's spouse; 24799

(b) The individual's child if the child is under twenty-one years of age or, under 42 U.S.C. 1382c, considered blind or disabled. 24800 24801 24802

(2) The individual qualifies, pursuant to the process 24803

established under division (C) of this section, for a waiver of this section due to a demonstrated hardship.

(C) The director shall establish a process by which individuals may obtain a waiver of this section due to a demonstrated hardship. The process shall be consistent with the process for such waivers established by the United States secretary of health and human services under 42 U.S.C. 1396p(f)(4).

(D) Nothing in this section shall be construed as preventing an individual from using a reverse mortgage or home equity loan to reduce the individual's total equity interest in the home.

Sec. ~~5111.015~~ 5162.24. (A) If the United States secretary of health and human services grants a waiver of any contrary federal requirements governing the ~~medical assistance~~ medicaid program or the director of ~~job and family services~~ health care administration determines that there are no contrary federal requirements, divisions (A)(1) and (2) of this section apply to determinations of eligibility under this chapter:

(1) In determining the eligibility of an assistance group for assistance under this chapter, the department of ~~job and family services~~ health care administration shall exclude from the income and resources applicable to the assistance group the value of any tuition payment contract entered into under section 3334.09 of the Revised Code or any scholarship awarded under section 3334.18 of the Revised Code and the amount of payments made by the Ohio tuition trust authority under section 3334.09 of the Revised Code pursuant to the contract or scholarship.

(2) The department shall not require any person to terminate a tuition payment contract entered into under Chapter 3334. of the Revised Code as a condition of an assistance group's eligibility for ~~assistance under this chapter~~ medicaid.

(B) To the extent required by federal law, the department 24835
shall include as income any refund paid under section 3334.10 of 24836
the Revised Code to a member of the assistance group. 24837

(C) Not later than sixty days after July 1, 1994, the 24838
department shall apply to the United States department of health 24839
and human services for a waiver of any federal requirements that 24840
otherwise would be violated by implementation of division (A) of 24841
this section. 24842

Sec. ~~5111.15~~ 5162.25. If a medicaid recipient ~~of medical~~ 24843
~~assistance~~ is the beneficiary of a trust created pursuant to 24844
section 5815.28 of the Revised Code, then, notwithstanding any 24845
contrary provision of this chapter or of a rule adopted pursuant 24846
to this chapter, divisions (C) and (D) of that section shall apply 24847
in determining the assets or resources of the recipient, the 24848
recipient's estate, the settlor, or the settlor's estate and to 24849
claims arising under this chapter against the recipient, the 24850
recipient's estate, the settlor, or the settlor's estate. 24851

Sec. ~~5111.151~~ 5162.26. (A) This section applies to 24852
eligibility determinations for all cases involving ~~medicaid~~ 24853
medical assistance provided ~~pursuant to this chapter~~ under the 24854
medicaid program, qualified medicare beneficiaries, specified 24855
low-income medicare beneficiaries, qualifying individuals-1, 24856
qualifying individuals-2, and ~~medical assistance~~ medicaid for 24857
covered families and children. 24858

(B) As used in this section: 24859

(1) "Trust" means any arrangement in which a grantor 24860
transfers real or personal property to a trust with the intention 24861
that it be held, managed, or administered by at least one trustee 24862
for the benefit of the grantor or beneficiaries. "Trust" includes 24863
any legal instrument or device similar to a trust. 24864

(2) "Legal instrument or device similar to a trust" includes, but is not limited to, escrow accounts, investment accounts, partnerships, contracts, and other similar arrangements that are not called trusts under state law but are similar to a trust and to which all of the following apply: 24865 24866 24867 24868 24869

(a) The property in the trust is held, managed, retained, or administered by a trustee. 24870 24871

(b) The trustee has an equitable, legal, or fiduciary duty to hold, manage, retain, or administer the property for the benefit of the beneficiary. 24872 24873 24874

(c) The trustee holds identifiable property for the beneficiary. 24875 24876

(3) "Grantor" is a person who creates a trust, including all of the following: 24877 24878

(a) An individual; 24879

(b) An individual's spouse; 24880

(c) A person, including a court or administrative body, with legal authority to act in place of or on behalf of an individual or an individual's spouse; 24881 24882 24883

(d) A person, including a court or administrative body, that acts at the direction or on request of an individual or the individual's spouse. 24884 24885 24886

(4) "Beneficiary" is a person or persons, including a grantor, who benefits in some way from a trust. 24887 24888

(5) "Trustee" is a person who manages a trust's principal and income for the benefit of the beneficiaries. 24889 24890

(6) "Person" has the same meaning as in section 1.59 of the Revised Code and includes an individual, corporation, business trust, estate, trust, partnership, and association. 24891 24892 24893

(7) "Applicant" is an individual who applies for medicaid or the individual's spouse. 24894 24895

(8) "Recipient" is an individual who receives medicaid or the individual's spouse. 24896 24897

(9) "Revocable trust" is a trust that can be revoked by the grantor or the beneficiary, including all of the following, even if the terms of the trust state that it is irrevocable: 24898 24899 24900

(a) A trust that provides that the trust can be terminated only by a court; 24901 24902

(b) A trust that terminates on the happening of an event, but only if the event occurs at the direction or control of the grantor, beneficiary, or trustee. 24903 24904 24905

(10) "Irrevocable trust" is a trust that cannot be revoked by the grantor or terminated by a court and that terminates only on the occurrence of an event outside of the control or direction of the beneficiary or grantor. 24906 24907 24908 24909

(11) "Payment" is any disbursal from the principal or income of the trust, including actual cash, noncash or property disbursements, or the right to use and occupy real property. 24910 24911 24912

(12) "Payments to or for the benefit of the applicant or recipient" is a payment to any person resulting in a direct or indirect benefit to the applicant or recipient. 24913 24914 24915

(13) "Testamentary trust" is a trust that is established by a will and does not take effect until after the death of the person who created the trust. 24916 24917 24918

(C) If an applicant or recipient is a beneficiary of a trust, the county department of job and family services shall determine what type of trust it is and shall treat the trust in accordance with the appropriate provisions of this section and rules adopted by the department of ~~job and family services~~ health care 24919 24920 24921 24922 24923

administration governing trusts. The county department of job and family services may determine that the trust or portion of the trust is one of the following: 24924 24925 24926

(1) A countable resource; 24927

(2) Countable income; 24928

(3) A countable resource and countable income; 24929

(4) Not a countable resource or countable income. 24930

(D)(1) A trust or legal instrument or device similar to a trust shall be considered a medicaid qualifying trust if all of the following apply: 24931 24932 24933

(a) The trust was established on or prior to August 10, 1993. 24934

(b) The trust was not established by a will. 24935

(c) The trust was established by an applicant or recipient. 24936

(d) The applicant or recipient is or may become the beneficiary of all or part of the trust. 24937 24938

(e) Payment from the trust is determined by one or more trustees who are permitted to exercise any discretion with respect to the distribution to the applicant or recipient. 24939 24940 24941

(2) If a trust meets the requirement of division (D)(1) of this section, the amount of the trust that is considered by the county department of job and family services as an available resource to the applicant or recipient shall be the maximum amount of payments permitted under the terms of the trust to be distributed to the applicant or recipient, assuming the full exercise of discretion by the trustee or trustees. The maximum amount shall include only amounts that are permitted to be distributed but are not distributed from either the income or principal of the trust. 24942 24943 24944 24945 24946 24947 24948 24949 24950 24951

(3) Amounts that are actually distributed from a medicaid 24952

qualifying trust to a beneficiary for any purpose shall be treated 24953
in accordance with rules adopted by the department of ~~job and~~ 24954
~~family services~~ health care administration governing income. 24955

(4) Availability of a medicaid qualifying trust shall be 24956
considered without regard to any of the following: 24957

(a) Whether or not the trust is irrevocable or was 24958
established for purposes other than to enable a grantor to qualify 24959
for medicaid, ~~medical assistance~~ medicaid for covered families and 24960
children, or as a qualified medicare beneficiary, specified 24961
low-income medicare beneficiary, qualifying individual-1, or 24962
qualifying individual-2; 24963

(b) Whether or not the trustee actually exercises discretion. 24964

(5) If any real or personal property is transferred to a 24965
medicaid qualifying trust that is not distributable to the 24966
applicant or recipient, the transfer shall be considered an 24967
improper disposition of assets and shall be subject to section 24968
~~5111.0116~~ 5162.21 of the Revised Code and rules to implement that 24969
section adopted under section ~~5111.011~~ 5162.20 of the Revised 24970
Code. 24971

(6) The baseline date for the look-back period for 24972
disposition of assets involving a medicaid qualifying trust shall 24973
be the date on which the applicant or recipient is both 24974
institutionalized and first applies for medicaid. 24975

(E)(1) A trust or legal instrument or device similar to a 24976
trust shall be considered a self-settled trust if all of the 24977
following apply: 24978

(a) The trust was established on or after August 11, 1993. 24979

(b) The trust was not established by a will. 24980

(c) The trust was established by an applicant or recipient, 24981
spouse of an applicant or recipient, or a person, including a 24982

court or administrative body, with legal authority to act in place of or on behalf of an applicant, recipient, or spouse, or acting at the direction or on request of an applicant, recipient, or spouse. 24983 24984 24985 24986

(2) A trust that meets the requirements of division (E)(1) of this section and is a revocable trust shall be treated by the county department of job and family services as follows: 24987 24988 24989

(a) The corpus of the trust shall be considered a resource available to the applicant or recipient. 24990 24991

(b) Payments from the trust to or for the benefit of the applicant or recipient shall be considered unearned income of the applicant or recipient. 24992 24993 24994

(c) Any other payments from the trust shall be considered an improper disposition of assets and shall be subject to section ~~5111.0116~~ 5162.21 of the Revised Code and rules to implement that section adopted under section ~~5111.011~~ 5162.20 of the Revised Code. 24995 24996 24997 24998 24999

(3) A trust that meets the requirements of division (E)(1) of this section and is an irrevocable trust shall be treated by the county department of job and family services as follows: 25000 25001 25002

(a) If there are any circumstances under which payment from the trust could be made to or for the benefit of the applicant or recipient, including a payment that can be made only in the future, the portion from which payments could be made shall be considered a resource available to the applicant or recipient. The county department of job and family services shall not take into account when payments can be made. 25003 25004 25005 25006 25007 25008 25009

(b) Any payment that is actually made to or for the benefit of the applicant or recipient from either the corpus or income shall be considered unearned income. 25010 25011 25012

(c) If a payment is made to someone other than to the applicant or recipient and the payment is not for the benefit of the applicant or recipient, the payment shall be considered an improper disposition of assets and shall be subject to section ~~5111.0116~~ <u>5162.21</u> of the Revised Code and rules to implement that section adopted under section ~~5111.011~~ <u>5162.20</u> of the Revised Code.

(d) The date of the disposition shall be the later of the date of establishment of the trust or the date of the occurrence of the event.

(e) When determining the value of the disposed asset under this provision, the value of the trust shall be its value on the date payment to the applicant or recipient was foreclosed.

(f) Any income earned or other resources added subsequent to the foreclosure date shall be added to the total value of the trust.

(g) Any payments to or for the benefit of the applicant or recipient after the foreclosure date but prior to the application date shall be subtracted from the total value. Any other payments shall not be subtracted from the value.

(h) Any addition of assets after the foreclosure date shall be considered a separate disposition.

(4) If a trust is funded with assets of another person or persons in addition to assets of the applicant or recipient, the applicable provisions of this section and rules adopted by the department of ~~job and family services~~ <u>health care administration</u> governing trusts shall apply only to the portion of the trust attributable to the applicant or recipient.

(5) The availability of a self-settled trust shall be considered without regard to any of the following:

(a) The purpose for which the trust is established; 25043

(b) Whether the trustees have exercised or may exercise discretion under the trust; 25044 25045

(c) Any restrictions on when or whether distributions may be made from the trust; 25046 25047

(d) Any restrictions on the use of distributions from the trust. 25048 25049

(6) The baseline date for the look-back period for dispositions of assets involving a self-settled trust shall be the date on which the applicant or recipient is both institutionalized and first applies for medicaid. 25050 25051 25052 25053

(F) The principal or income from any of the following shall be exempt from being counted as a resource by a county department of job and family services: 25054 25055 25056

(1)(a) A special needs trust that meets all of the following requirements: 25057 25058

(i) The trust contains assets of an applicant or recipient under sixty-five years of age and may contain the assets of other individuals. 25059 25060 25061

(ii) The applicant or recipient is disabled as defined in rules adopted by the department of ~~job and family services~~ health care administration. 25062 25063 25064

(iii) The trust is established for the benefit of the applicant or recipient by a parent, grandparent, legal guardian, or a court. 25065 25066 25067

(iv) The trust requires that on the death of the applicant or recipient the state will receive all amounts remaining in the trust up to an amount equal to the total amount of medicaid paid on behalf of the applicant or recipient. 25068 25069 25070 25071

(b) If a special needs trust meets the requirements of 25072

division (F)(1)(a) of this section and has been established for a disabled applicant or recipient under sixty-five years of age, the exemption for the trust granted pursuant to division (F) of this section shall continue after the disabled applicant or recipient becomes sixty-five years of age if the applicant or recipient continues to be disabled as defined in rules adopted by the department of ~~job and family services~~ health care administration. Except for income earned by the trust, the grantor shall not add to or otherwise augment the trust after the applicant or recipient attains sixty-five years of age. An addition or augmentation of the trust by the applicant or recipient with the applicant's own assets after the applicant or recipient attains sixty-five years of age shall be treated as an improper disposition of assets. 25073 25074 25075 25076 25077 25078 25079 25080 25081 25082 25083 25084 25085

(c) Cash distributions to the applicant or recipient shall be counted as unearned income. All other distributions from the trust shall be treated as provided in rules adopted by the department of ~~job and family services~~ health care administration governing in-kind income. 25086 25087 25088 25089 25090

(d) Transfers of assets to a special needs trust shall not be treated as an improper transfer of resources. Assets held prior to the transfer to the trust shall be considered as countable assets or countable income or countable assets and income. 25091 25092 25093 25094

(2)(a) A qualifying income trust that meets all of the following requirements: 25095 25096

(i) The trust is composed only of pension, social security, and other income to the applicant or recipient, including accumulated interest in the trust. 25097 25098 25099

(ii) The income is received by the individual and the right to receive the income is not assigned or transferred to the trust. 25100 25101

(iii) The trust requires that on the death of the applicant or recipient the state will receive all amounts remaining in the 25102 25103

trust up to an amount equal to the total amount of medicaid paid 25104
on behalf of the applicant or recipient. 25105

(b) No resources shall be used to establish or augment the 25106
trust. 25107

(c) If an applicant or recipient has irrevocably transferred 25108
or assigned the applicant's or recipient's right to receive income 25109
to the trust, the trust shall not be considered a qualifying 25110
income trust by the county department of job and family services. 25111

(d) Income placed in a qualifying income trust shall not be 25112
counted in determining an applicant's or recipient's eligibility 25113
for medicaid. The recipient of the funds may place any income 25114
directly into a qualifying income trust without those funds 25115
adversely affecting the applicant's or recipient's eligibility for 25116
medicaid. Income generated by the trust that remains in the trust 25117
shall not be considered as income to the applicant or recipient. 25118

(e) All income placed in a qualifying income trust shall be 25119
combined with any countable income not placed in the trust to 25120
arrive at a base income figure to be used for spend down 25121
calculations. 25122

(f) The base income figure shall be used for post-eligibility 25123
deductions, including personal needs allowance, monthly income 25124
allowance, family allowance, and medical expenses not subject to 25125
third party payment. Any income remaining shall be used toward 25126
payment of patient liability. Payments made from a qualifying 25127
income trust shall not be combined with the base income figure for 25128
post-eligibility calculations. 25129

(g) The base income figure shall be used when determining the 25130
spend down budget for the applicant or recipient. Any income 25131
remaining after allowable deductions are permitted as provided 25132
under rules adopted by the department of ~~job and family services~~ 25133
health care administration shall be considered the applicant's or 25134

recipient's spend down liability. 25135

(3)(a) A pooled trust that meets all of the following requirements: 25136 25137

(i) The trust contains the assets of the applicant or recipient of any age who is disabled as defined in rules adopted by the department of ~~job and family services~~ health care administration. 25138 25139 25140 25141

(ii) The trust is established and managed by a nonprofit association. 25142 25143

(iii) A separate account is maintained for each beneficiary of the trust but, for purposes of investment and management of funds, the trust pools the funds in these accounts. 25144 25145 25146

(iv) Accounts in the trust are established by the applicant or recipient, the applicant's or recipient's parent, grandparent, or legal guardian, or a court solely for the benefit of individuals who are disabled. 25147 25148 25149 25150

(v) The trust requires that, to the extent that any amounts remaining in the beneficiary's account on the death of the beneficiary are not retained by the trust, the trust pay to the state the amounts remaining in the trust up to an amount equal to the total amount of medicaid paid on behalf of the beneficiary. 25151 25152 25153 25154 25155

(b) Cash distributions to the applicant or recipient shall be counted as unearned income. All other distributions from the trust shall be treated as provided in rules adopted by the department of ~~job and family services~~ health care administration governing in-kind income. 25156 25157 25158 25159 25160

(c) Transfers of assets to a pooled trust shall not be treated as an improper disposition of assets. Assets held prior to the transfer to the trust shall be considered as countable assets, countable income, or countable assets and income. 25161 25162 25163 25164

(4) A supplemental services trust that meets the requirements of section 5815.28 of the Revised Code and to which all of the following apply: 25165 25166 25167

(a) A person may establish a supplemental services trust pursuant to section 5815.28 of the Revised Code only for another person who is eligible to receive services through one of the following agencies: 25168 25169 25170 25171

(i) The department of mental retardation and developmental disabilities; 25172 25173

(ii) A county board of mental retardation and developmental disabilities; 25174 25175

(iii) The department of mental health; 25176

(iv) A board of alcohol, drug addiction, and mental health services. 25177 25178

(b) A county department of job and family services shall not determine eligibility for another agency's program. An applicant or recipient shall do one of the following: 25179 25180 25181

(i) Provide documentation from one of the agencies listed in division (F)(4)(a) of this section that establishes that the applicant or recipient was determined to be eligible for services from the agency at the time of the creation of the trust; 25182 25183 25184 25185

(ii) Provide an order from a court of competent jurisdiction that states that the applicant or recipient was eligible for services from one of the agencies listed in division (F)(4)(a) of this section at the time of the creation of the trust. 25186 25187 25188 25189

(c) At the time the trust is created, the trust principal does not exceed the maximum amount permitted. The maximum amount permitted in calendar year 2006 is two hundred twenty-two thousand dollars. Each year thereafter, the maximum amount permitted is the prior year's amount plus two thousand dollars. 25190 25191 25192 25193 25194

(d) A county department of job and family services shall review the trust to determine whether it complies with the provisions of section 5815.28 of the Revised Code. 25195 25196 25197

(e) Payments from supplemental services trusts shall be exempt as long as the payments are for supplemental services as defined in rules adopted by the department of ~~job and family services~~ health care administration. All supplemental services shall be purchased by the trustee and shall not be purchased through direct cash payments to the beneficiary. 25198 25199 25200 25201 25202 25203

(f) If a trust is represented as a supplemental services trust and a county department of job and family services determines that the trust does not meet the requirements provided in division (F)(4) of this section and section 5815.28 of the Revised Code, the county department of job and family services shall not consider it an exempt trust. 25204 25205 25206 25207 25208 25209

(G)(1) A trust or legal instrument or device similar to a trust shall be considered a trust established by an individual for the benefit of the applicant or recipient if all of the following apply: 25210 25211 25212 25213

(a) The trust is created by a person other than the applicant or recipient. 25214 25215

(b) The trust names the applicant or recipient as a beneficiary. 25216 25217

(c) The trust is funded with assets or property in which the applicant or recipient has never held an ownership interest prior to the establishment of the trust. 25218 25219 25220

(2) Any portion of a trust that meets the requirements of division (G)(1) of this section shall be an available resource only if the trust permits the trustee to expend principal, corpus, or assets of the trust for the applicant's or recipient's medical care, care, comfort, maintenance, health, welfare, general well 25221 25222 25223 25224 25225

being, or any combination of these purposes. 25226

(3) A trust that meets the requirements of division (G)(1) of this section shall be considered an available resource even if the trust contains any of the following types of provisions: 25227 25228 25229

(a) A provision that prohibits the trustee from making payments that would supplant or replace medicaid or other public assistance; 25230 25231 25232

(b) A provision that prohibits the trustee from making payments that would impact or have an effect on the applicant's or recipient's right, ability, or opportunity to receive medicaid or other public assistance; 25233 25234 25235 25236

(c) A provision that attempts to prevent the trust or its corpus or principal from being counted as an available resource. 25237 25238

(4) A trust that meets the requirements of division (G)(1) of this section shall not be counted as an available resource if at least one of the following circumstances applies: 25239 25240 25241

(a) If a trust contains a clear statement requiring the trustee to preserve a portion of the trust for another beneficiary or remainderman, that portion of the trust shall not be counted as an available resource. Terms of a trust that grant discretion to preserve a portion of the trust shall not qualify as a clear statement requiring the trustee to preserve a portion of the trust. 25242 25243 25244 25245 25246 25247 25248

(b) If a trust contains a clear statement requiring the trustee to use a portion of the trust for a purpose other than medical care, care, comfort, maintenance, welfare, or general well being of the applicant or recipient, that portion of the trust shall not be counted as an available resource. Terms of a trust that grant discretion to limit the use of a portion of the trust shall not qualify as a clear statement requiring the trustee to use a portion of the trust for a particular purpose. 25249 25250 25251 25252 25253 25254 25255 25256

(c) If a trust contains a clear statement limiting the 25257
trustee to making fixed periodic payments, the trust shall not be 25258
counted as an available resource and payments shall be treated in 25259
accordance with rules adopted by the department of ~~job and family~~ 25260
~~services~~ health care administration governing income. Terms of a 25261
trust that grant discretion to limit payments shall not qualify as 25262
a clear statement requiring the trustee to make fixed periodic 25263
payments. 25264

(d) If a trust contains a clear statement that requires the 25265
trustee to terminate the trust if it is counted as an available 25266
resource, the trust shall not be counted as an available resource. 25267
Terms of a trust that grant discretion to terminate the trust do 25268
not qualify as a clear statement requiring the trustee to 25269
terminate the trust. 25270

(e) If a person obtains a judgment from a court of competent 25271
jurisdiction that expressly prevents the trustee from using part 25272
or all of the trust for the medical care, care, comfort, 25273
maintenance, welfare, or general well being of the applicant or 25274
recipient, the trust or that portion of the trust subject to the 25275
court order shall not be counted as a resource. 25276

(f) If a trust is specifically exempt from being counted as 25277
an available resource by a provision of the Revised Code, rules, 25278
or federal law, the trust shall not be counted as a resource. 25279

(g) If an applicant or recipient presents a final judgment 25280
from a court demonstrating that the applicant or recipient was 25281
unsuccessful in a civil action against the trustee to compel 25282
payments from the trust, the trust shall not be counted as an 25283
available resource. 25284

(h) If an applicant or recipient presents a final judgment 25285
from a court demonstrating that in a civil action against the 25286
trustee the applicant or recipient was only able to compel limited 25287

or periodic payments, the trust shall not be counted as an available resource and payments shall be treated in accordance with rules adopted by the department of ~~job and family services~~ health care administration governing income. 25288 25289 25290 25291

(i) If an applicant or recipient provides written documentation showing that the cost of a civil action brought to compel payments from the trust would be cost prohibitive, the trust shall not be counted as an available resource. 25292 25293 25294 25295

(5) Any actual payments to the applicant or recipient from a trust that meet the requirements of division (G)(1) of this section, including trusts that are not counted as an available resource, shall be treated as provided in rules adopted by the department of ~~job and family services~~ health care administration governing income. Payments to any person other than the applicant or recipient shall not be considered income to the applicant or recipient. Payments from the trust to a person other than the applicant or recipient shall not be considered an improper disposition of assets. 25296 25297 25298 25299 25300 25301 25302 25303 25304 25305

Sec. ~~5111.181~~ 5162.30. (A) The general assembly hereby finds that the state has an insurable interest in ~~medical assistance~~ medicaid recipients because of the state's statutory right to recover from the estate of a recipient state funds used to provide the recipient with medical care and services. 25306 25307 25308 25309 25310

(B) As used in this section: 25311

(1) "Beneficiary" means the person or entity designated in a life insurance policy to receive the proceeds of the policy on the death of the insured or maturity of the policy. 25312 25313 25314

(2) "Owner" means the person who has the right to designate the beneficiary of a life insurance policy and to change the designation. 25315 25316 25317

(C) Notwithstanding section ~~5111.011~~ 5162.20 of the Revised 25318
Code, the value of a life insurance policy that would otherwise be 25319
considered a resource in determining eligibility for the ~~medical~~ 25320
~~assistance~~ medicaid program shall be excluded from any 25321
determination of a person's eligibility for the ~~medical assistance~~ 25322
medicaid program if the owner designates the department of ~~job and~~ 25323
~~family services~~ health care administration as beneficiary of the 25324
policy. The department may pay premiums to keep the policy in 25325
force. Premiums paid by the department are ~~medical assistance~~ 25326
medicaid payments correctly paid on behalf of a ~~medical assistance~~ 25327
medicaid recipient and subject to recovery under section ~~5111.11~~ 25328
5162.40 of the Revised Code. 25329

(D) The director of ~~job and family services~~ health care 25330
administration shall deposit the proceeds of a life insurance 25331
policy that do not exceed the amount the department may recover 25332
against the property and estate of the owner under section ~~5111.11~~ 25333
5162.40 of the Revised Code into the general revenue fund. The 25334
director shall pay any remaining proceeds to the person designated 25335
by the owner. If the owner failed to designate a person, the 25336
director shall pay the remaining proceeds to the surviving spouse, 25337
or, if there is no surviving spouse, to the estate of the owner. 25338

(E) If the owner designates the department of ~~job and family~~ 25339
~~services~~ health care administration as the policy's beneficiary, 25340
the department shall notify the owner that the owner may designate 25341
a person to receive proceeds of the policy that exceed the amount 25342
the department may recover against the owner's property and estate 25343
under section ~~5111.11~~ 5162.40 of the Revised Code. The designation 25344
shall be made on a form provided by the department. 25345

(F) The department of ~~job and family services~~ health care 25346
administration shall not implement this section if implementation 25347
would violate any federal requirement unless the department 25348
receives a waiver of the requirement from the United States 25349

department of health and human services. 25350

Sec. ~~5111.0112~~ 5162.35. (A) The director of ~~job and family services~~ health care administration shall institute a cost-sharing program under the medicaid program. In instituting the cost-sharing program, the director shall comply with federal law. In the case of an individual participating in the children's buy-in program ~~established under sections 5101.5211 to 5101.5216 of the Revised Code~~, the cost-sharing program shall be consistent with sections ~~5101.5213~~ 5167.37 and ~~5101.5214~~ 5167.38 of the Revised Code if the children's buy-in program is a component of the medicaid program. The cost-sharing program shall establish a copayment requirement for at least dental services, vision services, nonemergency emergency department services, and prescription drugs, other than generic drugs. The cost-sharing program shall establish requirements regarding premiums, enrollment fees, deductions, and similar charges. The director shall adopt rules under section ~~5111.02~~ 5162.20 of the Revised Code governing the cost-sharing program. 25351 25352 25353 25354 25355 25356 25357 25358 25359 25360 25361 25362 25363 25364 25365 25366 25367

(B) The cost-sharing program shall, to the extent permitted by federal law, provide for all of the following with regard to any providers participating in the medicaid program: 25368 25369 25370

(1) No provider shall refuse to provide a service to a medicaid recipient who is unable to pay a required copayment for the service. 25371 25372 25373

(2) Division (B)(1) of this section shall not be considered to do either of the following with regard to a medicaid recipient who is unable to pay a required copayment: 25374 25375 25376

(a) Relieve the medicaid recipient from the obligation to pay a copayment; 25377 25378

(b) Prohibit the provider from attempting to collect an 25379

unpaid copayment. 25380

(3) Except as provided in division (C) of this section, no 25381
provider shall waive a medicaid recipient's obligation to pay the 25382
provider a copayment. 25383

(4) No provider or drug manufacturer, including the 25384
manufacturer's representative, employee, independent contractor, 25385
or agent, shall pay any copayment on behalf of a medicaid 25386
recipient. 25387

(5) If it is the routine business practice of the provider to 25388
refuse service to any individual who owes an outstanding debt to 25389
the provider, the provider may consider an unpaid copayment 25390
imposed by the cost-sharing program as an outstanding debt and may 25391
refuse service to a medicaid recipient who owes the provider an 25392
outstanding debt. If the provider intends to refuse service to a 25393
medicaid recipient who owes the provider an outstanding debt, the 25394
provider shall notify the individual of the provider's intent to 25395
refuse services. 25396

(C) In the case of a provider that is a hospital, the 25397
cost-sharing program shall permit the hospital to take action to 25398
collect a copayment by providing, at the time services are 25399
rendered to a medicaid recipient, notice that a copayment may be 25400
owed. If the hospital provides the notice and chooses not to take 25401
any further action to pursue collection of the copayment, the 25402
prohibition against waiving copayments specified in division 25403
(B)(3) of this section does not apply. 25404

(D) The department of ~~job and family services~~ health care 25405
administration may work with a state agency that is administering, 25406
pursuant to a contract entered into under section ~~5111.91~~ 5161.05 25407
of the Revised Code, one or more components of the medicaid 25408
program or one or more aspects of a component as necessary for the 25409
state agency to apply the cost-sharing program to the components 25410

or aspects of the medicaid program that the state agency administers.

Sec. ~~5111.114~~ 5162.36. As used in this section, "nursing facility" and "intermediate care facility for the mentally retarded" have the same meanings as in section ~~5111.20~~ 5164.01 of the Revised Code.

In determining the amount of income that a medicaid recipient ~~of medical assistance~~ must apply monthly toward payment of the cost of care in a nursing facility or intermediate care facility for the mentally retarded, the county department of job and family services shall deduct from the recipient's monthly income a monthly personal needs allowance in accordance with ~~section 1902 of the "Social Security Act," 49 Stat. 620 (1935),~~ 42 U.S.C.~~A. 1396a, as amended~~ 1396a(q).

For a resident of a nursing facility, the monthly personal needs allowance shall be not less than forty dollars for an individual resident and not less than eighty dollars for a married couple if both spouses are residents of a nursing facility.

For a resident of an intermediate care facility for the mentally retarded, the monthly personal needs allowance shall be forty dollars unless the resident has earned income, in which case the monthly personal needs allowance shall be determined by the ~~state~~ department of ~~job and family services~~ health care administration but shall not exceed one hundred five dollars.

Sec. ~~5111.113~~ 5162.37. (A) As used in this section:

(1) "Adult care facility" has the same meaning as in section 3722.01 of the Revised Code.

(2) "Commissioner" means a person appointed by a probate court under division (B) of section 2113.03 of the Revised Code to act as a commissioner.

(3) "Home" has the same meaning as in section 3721.10 of the 25441
Revised Code. 25442

(4) "Personal needs allowance account" means an account or 25443
petty cash fund that holds the money of a resident of an adult 25444
care facility or home and that the facility or home manages for 25445
the resident. 25446

(B) Except as provided in divisions (C) and (D) of this 25447
section, the owner or operator of an adult care facility or home 25448
shall transfer to the department of ~~job and family services~~ health 25449
care administration the money in the personal needs allowance 25450
account of a resident of the facility or home who was a medicaid 25451
recipient ~~of the medical assistance program~~ no earlier than sixty 25452
days but not later than ninety days after the resident dies. The 25453
adult care facility or home shall transfer the money even though 25454
the owner or operator of the facility or home has not been issued 25455
letters testamentary or letters of administration concerning the 25456
resident's estate. 25457

(C) If funeral or burial expenses for a resident of an adult 25458
care facility or home who has died have not been paid and the only 25459
resource the resident had that could be used to pay for the 25460
expenses is the money in the resident's personal needs allowance 25461
account, or all other resources of the resident are inadequate to 25462
pay the full cost of the expenses, the money in the resident's 25463
personal needs allowance account shall be used to pay for the 25464
expenses rather than being transferred to the department of ~~job~~ 25465
~~and family services~~ health care administration pursuant to 25466
division (B) of this section. 25467

(D) If, not later than sixty days after a resident of an 25468
adult care facility or home dies, letters testamentary or letters 25469
of administration are issued, or an application for release from 25470
administration is filed under section 2113.03 of the Revised Code, 25471
concerning the resident's estate, the owner or operator of the 25472

facility or home shall transfer the money in the resident's personal needs allowance account to the administrator, executor, commissioner, or person who filed the application for release from administration.

(E) The transfer or use of money in a resident's personal needs allowance account in accordance with division (B), (C), or (D) of this section discharges and releases the adult care facility or home, and the owner or operator of the facility or home, from any claim for the money from any source.

(F) If, sixty-one or more days after a resident of an adult care facility or home dies, letters testamentary or letters of administration are issued, or an application for release from administration under section 2113.03 of the Revised Code is filed, concerning the resident's estate, the department of ~~job and family services~~ health care administration shall transfer the funds to the administrator, executor, commissioner, or person who filed the application, unless the department is entitled to recover the money under the medicaid estate recovery program instituted under section ~~5111.11~~ 5162.40 of the Revised Code.

Sec. ~~5111.11~~ 5162.40. (A) As used in this section and section 5111.111 of the Revised Code:

(1) "Estate" includes both of the following:

(a) All real and personal property and other assets to be administered under Title XXI of the Revised Code and property that would be administered under that title if not for section 2113.03 or 2113.031 of the Revised Code;

(b) Any other real and personal property and other assets in which an individual had any legal title or interest at the time of death (to the extent of the interest), including assets conveyed to a survivor, heir, or assign of the individual through joint

tenancy, tenancy in common, survivorship, life estate, living trust, or other arrangement. 25503 25504

(2) "Institution" means a nursing facility, intermediate care facility for the mentally retarded, or a medical institution. 25505 25506

(3) "Intermediate care facility for the mentally retarded" and "nursing facility" have the same meanings as in section ~~5111.20~~ 5164.01 of the Revised Code. 25507 25508 25509

(4) "Permanently institutionalized individual" means an individual to whom all of the following apply: 25510 25511

(a) Is an inpatient in an institution; 25512

(b) Is required, as a condition of the medicaid program paying for the individual's services in the institution, to spend for costs of medical or nursing care all of the individual's income except for an amount for personal needs specified by the department of ~~job and family services~~ health care administration; 25513 25514 25515 25516 25517

(c) Cannot reasonably be expected to be discharged from the institution and return home as determined by the department of ~~job and family services~~ health care administration. 25518 25519 25520

(5) "Qualified state long-term care insurance partnership program" means the program established under section ~~5111.18~~ 5162.43 of the Revised Code. 25521 25522 25523

(6) "Time of death" shall not be construed to mean a time after which a legal title or interest in real or personal property or other asset may pass by survivorship or other operation of law due to the death of the decedent or terminate by reason of the decedent's death. 25524 25525 25526 25527 25528

(B) To the extent permitted by federal law, the department of ~~job and family services~~ health care administration shall institute a medicaid estate recovery program under which the department shall, except as provided in divisions (C) and (E) of this 25529 25530 25531 25532

section, and subject to division (D) of this section, do all of the following: 25533 25534

(1) For the costs of medicaid services the medicaid program correctly paid or will pay on behalf of a permanently institutionalized individual of any age, seek adjustment or recovery from the individual's estate or on the sale of property of the individual or spouse that is subject to a lien imposed under section ~~5111.111~~ 5162.41 of the Revised Code; 25535 25536 25537 25538 25539 25540

(2) For the costs of medicaid services the medicaid program correctly paid or will pay on behalf of an individual fifty-five years of age or older who is not a permanently institutionalized individual, seek adjustment or recovery from the individual's estate; 25541 25542 25543 25544 25545

(3) Seek adjustment or recovery from the estate of other individuals as permitted by federal law. 25546 25547

(C)(1) No adjustment or recovery may be made under division (B)(1) of this section from a permanently institutionalized individual's estate or on the sale of property of a permanently institutionalized individual that is subject to a lien imposed under section ~~5111.111~~ 5162.41 of the Revised Code or under division (B)(2) or (3) of this section from an individual's estate while either of the following are alive: 25548 25549 25550 25551 25552 25553 25554

(a) The spouse of the permanently institutionalized individual or individual; 25555 25556

(b) The son or daughter of a permanently institutionalized individual or individual if the son or daughter is under age twenty-one or, under 42 U.S.C. 1382c, is considered blind or disabled. 25557 25558 25559 25560

(2) No adjustment or recovery may be made under division (B)(1) of this section from a permanently institutionalized individual's home that is subject to a lien imposed under section 25561 25562 25563

~~5111.111~~ 5162.41 of the Revised Code while either of the following lawfully reside in the home: 25564 25565

(a) The permanently institutionalized individual's sibling who resided in the home for at least one year immediately before the date of the permanently institutionalized individual's admission to the institution and on a continuous basis since that time; 25566 25567 25568 25569 25570

(b) The permanently institutionalized individual's son or daughter who provided care to the permanently institutionalized individual that delayed the permanently institutionalized individual's institutionalization and resided in the home for at least two years immediately before the date of the permanently institutionalized individual's admission to the institution and on a continuous basis since that time. 25571 25572 25573 25574 25575 25576 25577

(D) In the case of a participant of the qualified state long-term care insurance partnership program, adjustment or recovery required by this section may be reduced in accordance with rules adopted under division (G) of this section. 25578 25579 25580 25581

(E) The department shall, in accordance with procedures and criteria established in rules adopted under division (G) of this section, waive seeking an adjustment or recovery otherwise required by this section if the director of ~~job and family services~~ health care administration determines that adjustment or recovery would work an undue hardship. The department may limit the duration of the waiver to the period during which the undue hardship exists. 25582 25583 25584 25585 25586 25587 25588 25589

(F) For the purpose of determining whether an individual meets the definition of "permanently institutionalized individual" established for this section, a rebuttable presumption exists that the individual cannot reasonably be expected to be discharged from an institution and return home if either of the following is the 25590 25591 25592 25593 25594

case: 25595

(1) The individual declares that he or she does not intend to return home. 25596 25597

(2) The individual has been an inpatient in an institution for at least six months. 25598 25599

(G) The director of ~~job and family services~~ health care administration shall adopt rules in accordance with Chapter 119. of the Revised Code regarding the medicaid estate recovery program, including rules that do both of the following: 25600 25601 25602 25603

(1) For the purpose of division (D) of this section and consistent with 42 U.S.C. 1396p(b)(1)(C), provide for reducing an adjustment or recovery in the case of a participant of the qualified state long-term care insurance partnership program; 25604 25605 25606 25607

(2) For the purpose of division (E) of this section and consistent with the standards specified by the United States secretary of health and human services under 42 U.S.C. 1396p(b)(3), establish procedures and criteria for waiving adjustment or recovery due to an undue hardship. 25608 25609 25610 25611 25612

Sec. ~~5111.111~~ 5162.41. (A) Except as provided in division (B) of this section and section ~~5111.12~~ 5162.45 of the Revised Code, no lien may be imposed against the property of an individual before the individual's death on account of medicaid services correctly paid or to be paid on the individual's behalf. 25613 25614 25615 25616 25617

(B) Except as provided in division (C) of this section, the department of ~~job and family services~~ health care administration may impose a lien against the real property of a medicaid recipient who is a permanently institutionalized individual and against the real property of the recipient's spouse, including any real property that is jointly held by the recipient and spouse. The lien may be imposed on account of medicaid paid or to be paid 25618 25619 25620 25621 25622 25623 25624

on the recipient's behalf. 25625

(C) No lien may be imposed under division (B) of this section against the home of a medicaid recipient if any of the following lawfully resides in the home: 25626 25627 25628

(1) The recipient's spouse; 25629

(2) The recipient's son or daughter who is under twenty-one years of age or, under 42 U.S.C. 1382c, considered to be blind or disabled; 25630 25631 25632

(3) The recipient's sibling who has an equity interest in the home and resided in the home for at least one year immediately before the date of the recipient's admission to the institution. 25633 25634 25635

(D) The director of ~~job and family services~~ health care administration or a person designated by the director shall sign a certificate to effectuate a lien required to be imposed under this section. The county department of job and family services shall file for recording and indexing the certificate, or a certified copy, in the real estate mortgage records in the office of the county recorder in every county in which real property of the recipient or spouse is situated. From the time of filing the certificate in the office of the county recorder, the lien attaches to all real property of the recipient or spouse described in the certificate for all amounts for which adjustment or recovery may be made under section ~~5111.11~~ 5162.40 of the Revised Code and, except as provided in division (E) of this section, shall remain a lien until satisfied. 25636 25637 25638 25639 25640 25641 25642 25643 25644 25645 25646 25647 25648 25649

Upon filing the certificate in the office of the recorder, all persons are charged with notice of the lien and the rights of the department of ~~job and family services~~ health care administration thereunder. 25650 25651 25652 25653

The county recorder shall keep a record of every certificate filed showing its date, the time of filing, the name and residence 25654 25655

of the recipient or spouse, and any release, waivers, or 25656
satisfaction of the lien. 25657

The priority of the lien shall be established in accordance 25658
with state and federal law. 25659

The department may waive the priority of its lien to provide 25660
for the costs of the last illness as determined by the department, 25661
administration, attorney fees, administrator fees, a sum for the 25662
payment of the costs of burial, which shall be computed by 25663
deducting from five hundred dollars whatever amount is available 25664
for the same purpose from all other sources, and a similar sum for 25665
the spouse of the decedent. 25666

(E) A lien imposed with respect to a medicaid recipient under 25667
this section shall dissolve on the recipient's discharge from the 25668
institution and return home. 25669

Sec. ~~5111.112~~ 5162.42. The department of ~~job and family~~ 25670
~~services~~ health care administration shall certify amounts due 25671
under the medicaid estate recovery program instituted under 25672
section ~~5111.11~~ 5162.40 of the Revised Code to the attorney 25673
general pursuant to section 131.02 of the Revised Code. The 25674
attorney general may enter into a contract with any person or 25675
government entity to collect the amounts due on behalf of the 25676
attorney general. 25677

The attorney general, in entering into a contract under this 25678
section, shall comply with all of the requirements that must be 25679
met for the state to receive federal financial participation for 25680
the costs incurred in entering into the contract and carrying out 25681
actions under the contract. The contract may provide for the 25682
person or government entity with which the attorney general 25683
contracts to be compensated from the property recovered under the 25684
medicaid estate recovery program or may provide for another manner 25685
of compensation agreed to by the parties to the contract. 25686

Regardless of whether the attorney general collects the 25687
amounts due under the medicaid estate recovery program or 25688
contracts with a person or government entity to collect the 25689
amounts due on behalf of the attorney general, the amounts due 25690
shall be collected in accordance with applicable requirements of 25691
federal statutes and regulations and state statutes and rules. 25692

Sec. ~~5111.18~~ 5162.43. Not later than September 1, 2007, the 25693
director of ~~job and family services~~ health care administration 25694
shall establish a qualified state long-term care insurance 25695
partnership program consistent with the definition of that term in 25696
42 U.S.C. 1396p(b)(1)(C)(iii). An individual participating in the 25697
program who is subject to the medicaid estate recovery program 25698
instituted under section ~~5111.11~~ 5162.40 of the Revised Code shall 25699
be eligible for the reduced adjustment or recovery under division 25700
(D) of that section. 25701

The director of ~~job and family services~~ health care 25702
administration may adopt rules in accordance with Chapter 119. of 25703
the Revised Code as necessary to implement this section. 25704

Sec. ~~5111.12~~ 5162.45. (A) The director of ~~job and family~~ 25705
~~services~~ health care administration shall establish rules under 25706
which county departments of job and family services may take 25707
action to recover benefits incorrectly paid on behalf of medicaid 25708
recipients ~~of medical assistance~~. The rules shall provide for 25709
recovery by the following methods: 25710

(1) Soliciting voluntary payments from recipients or from 25711
persons holding property in which a recipient has a legal or 25712
equitable interest; 25713

(2) Obtaining a lien on property pursuant to division (B) of 25714
this section. 25715

(B) A county department of job and family services may bring 25716

a civil action in a court of common pleas against a medicaid recipient ~~of medical assistance~~ for the recovery of any ~~medical assistance~~ medicaid benefits determined by the court to have been paid incorrectly on behalf of the recipient. All persons holding property in which the recipient has a legal or equitable interest may be joined as parties. The court may issue pre-judgment orders, including injunctive relief or attachment under Chapter 2715. of the Revised Code, for the preservation of real or personal property in which the recipient may have a legal or equitable interest. If the court determines that benefits were paid incorrectly and issues a judgment to that effect, the county department may obtain a lien upon property of the recipient in accordance with Chapter 2329. of the Revised Code. 25717 25718 25719 25720 25721 25722 25723 25724 25725 25726 25727 25728 25729

(C) The county department of job and family services shall retain fifty per cent of the balance remaining after deduction from the recovery of the amount required to be returned to the federal government and shall pay the other fifty per cent of the balance to the department of ~~job and family services~~ health care administration. 25730 25731 25732 25733 25734 25735

(D) Recovery of ~~medical assistance~~ medicaid benefits incorrectly paid to a recipient may not be accomplished by reducing the amount of benefits the recipient is entitled to receive under another government assistance program. 25736 25737 25738 25739

(E) The remedies provided pursuant to this section do not affect any other remedies county departments of job and family services may have to recover benefits incorrectly paid on behalf of medicaid recipients ~~of medical assistance~~. 25740 25741 25742 25743

Sec. ~~5111.06~~ 5163.01. (A)(1) As used in this section and in sections ~~5111.061~~ 5163.07 and ~~5111.062~~ 5163.09 of the Revised Code: 25744 25745 25746

(a) "Provider" means any person, institution, or entity that 25747

furnishes medicaid services under a medicaid provider agreement with the department of ~~job and family services pursuant to Title XIX of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended~~ health care administration.

(b) "Party" has the same meaning as in division (G) of section 119.01 of the Revised Code.

(c) "Adjudication" has the same meaning as in division (D) of section 119.01 of the Revised Code.

(2) This section does not apply to any action taken by the department of ~~job and family services~~ health care administration under sections ~~5111.35~~ 5164.50 to ~~5111.62~~ 5164.78 of the Revised Code.

(B) Except as provided in division (D) of this section and section ~~5111.914~~ 5163.06 of the Revised Code, the department shall do either of the following by issuing an order pursuant to an adjudication conducted in accordance with Chapter 119. of the Revised Code:

(1) Enter into or refuse to enter into a medicaid provider agreement with a provider, or suspend, terminate, renew, or refuse to renew an existing medicaid provider agreement with a provider;

(2) Take any action based upon a final fiscal audit of a provider.

(C) Any party who is adversely affected by the issuance of an adjudication order under division (B) of this section may appeal to the court of common pleas of Franklin county in accordance with section 119.12 of the Revised Code.

(D) The department is not required to comply with division (B)(1) of this section whenever any of the following occur:

(1) The terms of a medicaid provider agreement require the provider to hold a license, permit, or certificate or maintain a

certification issued by an official, board, commission, 25778
department, division, bureau, or other agency of state or federal 25779
government other than the department of ~~job and family services~~ 25780
health care administration, and the license, permit, certificate, 25781
or certification has been denied, revoked, not renewed, suspended, 25782
or otherwise limited. 25783

(2) The terms of a medicaid provider agreement require the 25784
provider to hold a license, permit, or certificate or maintain 25785
certification issued by an official, board, commission, 25786
department, division, bureau, or other agency of state or federal 25787
government other than the department of ~~job and family services~~ 25788
health care administration, and the provider has not obtained the 25789
license, permit, certificate, or certification. 25790

(3) The medicaid provider agreement is denied, terminated, or 25791
not renewed due to the termination, refusal to renew, or denial of 25792
a license, permit, certificate, or certification by an official, 25793
board, commission, department, division, bureau, or other agency 25794
of this state other than the department of ~~job and family services~~ 25795
health care administration, notwithstanding the fact that the 25796
provider may hold a license, permit, certificate, or certification 25797
from an official, board, commission, department, division, bureau, 25798
or other agency of another state. 25799

(4) The medicaid provider agreement is denied, terminated, or 25800
not renewed pursuant to division (C) or (F) of section ~~5111.03~~ 25801
5163.03 of the Revised Code; 25802

(5) The medicaid provider agreement is denied, terminated, or 25803
not renewed due to the provider's termination, suspension, or 25804
exclusion from the medicare program ~~established under Title XVIII~~ 25805
~~of the "Social Security Act,"~~ and the termination, suspension, or 25806
exclusion is binding on the provider's participation in the 25807
medicaid program; 25808

(6) The medicaid provider agreement is denied, terminated, or not renewed due to the provider's pleading guilty to or being convicted of a criminal activity materially related to either the medicare or medicaid program; 25809 25810 25811 25812

(7) The medicaid provider agreement is denied, terminated, or suspended as a result of action by the United States department of health and human services and that action is binding on the provider's participation in the medicaid program; 25813 25814 25815 25816

(8) The medicaid provider agreement is suspended pursuant to section ~~5111.031~~ 5163.031 of the Revised Code pending indictment of the provider. 25817 25818 25819

(9) The medicaid provider agreement is denied, terminated, or not renewed because the provider has been convicted of one of the offenses that caused the provider agreement to be suspended pursuant to section ~~5111.031~~ 5163.031 of the Revised Code. 25820 25821 25822 25823

(10) The medicaid provider agreement is converted under section ~~5111.028~~ 5163.011 of the Revised Code from a provider agreement that is not time-limited to a provider agreement that is time-limited. 25824 25825 25826 25827

(11) The medicaid provider agreement is terminated or an application for re-enrollment is denied because the provider has failed to apply for re-enrollment within the time or in the manner specified for re-enrollment pursuant to section ~~5111.028~~ 5163.011 of the Revised Code. 25828 25829 25830 25831 25832

(12) The medicaid provider agreement is terminated or not renewed because the provider has not billed or otherwise submitted a medicaid claim to the department for two years or longer, and the department has determined that the provider has moved from the address on record with the department without leaving an active forwarding address with the department. 25833 25834 25835 25836 25837 25838

In the case of a provider described in division (D)(12) of 25839

this section, the department may terminate or not renew the 25840
medicaid provider agreement by sending a notice explaining the 25841
department's proposed action to the address on record with the 25842
department. The notice may be sent by regular mail. 25843

(E) The department may withhold payments for services 25844
rendered by a medicaid provider under the ~~medical assistance~~ 25845
medicaid program during the pendency of proceedings initiated 25846
under division (B)(1) of this section. If the proceedings are 25847
initiated under division (B)(2) of this section, the department 25848
may withhold payments only to the extent that they equal amounts 25849
determined in a final fiscal audit as being due the state. This 25850
division does not apply if the department fails to comply with 25851
section 119.07 of the Revised Code, requests a continuance of the 25852
hearing, or does not issue a decision within thirty days after the 25853
hearing is completed. This division does not apply to nursing 25854
facilities and intermediate care facilities for the mentally 25855
retarded as defined in section ~~5111.20~~ 5164.01 of the Revised 25856
Code. 25857

Sec. ~~5111.028~~ 5163.011. (A) Pursuant to section ~~5111.02~~ 25858
5163.15 of the Revised Code, the director of ~~job and family~~ 25859
~~services~~ health care administration shall adopt rules establishing 25860
procedures for the use of time-limited provider agreements under 25861
the medicaid program. Except as provided in division (E) of this 25862
section, all provider agreements shall be time-limited in 25863
accordance with the procedures established in the rules. 25864

25865

The department of ~~job and family services~~ health care 25866
administration shall phase-in the use of time-limited provider 25867
agreements pursuant to this section during a period commencing not 25868
later than January 1, 2008, and ending January 1, 2011. 25869

(B) In the use of time-limited provider agreements pursuant 25870

to this section, all of the following apply: 25871

(1) Each provider agreement shall expire not later than three years from the effective date of the agreement. 25872 25873

(2) During the phase-in period specified in division (A) of this section, the department may provide for the conversion of a provider agreement without a time limit to a provider agreement with a time limit. The department may take an action to convert the provider agreement by sending a notice by regular mail to the address of the provider on record with the department advising the provider of the conversion. 25874 25875 25876 25877 25878 25879 25880

(3) The department may make the effective date of a provider agreement retroactive for a period not to exceed one year from the date of the provider's application for the agreement, as long as the provider met all medicaid program requirements during that period. 25881 25882 25883 25884 25885

(C) The rules for use of time-limited provider agreements pursuant to this section shall include a process for re-enrollment of providers. All of the following apply to the re-enrollment process: 25886 25887 25888 25889

(1) The department of ~~job and family services~~ health care administration may terminate a time-limited provider agreement or deny re-enrollment when a provider fails to file an application for re-enrollment within the time and in the manner required under the re-enrollment process. 25890 25891 25892 25893 25894

(2) If a provider files an application for re-enrollment within the time and in the manner required under the re-enrollment process, but the provider agreement expires before the department acts on the application or before the effective date of the department's decision on the application, the provider may continue operating under the terms of the expired provider agreement until the effective date of the department's decision. 25895 25896 25897 25898 25899 25900 25901

(3) A decision by the department to approve an application for re-enrollment becomes effective on the date of the department's decision. A decision by the department to deny re-enrollment shall take effect not sooner than thirty days after the date the department mails written notice of the decision to the provider. The department shall specify in the notice the date on which the provider is required to cease operating under the provider agreement.

(D) Pursuant to section ~~5111.06~~ 5163.01 of the Revised Code, the department is not required to take the actions specified in division (C)(1) of this section by issuing an order pursuant to an adjudication conducted in accordance with Chapter 119. of the Revised Code.

(E) The use of time-limited provider agreements pursuant to this section does not apply to provider agreements issued to the following, including any provider agreements issued to the following that are otherwise time-limited under the medicaid program:

(1) A managed care organization under contract with the department pursuant to section ~~5111.17~~ 5165.05 of the Revised Code;

(2) A nursing facility, as defined in section ~~5111.20~~ 5164.01 of the Revised Code;

(3) An intermediate care facility for the mentally retarded, as defined in section ~~5111.20~~ 5164.01 of the Revised Code.

Sec. ~~5111.05~~ 5163.02. (A) The department of ~~job and family services~~ health care administration may contract with any person or persons as a fiscal agent for the examination, processing, and determination of ~~medical assistance~~ medicaid claims ~~under this chapter~~. The contracting party may provide any of the following

services, as required by the contract: 25932

(1) Design and operate medicaid management information 25933
systems, including the provision of data processing services; 25934

(2) Determine the amounts of payments to be made upon claims 25935
for ~~medical assistance~~ medicaid; 25936

(3) Prepare and furnish to the department lists and computer 25937
tapes of such claims for payment; 25938

(4) In addition to audits which may be conducted by the 25939
department and by the auditor of state, make audits of providers 25940
and the claims of medicaid providers ~~of medical assistance~~ 25941
according to the standards set forth in the contract; 25942

(5) Assist medicaid providers ~~of medical assistance~~ in the 25943
development of procedures relating to utilization practices, make 25944
studies of the effectiveness of such procedures and methods for 25945
their improvement, implement and enforce standards of medical 25946
policy, and assist in the application of safeguards against 25947
unnecessary utilization; 25948

(6) Assist any institution, facility, or agency to qualify as 25949
a medicaid provider ~~of medical assistance~~; 25950

(7) Establish and maintain fiscal records for the ~~medical~~ 25951
~~assistance~~ medicaid program; 25952

(8) Perform statistical and research studies; 25953

(9) Develop and implement programs for ~~medical assistance~~ 25954
medicaid cost containment; 25955

(10) Perform such other duties as are necessary to carry out 25956
the ~~medical assistance~~ medicaid program. 25957

(B) The department of ~~job and family services~~ health care 25958
administration may contract with any person or persons as an 25959
insuring agent for the examination, processing, and determination 25960
of ~~medical assistance~~ medicaid claims, as provided in division (A) 25961

of this section, and for the payment of ~~medical assistance~~ 25962
medicaid claims through an underwritten program in which the state 25963
pays the insuring agent a monthly premium and the insuring agent 25964
pays for medical services authorized under the state's ~~medical~~ 25965
~~assistance~~ medicaid program. The person with whom the department 25966
contracts, with respect to the awarding, provisions, and 25967
performance of such contract, shall not be subject to the 25968
provisions of Title XXXIX of the Revised Code or to regulation by 25969
the department of insurance, nor to taxation as an insurance 25970
company pursuant to section 5725.18 or 5729.03 of the Revised 25971
Code. A contract with an insuring agent shall specify the 25972
qualifications, including capital and surplus requirements, and 25973
other conditions with which the insuring agent must comply. 25974

(C) In entering into a contract under this section, the 25975
department, in cooperation with the director of budget and 25976
management, shall determine that the contracting party is 25977
qualified to perform the required services and shall follow 25978
applicable procedures required of the department of administrative 25979
services in sections 125.07 to 125.11 of the Revised Code. A 25980
contract shall be awarded to the bidder who, with due 25981
consideration to the bidder's experience and financial capability, 25982
offers the lowest and best bid to the state for control of the 25983
costs of the ~~medical assistance~~ medicaid program consistent with 25984
meeting the obligations under that program for fair and equitable 25985
treatment of recipients and providers of medical services. Any 25986
arrangement whereby funds are paid to an insuring or fiscal agent 25987
for administrative functions under this section shall, for the 25988
purposes of section 125.081 of the Revised Code, be deemed to be a 25989
contract or purchase by the department of administrative services; 25990
however, money to be used by an insuring agent to pay for medical 25991
services authorized under the state's ~~medical assistance~~ medicaid 25992
program shall not be deemed a contract or purchase within the 25993
meaning of such section. 25994

Sec. ~~5111.03~~ 5163.03. (A) No provider of services or goods 25995
contracting with the department of ~~job and family services~~ health 25996
care administration pursuant to the medicaid program shall, by 25997
deception, obtain or attempt to obtain payments under this chapter 25998
to which the provider is not entitled pursuant to the provider 25999
agreement, or the rules of the federal government or the 26000
department of ~~job and family services~~ health care administration 26001
relating to the program. No provider shall willfully receive 26002
payments to which the provider is not entitled, or willfully 26003
receive payments in a greater amount than that to which the 26004
provider is entitled; nor shall any provider falsify any report or 26005
document required by state or federal law, rule, or provider 26006
agreement relating to medicaid payments. As used in this section, 26007
a provider engages in "deception" when the provider, acting with 26008
actual knowledge of the representation or information involved, 26009
acting in deliberate ignorance of the truth or falsity of the 26010
representation or information involved, or acting in reckless 26011
disregard of the truth or falsity of the representation or 26012
information involved, deceives another or causes another to be 26013
deceived by any false or misleading representation, by withholding 26014
information, by preventing another from acquiring information, or 26015
by any other conduct, act, or omission that creates, confirms, or 26016
perpetuates a false impression in another, including a false 26017
impression as to law, value, state of mind, or other objective or 26018
subjective fact. No proof of specific intent to defraud is 26019
required to show, for purposes of this section, that a provider 26020
has engaged in deception. 26021

(B) Any provider who violates division (A) of this section 26022
shall be liable, in addition to any other penalties provided by 26023
law, for all of the following civil penalties: 26024

(1) Payment of interest on the amount of the excess payments 26025
at the maximum interest rate allowable for real estate mortgages 26026

under section 1343.01 of the Revised Code on the date the payment was made to the provider for the period from the date upon which payment was made, to the date upon which repayment is made to the state; 26027 26028 26029 26030

(2) Payment of an amount equal to three times the amount of any excess payments; 26031 26032

(3) Payment of a sum of not less than five thousand dollars and not more than ten thousand dollars for each deceptive claim or falsification; 26033 26034 26035

(4) All reasonable expenses which the court determines have been necessarily incurred by the state in the enforcement of this section. 26036 26037 26038

(C) As used in this division, "intermediate care facility for the mentally retarded" and "nursing facility" have the same meanings given in section ~~5111.20~~ 5164.01 of the Revised Code. 26039 26040 26041

In addition to the civil penalties provided in division (B) of this section, the director of ~~job and family services~~ health care administration, upon the conviction of, or the entry of a judgment in either a criminal or civil action against, a medicaid provider or its owner, officer, authorized agent, associate, manager, or employee in an action brought pursuant to section 109.85 of the Revised Code, shall terminate the provider agreement between the department and the provider and stop reimbursement to the provider for services rendered from the date of conviction or entry of judgment. As used in this division, "owner" means any person having at least five per cent ownership in the medicaid provider. No such provider, owner, officer, authorized agent, associate, manager, or employee shall own or provide services to any other medicaid provider or risk contractor or arrange for, render, or order services for medicaid recipients, nor shall such provider, owner, officer, authorized agent, associate, manager, or 26042 26043 26044 26045 26046 26047 26048 26049 26050 26051 26052 26053 26054 26055 26056 26057

employee receive reimbursement in the form of direct payments from 26058
the department or indirect payments of medicaid funds in the form 26059
of salary, shared fees, contracts, kickbacks, or rebates from or 26060
through any participating provider or risk contractor. The 26061
provider agreement shall not be terminated or reimbursement 26062
terminated if the provider or owner can demonstrate that the 26063
provider or owner did not directly or indirectly sanction the 26064
action of its authorized agent, associate, manager, or employee 26065
that resulted in the conviction or entry of a judgment in a 26066
criminal or civil action brought pursuant to section 109.85 of the 26067
Revised Code. Nothing in this division prohibits any owner, 26068
officer, authorized agent, associate, manager, or employee of a 26069
medicaid provider from entering into a medicaid provider agreement 26070
if the person can demonstrate that the person had no knowledge of 26071
an action of the medicaid provider the person was formerly 26072
associated with that resulted in the conviction or entry of a 26073
judgment in a criminal or civil action brought pursuant to section 26074
109.85 of the Revised Code. 26075

26076

Nursing facility or intermediate care facility for the 26077
mentally retarded providers whose agreements are terminated 26078
pursuant to this section may continue to receive reimbursement for 26079
up to thirty days after the effective date of the termination if 26080
the provider makes reasonable efforts to transfer recipients to 26081
another facility or to alternate care and if federal funds are 26082
provided for such reimbursement. 26083

(D) For any reason permitted or required by federal law, the 26084
director of ~~job and family services~~ <u>health care administration</u> may 26085
deny a provider agreement or terminate a provider agreement. 26086

For any reason permitted or required by federal law, the 26087
director may exclude an individual, provider of services or goods, 26088
or other entity from participation in the medicaid program. No 26089

individual, provider, or entity excluded under this division shall 26090
own or provide services to any other medicaid provider or risk 26091
contractor or arrange for, render, or order services for medicaid 26092
recipients during the period of exclusion, nor, during the period 26093
of exclusion, shall such individual, provider, or entity receive 26094
reimbursement in the form of direct payments from the department 26095
or indirect payments of medicaid funds in the form of salary, 26096
shared fees, contracts, kickbacks, or rebates from or through any 26097
participating provider or risk contractor. An excluded individual, 26098
provider, or entity may request a reconsideration of the 26099
exclusion. The director shall adopt rules in accordance with 26100
Chapter 119. of the Revised Code governing the process for 26101
requesting a reconsideration. 26102

Nothing in this division limits the applicability of section 26103
5111.06 of the Revised Code to a medicaid provider. 26104

(E) Any provider of services or goods contracting with the 26105
department of ~~job and family services pursuant to Title XIX of~~ 26106
health care administration under the ~~"Social Security Act,"~~ 26107
medicaid program who, without intent, obtains payments under this 26108
chapter in excess of the amount to which the provider is entitled, 26109
thereby becomes liable for payment of interest on the amount of 26110
the excess payments at the maximum real estate mortgage rate on 26111
the date the payment was made to the provider for the period from 26112
the date upon which payment was made to the date upon which 26113
repayment is made to the state. 26114

(F) The attorney general on behalf of the state may commence 26115
proceedings to enforce this section in any court of competent 26116
jurisdiction; and the attorney general may settle or compromise 26117
any case brought under this section with the approval of the 26118
department of ~~job and family services~~ health care administration. 26119
Notwithstanding any other provision of law providing a shorter 26120
period of limitations, the attorney general may commence a 26121

proceeding to enforce this section at any time within six years after the conduct in violation of this section terminates. 26122 26123

(G) The authority, under state and federal law, of the department of ~~job and family services~~ health care administration or a county department of job and family services to recover excess payments made to a provider is not limited by the availability of remedies under sections ~~5111.11~~ 5162.40 and ~~5111.12~~ 5162.45 of the Revised Code for recovering benefits paid on behalf of medicaid recipients ~~of medical assistance~~. 26124 26125 26126 26127 26128 26129 26130

The penalties under this chapter apply to any overpayment, billing, or falsification occurring on and after April 24, 1978. All moneys collected by the state pursuant to this section shall be deposited in the state treasury to the credit of the general revenue fund. 26131 26132 26133 26134 26135

Sec. ~~5111.031~~ 5163.031. (A) As used in this section: 26136

(1) "Independent provider" has the same meaning as in section ~~5111.034~~ 5163.034 of the Revised Code. 26137 26138

(2) "Intermediate care facility for the mentally retarded" and "nursing facility" have the same meanings as in section ~~5111.20~~ 5164.01 of the Revised Code. 26139 26140 26141

(3) "Noninstitutional medicaid provider" means any person or entity with a medicaid provider agreement other than a hospital, nursing facility, or intermediate care facility for the mentally retarded. 26142 26143 26144 26145

(4) "Owner" means any person having at least five per cent ownership in a noninstitutional medicaid provider. 26146 26147

(B) Notwithstanding any provision of this chapter to the contrary, the department of ~~job and family services~~ health care administration shall take action under this section against a noninstitutional medicaid provider or its owner, officer, 26148 26149 26150 26151

authorized agent, associate, manager, or employee. 26152

(C) Except as provided in division (D) of this section and in rules adopted by the department under division (H) of this section, on receiving notice and a copy of an indictment that is issued on or after ~~the effective date of this section~~ September 29, 2007, and charges a noninstitutional medicaid provider or its owner, officer, authorized agent, associate, manager, or employee with committing an offense specified in division (E) of this section, the department shall suspend the provider agreement held by the noninstitutional medicaid provider. Subject to division (D) of this section, the department shall also terminate medicaid reimbursement to the provider for services rendered. 26153 26154 26155 26156 26157 26158 26159 26160 26161 26162 26163

The suspension shall continue in effect until the proceedings in the criminal case are completed through conviction, dismissal of the indictment, plea, or finding of not guilty. If the department commences a process to terminate the suspended provider agreement, the suspension shall continue in effect until the termination process is concluded. Pursuant to section ~~5111.06~~ 5163.01 of the Revised Code, the department is not required to take action under this division by issuing an order pursuant to an adjudication conducted in accordance with Chapter 119. of the Revised Code. 26164 26165 26166 26167 26168 26169 26170 26171 26172 26173

When subject to a suspension under this division, a provider, owner, officer, authorized agent, associate, manager, or employee shall not own or provide services to any other medicaid provider or risk contractor or arrange for, render, or order services for medicaid recipients during the period of suspension. During the period of suspension, the provider, owner, officer, authorized agent, associate, manager, or employee shall not receive reimbursement in the form of direct payments from the department or indirect payments of medicaid funds in the form of salary, shared fees, contracts, kickbacks, or rebates from or through any 26174 26175 26176 26177 26178 26179 26180 26181 26182 26183

participating provider or risk contractor. 26184

(D)(1) The department shall not suspend a provider agreement or terminate medicaid reimbursement under division (C) of this section if the provider or owner can demonstrate that the provider or owner did not directly or indirectly sanction the action of its authorized agent, associate, manager, or employee that resulted in the indictment. 26185 26186 26187 26188 26189 26190

(2) The termination of medicaid reimbursement applies only to payments for medicaid services rendered subsequent to the date on which the notice required under division (F) of this section is sent. Claims for reimbursement for medicaid services rendered by the provider prior to the issuance of the notice may be subject to prepayment review procedures whereby the department reviews claims to determine whether they are supported by sufficient documentation, are in compliance with state and federal statutes and rules, and are otherwise complete. 26191 26192 26193 26194 26195 26196 26197 26198 26199

(E)(1) In the case of a noninstitutional medicaid provider that is not an independent provider, the suspension of a provider agreement under division (C) of this section applies when an indictment charges a person with committing an act that would be a felony or misdemeanor under the laws of this state and the act relates to or results from either of the following: 26200 26201 26202 26203 26204 26205

(a) Furnishing or billing for medical care, services, or supplies under the medicaid program; 26206 26207

(b) Participating in the performance of management or administrative services relating to furnishing medical care, services, or supplies under the medicaid program. 26208 26209 26210

(2) In the case of a noninstitutional medicaid provider that is an independent provider, the suspension of a provider agreement under division (C) of this section applies when an indictment charges a person with committing an act that would constitute one 26211 26212 26213 26214

of the offenses specified in division (D) of section ~~5111.034~~ 26215
<u>5163.034</u> of the Revised Code. 26216

(F) Not later than five days after suspending a provider agreement under division (C) of this section, the department shall send notice of the suspension to the affected provider or owner. In providing the notice, the department shall do all of the following: 26217 26218 26219 26220 26221

(1) Describe the indictment that was the cause of the suspension, without necessarily disclosing specific information concerning any ongoing civil or criminal investigation; 26222 26223 26224

(2) State that the suspension will continue in effect until the proceedings in the criminal case are completed through conviction, dismissal of the indictment, plea, or finding of not guilty and, if the department commences a process to terminate the suspended provider agreement, until the termination process is concluded; 26225 26226 26227 26228 26229 26230

(3) Inform the provider or owner of the opportunity to submit to the department, not later than thirty days after receiving the notice, a request for a reconsideration pursuant to division (G) of this section. 26231 26232 26233 26234

(G)(1) A noninstitutional medicaid provider or owner subject to a suspension under this section may request a reconsideration. The request shall be made not later than thirty days after receipt of the notice provided under division (F) of this section. The reconsideration is not subject to an adjudication hearing pursuant to Chapter 119. of the Revised Code. 26235 26236 26237 26238 26239 26240

(2) In requesting a reconsideration, the provider or owner shall submit written information and documents to the department. The information and documents may pertain to any of the following issues: 26241 26242 26243 26244

(a) Whether the determination to suspend the provider 26245

agreement was based on a mistake of fact, other than the validity of the indictment; 26246 26247

(b) Whether any offense charged in the indictment resulted from an offense specified in division (E) of this section; 26248 26249

(c) Whether the provider or owner can demonstrate that the provider or owner did not directly or indirectly sanction the action of its authorized agent, associate, manager, or employee that resulted in the indictment. 26250 26251 26252 26253

(3) The department shall review the information and documents submitted in a request for reconsideration. After the review, the suspension may be affirmed, reversed, or modified, in whole or in part. The department shall notify the affected provider or owner of the results of the review. The review and notification of its results shall be completed not later than forty-five days after receiving the information and documents submitted in a request for reconsideration. 26254 26255 26256 26257 26258 26259 26260 26261

(H) The department may adopt rules in accordance with Chapter 119. of the Revised Code to implement this section. The rules may specify circumstances under which the department would not suspend a provider agreement pursuant to this section. 26262 26263 26264 26265

Sec. ~~5111.032~~ 5163.032. (A) As used in this section: 26266

(1) "Criminal records check" has the same meaning as in section 109.572 of the Revised Code. 26267 26268

(2) "Department" includes a designee of the department of ~~job and family services~~ health care administration. 26269 26270

(3) "Owner" means a person who has an ownership interest in a provider in an amount designated by the department of ~~job and family services~~ health care administration in rules adopted under this section. 26271 26272 26273 26274

(4) "Provider" means a person, institution, or entity that 26275

has a medicaid provider agreement with the department of ~~job and~~ 26276
~~family services pursuant to Title XIX of the "Social Security~~ 26277
~~Act," 49 State. 620 (1965), 42 U.S.C. 1396, as amended~~ health care 26278
administration. 26279

(B)(1) Except as provided in division (B)(2) of this section, 26280
the department of ~~job and family services~~ health care 26281
administration may require that any provider, applicant to be a 26282
provider, employee or prospective employee of a provider, owner or 26283
prospective owner of a provider, officer or prospective officer of 26284
a provider, or board member or prospective board member of a 26285
provider submit to a criminal records check as a condition of 26286
obtaining a provider agreement, continuing to hold a provider 26287
agreement, being employed by a provider, having an ownership 26288
interest in a provider, or being an officer or board member of a 26289
provider. The department may designate the categories of persons 26290
who are subject to the criminal records check requirement. The 26291
department shall designate the times at which the criminal records 26292
checks must be conducted. 26293

(2) The section does not apply to providers, applicants to be 26294
providers, employees of a provider, or prospective employees of a 26295
provider who are subject to criminal records checks under section 26296
~~5111.033~~ 5163.033 or ~~5111.034~~ 5163.034 of the Revised Code. 26297

(C)(1) The department shall inform each provider or applicant 26298
to be a provider whether the provider or applicant is subject to a 26299
criminal records check requirement under division (B) of this 26300
section. For providers, the information shall be given at times 26301
designated in rules adopted under this section. For applicants to 26302
be providers, the information shall be given at the time of 26303
initial application. When the information is given, the department 26304
shall specify which of the provider's or applicant's employees or 26305
prospective employees, owners or prospective owners, officers or 26306
prospective officers, or board members or prospective board 26307

members are subject to the criminal records check requirement. 26308

(2) At times designated in rules adopted under this section, a provider that is subject to the criminal records check requirement shall inform each person specified by the department under division (C)(1) of this section that the person is required, as applicable, to submit to a criminal records check for final consideration for employment in a full-time, part-time, or temporary position; as a condition of continued employment; or as a condition of becoming or continuing to be an officer, board member or owner of a provider. 26309 26310 26311 26312 26313 26314 26315 26316 26317

(D)(1) If a provider or applicant to be a provider is subject to a criminal records check under this section, the department shall require the conduct of a criminal records check by the superintendent of the bureau of criminal identification and investigation. If a provider or applicant to be a provider for whom a criminal records check is required does not present proof of having been a resident of this state for the five-year period immediately prior to the date the criminal records check is requested or provide evidence that within that five-year period the superintendent has requested information about the individual from the federal bureau of investigation in a criminal records check, the department shall require the provider or applicant to request that the superintendent obtain information from the federal bureau of investigation as part of the criminal records check of the provider or applicant. Even if a provider or applicant for whom a criminal records check request is required presents proof of having been a resident of this state for the five-year period, the department may require that the provider or applicant request that the superintendent obtain information from the federal bureau of investigation and include it in the criminal records check of the provider or applicant. 26318 26319 26320 26321 26322 26323 26324 26325 26326 26327 26328 26329 26330 26331 26332 26333 26334 26335 26336 26337 26338

(2) A provider shall require the conduct of a criminal 26339

records check by the superintendent with respect to each of the persons specified by the department under division (C)(1) of this section. If the person for whom a criminal records check is required does not present proof of having been a resident of this state for the five-year period immediately prior to the date the criminal records check is requested or provide evidence that within that five-year period the superintendent of the bureau of criminal identification and investigation has requested information about the individual from the federal bureau of investigation in a criminal records check, the individual shall request that the superintendent obtain information from the federal bureau of investigation as part of the criminal records check of the individual. Even if an individual for whom a criminal records check request is required presents proof of having been a resident of this state for the five-year period, the department may require the provider to request that the superintendent obtain information from the federal bureau of investigation and include it in the criminal records check of the person. 26340 26341 26342 26343 26344 26345 26346 26347 26348 26349 26350 26351 26352 26353 26354 26355 26356 26357

(E)(1) Criminal records checks required under this section for providers or applicants to be providers shall be obtained as follows: 26358 26359 26360

(a) The department shall provide each provider or applicant information about accessing and completing the form prescribed pursuant to division (C)(1) of section 109.572 of the Revised Code and the standard fingerprint impression sheet prescribed pursuant to division (C)(2) of that section. 26361 26362 26363 26364 26365

(b) The provider or applicant shall submit the required form and one complete set of fingerprint impressions directly to the superintendent for purposes of conducting the criminal records check using the applicable methods prescribed by division (C) of section 109.572 of the Revised Code. The applicant or provider shall pay all fees associated with obtaining the criminal records 26366 26367 26368 26369 26370 26371

check. 26372

(c) The superintendent shall conduct the criminal records check in accordance with section 109.572 of the Revised Code. The provider or applicant shall instruct the superintendent to submit the report of the criminal records check directly to the director of job and family services. 26373 26374 26375 26376 26377

(2) Criminal records checks required under this section for persons specified by the department under division (C)(1) of this section shall be obtained as follows: 26378 26379 26380

(a) The provider shall give to each person subject to criminal records check requirement information about accessing and completing the form prescribed pursuant to division (C)(1) of section 109.572 of the Revised Code and the standard fingerprint impression sheet prescribed pursuant to division (C)(2) of that section. 26381 26382 26383 26384 26385 26386

(b) The person shall submit the required form and one complete set of fingerprint impressions directly to the superintendent for purposes of conducting the criminal records check using the applicable methods prescribed by division (C) of section 109.572 of the Revised Code. The person shall pay all fees associated with obtaining the criminal records check. 26387 26388 26389 26390 26391 26392

(c) The superintendent shall conduct the criminal records check in accordance with section 109.572 of the Revised Code. The person subject to the criminal records check shall instruct the superintendent to submit the report of the criminal records check directly to the provider. The department may require the provider to submit the report to the department. 26393 26394 26395 26396 26397 26398

(F) If a provider or applicant to be a provider is given the information specified in division (E)(1)(a) of this section but fails to obtain a criminal records check, the department shall, as applicable, terminate the provider agreement or deny the 26399 26400 26401 26402

application to be a provider. 26403

If a person is given the information specified in division (E)(2)(a) of this section but fails to obtain a criminal records check, the provider shall not, as applicable, permit the person to be an employee, owner, officer, or board member of the provider. 26404 26405 26406 26407

(G) Except as provided in rules adopted under division (J) of this section, the department shall terminate the provider agreement of a provider or the department shall not issue a provider agreement to an applicant if the provider or applicant is subject to a criminal records check under this section and the provider or applicant has been convicted of, has pleaded guilty to, or has been found eligible for intervention in lieu of conviction for any of the following: 26408 26409 26410 26411 26412 26413 26414 26415

(1) A violation of section 2903.01, 2903.02, 2903.03, 2903.04, 2903.041, 2903.11, 2903.12, 2903.13, 2903.16, 2903.21, 2903.34, 2905.01, 2905.02, 2905.05, 2905.11, 2905.12, 2907.02, 2907.03, 2907.04, 2907.05, 2907.06, 2907.07, 2907.08, 2907.09, 2907.21, 2907.22, 2907.23, 2907.24, 2907.25, 2907.31, 2907.32, 2907.321, 2907.322, 2907.323, 2911.01, 2911.02, 2911.11, 2911.12, 2911.13, 2913.02, 2913.03, 2913.04, 2913.11, 2913.21, 2913.31, 2913.40, 2913.43, 2913.47, 2913.48, 2913.49, 2913.51, 2917.11, 2919.12, 2919.22, 2919.24, 2919.25, 2921.13, 2921.36, 2923.02, 2923.12, 2923.13, 2923.161, 2923.32, 2925.02, 2925.03, 2925.04, 2925.05, 2925.06, 2925.11, 2925.13, 2925.14, 2925.22, 2925.23, or 3716.11 of the Revised Code, felonious sexual penetration in violation of former section 2907.12 of the Revised Code, a violation of section 2905.04 of the Revised Code as it existed prior to July 1, 1996, a violation of section 2919.23 of the Revised Code that would have been a violation of section 2905.04 of the Revised Code as it existed prior to July 1, 1996, had the violation been committed prior to that date; 26416 26417 26418 26419 26420 26421 26422 26423 26424 26425 26426 26427 26428 26429 26430 26431 26432 26433

(2) An existing or former law of this state, any other state, 26434

or the United States that is substantially equivalent to any of 26435
the offenses listed in division (G)(1) of this section. 26436

(H)(1)(a) Except as provided in rules adopted under division 26437
(J) of this section and subject to division (H)(2) of this 26438
section, no provider shall permit a person to be an employee, 26439
owner, officer, or board member of the provider if the person is 26440
subject to a criminal records check under this section and the 26441
person has been convicted of, has pleaded guilty to, or has been 26442
found eligible for intervention in lieu of conviction for any of 26443
the offenses specified in division (G)(1) or (2) of this section. 26444

(b) No provider shall employ a person who has been excluded 26445
from participating in the medicaid program, the medicare program 26446
~~operated pursuant to Title XVIII of the "Social Security Act,"~~ or 26447
any other federal health care program. 26448

(2)(a) A provider may employ conditionally a person for whom 26449
a criminal records check is required under this section prior to 26450
obtaining the results of a criminal records check regarding the 26451
person, but only if the person submits a request for a criminal 26452
records check not later than five business days after the 26453
individual begins conditional employment. 26454

(b) A provider that employs a person conditionally under 26455
authority of division (H)(2)(a) of this section shall terminate 26456
the person's employment if the results of the criminal records 26457
check request are not obtained within the period ending sixty days 26458
after the date the request is made. Regardless of when the results 26459
of the criminal records check are obtained, if the results 26460
indicate that the individual has been convicted of, has pleaded 26461
guilty to, or has been found eligible for intervention in lieu of 26462
conviction for any of the offenses specified in division (G)(1) or 26463
(2) of this section, the provider shall terminate the person's 26464
employment unless the provider chooses to employ the individual 26465
pursuant to division (J) of this section. 26466

(I) The report of a criminal records check conducted pursuant 26467
to this section is not a public record for the purposes of section 26468
149.43 of the Revised Code and shall not be made available to any 26469
person other than the following: 26470

(1) The person who is the subject of the criminal records 26471
check or the person's representative; 26472

(2) The director of ~~job and family services~~ health care 26473
administration and the staff of the department in the 26474
administration of the medicaid program; 26475

(3) A court, hearing officer, or other necessary individual 26476
involved in a case dealing with the denial or termination of a 26477
provider agreement; 26478

(4) A court, hearing officer, or other necessary individual 26479
involved in a case dealing with a person's denial of employment, 26480
termination of employment, or employment or unemployment benefits. 26481

(J) The department may adopt rules in accordance with Chapter 26482
119. of the Revised Code to implement this section. The rules may 26483
specify circumstances under which the department may continue a 26484
provider agreement or issue a provider agreement to an applicant 26485
when the provider or applicant has been convicted of, has pleaded 26486
guilty to, or has been found eligible for intervention in lieu of 26487
conviction for any of the offenses specified in division (G)(1) or 26488
(2) of this section. The rules may also specify circumstances 26489
under which a provider may permit a person to be an employee, 26490
owner, officer, or board member of the provider, when the person 26491
has been convicted of, has pleaded guilty to, or has been found 26492
eligible for intervention in lieu of conviction for any of the 26493
offenses specified in division (G)(1) or (2) of this section. 26494

Sec. ~~5111.033~~ 5163.033. (A) As used in this section: 26495

(1) "Applicant" means a person who is under final 26496

consideration for employment or, after September 26, 2003, an 26497
existing employee with a waiver agency in a full-time, part-time, 26498
or temporary position that involves providing home and 26499
community-based waiver services to a person with disabilities. 26500
"Applicant" also means an existing employee with a waiver agency 26501
in a full-time, part-time, or temporary position that involves 26502
providing home and community-based waiver services to a person 26503
with disabilities after September 26, 2003. 26504

(2) "Criminal records check" has the same meaning as in 26505
section 109.572 of the Revised Code. 26506

(3) "Waiver agency" means a person or government entity that 26507
is not certified under the medicare program and is accredited by 26508
the community health accreditation program or the joint commission 26509
on accreditation of health care organizations or a company that 26510
provides home and community-based waiver services to persons with 26511
disabilities through department of ~~job and family services~~ health 26512
care administration administered home and community-based waiver 26513
programs. 26514

(4) "Home and community-based waiver services" means services 26515
furnished under the provision of 42 C.F.R. 441, subpart G, that 26516
permit individuals to live in a home setting rather than a nursing 26517
facility or hospital. Home and community-based waiver services are 26518
approved by the centers for medicare and medicaid for specific 26519
populations and are not otherwise available under the medicaid 26520
state plan. 26521

(B)(1) The chief administrator of a waiver agency shall 26522
require each applicant to request that the superintendent of the 26523
bureau of criminal identification and investigation conduct a 26524
criminal records check with respect to the applicant. If an 26525
applicant for whom a criminal records check request is required 26526
under this division does not present proof of having been a 26527
resident of this state for the five-year period immediately prior 26528

to the date the criminal records check is requested or provide evidence that within that five-year period the superintendent has requested information about the applicant from the federal bureau of investigation in a criminal records check, the chief administrator shall require the applicant to request that the superintendent obtain information from the federal bureau of investigation as part of the criminal records check of the applicant. Even if an applicant for whom a criminal records check request is required under this division presents proof of having been a resident of this state for the five-year period, the chief administrator may require the applicant to request that the superintendent include information from the federal bureau of investigation in the criminal records check. 26529 26530 26531 26532 26533 26534 26535 26536 26537 26538 26539 26540 26541

(2) The chief administrator shall provide the following to each applicant for whom a criminal records check request is required under division (B)(1) of this section: 26542 26543 26544

(a) Information about accessing, completing, and forwarding to the superintendent of the bureau of criminal identification and investigation the form prescribed pursuant to division (C)(1) of section 109.572 of the Revised Code and the standard fingerprint impression sheet prescribed pursuant to division (C)(2) of that section; 26545 26546 26547 26548 26549 26550

(b) Written notification that the applicant is to instruct the superintendent to submit the completed report of the criminal records check directly to the chief administrator. 26551 26552 26553

(3) An applicant given information and notification under divisions (B)(2)(a) and (b) of this section who fails to access, complete, and forward to the superintendent the form or the standard fingerprint impression sheet, or who fails to instruct the superintendent to submit the completed report of the criminal records check directly to the chief administrator, shall not be employed in any position in a waiver agency for which a criminal 26554 26555 26556 26557 26558 26559 26560

records check is required by this section. 26561

(C)(1) Except as provided in rules adopted by the department of ~~job and family services~~ health care administration in accordance with division (F) of this section and subject to division (C)(2) of this section, no waiver agency shall employ a person in a position that involves providing home and community-based waiver services to persons with disabilities if the person has been convicted of, has pleaded guilty to, or has been found eligible for intervention in lieu of conviction for any of the following: 26562 26563 26564 26565 26566 26567 26568 26569 26570

(a) A violation of section 2903.01, 2903.02, 2903.03, 2903.04, 2903.041, 2903.11, 2903.12, 2903.13, 2903.16, 2903.21, 2903.34, 2905.01, 2905.02, 2905.05, 2905.11, 2905.12, 2907.02, 2907.03, 2907.04, 2907.05, 2907.06, 2907.07, 2907.08, 2907.09, 2907.21, 2907.22, 2907.23, 2907.24, 2907.25, 2907.31, 2907.32, 2907.321, 2907.322, 2907.323, 2911.01, 2911.02, 2911.11, 2911.12, 2911.13, 2913.02, 2913.03, 2913.04, 2913.11, 2913.21, 2913.31, 2913.40, 2913.43, 2913.47, 2913.48, 2913.49, 2913.51, 2917.11, 2919.12, 2919.22, 2919.24, 2919.25, 2921.13, 2921.36, 2923.02, 2923.12, 2923.13, 2923.161, 2923.32, 2925.02, 2925.03, 2925.04, 2925.05, 2925.06, 2925.11, 2925.13, 2925.14, 2925.22, 2925.23, or 3716.11 of the Revised Code, felonious sexual penetration in violation of former section 2907.12 of the Revised Code, a violation of section 2905.04 of the Revised Code as it existed prior to July 1, 1996, a violation of section 2919.23 of the Revised Code that would have been a violation of section 2905.04 of the Revised Code as it existed prior to July 1, 1996, had the violation been committed prior to that date; 26571 26572 26573 26574 26575 26576 26577 26578 26579 26580 26581 26582 26583 26584 26585 26586 26587 26588

(b) An existing or former law of this state, any other state, or the United States that is substantially equivalent to any of the offenses listed in division (C)(1)(a) of this section. 26589 26590 26591

(2)(a) A waiver agency may employ conditionally an applicant 26592

for whom a criminal records check request is required under division (B) of this section prior to obtaining the results of a criminal records check regarding the individual, provided that the agency shall require the individual to request a criminal records check regarding the individual in accordance with division (B)(1) of this section not later than five business days after the individual begins conditional employment. 26593 26594 26595 26596 26597 26598 26599

(b) A waiver agency that employs an individual conditionally under authority of division (C)(2)(a) of this section shall terminate the individual's employment if the results of the criminal records check request under division (B) of this section, other than the results of any request for information from the federal bureau of investigation, are not obtained within the period ending sixty days after the date the request is made. Regardless of when the results of the criminal records check are obtained, if the results indicate that the individual has been convicted of, has pleaded guilty to, or has been found eligible for intervention in lieu of conviction for any of the offenses listed or described in division (C)(1) of this section, the agency shall terminate the individual's employment unless the agency chooses to employ the individual pursuant to division (F) of this section. 26600 26601 26602 26603 26604 26605 26606 26607 26608 26609 26610 26611 26612 26613 26614

(D)(1) The fee prescribed pursuant to division (C)(3) of section 109.572 of the Revised Code for each criminal records check conducted pursuant to a request made under division (B) of this section shall be paid to the bureau of criminal identification and investigation by the applicant or the waiver agency. 26615 26616 26617 26618 26619 26620

(2) If a waiver agency pays the fee, it may charge the applicant a fee not exceeding the amount the agency pays under division (D)(1) of this section. An agency may collect a fee only if the agency notifies the person at the time of initial 26621 26622 26623 26624

application for employment of the amount of the fee and that, unless the fee is paid, the person will not be considered for employment. 26625 26626 26627

(E) The report of any criminal records check conducted pursuant to a request made under this section is not a public record for the purposes of section 149.43 of the Revised Code and shall not be made available to any person other than the following: 26628 26629 26630 26631 26632

(1) The individual who is the subject of the criminal records check or the individual's representative; 26633 26634

(2) The chief administrator of the agency requesting the criminal records check or the administrator's representative; 26635 26636

(3) An administrator at the department; 26637

(4) A court, hearing officer, or other necessary individual involved in a case dealing with a denial of employment of the applicant or dealing with employment or unemployment benefits of the applicant. 26638 26639 26640 26641

(F) The department shall adopt rules in accordance with Chapter 119. of the Revised Code to implement this section. The rules shall specify circumstances under which a waiver agency may employ a person who has been convicted of, has pleaded guilty to, or has been found eligible for intervention in lieu of conviction for an offense listed or described in division (C)(1) of this section. 26642 26643 26644 26645 26646 26647 26648

(G) The chief administrator of a waiver agency shall inform each person, at the time of initial application for a position that involves providing home and community-based waiver services to a person with a disability, that the person is required to provide a set of fingerprint impressions and that a criminal records check is required to be conducted if the person comes under final consideration for employment. 26649 26650 26651 26652 26653 26654 26655

(H)(1) A person who, on September 26, 2003, is an employee of 26656
a waiver agency in a full-time, part-time, or temporary position 26657
that involves providing home and community-based waiver services 26658
to a person with disabilities shall comply with this section 26659
within sixty days after September 26, 2003, unless division (H)(2) 26660
of this section applies. 26661

(2) This section shall not apply to a person to whom all of 26662
the following apply: 26663

(a) On September 26, 2003, the person is an employee of a 26664
waiver agency in a full-time, part-time, or temporary position 26665
that involves providing home and community-based waiver services 26666
to a person with disabilities. 26667

(b) The person previously had been the subject of a criminal 26668
background check relating to that position; 26669

(c) The person has been continuously employed in that 26670
position since that criminal background check had been conducted. 26671

Sec. ~~5111.034~~ 5163.034. (A) As used in this section: 26672

(1) "Anniversary date" means the later of the effective date 26673
of the provider agreement relating to the independent provider or 26674
sixty days after September 26, 2003. 26675

(2) "Criminal records check" has the same meaning as in 26676
section 109.572 of the Revised Code. 26677

(3) "Department" includes a designee of the department of ~~job~~ 26678
~~and family services~~ health care administration. 26679

(4) "Independent provider" means a person who is submitting 26680
an application for a provider agreement or who has a provider 26681
agreement as an independent provider in a department of ~~job and~~ 26682
~~family services~~ health care administration administered home and 26683
community-based services program providing home and 26684
community-based waiver services to consumers with disabilities. 26685

(5) "Home and community-based waiver services" has the same meaning as in section ~~5111.033~~ 5163.033 of the Revised Code. 26686 26687

(B)(1) The department of ~~job and family services~~ health care administration shall inform each independent provider, at the time of initial application for a provider agreement that involves providing home and community-based waiver services to consumers with disabilities, that the independent provider is required to provide a set of fingerprint impressions and that a criminal records check is required to be conducted if the person is to become an independent provider in a department administered home and community-based waiver program. 26688 26689 26690 26691 26692 26693 26694 26695 26696

(2) Beginning on September 26, 2003, the department shall inform each enrolled medicaid independent provider on or before time of the anniversary date of the provider agreement that involves providing home and community-based waiver services to consumers with disabilities that the independent provider is required to provide a set of fingerprint impressions and that a criminal records check is required to be conducted. 26697 26698 26699 26700 26701 26702 26703

(C)(1) The department shall require the independent provider to complete a criminal records check prior to entering into a provider agreement with the independent provider and at least annually thereafter. If an independent provider for whom a criminal records check is required under this division does not present proof of having been a resident of this state for the five-year period immediately prior to the date the criminal records check is requested or provide evidence that within that five-year period the superintendent of the bureau of criminal identification and investigation has requested information about the independent provider from the federal bureau of investigation in a criminal records check, the department shall request that the independent provider obtain through the superintendent a criminal records request from the federal bureau of investigation as part 26704 26705 26706 26707 26708 26709 26710 26711 26712 26713 26714 26715 26716 26717

of the criminal records check of the independent provider. Even if an independent provider for whom a criminal records check request is required under this division presents proof of having been a resident of this state for the five-year period, the department may request that the independent provider obtain information through the superintendent from the federal bureau of investigation in the criminal records check. 26718 26719 26720 26721 26722 26723 26724

(2) The department shall provide the following to each independent provider for whom a criminal records check request is required under division (C)(1) of this section: 26725 26726 26727

(a) Information about accessing, completing, and forwarding to the superintendent of the bureau of criminal identification and investigation the form prescribed pursuant to division (C)(1) of section 109.572 of the Revised Code and the standard fingerprint impression sheet prescribed pursuant to division (C)(2) of that section; 26728 26729 26730 26731 26732 26733

(b) Written notification that the independent provider is to instruct the superintendent to submit the completed report of the criminal records check directly to the department. 26734 26735 26736

(3) An independent provider given information and notification under divisions (C)(2)(a) and (b) of this section who fails to access, complete, and forward to the superintendent the form or the standard fingerprint impression sheet, or who fails to instruct the superintendent to submit the completed report of the criminal records check directly to the department, shall not be approved as an independent provider. 26737 26738 26739 26740 26741 26742 26743

(D) Except as provided in rules adopted by the department in accordance with division (G) of this section, the department shall not issue a new provider agreement to, and shall terminate an existing provider agreement of, an independent provider if the person has been convicted of, has pleaded guilty to, or has been 26744 26745 26746 26747 26748

found eligible for intervention in lieu of conviction for any of the following: 26749 26750

(1) A violation of section 2903.01, 2903.02, 2903.03, 2903.04, 2903.041, 2903.11, 2903.12, 2903.13, 2903.16, 2903.21, 2903.34, 2905.01, 2905.02, 2905.05, 2905.11, 2905.12, 2907.02, 2907.03, 2907.04, 2907.05, 2907.06, 2907.07, 2907.08, 2907.09, 2907.21, 2907.22, 2907.23, 2907.24, 2907.25, 2907.31, 2907.32, 2907.321, 2907.322, 2907.323, 2911.01, 2911.02, 2911.11, 2911.12, 2911.13, 2913.02, 2913.03, 2913.04, 2913.11, 2913.21, 2913.31, 2913.40, 2913.43, 2913.47, 2913.48, 2913.49, 2913.51, 2917.11, 2919.12, 2919.22, 2919.24, 2919.25, 2921.13, 2921.36, 2923.02, 2923.12, 2923.13, 2923.161, 2923.32, 2925.02, 2925.03, 2925.04, 2925.05, 2925.06, 2925.11, 2925.13, 2925.14, 2925.22, 2925.23, or 3716.11 of the Revised Code, felonious sexual penetration in violation of former section 2907.12 of the Revised Code, a violation of section 2905.04 of the Revised Code as it existed prior to July 1, 1996, a violation of section 2919.23 of the Revised Code that would have been a violation of section 2905.04 of the Revised Code as it existed prior to July 1, 1996, had the violation been committed prior to that date; 26751 26752 26753 26754 26755 26756 26757 26758 26759 26760 26761 26762 26763 26764 26765 26766 26767 26768

(2) An existing or former law of this state, any other state, or the United States that is substantially equivalent to any of the offenses listed in division (D)(1) of this section. 26769 26770 26771

(E) Each independent provider shall pay to the bureau of criminal identification and investigation the fee prescribed pursuant to division (C)(3) of section 109.572 of the Revised Code for each criminal records check conducted pursuant to a request made under division (C) of this section. 26772 26773 26774 26775 26776

(F) The report of any criminal records check conducted by the bureau of criminal identification and investigation in accordance with section 109.572 of the Revised Code and pursuant to a request made under division (C) of this section is not a public record for 26777 26778 26779 26780

the purposes of section 149.43 of the Revised Code and shall not 26781
be made available to any person other than the following: 26782

(1) The person who is the subject of the criminal records 26783
check or the person's representative; 26784

(2) An administrator at the department or the administrator's 26785
representative; 26786

(3) A court, hearing officer, or other necessary individual 26787
involved in a case dealing with a denial or termination of a 26788
provider agreement related to the criminal records check. 26789

(G) The department shall adopt rules in accordance with 26790
Chapter 119. of the Revised Code to implement this section. The 26791
rules shall specify circumstances under which the department may 26792
either issue a provider agreement to an independent provider or 26793
allow an independent provider to maintain an existing provider 26794
agreement when the independent provider has been convicted of, has 26795
pleaded guilty to, or has been found eligible for intervention in 26796
lieu of conviction for an offense listed or described in division 26797
(C)(1) of this section. 26798

Sec. 5163.04. The department of health care administration 26799
may conduct final fiscal audits under the medicaid program in 26800
accordance with the applicable requirements set forth in federal 26801
laws and regulations and determine any amounts the provider may 26802
owe the state. When conducting final fiscal audits, the department 26803
shall consider generally accepted auditing standards, which 26804
include the use of statistical sampling. 26805

Sec. ~~5111.914~~ 5163.06. (A) As used in this section, 26806
"provider" has the same meaning as in section ~~5111.06~~ 5163.01 of 26807
the Revised Code. 26808

(B) If a state agency that enters into a contract with the 26809
department of ~~job and family services~~ health care administration 26810

under section ~~5111.91~~ <u>5161.05</u> of the Revised Code identifies that 26811
a medicaid overpayment has been made to a provider, the state 26812
agency may commence actions to recover the overpayment on behalf 26813
of the department. 26814

(C) In recovering an overpayment pursuant to this section, a 26815
state agency shall comply with the following procedures: 26816

(1) The state agency shall attempt to recover the overpayment 26817
by notifying the provider of the overpayment and requesting 26818
voluntary repayment. Not later than five business days after 26819
notifying the provider, the state agency shall notify the 26820
department in writing of the overpayment. The state agency may 26821
negotiate a settlement of the overpayment and notify the 26822
department of the settlement. A settlement negotiated by the state 26823
agency is not valid and shall not be implemented until the 26824
department has given its written approval of the settlement. 26825

(2) If the state agency is unable to obtain voluntary 26826
repayment of an overpayment, the agency shall give the provider 26827
notice of an opportunity for a hearing in accordance with Chapter 26828
119. of the Revised Code. If the provider timely requests a 26829
hearing in accordance with section 119.07 of the Revised Code, the 26830
state agency shall conduct the hearing to determine the legal and 26831
factual validity of the overpayment. On completion of the hearing, 26832
the state agency shall submit its hearing officer's report and 26833
recommendation and the complete record of proceedings, including 26834
all transcripts, to the director of ~~job and family services~~ <u>health</u> 26835
<u>care administration</u> for final adjudication. The director may issue 26836
a final adjudication order in accordance with Chapter 119. of the 26837
Revised Code. The state agency shall pay any attorney's fees 26838
imposed under section 119.092 of the Revised Code. The department 26839
of job and family services shall pay any attorney's fees imposed 26840
under section 2335.39 of the Revised Code. 26841

(D) In any action taken by a state agency under this section 26842

that requires the agency to give notice of an opportunity for a 26843
hearing in accordance with Chapter 119. of the Revised Code, if 26844
the agency gives notice of the opportunity for a hearing but the 26845
provider subject to the notice does not request a hearing or 26846
timely request a hearing in accordance with section 119.07 of the 26847
Revised Code, the agency is not required to hold a hearing. The 26848
agency may request that the director of ~~job and family services~~ 26849
health care administration issue a final adjudication order in 26850
accordance with Chapter 119. of the Revised Code. 26851

(E) This section does not preclude the department of ~~job and~~ 26852
~~family services~~ health care administration from adjudicating a 26853
final fiscal audit under section ~~5111.06~~ 5163.01 of the Revised 26854
Code, recovering overpayments under section ~~5111.061~~ 5163.07 of 26855
the Revised Code, or making findings or taking other actions 26856
authorized by this chapter. 26857

Sec. ~~5111.061~~ 5163.07. (A) The department of ~~job and family~~ 26858
~~services~~ health care administration may recover a medicaid payment 26859
or portion of a payment made to a provider to which the provider 26860
is not entitled if the department notifies the provider of the 26861
overpayment during the five-year period immediately following the 26862
end of the state fiscal year in which the overpayment was made. 26863

(B) Among the overpayments that may be recovered under this 26864
section are the following: 26865

(1) Payment for a service, or a day of service, not rendered; 26866

(2) Payment for a day of service at a full per diem rate that 26867
should have been paid at a percentage of the full per diem rate; 26868

(3) Payment for a service, or day of service, that was paid 26869
by, or partially paid by, a third-party, as defined in section 26870
~~5101.571~~ 5160.36 of the Revised Code, and the third-party's 26871
payment or partial payment was not offset against the amount paid 26872

by the medicaid program to reduce or eliminate the amount that was paid by the medicaid program;

(4) Payment when a medicaid recipient's responsibility for payment was understated and resulted in an overpayment to the provider.

(C) The department may recover an overpayment under this section prior to or after any of the following:

(1) Adjudication of a final fiscal audit that section ~~5111.06~~ 5163.01 of the Revised Code requires to be conducted in accordance with Chapter 119. of the Revised Code;

(2) Adjudication of a finding under any other provision of this chapter or the rules adopted under it;

(3) Expiration of the time to issue a final fiscal audit that section ~~5111.06~~ 5163.01 of the Revised Code requires to be conducted in accordance with Chapter 119. of the Revised Code;

(4) Expiration of the time to issue a finding under any other provision of this chapter or the rules adopted under it.

(D)(1) Subject to division (D)(2) of this section, the recovery of an overpayment under this section does not preclude the department from subsequently doing the following:

(a) Issuing a final fiscal audit in accordance with Chapter 119. of the Revised Code, as required under section ~~5111.06~~ 5163.01 of the Revised Code;

(b) Issuing a finding under any other provision of this chapter or the rules adopted under it.

(2) A final fiscal audit or finding issued subsequent to the recovery of an overpayment under this section shall be reduced by the amount of the prior recovery, as appropriate.

(E) Nothing in this section limits the department's authority to recover overpayments pursuant to any other provision of the

Revised Code. 26903

Sec. ~~5111.022~~ 5163.08. Under the medicaid program, any amount 26904
determined to be owed the state by a final fiscal audit conducted 26905
pursuant to ~~division (D) of~~ section ~~5111.021~~ 5163.04 of the 26906
Revised Code, upon the issuance of an adjudication order pursuant 26907
to Chapter 119. of the Revised Code that contains a finding that 26908
there is a preponderance of the evidence that the provider will 26909
liquidate assets or file bankruptcy in order to prevent payment of 26910
the amount determined to be owed the state, becomes a lien upon 26911
the real and personal property of the provider. Upon failure of 26912
the provider to pay the amount to the state, the director of ~~job~~ 26913
~~and family services~~ health care administration shall file notice 26914
of the lien, for which there shall be no charge, in the office of 26915
the county recorder of the county in which it is ascertained that 26916
the provider owns real or personal property. The director shall 26917
notify the provider by mail of the lien, but absence of proof that 26918
the notice was sent does not affect the validity of the lien. The 26919
lien is not valid as against the claim of any mortgagee, pledgee, 26920
purchaser, judgment creditor, or other lienholder of record at the 26921
time the notice is filed. 26922

26923

If the provider acquires real or personal property after 26924
notice of the lien is filed, the lien shall not be valid as 26925
against the claim of any mortgagee, pledgee, subsequent bona fide 26926
purchaser for value, judgment creditor, or other lienholder of 26927
record to such after-acquired property unless the notice of lien 26928
is refiled after the property is acquired by the provider and 26929
before the competing lien attaches to the after-acquired property 26930
or before the conveyance to the subsequent bona fide purchaser for 26931
value. 26932

When the amount has been paid, the provider may record with 26933

the recorder notice of the payment. For recording such notice of payment, the recorder shall charge and receive from the provider a base fee of one dollar for services and a housing trust fund fee of one dollar pursuant to section 317.36 of the Revised Code. 26934 26935 26936 26937

In the event of a distribution of a provider's assets pursuant to an order of any court under the law of this state including any receivership, assignment for benefit of creditors, adjudicated insolvency, or similar proceedings, amounts then or thereafter due the state under this chapter have the same priority as provided by law for the payment of taxes due the state and shall be paid out of the receivership trust fund or other such trust fund in the same manner as provided for claims for unpaid taxes due the state. 26938 26939 26940 26941 26942 26943 26944 26945 26946

If the attorney general finds after investigation that any amount due the state under this chapter is uncollectable, in whole or in part, the attorney general shall recommend to the director the cancellation of all or part of the claim. The director may thereupon effect the cancellation. 26947 26948 26949 26950 26951

Sec. ~~5111.062~~ 5163.09. In any action taken by the department of ~~job and family services~~ health care administration under section ~~5111.06~~ 5163.01 or ~~5111.061~~ 5163.07 of the Revised Code or any other provision of ~~this chapter~~ law governing the medicaid program that requires the department to give notice of an opportunity for a hearing in accordance with Chapter 119. of the Revised Code, if the department gives notice of the opportunity for a hearing but the provider or other entity subject to the notice does not request a hearing or timely request a hearing in accordance with section 119.07 of the Revised Code, the department is not required to hold a hearing. The director of ~~job and family service~~ health care administration may proceed by issuing a final adjudication order in accordance with Chapter 119. of the Revised 26952 26953 26954 26955 26956 26957 26958 26959 26960 26961 26962 26963 26964

Code. 26965

Sec. ~~5111.101~~ 5163.12. (A) As used in this section; 26966

"Agent" and "contractor" include any agent, contractor, subcontractor, or other person who, on behalf of an entity, furnishes or authorizes the furnishing of health care items or services under the medicaid program, performs billing or coding functions, or is involved in monitoring of health care that an entity provides. 26967 26968 26969 26970 26971 26972

"Employee" includes any officer or employee (including management employees) of an entity. 26973 26974

"Entity" includes a governmental entity or an organization, unit, corporation, partnership, or other business arrangement, including any medicaid managed care organization, irrespective of the form of business structure or arrangement by which it exists, whether for-profit or not-for-profit. "Entity" does not include a government entity that administers one or more components of the medicaid program, unless the government entity receives medicaid payments for providing items or services. 26975 26976 26977 26978 26979 26980 26981 26982

"Federal health care programs" has the same meaning as in 42 U.S.C. 1320a-7b(f). 26983 26984

(B) Each entity that receives or makes in a federal fiscal year payments under the medicaid program, either through the state medicaid plan or a federal medicaid waiver, totaling at least five million dollars shall, as a condition of receiving such payments, do all of the following not later than the first day of the succeeding calendar year: 26985 26986 26987 26988 26989 26990

(1) Establish written policies for all of the entity's employees, contractors, and agents that provide detailed information about the role of all of the following in preventing and detecting fraud, waste, and abuse in federal health care 26991 26992 26993 26994

programs: 26995

(a) Federal false claims law under 31 U.S.C. 3729 to 3733; 26996

(b) Federal administrative remedies for false claims and statements available under 31 U.S.C. 3801 to 3812; 26997 26998

(c) Sections 124.341, 2913.40, 2913.401, and 2921.13 of the Revised Code and any other state laws pertaining to civil or criminal penalties for false claims and statements; 26999 27000 27001

(d) Whistleblower protections under the laws specified in divisions (B)(1)(a) to (c) of this section. 27002 27003

(2) Include as part of the written policies required by division (B)(1) of this section detailed provisions regarding the entity's policies and procedures for preventing and detecting fraud, waste, and abuse. 27004 27005 27006 27007

(3) Disseminate the written policies required by division (B)(1) of this section to each of the entity's employees, contractors, and agents in a paper or electronic form and make the written policies readily available to the entity's employees, contractors, and agents. 27008 27009 27010 27011 27012

(4) If the entity has an employee handbook, include in the employee handbook a specific discussion of the laws specified in division (B)(1) of this section, the rights of employees to be protected as whistleblowers, and the entity's policies and procedures for preventing and detecting fraud, waste, and abuse. 27013 27014 27015 27016 27017

(5) Require the entity's contractors and agents to adopt the entity's written policies required by division (B)(1) of this section. 27018 27019 27020

(C) An entity that furnishes items or services at multiple locations or under multiple contractual or other payment arrangements is required to comply with division (B) of this section if the entity receives in a federal fiscal year medicaid 27021 27022 27023 27024

payments totaling in the aggregate at least five million dollars. This applies regardless of whether the entity submits claims for medicaid payments using multiple provider identification or tax identification numbers.

Sec. ~~5111.02~~ 5163.15. The director of ~~job and family services~~ health care administration shall adopt, and may amend or rescind, rules under Chapter 119. of the Revised Code establishing the amount, duration, and scope of medicaid services. The rules shall be consistent with federal and state law. The rules may be different for different medicaid services. The rules shall establish all of the following:

(A) The conditions under which the medicaid program shall cover and reimburse medicaid services;

(B) The method of reimbursement applicable to each medicaid service;

(C) The amount of reimbursement or, in lieu of amounts, methods by which amounts are to be determined for each medicaid service;

(D) Procedures for enforcing the rules adopted under this section that provide due process protections, including procedures for corrective action plans for, and imposing financial and administrative sanctions on, persons and government entities that violate the rules.

Sec. ~~5111.021~~ 5163.16. Under the medicaid program:

(A) Except as otherwise permitted by federal statute or regulation and at the department's discretion, reimbursement by the department of ~~job and family services~~ health care administration to a medical provider for any medical service rendered under the program shall not exceed the authorized reimbursement level for the same service under the medicare

program ~~established under Title XVIII of the "Social Security Act," 79 Stat. 286 (1965), 42 U.S.C. 1395, as amended~~.

(B) Reimbursement for freestanding medical laboratory charges shall not exceed the customary and usual fee for laboratory profiles.

(C) The department may deduct from payments for services rendered by a medicaid provider under the medicaid program any amounts the provider owes the state as the result of incorrect medicaid payments the department has made to the provider.

(D) ~~The department may conduct final fiscal audits in accordance with the applicable requirements set forth in federal laws and regulations and determine any amounts the provider may owe the state. When conducting final fiscal audits, the department shall consider generally accepted auditing standards, which include the use of statistical sampling.~~

~~(E)~~ The number of days of inpatient hospital care for which reimbursement is made on behalf of a medicaid recipient to a hospital that is not paid under a diagnostic-related-group prospective payment system shall not exceed thirty days during a period beginning on the day of the recipient's admission to the hospital and ending sixty days after the termination of that hospital stay, except that the department may make exceptions to this limitation. The limitation does not apply to children participating in the program for medically handicapped children established under section 3701.023 of the Revised Code.

~~(F)~~(E) The division of any reimbursement between a collaborating physician or podiatrist and a clinical nurse specialist, certified nurse-midwife, or certified nurse practitioner for services performed by the nurse shall be determined and agreed on by the nurse and collaborating physician or podiatrist. In no case shall reimbursement exceed the payment

that the physician or podiatrist would have received had the physician or podiatrist provided the entire service. 27086 27087

Sec. ~~5111.025~~ 5163.17. (A) In rules adopted under section ~~5111.02~~ 5163.15 of the Revised Code, the director of ~~job and family services~~ health care administration shall modify the manner or establish a new manner in which the following are paid under medicaid: 27088 27089 27090 27091 27092

(1) Community mental health facilities for providing mental health services included in the state medicaid plan pursuant to section ~~5111.023~~ 5163.20 of the Revised Code; 27093 27094 27095

(2) Providers of alcohol and drug addiction services for providing alcohol and drug addiction services included in the medicaid program pursuant to rules adopted under section ~~5111.02~~ 5163.15 of the Revised Code. 27096 27097 27098 27099

(B) The director's authority to modify the manner, or to establish a new manner, for medicaid to pay for the services specified in division (A) of this section is not limited by any rules adopted under section ~~5111.02~~ 5163.15 or 5119.61 of the Revised Code that are in effect on June 26, 2003, and govern the way medicaid pays for those services. This is the case regardless of what state agency adopted the rules. 27100 27101 27102 27103 27104 27105 27106

Sec. ~~5111.018~~ 5163.18. (A) The ~~provision of medical assistance under this chapter~~ medicaid program shall ~~include coverage of~~ cover inpatient care and follow-up care for a mother and her newborn as follows: 27107 27108 27109 27110

(1) The ~~medical assistance~~ medicaid program shall cover a minimum of forty-eight hours of inpatient care following a normal vaginal delivery and a minimum of ninety-six hours of inpatient care following a cesarean delivery. Services covered as inpatient care shall include medical, educational, and any other services 27111 27112 27113 27114 27115

that are consistent with the inpatient care recommended in the protocols and guidelines developed by national organizations that represent pediatric, obstetric, and nursing professionals. 27116 27117 27118

(2) The ~~medical assistance~~ medicaid program shall cover a physician-directed source of follow-up care. Services covered as follow-up care shall include physical assessment of the mother and newborn, parent education, assistance and training in breast or bottle feeding, assessment of the home support system, performance of any medically necessary and appropriate clinical tests, and any other services that are consistent with the follow-up care recommended in the protocols and guidelines developed by national organizations that represent pediatric, obstetric, and nursing professionals. The coverage shall apply to services provided in a medical setting or through home health care visits. The coverage shall apply to a home health care visit only if the health care professional who conducts the visit is knowledgeable and experienced in maternity and newborn care. 27119 27120 27121 27122 27123 27124 27125 27126 27127 27128 27129 27130 27131 27132

When a decision is made in accordance with division (B) of this section to discharge a mother or newborn prior to the expiration of the applicable number of hours of inpatient care required to be covered, the coverage of follow-up care shall apply to all follow-up care that is provided within forty-eight hours after discharge. When a mother or newborn receives at least the number of hours of inpatient care required to be covered, the coverage of follow-up care shall apply to follow-up care that is determined to be medically necessary by the health care professionals responsible for discharging the mother or newborn. 27133 27134 27135 27136 27137 27138 27139 27140 27141 27142

(B) Any decision to shorten the length of inpatient stay to less than that specified under division (A)(1) of this section shall be made by the physician attending the mother or newborn, except that if a nurse-midwife is attending the mother in collaboration with a physician, the decision may be made by the 27143 27144 27145 27146 27147

nurse-midwife. Decisions regarding early discharge shall be made 27148
only after conferring with the mother or a person responsible for 27149
the mother or newborn. For purposes of this division, a person 27150
responsible for the mother or newborn may include a parent, 27151
guardian, or any other person with authority to make medical 27152
decisions for the mother or newborn. 27153

(C) The department of ~~job and family services~~ health care 27154
administration, in administering the ~~medical assistance~~ medicaid 27155
program, may not do either of the following: 27156

(1) Terminate the participation of a health care professional 27157
or health care facility as a provider under the program solely for 27158
making recommendations for inpatient or follow-up care for a 27159
particular mother or newborn that are consistent with the care 27160
required to be covered by this section; 27161

(2) Establish or offer monetary or other financial incentives 27162
for the purpose of encouraging a person to decline the inpatient 27163
or follow-up care required to be covered by this section. 27164

(D) This section does not do any of the following: 27165

(1) Require the ~~medical assistance~~ medicaid program to cover 27166
inpatient or follow-up care that is not received in accordance 27167
with the program's terms pertaining to the health care 27168
professionals and facilities from which an individual is 27169
authorized to receive health care services. 27170

(2) Require a mother or newborn to stay in a hospital or 27171
other inpatient setting for a fixed period of time following 27172
delivery; 27173

(3) Require a child to be delivered in a hospital or other 27174
inpatient setting; 27175

(4) Authorize a nurse-midwife to practice beyond the 27176
authority to practice nurse-midwifery in accordance with Chapter 27177

4723. of the Revised Code; 27178

(5) Establish minimum standards of medical diagnosis, care, 27179
or treatment for inpatient or follow-up care for a mother or 27180
newborn. A deviation from the care required to be covered under 27181
this section shall not, on the basis of this section, give rise to 27182
a medical claim or derivative medical claim, as those terms are 27183
defined in section 2305.113 of the Revised Code. 27184

Sec. ~~5111.024~~ 5163.19. (A) As used in this section, 27185
"screening mammography" means a radiologic examination utilized to 27186
detect unsuspected breast cancer at an early stage in asymptomatic 27187
women and includes the x-ray examination of the breast using 27188
equipment that is dedicated specifically for mammography, 27189
including the x-ray tube, filter, compression device, screens, 27190
film, and cassettes, and that has an average radiation exposure 27191
delivery of less than one rad mid-breast. "Screening mammography" 27192
includes two views for each breast. The term also includes the 27193
professional interpretation of the film. 27194

"Screening mammography" does not include diagnostic 27195
mammography. 27196

(B) ~~In addition to any other services required to be included~~ 27197
~~in the program or for which federal approval is received, the~~ 27198
~~medical assistance~~ The medicaid program shall ~~include~~ cover both 27199
of the following if ~~approval for use of federal funds is granted~~ 27200
~~to the department by the federal agency responsible for~~ 27201
~~distributing funds under Title XIX of the "Social Security Act,"~~ 27202
~~49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended~~ federal financial 27203
participation is available for them: 27204

(1) ~~Effective July 1, 1993, screening~~ Screening mammography 27205
to detect the presence of breast cancer in adult women; 27206

(2) ~~Effective January 1, 1993, cytologic~~ Cytologic screening 27207

for the presence of cervical cancer. 27208

(C) The service provided under division (B)(1) of this 27209
section shall be provided in accordance with all of the following: 27210

(1) If a woman is at least thirty-five years of age but under 27211
forty years of age, one screening mammography; 27212

(2) If a woman is at least forty years of age but under fifty 27213
years of age, either of the following: 27214

(a) One screening mammography every two years; 27215

(b) If a licensed physician has determined that the woman has 27216
risk factors to breast cancer, one screening mammography every 27217
year. 27218

(3) If a woman is at least fifty years of age but under 27219
sixty-five years of age, one screening mammography every year. 27220

(D) The service provided under division (B)(1) of this 27221
section shall be provided only for screening mammographies that 27222
are performed in a facility or mobile mammography screening unit 27223
that is accredited under the American college of radiology 27224
mammography accreditation program or in a hospital as defined in 27225
section 3727.01 of the Revised Code. 27226

(E) The service provided under division (B)(2) of this 27227
section shall be provided only for cytologic screenings that are 27228
processed and interpreted in a laboratory certified by the college 27229
of American pathologists or in a hospital as defined in section 27230
3727.01 of the Revised Code. 27231

Sec. ~~5111.023~~ 5163.20. (A) As used in this section: 27232

(1) "Community mental health facility" means a community 27233
mental health facility that has a quality assurance program 27234
accredited by the joint commission on accreditation of healthcare 27235
organizations or is certified by the department of mental health 27236

or department of ~~job and family services~~ health care administration. 27237 27238

(2) "Mental health professional" means a person qualified to work with mentally ill persons under the standards established by the director of mental health pursuant to section 5119.611 of the Revised Code. 27239 27240 27241 27242

(B) The state medicaid plan shall include provision of the following mental health services when provided by community mental health facilities: 27243 27244 27245

(1) Outpatient mental health services, including, but not limited to, preventive, diagnostic, therapeutic, rehabilitative, and palliative interventions rendered to individuals in an individual or group setting by a mental health professional in accordance with a plan of treatment appropriately established, monitored, and reviewed; 27246 27247 27248 27249 27250 27251

(2) Partial-hospitalization mental health services rendered by persons directly supervised by a mental health professional; 27252 27253

(3) Unscheduled, emergency mental health services of a kind ordinarily provided to persons in crisis when rendered by persons supervised by a mental health professional; 27254 27255 27256

(4) Subject to receipt of federal approval, assertive community treatment and intensive home-based mental health services. 27257 27258 27259

(C) The comprehensive annual plan shall certify the availability of sufficient unencumbered community mental health state subsidy and local funds to match federal medicaid reimbursement funds earned by community mental health facilities. 27260 27261 27262 27263

(D) The department of ~~job and family services~~ health care administration shall enter into a separate contract with the department of mental health under section ~~5111.91~~ 5161.05 of the 27264 27265 27266

Revised Code with regard to the component of the medicaid program provided for by this section. 27267 27268

(E) Not later than July 21, 2006, the department of ~~job and family services~~ health care administration shall request federal approval to provide assertive community treatment and intensive home-based mental health services under medicaid pursuant to this section. 27269 27270 27271 27272 27273

(F) On receipt of federal approval sought under division (E) of this section, the director of ~~job and family services~~ health care administration shall adopt rules in accordance with Chapter 119. of the Revised Code for assertive community treatment and intensive home-based mental health services provided under medicaid pursuant to this section. The director shall consult with the department of mental health in adopting the rules. 27274 27275 27276 27277 27278 27279 27280

Sec. ~~5111.04~~ 5163.21. (A) As used in this section: 27281

(1) "Outpatient health facility" means a facility that provides comprehensive primary health services by or under the direction of a physician at least five days per week on a forty-hour per week basis to outpatients, is operated by the board of health of a city or general health district or another public agency or by a nonprofit private agency or organization under the direction and control of a governing board that has no health-related responsibilities other than the direction and control of one or more such outpatient health facilities, and receives at least seventy-five per cent of its operating funds from public sources, except that it does not include an outpatient hospital facility or a federally qualified health center as defined in Sec. 1905(l) (2)(B) of the "Social Security Act," 103 Stat. 2264 (1989), 42 U.S.C.A. 1396d(l)(2)(B). 27282 27283 27284 27285 27286 27287 27288 27289 27290 27291 27292 27293 27294 27295

(2) "Comprehensive primary health services" means preventive, diagnostic, therapeutic, rehabilitative, or palliative items or 27296 27297

services that include all of the following: 27298

(a) Services of physicians, physician assistants, and 27299
certified nurse practitioners; 27300

(b) Diagnostic laboratory and radiological services; 27301

(c) Preventive health services, such as children's eye and 27302
ear examinations, perinatal services, well child services, and 27303
family planning services; 27304

(d) Arrangements for emergency medical services; 27305

(e) Transportation services. 27306

(3) "Certified nurse practitioner" has the same meaning as in 27307
section 4723.01 of the Revised Code. 27308

(B) Outpatient health facilities are a separate category of 27309
medical care provider under the rules governing the administration 27310
of the ~~medical assistance~~ medicaid program ~~established under~~ 27311
~~section 5111.01 of the Revised Code~~. Rates of reimbursement for 27312
items and services provided by an outpatient health facility under 27313
this section shall be prospectively determined by the department 27314
of ~~job and family services~~ health care administration not less 27315
often than once each year, shall not be subject to retroactive 27316
adjustment based on actual costs incurred, and shall not exceed 27317
the maximum fee schedule or rates of payment, limitations based on 27318
reasonable costs or customary charges, and limitations based on 27319
combined payments received for furnishing comparable services, as 27320
are applicable to outpatient hospital facilities under ~~Title XVIII~~ 27321
~~of~~ the ~~"Social Security Act~~ medicare program.~~"~~ In determining 27322
rates of reimbursement prospectively, the department shall take 27323
into account the historic expenses of the facility, the operating 27324
requirements and services offered by the facility, and the 27325
geographical location of the facility, shall provide incentives 27326
for the efficient and economical utilization of the facility's 27327
resources, and shall ensure that the facility does not 27328

discriminate between classes of persons for whom or by whom payment for items and services is made. 27329 27330

(C) A facility does not qualify for classification as an outpatient health facility under this section unless it: 27331 27332

(1) Has health and medical care policies developed with the advice of and subject to review by an advisory committee of professional personnel, including one or more physicians, one or more dentists if dental care is provided, and one or more registered nurses; 27333 27334 27335 27336 27337

(2) Has a medical director, a dental director, if dental care is provided, and a nursing director responsible for the execution of such policies, and has physicians, dentists, nursing, and ancillary staff appropriate to the scope of services provided; 27338 27339 27340 27341

(3) Requires that the care of every patient be under the supervision of a physician, provides for medical care in case of emergency, has in effect a written agreement with one or more hospitals and one or more other outpatient facilities, and has an established system for the referral of patients to other resources and a utilization review plan and program; 27342 27343 27344 27345 27346 27347

(4) Maintains clinical records on all patients; 27348

(5) Provides nursing services and other therapeutic services in compliance with applicable laws and rules and under the supervision of a registered nurse, and has a registered nurse on duty at all times when the facility is in operation; 27349 27350 27351 27352

(6) Follows approved methods and procedures for the dispensing and administration of drugs and biologicals; 27353 27354

(7) Maintains the accounting and record-keeping system required under federal laws and regulations for the determination of reasonable and allowable costs. 27355 27356 27357

Sec. ~~5111.14~~ 5163.22. The department of ~~job and family~~ 27358

~~services~~ health care administration may require county departments of job and family services to provide case management of nonemergency transportation services provided under the ~~medical assistance~~ medicaid program. County departments shall provide the case management if required by the department in accordance with rules adopted by the director of ~~job and family services~~ health care administration.

The department shall determine, for the purposes of claiming federal reimbursement under the ~~medical assistance~~ medicaid program, whether it will claim expenditures for nonemergency transportation services as administrative or program expenditures.

Sec. ~~5111.19~~ 5163.23. The director of ~~job and family services~~ health care administration shall adopt rules governing the calculation and payment of graduate medical education costs associated with services rendered to medicaid recipients after June 30, 1994. Subject to section ~~5111.191~~ 5163.231 of the Revised Code, the rules shall provide for reimbursement of graduate medical education costs associated with services rendered to medicaid recipients, including recipients enrolled in a managed care organization under contract with the department under section ~~5111.17~~ 5165.05 of the Revised Code, that the department determines are allowable and reasonable.

If the department requires a managed care organization to pay a provider for graduate medical education costs associated with the delivery of services to medicaid recipients enrolled in the organization, the department shall include in its payment to the organization an amount sufficient for the organization to pay such costs. If the department does not include in its payments to the managed care organization amounts for graduate medical education costs of providers, all of the following apply:

(A) Except as provided in section ~~5111.191~~ 5163.231 of the

Revised Code, the department shall pay the provider for graduate medical education costs associated with the delivery of services to medicaid recipients enrolled in the organization;

(B) No provider shall seek reimbursement from the organization for such costs;

(C) The organization is not required to pay providers for such costs.

Sec. ~~5111.191~~ 5163.231. (A) Except as provided in division (B) of this section, the department of ~~job and family services~~ health care administration may deny payment to a hospital for direct graduate medical education costs associated with the delivery of services to any medicaid recipient if the hospital refuses without good cause to contract with a managed care organization that serves participants in the care management system established under section ~~5111.16~~ 5165.03 of the Revised Code who are required to be enrolled in a managed care organization and the managed care organization serves the area in which the hospital is located.

(B) A hospital is not subject to division (A) of this section if all of the following are the case:

(1) The hospital is located in a county in which participants in the care management system are required before January 1, 2006, to be enrolled in a medicaid managed care organization that is a health insuring corporation.

(2) The hospital has entered into a contract before January 1, 2006, with at least one health insuring corporation serving the participants specified in division (B)(1) of this section.

(3) The hospital remains under contract with at least one health insuring corporation serving participants in the care management system who are required to be enrolled in a health

insuring corporation. 27420

(C) The director of ~~job and family services~~ health care 27421
administration shall specify in the rules adopted under section 27422
~~5111.19~~ 5163.231 of the Revised Code what constitutes good cause 27423
for a hospital to refuse to contract with a managed care 27424
organization. 27425

Sec. ~~5111.082~~ 5163.24. (A) As used in this section: 27426

(1) "State maximum allowable cost" means the per unit amount 27427
the department of ~~job and family services~~ health care 27428
administration reimburses a terminal distributor of dangerous 27429
drugs for a prescription drug included in the state maximum 27430
allowable cost program established under division (B) of this 27431
section. "State maximum allowable cost" excludes dispensing fees 27432
and copayments, coinsurance, or other cost-sharing charges, if 27433
any. 27434

(2) "Terminal distributor of dangerous drugs" has the same 27435
meaning as in section 4729.01 of the Revised Code. 27436

(B) The director of ~~job and family services~~ health care 27437
administration shall establish a state maximum allowable cost 27438
program for purposes of managing reimbursement to terminal 27439
distributors of dangerous drugs for prescription drugs identified 27440
by the director pursuant to this division. The director shall do 27441
all of the following with respect to the program: 27442

(1) Identify and create a list of prescription drugs to be 27443
included in the program. 27444

(2) Update the list of prescription drugs described in 27445
division (B)(1) of this section on a weekly basis. 27446

(3) Review the state maximum allowable cost for each drug 27447
included on the list described in division (B)(1) of this section 27448
on a weekly basis. 27449

(C) The director may adopt rules in accordance with Chapter 27450
119. of the Revised Code to implement this section. 27451

Sec. ~~5111.08~~ 5163.241. In accordance with ~~subsection (g) of~~ 27452
~~section 1927 of the "Social Security Act," 49 Stat. 320 (1935),~~ 42 27453
U.S.C.~~A.~~ 1396r-8(g), ~~as amended,~~ the department of ~~job and family~~ 27454
~~services~~ health care administration shall establish an outpatient 27455
drug use review program to assure that prescriptions obtained by 27456
recipients of medical assistance under this chapter are 27457
appropriate, medically necessary, and unlikely to cause adverse 27458
medical results. 27459

Sec. ~~5111.027~~ 5163.242. If the medicaid program provides 27460
prescription drug services to medicaid recipients, the program 27461
shall not provide reimbursement for prescription drugs for 27462
treatment of erectile dysfunction. 27463

Sec. ~~5111.083~~ 5163.243. (A) As used in this section, 27464
"licensed health professional authorized to prescribe drugs" has 27465
the same meaning as in section 4729.01 of the Revised Code. 27466

(B) The director of ~~job and family services~~ health care 27467
administration may establish an e-prescribing system for the 27468
medicaid program under which a medicaid provider who is a licensed 27469
health professional authorized to prescribe drugs shall use an 27470
electronic system to prescribe a drug for a medicaid recipient 27471
when required to do so by division (C) of this section. The 27472
e-prescribing system shall eliminate the need for such medicaid 27473
providers to make prescriptions for medicaid recipients by 27474
handwriting or telephone. The e-prescribing system also shall 27475
provide such medicaid providers with an up-to-date, clinically 27476
relevant drug information database and a system of electronically 27477
monitoring medicaid recipients' medical history, drug regimen 27478
compliance, and fraud and abuse. 27479

(C) If the director establishes an e-prescribing system under 27480
division (B) of this section, the director shall do all of the 27481
following: 27482

(1) Require that a medicaid provider who is a licensed health 27483
professional authorized to prescribe drugs use the e-prescribing 27484
system during a fiscal year if the medicaid provider was one of 27485
the ten medicaid providers who, during the calendar year that 27486
precedes that fiscal year, issued the most prescriptions for 27487
medicaid recipients receiving hospital services; 27488

(2) Before the beginning of each fiscal year, determine the 27489
ten medicaid providers that issued the most prescriptions for 27490
medicaid recipients receiving hospital services during the 27491
calendar year that precedes the upcoming fiscal year and notify 27492
those medicaid providers that they must use the e-prescribing 27493
system for the upcoming fiscal year; 27494

(3) Seek the most federal financial participation available 27495
for the development and implementation of the e-prescribing 27496
system. 27497

Sec. ~~5111.07~~ 5163.25. Commencing in July, 1986, and every 27498
second July thereafter, the department of ~~job and family services~~ 27499
health care administration shall initiate a private survey of 27500
retail pharmacy operations in the state as the basis for 27501
establishing a current maximum dispensing fee for licensed 27502
pharmacists who are providers of drugs under this chapter. The 27503
survey shall be conducted in conformance with the requirements set 27504
forth in 42 C.F.R. 447.331 through 447.333, as amended or 27505
superseded, and shall include operational data and direct 27506
prescription expenses, professional services and personnel costs, 27507
usual and customary overhead expenses, and profit data of the 27508
retail pharmacies surveyed. The survey shall be completed and its 27509
results published no later than the last day of October of the 27510

year in which the survey is conducted, and the survey shall 27511
compute and report dispensing fees on a basis of the usual and 27512
customary charges by retail pharmacies to their customers for 27513
dispensing drugs. The director of ~~job and family services~~ health 27514
care administration shall take into account the results of the 27515
survey in establishing a dispensing fee. 27516

Sec. ~~5111.071~~ 5163.251. Commencing in December, 1986, and 27517
every second December thereafter, the director of ~~job and family~~ 27518
~~services~~ health care administration shall establish a dispensing 27519
fee, effective the following January, for licensed pharmacists who 27520
are medicaid providers ~~under this chapter~~. The dispensing fee 27521
shall take into consideration the results of the survey conducted 27522
under section ~~5111.07~~ 5163.25 of the Revised Code. 27523

Sec. ~~5111.081~~ 5163.26. The director of ~~job and family~~ 27524
~~services~~ health care administration, in rules adopted under 27525
section ~~5111.02~~ 5163.15 of the Revised Code, may establish and 27526
implement a supplemental drug rebate program under which drug 27527
manufacturers may be required to provide the department of ~~job and~~ 27528
~~family services~~ health care administration a supplemental rebate 27529
as a condition of having the drug manufacturers' drug products 27530
covered by the medicaid program without prior approval. The 27531
department may receive a supplemental rebate negotiated under the 27532
program for a drug dispensed to a medicaid recipient pursuant to a 27533
prescription or a drug purchased by a medicaid provider for 27534
administration to a medicaid recipient in the provider's primary 27535
place of business. If necessary, the director may apply to the 27536
United States secretary of health and human services for a waiver 27537
of federal statutes and regulations to establish the supplemental 27538
drug rebate program. 27539

If the director establishes a supplemental drug rebate 27540
program, the director shall consult with drug manufacturers 27541

regarding the establishment and implementation of the program. 27542

Sec. ~~5111.0114~~ 5163.261. (A) As used in this section, 27543
"dangerous drug" and "manufacturer of dangerous drugs" have the 27544
same meaning as in section 4729.01 of the Revised Code. 27545

(B) The director of ~~job and family services~~ health care 27546
administration may enter into or administer an agreement or 27547
cooperative arrangement with other states to create or join a 27548
multiple-state prescription drug purchasing program for the 27549
purpose of negotiating with manufacturers of dangerous drugs to 27550
receive discounts or rebates for dangerous drugs dispensed under 27551
the medicaid program. 27552

Sec. ~~5111.029~~ 5163.27. The medicaid program shall cover 27553
occupational therapy services provided by an occupational 27554
therapist licensed under section 4755.08 of the Revised Code. 27555
Coverage shall not be limited to services provided in a hospital 27556
or nursing facility. Any licensed occupational therapist may enter 27557
into a medicaid provider agreement with the department of ~~job and~~ 27558
~~family services~~ health care administration to provide occupational 27559
therapy services under the medicaid program. 27560

Sec. ~~5111.042~~ 5163.28. The departments of mental retardation 27561
and developmental disabilities and ~~job and family services~~ health 27562
care administration may approve, reduce, deny, or terminate a 27563
service included in the individualized service plan developed for 27564
a medicaid recipient with mental retardation or other 27565
developmental disability who is eligible for medicaid case 27566
management services. If either department approves, reduces, 27567
denies, or terminates a service, that department shall timely 27568
notify the medicaid recipient that the recipient may request a 27569
hearing under section ~~5101.35~~ 5160.34 of the Revised Code. 27570

Sec. ~~5111.71~~ 5163.30. (A) As used in sections ~~5111.71~~ 5163.30 to ~~5111.715~~ 5163.305 of the Revised Code, "qualified medicaid school provider" means the board of education of a city, local, or exempted village school district, the governing authority of a community school established under Chapter 3314. of the Revised Code, the state school for the deaf, and the state school for the blind to which both of the following apply:

(1) It holds a valid medicaid provider agreement.

(2) It meets all other conditions for participation in the medicaid school component of the medicaid program established in rules adopted under section ~~5111.715~~ 5163.305 of the Revised Code.

(B) The director of ~~job and family services~~ health care administration shall submit a state medicaid plan amendment to the United States secretary of health and human services for the purpose of creating, in accordance with sections ~~5111.71~~ 5163.30 to ~~5111.715~~ 5163.305 of the Revised Code, the medicaid school component of the medicaid program. The director shall create the medicaid school component on receipt of the United States secretary's approval of the amendment.

Sec. ~~5111.711~~ 5163.301. A qualified medicaid school provider participating in the medicaid school component of the medicaid program may submit a claim to the department of ~~job and family services~~ health care administration for federal financial participation for providing, in schools, services covered by the medicaid school component to medicaid recipients who are eligible for the services. No qualified medicaid school provider may submit such a claim before the provider incurs the cost of providing the service.

The claim shall include certification of the qualified medicaid school provider's expenditures for the service. The

certification shall show that the money the qualified medicaid school provider used for the expenditures was nonfederal money the provider may legally use for providing the service and that the amount of the expenditures was sufficient to pay the full cost of the service.

Except as otherwise provided in sections ~~5111.71~~ 5163.30 to ~~5111.715~~ 5163.305 of the Revised Code and rules adopted under sections ~~5111.713~~ 5163.303 and ~~5111.715~~ 5163.305 of the Revised Code, a qualified medicaid school provider is subject to all conditions of participation in the medicaid program that generally apply to providers of goods and services under the medicaid program, including conditions regarding audits and recovery of overpayments.

Sec. ~~5111.712~~ 5163.302. The department of ~~job and family services~~ health care administration shall seek federal financial participation for each claim a qualified medicaid school provider properly submits to the department under section ~~5111.711~~ 5163.301 of the Revised Code. The department shall disburse the federal financial participation the department receives from the federal government for such a claim to the qualified medicaid school provider that submitted the claim. The department may not pay the qualified medicaid school provider the nonfederal share of the cost of the services for which the claim was submitted.

Sec. ~~5111.713~~ 5163.303. The department of ~~job and family services~~ health care administration shall enter into an interagency agreement with the department of education under section ~~5111.91~~ 5161.05 of the Revised Code that provides for the department of education to administer the medicaid school component of the medicaid program other than the aspects of the component that sections ~~5111.71~~ 5163.30 to ~~5111.715~~ 5163.305 of the Revised Code require the department of ~~job and family services~~

health care administration to administer. The interagency 27632
agreement may include a provision that provides for the department 27633
of education to pay to the department of ~~job and family services~~ 27634
health care administration the nonfederal share of a portion of 27635
the administrative expenses the department of ~~job and family~~ 27636
~~services~~ health care administration incurs in administering the 27637
aspects of the component that the department of ~~job and family~~ 27638
~~services~~ health care administration administers. 27639

The department of education shall establish, in rules adopted 27640
under Chapter 119. of the Revised Code, a process by which 27641
qualified medicaid school providers participating in the medicaid 27642
school component pay to the department of education the nonfederal 27643
share of the department's expenses incurred in administering the 27644
component. 27645

Sec. ~~5111.714~~ 5163.304. (A) There is hereby created in the 27646
state treasury the medicaid school program administrative fund. 27647

(B) Both of the following shall be deposited into the 27648
medicaid school program administrative fund: 27649

(1) The federal funds the department of education receives 27650
for the expenses the department incurs in administering the 27651
medicaid school component of the medicaid program; 27652

(2) The money the department collects from qualified medicaid 27653
school providers in the process established in rules adopted under 27654
section ~~5111.713~~ 5163.303 of the Revised Code. 27655

(C) No funds shall be deposited into the medicaid school 27656
program administrative fund in violation of federal statutes or 27657
regulations. 27658

(D) The department of education shall use money in the 27659
medicaid school program administrative fund for both of the 27660
following purposes: 27661

(1) Paying for the expenses the department incurs in administering the medicaid school component of the medicaid program;

(2) Paying a qualified medicaid school provider a refund for any overpayment the provider makes to the department under the process established in rules adopted under section ~~5111.713~~ 5163.303 of the Revised Code if the process results in an overpayment.

Sec. ~~5111.715~~ 5163.305. The director of ~~job and family services~~ health care administration shall adopt rules under Chapter 119. of the Revised Code as necessary to implement the medicaid school component of the medicaid program, including rules that establish or specify all of the following:

(A) Conditions a board of education of a city, local, or exempted school district, governing authority of a community school established under Chapter 3314. of the Revised Code, the state school for the deaf, and the state school for the blind must meet to participate in the component;

(B) Services the component covers;

(C) Reimbursement rates for the services the component covers.

Sec. ~~5111.85~~ 5163.50. (A) As used in this section and sections ~~5111.851~~ 5163.51 to ~~5111.856~~ 5163.56 of the Revised Code, "medicaid waiver component" means a component of the medicaid program authorized by a waiver granted by the United States department of health and human services under ~~section 1115 or 1915 of the "Social Security Act," 49 Stat. 620 (1935),~~ 42 U.S.C.~~A.~~ 1315 or 1396n. "Medicaid waiver component" does not include a care management system established under section ~~5111.16~~ 5165.03 of the Revised Code.

(B) The director of ~~job and family services~~ health care 27692
administration may adopt rules under Chapter 119. of the Revised 27693
Code governing medicaid waiver components that establish all of 27694
the following: 27695

(1) Eligibility requirements for the medicaid waiver 27696
components; 27697

(2) The type, amount, duration, and scope of services the 27698
medicaid waiver components provide; 27699

(3) The conditions under which the medicaid waiver components 27700
cover services; 27701

(4) The amount the medicaid waiver components pay for 27702
services or the method by which the amount is determined; 27703

(5) The manner in which the medicaid waiver components pay 27704
for services; 27705

(6) Safeguards for the health and welfare of medicaid 27706
recipients receiving services under a medicaid waiver component; 27707

(7) Procedures for enforcing the rules, including 27708
establishing corrective action plans for, and imposing financial 27709
and administrative sanctions on, persons and government entities 27710
that violate the rules. Sanctions shall include terminating 27711
medicaid provider agreements. The procedures shall include due 27712
process protections. 27713

(8) Other policies necessary for the efficient administration 27714
of the medicaid waiver components. 27715

(C) The director of ~~job and family services~~ health care 27716
administration may adopt different rules for the different 27717
medicaid waiver components. The rules shall be consistent with the 27718
terms of the waiver authorizing the medicaid waiver component. 27719

Sec. ~~5111.84~~ 5163.501. The director of ~~job and family~~ 27720

~~services~~ health care administration may not submit a request to the United States secretary of health and human services for a medicaid waiver under ~~section 1115 of the "Social Security Act of 1935,"~~ 42 U.S.C. 1315~~,~~ unless the director provides the speaker of the house of representatives and president of the senate written notice of the director's intent to submit the request at least ten days before the date the director submits the request to the United States secretary. The notice shall include a detailed explanation of the medicaid waiver the director proposes to seek.

Sec. ~~5111.851~~ 5163.51. (A) As used in sections ~~5111.851~~ 5163.51 to ~~5111.855~~ 5163.55 of the Revised Code:

"Administrative agency" means, with respect to a home and community-based services medicaid waiver component, the department of ~~job and family services~~ health care administration or, if a state agency or political subdivision contracts with the department under section ~~5111.91~~ 5161.05 of the Revised Code to administer the component, that state agency or political subdivision.

"Home and community-based services medicaid waiver component" means a medicaid waiver component under which home and community-based services are provided as an alternative to hospital, nursing facility, or intermediate care facility for the mentally retarded services.

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

"Intermediate care facility for the mentally retarded" has the same meaning as in section ~~5111.20~~ 5164.01 of the Revised Code.

"Level of care determination" means a determination of

whether an individual needs the level of care provided by a 27751
hospital, nursing facility, or intermediate care facility for the 27752
mentally retarded and whether the individual, if determined to 27753
need that level of care, would receive hospital, nursing facility, 27754
or intermediate care facility for the mentally retarded services 27755
if not for a home and community-based services medicaid waiver 27756
component. 27757

"Medicaid buy-in for workers with disabilities program" means 27758
the component of the medicaid program established under sections 27759
~~5111.70~~ 5162.10 to ~~5111.7011~~ 5162.1011 of the Revised Code. 27760

"Nursing facility" has the same meaning as in section ~~5111.20~~ 27761
5164.01 of the Revised Code. 27762

"Skilled nursing facility" means a facility certified as a 27763
skilled nursing facility ~~under Title XVIII of the "Social Security~~ 27764
~~Act," 79 Stat. 286 (1965), 42 U.S.C. 1395, as amended~~ for the 27765
medicare program. 27766

(B) The following requirements apply to each home and 27767
community-based services medicaid waiver component: 27768

(1) Only an individual who qualifies for a component shall 27769
receive that component's services. 27770

(2) A level of care determination shall be made as part of 27771
the process of determining whether an individual qualifies for a 27772
component and shall be made each year after the initial 27773
determination if, during such a subsequent year, the 27774
administrative agency determines there is a reasonable indication 27775
that the individual's needs have changed. 27776

(3) A written plan of care or individual service plan based 27777
on an individual assessment of the services that an individual 27778
needs to avoid needing admission to a hospital, nursing facility, 27779
or intermediate care facility for the mentally retarded shall be 27780
created for each individual determined eligible for a component. 27781

(4) Each individual determined eligible for a component shall receive that component's services in accordance with the individual's level of care determination and written plan of care or individual service plan. 27782 27783 27784 27785

(5) No individual may receive services under a component while the individual is a hospital inpatient or resident of a skilled nursing facility, nursing facility, or intermediate care facility for the mentally retarded. 27786 27787 27788 27789

(6) No individual may receive prevocational, educational, or supported employment services under a component if the individual is eligible for such services that are funded with federal funds provided under 29 U.S.C. 730 or the "Individuals with Disabilities Education Act," 111 Stat. 37 (1997), 20 U.S.C. 1400, as amended. 27790 27791 27792 27793 27794

(7) Safeguards shall be taken to protect the health and welfare of individuals receiving services under a component, including safeguards established in rules adopted under section ~~5111.85~~ <u>5163.50</u> of the Revised Code and safeguards established by licensing and certification requirements that are applicable to the providers of that component's services. 27795 27796 27797 27798 27799 27800

(8) No services may be provided under a component by a provider that is subject to standards that 42 U.S.C. 1382e(e)(1) requires be established if the provider fails to comply with the standards applicable to the provider. 27801 27802 27803 27804

(9) Individuals determined to be eligible for a component, or such individuals' representatives, shall be informed of that component's services, including any choices that the individual or representative may make regarding the component's services, and given the choice of either receiving services under that component or, as appropriate, hospital, nursing facility, or intermediate care facility for the mentally retarded services. 27805 27806 27807 27808 27809 27810 27811

(10) No individual shall lose eligibility for services under 27812

a component, or have the services reduced or otherwise disrupted, on the basis that the individual also receives services under the medicaid buy-in for workers with disabilities program. 27813 27814 27815

(11) No individual shall lose eligibility for services under a component, or have the services reduced or otherwise disrupted, on the basis that the individual's income or resources increase to an amount above the eligibility limit for the component if the individual is participating in the medicaid buy-in for workers with disabilities program and the amount of the individual's income or resources does not exceed the eligibility limit for the medicaid buy-in for workers with disabilities program. 27816 27817 27818 27819 27820 27821 27822 27823

(12) No individual receiving services under a component shall be required to pay any cost sharing expenses for the services for any period during which the individual also participates in the medicaid buy-in for workers with disabilities program. 27824 27825 27826 27827

Sec. ~~5111.852~~ 5163.52. The department of ~~job and family services~~ health care administration may review and approve, modify, or deny written plans of care and individual service plans that section ~~5111.851~~ 5163.51 of the Revised Code requires be created for individuals determined eligible for a home and community-based services medicaid waiver component. If a state agency or political subdivision contracts with the department under section ~~5111.91~~ 5161.05 of the Revised Code to administer a home and community-based services medicaid waiver component and approves, modifies, or denies a written plan of care or individual service plan pursuant to the agency's or subdivision's administration of the component, the department may review the agency's or subdivision's approval, modification, or denial and order the agency or subdivision to reverse or modify the approval, modification, or denial. The state agency or political subdivision shall comply with the department's order. 27828 27829 27830 27831 27832 27833 27834 27835 27836 27837 27838 27839 27840 27841 27842 27843

The department of ~~job and family services~~ health care administration shall be granted full and immediate access to any records the department needs to implement its duties under this section.

Sec. ~~5111.853~~ 5163.53. Each administrative agency shall maintain, for a period of time the department of ~~job and family services~~ health care administration shall specify, financial records documenting the costs of services provided under the home and community-based services medicaid waiver components that the agency administers, including records of independent audits. The administrative agency shall make the financial records available on request to the United States secretary of health and human services, United States comptroller general, and their designees.

Sec. ~~5111.854~~ 5163.54. Each administrative agency is financially accountable for funds expended for services provided under the home and community-based services medicaid waiver components that the agency administers.

Sec. ~~5111.855~~ 5163.55. Each state agency and political subdivision that enters into a contract with the department of ~~job and family services~~ health care administration under section ~~5111.91~~ 5161.05 of the Revised Code to administer a home and community-based services medicaid waiver component, or one or more aspects of such a component, shall provide the department a written assurance that the agency or subdivision will not violate any of the requirements of sections ~~5111.85~~ 5163.50 to ~~5111.854~~ 5163.54 of the Revised Code.

Sec. ~~5111.856~~ 5163.56. To the extent necessary for the efficient and economical administration of medicaid waiver components, the department of ~~job and family services~~ health care

administration may transfer an individual enrolled in a medicaid waiver component administered by the department to another medicaid waiver component the department administers if the individual is eligible for the medicaid waiver component and the transfer does not jeopardize the individual's health or safety. 27873 27874 27875 27876 27877

Sec. ~~5111.86~~ 5163.60. (A) As used in this section: 27878

(1) "Hospital" has the same meaning as in section 3727.01 of the Revised Code. 27879 27880

(2) "Medicaid waiver component" has the same meaning as in section ~~5111.85~~ 5163.50 of the Revised Code. 27881 27882

(3) "Nursing facility" has the same meaning as in section ~~5111.20~~ 5164.01 of the Revised Code. 27883 27884

(4) "Ohio home care program" means the program the department of ~~job and family services~~ health care administration administers that provides state plan services and medicaid waiver component services pursuant to rules adopted under sections ~~5111.01~~ 5162.20 and ~~5111.02~~ 5163.15 of the Revised Code and a medicaid waiver that went into effect July 1, 1998. 27885 27886 27887 27888 27889 27890

(B) The director of ~~job and family services~~ health care administration may submit requests to the United States secretary of health and human services pursuant to ~~section 1915 of the "Social Security Act," 79 Stat. 286 (1965),~~ 42 U.S.C. 1396n~~, as amended,~~ to obtain waivers of federal medicaid requirements that would otherwise be violated in the creation and implementation of two or more medicaid waiver components under which home and community-based services are provided to eligible individuals who need the level of care provided by a nursing facility or hospital. In the requests, the director may specify the following: 27891 27892 27893 27894 27895 27896 27897 27898 27899 27900

(1) The maximum number of individuals who may be enrolled in each of the medicaid waiver components included in the requests; 27901 27902

(2) The maximum amount the medicaid program may expend each year for each individual enrolled in the medicaid waiver components; 27903 27904 27905

(3) The maximum amount the medicaid program may expend each year for all individuals enrolled in the medicaid waiver components; 27906 27907 27908

(4) Any other requirements the director selects for the medicaid waiver components. 27909 27910

(C) If the secretary approves the medicaid waivers requested under this section, the director may create and implement the medicaid waiver components in accordance with the provisions of the approved waivers. The department of ~~job and family services~~ health care administration shall administer the medicaid waiver components. 27911 27912 27913 27914 27915 27916

After the first of any medicaid waiver components created under this section begins to enroll eligible individuals, the director may submit to the United States secretary of health and human services an amendment to a medicaid waiver component of the Ohio home care program authorizing the department to cease enrolling additional individuals in that medicaid waiver component of the Ohio home care program. If the secretary approves the amendment, the director may cease to enroll additional individuals in that medicaid waiver component of the Ohio home care program. 27917 27918 27919 27920 27921 27922 27923 27924 27925

Sec. ~~5111.87~~ 5163.65. (A) As used in this section and section ~~5111.871~~ 5163.651 of the Revised Code: 27926 27927

(1) "Intermediate care facility for the mentally retarded" has the same meaning as in section ~~5111.20~~ 5164.01 of the Revised Code. 27928 27929 27930

(2) "Medicaid waiver component" has the same meaning as in section ~~5111.85~~ 5163.50 of the Revised Code. 27931 27932

(B) The director of ~~job and family services~~ health care administration may apply to the United States secretary of health and human services for both of the following: 27933 27934 27935

(1) One or more medicaid waiver components under which home and community-based services are provided to individuals with mental retardation or other developmental disability as an alternative to placement in an intermediate care facility for the mentally retarded; 27936 27937 27938 27939 27940

(2) One or more medicaid waiver components under which home and community-based services are provided in the form of any of the following: 27941 27942 27943

(a) Early intervention and supportive services for children under three years of age who have developmental delays or disabilities the director determines are significant; 27944 27945 27946

(b) Therapeutic services for children who have autism; 27947

(c) Specialized habilitative services for individuals who are eighteen years of age or older and have autism. 27948 27949

(C) No medicaid waiver component authorized by division (B)(2)(b) or (c) of this section shall provide services that are available under another medicaid waiver component. No medicaid waiver component authorized by division (B)(2)(b) of this section shall provide services to an individual that the individual is eligible to receive through an individualized education program as defined in section 3323.01 of the Revised Code. 27950 27951 27952 27953 27954 27955 27956

(D) The director of mental retardation and developmental disabilities or director of health may request that the director of ~~job and family services~~ health care administration apply for one or more medicaid waivers under this section. 27957 27958 27959 27960

(E) Before applying for a waiver under this section, the director of ~~job and family services~~ health care administration 27961 27962

shall seek, accept, and consider public comments.

Sec. ~~5111.871~~ 5163.651. The department of ~~job and family services~~ health care administration shall enter into a contract with the department of mental retardation and developmental disabilities under section ~~5111.91~~ 5161.05 of the Revised Code with regard to one or more of the components of the medicaid program established by the department of ~~job and family services~~ health care administration under one or more of the medicaid waivers sought under section ~~5111.87~~ 5163.65 of the Revised Code. The contract shall provide for the department of mental retardation and developmental disabilities to administer the components in accordance with the terms of the waivers. The directors of ~~job and family services~~ health care administration and mental retardation and developmental disabilities shall adopt rules in accordance with Chapter 119. of the Revised Code governing the components.

If the department of mental retardation and developmental disabilities or the department of ~~job and family services~~ health care administration denies an individual's application for home and community-based services provided under any of these medicaid components, the department that denied the services shall give timely notice to the individual that the individual may request a hearing under section ~~5101.35~~ 5160.34 of the Revised Code.

The departments of mental retardation and developmental disabilities and ~~job and family services~~ health care administration may approve, reduce, deny, or terminate a service included in the individualized service plan developed for a medicaid recipient eligible for home and community-based services provided under any of these medicaid components. The departments shall consider the recommendations a county board of mental retardation and developmental disabilities makes under division

(A)(1)(c) of section 5126.055 of the Revised Code. If either 27994
department approves, reduces, denies, or terminates a service, 27995
that department shall give timely notice to the medicaid recipient 27996
that the recipient may request a hearing under section 5101.35 of 27997
the Revised Code. 27998

If supported living, as defined in section 5126.01 of the 27999
Revised Code, is to be provided as a service under any of these 28000
components, any person or government entity with a current, valid 28001
medicaid provider agreement and a current, valid certificate under 28002
section 5123.161 of the Revised Code may provide the service. 28003
28004

If a service is to be provided under any of these components 28005
by a residential facility, as defined in section 5123.19 of the 28006
Revised Code, any person or government entity with a current, 28007
valid medicaid provider agreement and a current, valid license 28008
under section 5123.19 of the Revised Code may provide the service. 28009

Sec. ~~5111.872~~ 5163.652. When the department of mental 28010
retardation and developmental disabilities allocates enrollment 28011
numbers to a county board of mental retardation and developmental 28012
disabilities for home and community-based services specified in 28013
division (B)(1) of section ~~5111.87~~ 5163.65 of the Revised Code and 28014
provided under any of the components of the medicaid program that 28015
the department administers under section ~~5111.871~~ 5163.651 of the 28016
Revised Code, the department shall consider all of the following: 28017
28018

(A) The number of individuals with mental retardation or 28019
other developmental disability who are on a waiting list the 28020
county board establishes under division (C) of section 5126.042 of 28021
the Revised Code for those services and are given priority on the 28022
waiting list pursuant to division (D) or (E) of that section; 28023

(B) The implementation component required by division (A)(3) 28024

of section 5126.054 of the Revised Code of the county board's plan 28025
approved under section 5123.046 of the Revised Code; 28026

(C) Anything else the department considers necessary to 28027
enable county boards to provide those services to individuals in 28028
accordance with the priority requirements of divisions (D) and (E) 28029
of section 5126.042 of the Revised Code. 28030

Sec. ~~5111.873~~ 5163.653. (A) Not later than the effective date 28031
of the first of any medicaid waivers the United States secretary 28032
of health and human services grants pursuant to a request made 28033
under section ~~5111.87~~ 5163.65 of the Revised Code, the director of 28034
~~job and family services~~ health care administration shall adopt 28035
rules in accordance with Chapter 119. of the Revised Code 28036
establishing statewide fee schedules for home and community-based 28037
services specified in division (B)(1) of section ~~5111.87~~ 5163.65 28038
of the Revised Code and provided under the components of the 28039
medicaid program that the department of mental retardation and 28040
developmental disabilities administers under section ~~5111.871~~ 28041
5163.651 of the Revised Code. The rules shall provide for all of 28042
the following: 28043

(1) The department of mental retardation and developmental 28044
disabilities arranging for the initial and ongoing collection of 28045
cost information from a comprehensive, statistically valid sample 28046
of persons and government entities providing the services at the 28047
time the information is obtained; 28048

(2) The collection of consumer-specific information through 28049
an assessment instrument the department of mental retardation and 28050
developmental disabilities shall provide to the department of ~~job~~ 28051
~~and family services~~ health care administration; 28052

(3) With the information collected pursuant to divisions 28053
(A)(1) and (2) of this section, an analysis of that information, 28054
and other information the director determines relevant, methods 28055

and standards for calculating the fee schedules that do all of the following: 28056 28057

(a) Assure that the fees are consistent with efficiency, economy, and quality of care; 28058 28059

(b) Consider the intensity of consumer resource need; 28060

(c) Recognize variations in different geographic areas regarding the resources necessary to assure the health and welfare of consumers; 28061 28062 28063

(d) Recognize variations in environmental supports available to consumers. 28064 28065

(B) As part of the process of adopting rules under this section, the director shall consult with the director of mental retardation and developmental disabilities, representatives of county boards of mental retardation and developmental disabilities, persons who provide the home and community-based services, and other persons and government entities the director identifies. 28066 28067 28068 28069 28070 28071 28072

(C) The directors of ~~job and family services~~ <u>health care administration</u> and mental retardation and developmental disabilities shall review the rules adopted under this section at times they determine to ensure that the methods and standards established by the rules for calculating the fee schedules continue to do everything that division (A)(3) of this section requires. 28073 28074 28075 28076 28077 28078 28079

Sec. ~~5111.874~~ <u>5163.66</u>. (A) As used in sections ~~5111.874~~ <u>5163.66</u> to ~~5111.8710~~ <u>5163.666</u> of the Revised Code: 28080 28081

"Home and community-based services" has the same meaning as in section 5123.01 of the Revised Code. 28082 28083

"ICF/MR services" means intermediate care facility for the mentally retarded services covered by the medicaid program that an 28084 28085

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~~ 5163.663 and ~~5111.878~~ 5163.664 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~~ health care administration, and mental retardation 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~~ 5164.82 to ~~5111.688~~ 5164.858 of the Revised Code regarding a voluntary termination as defined in section ~~5111.65~~ 5164.82 of

the Revised Code if those requirements are applicable. 28117

(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: 28118 28119 28120

(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; 28121 28122 28123 28124

(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. 28125 28126 28127 28128 28129

(4) The operator meets the requirements for providing home and community-based services, including the following: 28130 28131

(a) Such requirements applicable to a residential facility if the operator maintains the facility's license as a residential facility; 28132 28133 28134

(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. 28135 28136 28137 28138

(5) The director of mental retardation and developmental disabilities approves the conversion. 28139 28140

(C) The notice to the director of mental retardation and 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. 28141 28142 28143 28144 28145

(D) If the director of mental retardation and developmental 28146

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~~ health care administration of the termination. On receipt of the director of health's notice, the director of ~~job and family services~~ health care administration 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~~ health care administration terminates the medicaid provider agreement.

Sec. ~~5111.875~~ 5163.661. (A) For the purpose of increasing the number of slots available for home and community-based services and subject to sections ~~5111.877~~ 5163.663 and ~~5111.878~~ 5163.664 of the Revised Code, a person who acquires, through a request for proposals issued by the director of mental retardation and 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~~ health care administration, and mental retardation 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~~ 5164.82 to ~~5111.688~~ 5164.858 of the Revised Code regarding

a voluntary termination as defined in section ~~5111.65~~ 5164.82 of the Revised Code if those requirements are applicable. 28178 28179

(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: 28180 28181 28182 28183

(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; 28184 28185 28186 28187

(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. 28188 28189 28190 28191 28192

(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: 28193 28194 28195 28196 28197 28198

(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; 28199 28200 28201 28202

(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. 28203 28204 28205 28206 28207

(5) The person meets the requirements for providing home and 28208

community-based services at a residential facility. 28209

(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. 28210 28211 28212 28213 28214 28215

(C) On receipt of a notice under division (A)(1) of this section, the director of health shall do the following: 28216 28217

(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; 28218 28219 28220

(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. 28221 28222 28223

(D) The director of health shall notify the director of ~~job and family services~~ health care administration 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~~ health care administration shall do the following: 28224 28225 28226 28227 28228

(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; 28229 28230 28231

(2) Amend the person's medicaid provider agreement to reflect the facility's reduced certified capacity if the facility's certified capacity is reduced. 28232 28233 28234

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~~ health care administration terminates or amends the medicaid provider agreement. 28235 28236 28237 28238

Sec. ~~5111.876~~ 5163.662. Subject to section ~~5111.877~~ 5163.663 28239
of the Revised Code, the director of mental retardation and 28240
developmental disabilities may request that the director of ~~job~~ 28241
~~and family services~~ health care administration seek the approval 28242
of the United States secretary of health and human services to 28243
increase the number of slots available for home and 28244
community-based services by a number not exceeding the number of 28245
beds that were part of the licensed capacity of a residential 28246
facility that had its license revoked or surrendered under section 28247
5123.19 of the Revised Code if the residential facility was an 28248
intermediate care facility for the mentally retarded at the time 28249
of the license revocation or surrender. The revocation or 28250
surrender may have occurred before, or may occur on or after, ~~the~~ 28251
~~effective date of this section~~ June 24, 2008. The request may 28252
include beds the director removed from such a residential 28253
facility's licensed capacity before transferring ownership or 28254
operation of the residential facility pursuant to a request for 28255
proposals. 28256

Sec. ~~5111.877~~ 5163.663. The director of ~~job and family~~ 28257
~~services~~ health care administration may seek approval from the 28258
United States secretary of health and human services for not more 28259
than a total of one hundred slots for home and community-based 28260
services for the purposes of sections ~~5111.874~~ 5163.66, ~~5111.875~~ 28261
5163.661, and ~~5111.876~~ 5163.662 of the Revised Code. 28262

Sec. ~~5111.878~~ 5163.664. Not more than a total of one hundred 28263
beds may be converted from providing ICF/MR services to providing 28264
home and community-based services under sections ~~5111.874~~ 5163.66 28265
and ~~5111.875~~ 5163.661 of the Revised Code. 28266

Sec. ~~5111.879~~ 5163.665. No person or government entity may 28267
reconvert a bed to be used for ICF/MR services if the bed was 28268

converted to use for home and community-based services under section ~~5111.874~~ 5163.66 or ~~5111.875~~ 5163.661 of the Revised Code. This prohibition applies regardless of either of the following:

(A) The bed is part of the licensed capacity of a residential facility.

(B) The bed has been sold, leased, or otherwise transferred to another person or government entity.

Sec. ~~5111.8710~~ 5163.666. The directors of ~~job and family services~~ health care administration and mental retardation and developmental disabilities may adopt rules in accordance with Chapter 119. of the Revised Code as necessary to implement sections ~~5111.874~~ 5163.66 to ~~5111.8710~~ 5163.666 of the Revised Code.

Sec. ~~5111.89~~ 5163.68. (A) As used in sections ~~5111.89~~ 5163.68 to ~~5111.894~~ 5163.684 of the Revised Code:

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

"Assisted living program" means the medicaid waiver component for which the director of ~~job and family services~~ health care administration is authorized by this section to request a medicaid waiver.

"Assisted living services" means the following home and community-based services: personal care, homemaker, chore, attendant care, companion, medication oversight, and therapeutic social and recreational programming.

"County or district home" means a county or district home operated under Chapter 5155. of the Revised Code.

"Long-term care consultation program" means the program the department of aging is required to develop under section 173.42 of the Revised Code. 28297 28298 28299

"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. 28300 28301 28302 28303 28304

"Medicaid waiver component" has the same meaning as in section ~~5111.85~~ 5163.50 of the Revised Code. 28305 28306

"Nursing facility" has the same meaning as in section ~~5111.20~~ 5164.01 of the Revised Code. 28307 28308

"Residential care facility" has the same meaning as in section 3721.01 of the Revised Code. 28309 28310

"State administrative agency" means the department of ~~job and family services~~ health care administration if the department of ~~job and family services~~ health care administration administers the assisted living program or the department of aging if the department of aging administers the assisted living program. 28311 28312 28313 28314 28315

(B) The director of ~~job and family services~~ health care administration may submit a request to the United States secretary of health and human services under 42 U.S.C. 1396n to obtain a waiver of federal medicaid requirements that would otherwise be violated in the creation and implementation of a program under which assisted living services are provided to not more than one thousand eight hundred individuals who meet the program's eligibility requirements established under section ~~5111.891~~ 5163.681 of the Revised Code. 28316 28317 28318 28319 28320 28321 28322 28323 28324

If the secretary approves the medicaid waiver requested under this section and the director of budget and management approves the contract, the department of ~~job and family services~~ health 28325 28326 28327

care administration shall enter into a contract with the 28328
department of aging under section ~~5111.91~~ 5161.05 of the Revised 28329
Code that provides for the department of aging to administer the 28330
assisted living program. The contract shall include an estimate of 28331
the program's costs. 28332

The director of ~~job and family services~~ health care 28333
administration may adopt rules under section ~~5111.85~~ 5163.50 of 28334
the Revised Code regarding the assisted living program. The 28335
director of aging may adopt rules under Chapter 119. of the 28336
Revised Code regarding the program that the rules adopted by the 28337
director of ~~job and family services~~ health care administration 28338
authorize the director of aging to adopt. 28339

Sec. ~~5111.891~~ 5163.681. To be eligible for the assisted 28340
living program, an individual must meet all of the following 28341
requirements: 28342

(A) Need an intermediate level of care as determined under 28343
rule 5101:3-3-06 of the Administrative Code; 28344

(B) At the time the individual applies for the assisted 28345
living program, be one of the following: 28346

(1) A nursing facility resident who is seeking to move to a 28347
residential care facility and would remain in a nursing facility 28348
for long term care if not for the assisted living program; 28349

(2) A participant of any of the following medicaid waiver 28350
components who would move to a nursing facility if not for the 28351
assisted living program: 28352

(a) The PASSPORT program created under section 173.40 of the 28353
Revised Code; 28354

(b) The medicaid waiver component called the choices program 28355
that the department of aging administers; 28356

(c) A medicaid waiver component that the department of ~~job~~ 28357

~~and family services~~ <u>health care administration</u> administers. 28358

(3) A resident of a residential care facility who has resided in a residential care facility for at least six months immediately before the date the individual applies for the assisted living program. 28359 28360 28361 28362

(C) At the time the individual receives assisted living services under the assisted living program, reside in a residential care facility that is authorized by a valid medicaid provider agreement to participate in the assisted living program, including both of the following: 28363 28364 28365 28366 28367

(1) A residential care facility that is owned or operated by a metropolitan housing authority that has a contract with the United States department of housing and urban development to receive an operating subsidy or rental assistance for the residents of the facility; 28368 28369 28370 28371 28372

(2) A county or district home licensed as a residential care facility. 28373 28374

(D) Meet all other eligibility requirements for the assisted living program established in rules adopted under section ~~5111.85~~ <u>5163.50</u> of the Revised Code. 28375 28376 28377

Sec. ~~5111.892~~ <u>5163.682</u>. A residential care facility providing services covered by the assisted living program to an individual enrolled in the program shall have staff on-site twenty-four hours each day who are able to do all of the following: 28378 28379 28380 28381 28382

(A) Meet the scheduled and unpredicted needs of the individuals enrolled in the assisted living program in a manner that promotes the individuals' dignity and independence; 28383 28384 28385

(B) Provide supervision services for those individuals; 28386

(C) Help keep the individuals safe and secure. 28387

Sec. ~~5111.893~~ 5163.683. If the United States secretary of health and human services approves a medicaid waiver authorizing the assisted living program, the director of aging shall contract with a person or government entity to evaluate the program's cost effectiveness. The director shall provide the results of the evaluation to the governor, president and minority leader of the senate, and speaker and minority leader of the house of representatives not later than June 30, 2007. 28388 28389 28390 28391 28392 28393 28394 28395

Sec. ~~5111.894~~ 5163.684. 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. 28396 28397 28398 28399

Each month, each area agency on aging shall determine whether any individual who resides in the area that the area agency on aging serves and is on a waiting list for the assisted living program has been admitted to a nursing facility. If an area agency on aging determines that such an individual has been admitted to a nursing facility and 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 in the 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 in the nursing facility, the administrator shall so notify the state administrative agency. 28400 28401 28402 28403 28404 28405 28406 28407 28408 28409 28410 28411 28412 28413 28414 28415 28416 28417

28418

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 waiting list for the assisted living program, unless the enrollment would cause the assisted living program to exceed the limit on the number of individuals who may participate in the program as set by section ~~5111.89~~ 5163.68 of the Revised Code. 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. 28419 28420 28421 28422 28423 28424 28425 28426 28427 28428 28429

Not later than the last day of each calendar year, the director of ~~job and family services~~ health care administration shall submit to the general assembly a report regarding the number of individuals enrolled in the assisted living program pursuant to this section and the costs incurred and savings achieved as a result of the enrollments. 28430 28431 28432 28433 28434 28435

Sec. ~~5111.971~~ 5163.69. (A) As used in this section, "long-term care medicaid waiver component" means any of the following: 28436 28437 28438

(1) The PASSPORT program created under section 173.40 of the Revised Code; 28439 28440

(2) The medicaid waiver component called the choices program that the department of aging administers; 28441 28442

(3) A medicaid waiver component that the department of ~~job and family services~~ health care administration administers. 28443 28444

(B) The director of ~~job and family services~~ health care administration shall submit a request to the United States secretary of health and human services for a waiver of federal medicaid requirements that would be otherwise violated in the 28445 28446 28447 28448

creation of a pilot program under which not more than two hundred 28449
individuals who meet the pilot program's eligibility requirements 28450
specified in division (D) of this section receive a spending 28451
authorization to pay for the cost of medically necessary home and 28452
community-based services that the pilot program covers. The 28453
spending authorization shall be in an amount not exceeding seventy 28454
per cent of the average cost under the medicaid program for 28455
providing nursing facility services to an individual. An 28456
individual participating in the pilot program shall also receive 28457
necessary support services, including fiscal intermediary and 28458
other case management services, that the pilot program covers. 28459

(C) If the United States secretary of health and human 28460
services approves the waiver submitted under division (B) of this 28461
section, the department of ~~job and family services~~ health care 28462
administration shall enter into a contract with the department of 28463
aging under section ~~5111.91~~ 5161.05 of the Revised Code that 28464
provides for the department of aging to administer the pilot 28465
program that the waiver authorizes. 28466

(D) To be eligible to participate in the pilot program 28467
created under division (B) of this section, an individual must 28468
meet all of the following requirements: 28469

(1) Need an intermediate level of care as determined under 28470
rule 5101:3-3-06 of the Administrative Code or a skilled level of 28471
care as determined under rule 5101:3-3-05 of the Administrative 28472
Code; 28473

(2) At the time the individual applies to participate in the 28474
pilot program, be one of the following: 28475

(a) A nursing facility resident who would remain in a nursing 28476
facility if not for the pilot program; 28477

(b) A participant of any long-term care medicaid waiver 28478
component who would move to a nursing facility if not for the 28479

pilot program. 28480

(3) Meet all other eligibility requirements for the pilot 28481
program established in rules adopted under section ~~5111.85~~ 5163.50 28482
of the Revised Code. 28483

(E) The director of ~~job and family services~~ health care 28484
administration may adopt rules under section ~~5111.85~~ 5163.50 of 28485
the Revised Code as the director considers necessary to implement 28486
the pilot program created under division (B) of this section. The 28487
director of aging may adopt rules under Chapter 119. of the 28488
Revised Code as the director considers necessary for the pilot 28489
program's implementation. The rules may establish a list of 28490
medicaid-covered services not covered by the pilot program that an 28491
individual participating in the pilot program may not receive if 28492
the individual also receives medicaid-covered services outside of 28493
the pilot program. 28494

Sec. ~~5111.97~~ 5163.73. (A) As used in this section and in 28495
section ~~5111.971~~ 5163.69 of the Revised Code, "nursing facility" 28496
has the same meaning as in section ~~5111.20~~ 5164.01 of the Revised 28497
Code. 28498

(B) To the extent funds are available, the director of ~~job~~ 28499
~~and family services~~ health care administration may establish the 28500
Ohio access success project to help medicaid recipients make the 28501
transition from residing in a nursing facility to residing in a 28502
community setting. The program may be established as a separate 28503
~~non-medicaid~~ nonmedicaid program or integrated into a new or 28504
existing program of medicaid-funded home and community-based 28505
services authorized by a waiver approved by the United States 28506
department of health and human services. The director shall permit 28507
any recipient of medicaid-funded nursing facility services to 28508
apply for participation in the program, but may limit the number 28509
of program participants. If an application is received before the 28510

applicant has been a recipient of medicaid-funded nursing facility 28511
services for six months, the director shall ensure that an 28512
assessment is conducted as soon as practicable to determine 28513
whether the applicant is eligible for participation in the 28514
program. To the maximum extent possible, the assessment and 28515
eligibility determination shall be completed not later than the 28516
date that occurs six months after the applicant became a recipient 28517
of medicaid-funded nursing facility services. 28518

(C) To be eligible for benefits under the project, a medicaid 28519
recipient must satisfy all of the following requirements: 28520

(1) Be a recipient of medicaid-funded nursing facility 28521
services, at the time of applying for the benefits; 28522

(2) Need the level of care provided by nursing facilities; 28523

(3) For participation in a ~~non-medicaid~~ nonmedicaid program, 28524
receive services to remain in the community with a projected cost 28525
not exceeding eighty per cent of the average monthly medicaid cost 28526
of a medicaid recipient in a nursing facility; 28527

(4) For participation in a program established as part of a 28528
medicaid-funded home and community-based services waiver program, 28529
meet waiver enrollment criteria. 28530

(D) If the director establishes the Ohio access success 28531
project, the benefits provided under the project may include 28532
payment of all of the following: 28533

(1) The first month's rent in a community setting; 28534

(2) Rental deposits; 28535

(3) Utility deposits; 28536

(4) Moving expenses; 28537

(5) Other expenses not covered by the medicaid program that 28538
facilitate a medicaid recipient's move from a nursing facility to 28539
a community setting. 28540

(E) If the project is established as a ~~non-medicaid~~ 28541
nonmedicaid program, no participant may receive more than two 28542
thousand dollars worth of benefits under the project. 28543

(F) The director may submit a request to the United States 28544
secretary of health and human services pursuant to ~~section 1915 of~~ 28545
~~the "Social Security Act," 79 Stat. 286 (1965),~~ 42 U.S.C. 1396n~~,~~ 28546
~~as amended,~~ to create a medicaid home and community-based services 28547
waiver program to serve individuals who meet the criteria for 28548
participation in the Ohio access success project. The director may 28549
adopt rules under Chapter 119. of the Revised Code for the 28550
administration and operation of the program. 28551

Sec. ~~5111.20~~ 5164.01. As used in sections ~~5111.20~~ 5164.01 to 28552
~~5111.34~~ 5164.47 of the Revised Code: 28553

(A) "Allowable costs" are those costs determined by the 28554
department of ~~job and family services~~ health care administration 28555
to be reasonable and do not include fines paid under sections 28556
~~5111.35~~ 5164.50 to ~~5111.61~~ 5164.78 and section ~~5111.99~~ 5164.99 of 28557
the Revised Code. 28558

(B) "Ancillary and support costs" means all reasonable costs 28559
incurred by a nursing facility other than direct care costs or 28560
capital costs. "Ancillary and support costs" includes, but is not 28561
limited to, costs of activities, social services, pharmacy 28562
consultants, habilitation supervisors, qualified mental 28563
retardation professionals, program directors, medical and 28564
habilitation records, program supplies, incontinence supplies, 28565
food, enterals, dietary supplies and personnel, laundry, 28566
housekeeping, security, administration, medical equipment, 28567
utilities, liability insurance, bookkeeping, purchasing 28568
department, human resources, communications, travel, dues, license 28569
fees, subscriptions, home office costs not otherwise allocated, 28570
legal services, accounting services, minor equipment, maintenance 28571

and repairs, help-wanted advertising, informational advertising, start-up costs, organizational expenses, other interest, property insurance, employee training and staff development, employee benefits, payroll taxes, and workers' compensation premiums or costs for self-insurance claims and related costs as specified in rules adopted ~~by the director of job and family services~~ under section ~~5111.02~~ 5163.15 of the Revised Code, for personnel listed in this division. "Ancillary and support costs" also means the cost of equipment, including vehicles, acquired by operating lease executed before December 1, 1992, if the costs are reported as administrative and general costs on the facility's cost report for the cost reporting period ending December 31, 1992. 28572 28573 28574 28575 28576 28577 28578 28579 28580 28581 28582 28583

(C) "Capital costs" means costs of ownership and, in the case of an intermediate care facility for the mentally retarded, costs of nonextensive renovation. 28584 28585 28586

(1) "Cost of ownership" means the actual expense incurred for all of the following: 28587 28588

(a) Depreciation and interest on any capital assets that cost five hundred dollars or more per item, including the following: 28589 28590

(i) Buildings; 28591

(ii) Building improvements that are not approved as nonextensive renovations under section ~~5111.251~~ 5164.08 of the Revised Code; 28592 28593 28594

(iii) Except as provided in division (B) of this section, equipment; 28595 28596

(iv) In the case of an intermediate care facility for the mentally retarded, extensive renovations; 28597 28598

(v) Transportation equipment. 28599

(b) Amortization and interest on land improvements and leasehold improvements; 28600 28601

(c) Amortization of financing costs; 28602

(d) Except as provided in division (K) of this section, lease 28603
and rent of land, building, and equipment. 28604

The costs of capital assets of less than five hundred dollars 28605
per item may be considered capital costs in accordance with a 28606
provider's practice. 28607

(2) "Costs of nonextensive renovation" means the actual 28608
expense incurred by an intermediate care facility for the mentally 28609
retarded for depreciation or amortization and interest on 28610
renovations that are not extensive renovations. 28611

(D) "Capital lease" and "operating lease" shall be construed 28612
in accordance with generally accepted accounting principles. 28613

(E) "Case-mix score" means the measure determined under 28614
section 5164.051 of the Revised Code of the relative direct-care 28615
resources needed to provide care and habilitation to a resident of 28616
an intermediate care facility for the mentally retarded and the 28617
measure determined under section ~~5111.232~~ 5164.191 of the Revised 28618
Code of the relative direct-care resources needed to provide care 28619
and habilitation to a resident of a nursing facility ~~or~~ 28620
~~intermediate care facility for the mentally retarded~~. 28621

(F)(1) "Date of licensure," for a facility originally 28622
licensed as a nursing home under Chapter 3721. of the Revised 28623
Code, means the date specific beds were originally licensed as 28624
nursing home beds under that chapter, regardless of whether they 28625
were subsequently licensed as residential facility beds under 28626
section 5123.19 of the Revised Code. For a facility originally 28627
licensed as a residential facility under section 5123.19 of the 28628
Revised Code, "date of licensure" means the date specific beds 28629
were originally licensed as residential facility beds under that 28630
section. 28631

If nursing home beds licensed under Chapter 3721. of the 28632

Revised Code or residential facility beds licensed under section 5123.19 of the Revised Code were not required by law to be licensed when they were originally used to provide nursing home or residential facility services, "date of licensure" means the date the beds first were used to provide nursing home or residential facility services, regardless of the date the present provider obtained licensure. 28633 28634 28635 28636 28637 28638 28639

If a facility adds nursing home beds or residential facility beds or extensively renovates all or part of the facility after its original date of licensure, it will have a different date of licensure for the additional beds or extensively renovated portion of the facility, unless the beds are added in a space that was constructed at the same time as the previously licensed beds but was not licensed under Chapter 3721. or section 5123.19 of the Revised Code at that time. 28640 28641 28642 28643 28644 28645 28646 28647

(2) The definition of "date of licensure" in this section applies in determinations of the medicaid reimbursement rate for a nursing facility or intermediate care facility for the mentally retarded but does not apply in determinations of the franchise permit fee for a nursing facility or intermediate care facility for the mentally retarded. 28648 28649 28650 28651 28652 28653

(G) "Desk-reviewed" means that costs as reported on a cost report submitted under section ~~5111.26~~ <u>5164.37</u> of the Revised Code have been subjected to a desk review under division (A) of section ~~5111.27~~ <u>5164.38</u> of the Revised Code and preliminarily determined to be allowable costs. 28654 28655 28656 28657 28658

(H) "Direct care costs" means all of the following: 28659

(1)(a) Costs for registered nurses, licensed practical nurses, and nurse aides employed by the facility; 28660 28661

(b) Costs for direct care staff, administrative nursing staff, medical directors, respiratory therapists, and except as 28662 28663

provided in division (H)(2) of this section, other persons holding degrees qualifying them to provide therapy; 28664 28665

(c) Costs of purchased nursing services; 28666

(d) Costs of quality assurance; 28667

(e) Costs of training and staff development, employee benefits, payroll taxes, and workers' compensation premiums or costs for self-insurance claims and related costs as specified in rules adopted ~~by the director of job and family services in accordance with Chapter 119.~~ under section 5163.15 of the Revised Code, for personnel listed in divisions (H)(1)(a), (b), and (d) of this section; 28668 28669 28670 28671 28672 28673 28674

(f) Costs of consulting and management fees related to direct care; 28675 28676

(g) Allocated direct care home office costs. 28677

(2) In addition to the costs specified in division (H)(1) of this section, for nursing facilities only, direct care costs include costs of habilitation staff (other than habilitation supervisors), medical supplies, emergency oxygen, habilitation supplies, and universal precautions supplies. 28678 28679 28680 28681 28682

(3) In addition to the costs specified in division (H)(1) of this section, for intermediate care facilities for the mentally retarded only, direct care costs include both of the following: 28683 28684 28685

(a) Costs for physical therapists and physical therapy assistants, occupational therapists and occupational therapy assistants, speech therapists, audiologists, habilitation staff (including habilitation supervisors), qualified mental retardation professionals, program directors, social services staff, activities staff, off-site day programming, psychologists and psychology assistants, and social workers and counselors; 28686 28687 28688 28689 28690 28691 28692

(b) Costs of training and staff development, employee 28693

benefits, payroll taxes, and workers' compensation premiums or 28694
costs for self-insurance claims and related costs as specified in 28695
rules adopted under section ~~5111.02~~ 5163.15 of the Revised Code, 28696
for personnel listed in division (H)(3)(a) of this section. 28697

(4) Costs of other direct-care resources that are specified 28698
as direct care costs in rules adopted under section ~~5111.02~~ 28699
5163.15 of the Revised Code. 28700

(I) "Fiscal year" means the fiscal year of this state, as 28701
specified in section 9.34 of the Revised Code. 28702

(J) "Franchise permit fee" means the following: 28703

(1) In the context of nursing facilities, the fee imposed by 28704
sections ~~3721.50~~ 5166.20 to ~~3721.58~~ 5166.30 of the Revised Code; 28705

(2) In the context of intermediate care facilities for the 28706
mentally retarded, the fee imposed by sections ~~5112.30~~ 5166.40 to 28707
~~5112.39~~ 5166.50 of the Revised Code. 28708

(K) "Indirect care costs" means all reasonable costs incurred 28709
by an intermediate care facility for the mentally retarded other 28710
than direct care costs, other protected costs, or capital costs. 28711
"Indirect care costs" includes but is not limited to costs of 28712
habilitation supplies, pharmacy consultants, medical and 28713
habilitation records, program supplies, incontinence supplies, 28714
food, enterals, dietary supplies and personnel, laundry, 28715
housekeeping, security, administration, liability insurance, 28716
bookkeeping, purchasing department, human resources, 28717
communications, travel, dues, license fees, subscriptions, home 28718
office costs not otherwise allocated, legal services, accounting 28719
services, minor equipment, maintenance and repairs, help-wanted 28720
advertising, informational advertising, start-up costs, 28721
organizational expenses, other interest, property insurance, 28722
employee training and staff development, employee benefits, 28723
payroll taxes, and workers' compensation premiums or costs for 28724

self-insurance claims and related costs as specified in rules adopted under section ~~5111.02~~ 5163.15 of the Revised Code, for personnel listed in this division. Notwithstanding division (C)(1) of this section, "indirect care costs" also means the cost of equipment, including vehicles, acquired by operating lease executed before December 1, 1992, if the costs are reported as administrative and general costs on the facility's cost report for the cost reporting period ending December 31, 1992. 28725 28726 28727 28728 28729 28730 28731 28732

(L) "Inpatient days" means all days during which a resident, regardless of payment source, occupies a bed in a nursing facility or intermediate care facility for the mentally retarded that is included in the facility's certified capacity under Title XIX. Therapeutic or hospital leave days for which payment is made under section ~~5111.33~~ 5164.35 of the Revised Code are considered inpatient days proportionate to the percentage of the facility's per resident per day rate paid for those days. 28733 28734 28735 28736 28737 28738 28739 28740

(M) "Intermediate care facility for the mentally retarded" means an intermediate care facility for the mentally retarded certified as in compliance with applicable standards for the medicaid program by the director of health in accordance with Title XIX. 28741 28742 28743 28744 28745

(N) "Maintenance and repair expenses" means, except as provided in division (BB)(2) of this section, expenditures that are necessary and proper to maintain an asset in a normally efficient working condition and that do not extend the useful life of the asset two years or more. "Maintenance and repair expenses" includes but is not limited to the cost of ordinary repairs such as painting and wallpapering. 28746 28747 28748 28749 28750 28751 28752

(O) "Medicaid days" means all days during which a resident who is a Medicaid recipient eligible for nursing facility services occupies a bed in a nursing facility that is included in the nursing facility's certified capacity under Title XIX. Therapeutic 28753 28754 28755 28756

or hospital leave days for which payment is made under section 28757
~~5111.33~~ 5164.35 of the Revised Code are considered Medicaid days 28758
proportionate to the percentage of the nursing facility's per 28759
resident per day rate paid for those days. 28760

(P) "Nursing facility" means a facility, or a distinct part 28761
of a facility, that is certified as a nursing facility by the 28762
director of health ~~in accordance with Title XIX~~ for the medicaid 28763
program and is not an intermediate care facility for the mentally 28764
retarded. "Nursing facility" includes a facility, or a distinct 28765
part of a facility, that is certified as a nursing facility by the 28766
director of health ~~in accordance with Title XIX~~ for the medicaid 28767
program and is certified as a skilled nursing facility by the 28768
director ~~in accordance with Title XVIII~~ for the medicare program. 28769
28770

(Q) "Operator" means the person or government entity 28771
responsible for the daily operating and management decisions for a 28772
nursing facility or intermediate care facility for the mentally 28773
retarded. 28774

(R) "Other protected costs" means costs incurred by an 28775
intermediate care facility for the mentally retarded for medical 28776
supplies; real estate, franchise, and property taxes; natural gas, 28777
fuel oil, water, electricity, sewage, and refuse and hazardous 28778
medical waste collection; allocated other protected home office 28779
costs; and any additional costs defined as other protected costs 28780
in rules adopted under section ~~5111.02~~ 5163.15 of the Revised 28781
Code. 28782

(S)(1) "Owner" means any person or government entity that has 28783
at least five per cent ownership or interest, either directly, 28784
indirectly, or in any combination, in any of the following 28785
regarding a nursing facility or intermediate care facility for the 28786
mentally retarded: 28787

(a) The land on which the facility is located; 28788

(b) The structure in which the facility is located; 28789

(c) Any mortgage, contract for deed, or other obligation secured in whole or in part by the land or structure on or in which the facility is located; 28790 28791 28792

(d) Any lease or sublease of the land or structure on or in which the facility is located. 28793 28794

(2) "Owner" does not mean a holder of a debenture or bond related to the nursing facility or intermediate care facility for the mentally retarded and purchased at public issue or a regulated lender that has made a loan related to the facility unless the holder or lender operates the facility directly or through a subsidiary. 28795 28796 28797 28798 28799 28800

(T) "Patient" includes "resident." 28801

(U) Except as provided in divisions (U)(1) and (2) of this section, "per diem" means a nursing facility's or intermediate care facility for the mentally retarded's actual, allowable costs in a given cost center in a cost reporting period, divided by the facility's inpatient days for that cost reporting period. 28802 28803 28804 28805 28806

(1) When calculating indirect care costs for the purpose of establishing rates under section ~~5111.241~~ 5164.07 of the Revised Code, "per diem" means an intermediate care facility for the mentally retarded's actual, allowable indirect care costs in a cost reporting period divided by the greater of the facility's inpatient days for that period or the number of inpatient days the facility would have had during that period if its occupancy rate had been eighty-five per cent. 28807 28808 28809 28810 28811 28812 28813 28814

(2) When calculating capital costs for the purpose of establishing rates under section ~~5111.251~~ 5164.08 of the Revised Code, "per diem" means a facility's actual, allowable capital 28815 28816 28817

costs in a cost reporting period divided by the greater of the facility's inpatient days for that period or the number of inpatient days the facility would have had during that period if its occupancy rate had been ninety-five per cent. 28818 28819 28820 28821

(V) "Provider" means an operator with a provider agreement. 28822

(W) "Provider agreement" means a contract between the department of ~~job and family services~~ health care administration and the operator of a nursing facility or intermediate care facility for the mentally retarded for the provision of nursing facility services or intermediate care facility services for the mentally retarded under the medicaid program. 28823 28824 28825 28826 28827 28828

(X) "Purchased nursing services" means services that are provided in a nursing facility by registered nurses, licensed practical nurses, or nurse aides who are not employees of the facility. 28829 28830 28831 28832

(Y) "Reasonable" means that a cost is an actual cost that is appropriate and helpful to develop and maintain the operation of patient care facilities and activities, including normal standby costs, and that does not exceed what a prudent buyer pays for a given item or services. Reasonable costs may vary from provider to provider and from time to time for the same provider. 28833 28834 28835 28836 28837 28838

(Z) "Related party" means an individual or organization that, to a significant extent, has common ownership with, is associated or affiliated with, has control of, or is controlled by, the provider. 28839 28840 28841 28842

(1) An individual who is a relative of an owner is a related party. 28843 28844

(2) Common ownership exists when an individual or individuals possess significant ownership or equity in both the provider and the other organization. Significant ownership or equity exists when an individual or individuals possess five per cent ownership 28845 28846 28847 28848

or equity in both the provider and a supplier. Significant ownership or equity is presumed to exist when an individual or individuals possess ten per cent ownership or equity in both the provider and another organization from which the provider purchases or leases real property. 28849 28850 28851 28852 28853

(3) Control exists when an individual or organization has the power, directly or indirectly, to significantly influence or direct the actions or policies of an organization. 28854 28855 28856

(4) An individual or organization that supplies goods or services to a provider shall not be considered a related party if all of the following conditions are met: 28857 28858 28859

(a) The supplier is a separate bona fide organization. 28860

(b) A substantial part of the supplier's business activity of the type carried on with the provider is transacted with others than the provider and there is an open, competitive market for the types of goods or services the supplier furnishes. 28861 28862 28863 28864

(c) The types of goods or services are commonly obtained by other nursing facilities or intermediate care facilities for the mentally retarded from outside organizations and are not a basic element of patient care ordinarily furnished directly to patients by the facilities. 28865 28866 28867 28868 28869

(d) The charge to the provider is in line with the charge for the goods or services in the open market and no more than the charge made under comparable circumstances to others by the supplier. 28870 28871 28872 28873

(AA) "Relative of owner" means an individual who is related to an owner of a nursing facility or intermediate care facility for the mentally retarded by one of the following relationships: 28874 28875 28876

(1) Spouse; 28877

(2) Natural parent, child, or sibling; 28878

(3) Adopted parent, child, or sibling; 28879

(4) Stepparent, stepchild, stepbrother, or stepsister; 28880

(5) Father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, or sister-in-law; 28881 28882

(6) Grandparent or grandchild; 28883

(7) Foster caregiver, foster child, foster brother, or foster sister. 28884 28885

(BB) "Renovation" and "extensive renovation" mean: 28886

(1) Any betterment, improvement, or restoration of an intermediate care facility for the mentally retarded started before July 1, 1993, that meets the definition of a renovation or extensive renovation established in rules ~~adopted by the director of job and family services~~ in effect on December 22, 1992. 28887 28888 28889 28890 28891

(2) In the case of betterments, improvements, and restorations of intermediate care facilities for the mentally retarded started on or after July 1, 1993: 28892 28893 28894

(a) "Renovation" means the betterment, improvement, or restoration of an intermediate care facility for the mentally retarded beyond its current functional capacity through a structural change that costs at least five hundred dollars per bed. A renovation may include betterment, improvement, restoration, or replacement of assets that are affixed to the building and have a useful life of at least five years. A renovation may include costs that otherwise would be considered maintenance and repair expenses if they are an integral part of the structural change that makes up the renovation project. "Renovation" does not mean construction of additional space for beds that will be added to a facility's licensed or certified capacity. 28895 28896 28897 28898 28899 28900 28901 28902 28903 28904 28905 28906 28907

(b) "Extensive renovation" means a renovation that costs more 28908

than sixty-five per cent and no more than eighty-five per cent of the cost of constructing a new bed and that extends the useful life of the assets for at least ten years. 28909 28910 28911

For the purposes of division (BB)(2) of this section, the cost of constructing a new bed shall be considered to be forty thousand dollars, adjusted for the estimated rate of inflation from January 1, 1993, to the end of the calendar year during which the renovation is completed, using the consumer price index for shelter costs for all urban consumers for the north central region, as published by the United States bureau of labor statistics. 28912 28913 28914 28915 28916 28917 28918 28919

The department of ~~job and family services~~ health care administration may treat a renovation that costs more than eighty-five per cent of the cost of constructing new beds as an extensive renovation if the department determines that the renovation is more prudent than construction of new beds. 28920 28921 28922 28923 28924

(CC) "Title XIX" means Title XIX of the "Social Security Act," 79 Stat. 286 (1965), 42 U.S.C. 1396, as amended. 28925 28926

(DD) "Title XVIII" means Title XVIII of the "Social Security Act," 79 Stat. 286 (1965), 42 U.S.C. 1395, as amended. 28927 28928

Sec. ~~5111.201~~ 5164.011. Whenever "skilled nursing facility," "intermediate care facility," or "dual skilled nursing and intermediate care facility" is referred to or designated in any statute, rule, contract, provider agreement, or other document pertaining to the ~~medical assistance~~ medicaid program, the reference or designation is deemed to refer to a nursing facility, except that a reference to or designation of an "intermediate care facility for the mentally retarded" is not deemed to refer to a nursing facility. 28929 28930 28931 28932 28933 28934 28935 28936 28937

Sec. ~~5111.21~~ 5164.02. (A) In order to be eligible for 28938

medicaid payments, the operator of a nursing facility or intermediate care facility for the mentally retarded shall do all of the following: 28939 28940 28941

(1) Enter into a provider agreement with the department of health care administration as provided in section ~~5111.22~~ 5164.03, ~~5111.671~~ 5164.841, or ~~5111.672~~ 5164.842 of the Revised Code; 28942 28943 28944

(2) Apply for and maintain a valid license to operate if so required by law; 28945 28946

(3) Comply with all applicable state and federal laws and rules. 28947 28948

(B)(1) Except as provided in division (B)(2) of this section, the operator of a nursing facility that elects to obtain and maintain eligibility for payments under the medicaid program shall qualify all of the facility's medicaid-certified beds in the medicare program ~~established by Title XVIII~~. The director of ~~job and family services~~ health care administration may adopt rules under section ~~5111.02~~ 5163.15 of the Revised Code to establish the time frame in which a nursing facility must comply with this requirement. 28949 28950 28951 28952 28953 28954 28955 28956 28957

(2) The Ohio veteran's home agency is not required to qualify all of the medicaid-certified beds in a nursing facility the agency maintains and operates under section 5907.01 of the Revised Code in the medicare program. 28958 28959 28960 28961

Sec. ~~5111.22~~ 5164.03. A provider agreement between the department of ~~job and family services~~ health care administration and the provider of a nursing facility or intermediate care facility for the mentally retarded shall contain the following provisions: 28962 28963 28964 28965 28966

(A) The department agrees to make payments to the provider, as provided in sections ~~5111.20~~ 5164.01 to ~~5111.33~~ 5164.47 of the 28967 28968

Revised Code, for medicaid-covered services the facility provides 28969
to a resident of the facility who is a medicaid recipient. No 28970
payment shall be made for the day a medicaid recipient is 28971
discharged from the facility. 28972

(B) The provider agrees to: 28973

(1) Maintain eligibility as provided in section ~~5111.21~~ 28974
5164.02 of the Revised Code; 28975

(2) Keep records relating to a cost reporting period for the 28976
greater of seven years after the cost report is filed or, if the 28977
department issues an audit report in accordance with division (B) 28978
of section ~~5111.27~~ 5164.38 of the Revised Code, six years after 28979
all appeal rights relating to the audit report are exhausted; 28980

(3) File reports as required by the department; 28981

(4) Open all records relating to the costs of its services 28982
for inspection and audit by the department; 28983

(5) Open its premises for inspection by the department, the 28984
department of health, and any other state or local authority 28985
having authority to inspect; 28986

(6) Supply to the department such information as it requires 28987
concerning the facility's services to residents who are or are 28988
eligible to be medicaid recipients; 28989

(7) Comply with section ~~5111.31~~ 5164.033 of the Revised Code. 28990

The provider agreement may contain other provisions that are 28991
consistent with law and considered necessary by the department. 28992

A provider agreement shall be effective for no longer than 28993
twelve months, except that if federal statute or regulations 28994
authorize a longer term, it may be effective for a longer term so 28995
authorized. A provider agreement may be renewed only if the 28996
facility is certified by the department of health for 28997
participation in the medicaid program. 28998

The department of ~~job and family services~~ health care administration, in accordance with rules adopted under section ~~5111.02~~ 5163.15 of the Revised Code, may elect not to enter into, not to renew, or to terminate a provider agreement when the department determines that such an agreement would not be in the best interests of medicaid recipients or of the state.

Sec. ~~5111.223~~ 5164.031. The operator of a nursing facility or intermediate care facility for the mentally retarded may enter into provider agreements for more than one nursing facility or intermediate care facility for the mentally retarded.

Sec. ~~5111.30~~ 5164.032. The department of ~~job and family services~~ health care administration shall terminate the provider agreement with a provider that does not comply with the requirements of section 3721.071 of the Revised Code for the installation of fire extinguishing and fire alarm systems.

Sec. ~~5111.31~~ 5164.033. (A) Every provider agreement with the provider of a nursing facility or intermediate care facility for the mentally retarded shall:

(1) Prohibit the provider from failing or refusing to retain as a patient any person because the person is, becomes, or may, as a patient in the facility, become a medicaid recipient. For the purposes of this division, a medicaid recipient who is a patient in a facility shall be considered a patient in the facility during any hospital stays totaling less than twenty-five days during any twelve-month period. Recipients who have been identified by the department of ~~job and family services~~ health care administration or its designee as requiring the level of care of an intermediate care facility for the mentally retarded shall not be subject to a maximum period of absences during which they are considered patients if prior authorization of the department for visits with

relatives and friends and participation in therapeutic programs is obtained under rules adopted under section ~~5111.02~~ 5163.15 of the Revised Code.

(2) Except as provided by division (B)(1) of this section, include any part of the facility that meets standards for certification of compliance with federal and state laws and rules for participation in the medicaid program.

(3) Prohibit the provider from discriminating against any patient on the basis of race, color, sex, creed, or national origin.

(4) Except as otherwise prohibited under section ~~5111.55~~ 5164.71 of the Revised Code, prohibit the provider from failing or refusing to accept a patient because the patient is, becomes, or may, as a patient in the facility, become a medicaid recipient if less than eighty per cent of the patients in the facility are medicaid recipients.

(B)(1) Except as provided by division (B)(2) of this section, the following are not required to be included in a provider agreement unless otherwise required by federal law:

(a) Beds added during the period beginning July 1, 1987, and ending July 1, 1993, to a nursing home licensed under Chapter 3721. of the Revised Code;

(b) Beds in an intermediate care facility for the mentally retarded that are designated for respite care under a medicaid waiver component operated pursuant to a waiver sought under section ~~5111.87~~ 5163.65 of the Revised Code.

(2) If a provider chooses to include a bed specified in division (B)(1)(a) of this section in a provider agreement, the bed may not be removed from the provider agreement unless the provider withdraws the facility in which the bed is located from the medicaid program.

(C) Nothing in this section shall bar a provider that is a religious organization operating a religious or denominational nursing facility or intermediate care facility for the mentally retarded from giving preference to persons of the same religion or denomination. Nothing in this section shall bar any provider from giving preference to persons with whom the provider has contracted to provide continuing care. 29060 29061 29062 29063 29064 29065 29066

(D) Nothing in this section shall bar the provider of a county home organized under Chapter 5155. of the Revised Code from admitting residents exclusively from the county in which the county home is located. 29067 29068 29069 29070

(E) No provider of a nursing facility or intermediate care facility for the mentally retarded for which a provider agreement is in effect shall violate the provider contract obligations imposed under this section. 29071 29072 29073 29074

(F) Nothing in divisions (A) and (C) of this section shall bar a provider from retaining patients who have resided in the provider's facility for not less than one year as private pay patients and who subsequently become medicaid recipients, but refusing to accept as a patient any person who is or may, as a patient in the facility, become a medicaid recipient, if all of the following apply: 29075 29076 29077 29078 29079 29080 29081

(1) The provider does not refuse to retain any patient who has resided in the provider's facility for not less than one year as a private pay patient because the patient becomes a medicaid recipient, except as necessary to comply with division (F)(2) of this section; 29082 29083 29084 29085 29086

(2) The number of medicaid recipients retained under this division does not at any time exceed ten per cent of all the patients in the facility; 29087 29088 29089

(3) On July 1, 1980, all the patients in the facility were 29090

private pay patients.

Sec. ~~5111.32~~ 5164.034. Any patient has a cause of action against the provider of a nursing facility or intermediate care facility for the mentally retarded for breach of the provider agreement obligations or other duties imposed by section ~~5111.31~~ 5164.033 of the Revised Code. The action may be commenced by the patient, or on the patient's behalf by the patient's sponsor or a residents' rights advocate, as either is defined under section 3721.10 of the Revised Code, by the filing of a civil action in the court of common pleas of the county in which the facility is located, or in the court of common pleas of Franklin county.

If the court finds that a breach of the provider agreement obligations imposed by section ~~5111.31~~ 5164.033 of the Revised Code has occurred, the court may enjoin the provider from engaging in the practice, order such affirmative relief as may be necessary, and award to the patient and a person or public agency that brings an action on behalf of a patient actual damages, costs, and reasonable attorney's fees.

Sec. ~~5111.23~~ 5164.05. (A) The department of ~~job and family services~~ health care administration shall pay a provider for each of the provider's eligible intermediate care facilities for the mentally retarded a per resident per day rate for direct care costs established prospectively for each facility. The department shall establish each facility's rate for direct care costs quarterly.

(B) Each facility's rate for direct care costs shall be based on the facility's cost per case-mix unit, subject to the maximum costs per case-mix unit established under division (B)(2) of this section, from the calendar year preceding the fiscal year in which the rate is paid. To determine the rate, the department shall do

all of the following: 29121

(1) Determine each facility's cost per case-mix unit for the 29122
calendar year preceding the fiscal year in which the rate will be 29123
paid by dividing the facility's desk-reviewed, actual, allowable, 29124
per diem direct care costs for that year by its average case-mix 29125
score determined under section ~~5111.232~~ 5164.051 of the Revised 29126
Code for the same calendar year. 29127

(2)(a) Set the maximum cost per case-mix unit for each peer 29128
group of intermediate care facilities for the mentally retarded 29129
with more than eight beds specified in rules adopted under 29130
division (E) of this section at a percentage above the cost per 29131
case-mix unit of the facility in the group that has the group's 29132
median medicaid inpatient day for the calendar year preceding the 29133
fiscal year in which the rate will be paid, as calculated under 29134
division (B)(1) of this section, that is no less than the 29135
percentage calculated under division (D)(2) of this section. 29136

(b) Set the maximum cost per case-mix unit for each peer 29137
group of intermediate care facilities for the mentally retarded 29138
with eight or fewer beds specified in rules adopted under division 29139
(E) of this section at a percentage above the cost per case-mix 29140
unit of the facility in the group that has the group's median 29141
medicaid inpatient day for the calendar year preceding the fiscal 29142
year in which the rate will be paid, as calculated under division 29143
(B)(1) of this section, that is no less than the percentage 29144
calculated under division (D)(3) of this section. 29145

(c) In calculating the maximum cost per case-mix unit under 29146
divisions (B)(2)(a) ~~to~~ and (b) of this section for each peer 29147
group, the department shall exclude from its calculations the cost 29148
per case-mix unit of any facility in the group that participated 29149
in the medicaid program under the same operator for less than 29150
twelve months during the calendar year preceding the fiscal year 29151
in which the rate will be paid. 29152

(3) Estimate the rate of inflation for the eighteen-month 29153
period beginning on the first day of July of the calendar year 29154
preceding the fiscal year in which the rate will be paid and 29155
ending on the thirty-first day of December of the fiscal year in 29156
which the rate will be paid, using the employment cost index for 29157
total compensation, health services component, published by the 29158
United States bureau of labor statistics. If the estimated 29159
inflation rate for the eighteen-month period is different from the 29160
actual inflation rate for that period, as measured using the same 29161
index, the difference shall be added to or subtracted from the 29162
inflation rate estimated under division (B)(3) of this section for 29163
the following fiscal year. 29164

(4) The department shall not recalculate a maximum cost per 29165
case-mix unit under division (B)(2) of this section or a 29166
percentage under division (D) of this section based on additional 29167
information that it receives after the maximum costs per case-mix 29168
unit or percentages are set. The department shall recalculate a 29169
maximum cost per case-mix units or percentage only if it made an 29170
error in computing the maximum cost per case-mix unit or 29171
percentage based on information available at the time of the 29172
original calculation. 29173

(C) Each facility's rate for direct care costs shall be 29174
determined as follows for each calendar quarter within a fiscal 29175
year: 29176

(1) Multiply the lesser of the following by the facility's 29177
average case-mix score determined under section ~~5111.232~~ 5164.051 29178
of the Revised Code for the calendar quarter that preceded the 29179
immediately preceding calendar quarter: 29180

(a) The facility's cost per case-mix unit for the calendar 29181
year preceding the fiscal year in which the rate will be paid, as 29182
determined under division (B)(1) of this section; 29183

(b) The maximum cost per case-mix unit established for the 29184
fiscal year in which the rate will be paid for the facility's peer 29185
group under division (B)(2) of this section; 29186

(2) Adjust the product determined under division (C)(1) of 29187
this section by the inflation rate estimated under division (B)(3) 29188
of this section. 29189

(D)(1) The department shall calculate the percentage above 29190
the median cost per case-mix unit determined under division (B)(1) 29191
of this section for the facility that has the median medicaid 29192
inpatient day for calendar year 1992 for all intermediate care 29193
facilities for the mentally retarded with more than eight beds 29194
that would result in payment of all desk-reviewed, actual, 29195
allowable direct care costs for eighty and one-half per cent of 29196
the medicaid inpatient days for such facilities for calendar year 29197
1992. 29198

(2) The department shall calculate the percentage above the 29199
median cost per case-mix unit determined under division (B)(1) of 29200
this section for the facility that has the median medicaid 29201
inpatient day for calendar year 1992 for all intermediate care 29202
facilities for the mentally retarded with eight or fewer beds that 29203
would result in payment of all desk-reviewed, actual, allowable 29204
direct care costs for eighty and one-half per cent of the medicaid 29205
inpatient days for such facilities for calendar year 1992. 29206

(E) The director of ~~job and family services~~ health care 29207
administration shall adopt rules under section ~~5111.02~~ 5163.15 of 29208
the Revised Code that specify peer groups of intermediate care 29209
facilities for the mentally retarded with more than eight beds and 29210
intermediate care facilities for the mentally retarded with eight 29211
or fewer beds, based on findings of significant per diem direct 29212
care cost differences due to geography and facility bed-size. The 29213
rules also may specify peer groups based on findings of 29214
significant per diem direct care cost differences due to other 29215

factors which may include case-mix. 29216

(F) The department, in accordance with division ~~(D)~~(C) of section ~~5111.232~~ 5164.051 of the Revised Code and rules adopted under division ~~(E)~~(D) of that section, may assign case-mix scores or costs per case-mix unit if a provider fails to submit assessment data necessary to calculate an intermediate care facility for the mentally retarded's case-mix score in accordance with that section. 29217 29218 29219 29220 29221 29222 29223

Sec. 5164.051. (A) The department of health care administration shall determine case-mix scores for intermediate care facilities for the mentally retarded using data for each resident, regardless of payment source, from a resident assessment instrument and grouper methodology prescribed in rules adopted under section 5163.15 of the Revised Code and expressed in case-mix values established by the department in those rules. 29224 29225 29226 29227 29228 29229 29230

(B) Each calendar quarter, each provider of an intermediate care facility for the mentally retarded shall compile complete assessment data, from the resident assessment instrument specified in rules authorized by division (A) of this section, for each resident of each of the provider's intermediate care facilities for the mentally retarded, regardless of payment source, who was in the facility or on hospital or therapeutic leave from the facility on the last day of the quarter. Providers shall submit the data to the department of health care administration. The data shall be submitted not later than fifteen days after the end of the calendar quarter for which the data is compiled. 29231 29232 29233 29234 29235 29236 29237 29238 29239 29240 29241

Except as provided in division (C) of this section, the department, after the end of each calendar year, shall calculate an annual average case-mix score for each intermediate care facility for the mentally retarded using the facility's quarterly case-mix scores for that calendar year. The department shall make 29242 29243 29244 29245 29246

the calculations pursuant to procedures specified in rules adopted under section 5163.15 of the Revised Code. 29247 29248

(C)(1) If a provider of an intermediate care facility for the mentally retarded does not timely submit information for a calendar quarter necessary to calculate the facility's case-mix score, or submits incomplete or inaccurate information for a calendar quarter, the department may assign the facility a quarterly average case-mix score that is five per cent less than the facility's quarterly average case-mix score for the preceding calendar quarter. If the facility was subject to an exception review under division (C) of section 5164.38 of the Revised Code for the preceding calendar quarter, the department may assign a quarterly average case-mix score that is five per cent less than the score determined by the exception review. If the facility was assigned a quarterly average case-mix score for the preceding quarter, the department may assign a quarterly average case-mix score that is five per cent less than that score assigned for the preceding quarter. 29249 29250 29251 29252 29253 29254 29255 29256 29257 29258 29259 29260 29261 29262 29263 29264

The department may use a quarterly average case-mix score assigned under division (C)(1) of this section, instead of a quarterly average case-mix score calculated based on the provider's submitted information, to calculate the facility's rate for direct care costs being established under section 5164.05 of the Revised Code for one or more months, as specified in rules authorized by division (D) of this section, of the quarter for which the rate established under section 5164.05 of the Revised Code will be paid. 29265 29266 29267 29268 29269 29270 29271 29272 29273

Before taking action under division (C)(1) of this section, the department shall permit the provider a reasonable period of time, specified in rules authorized by division (D) of this section, to correct the information. The department shall not assign a quarterly average case-mix score due to late submission 29274 29275 29276 29277 29278

of corrections to assessment information unless the provider fails to submit corrected information prior to the eighty-first day after the end of the calendar quarter to which the information pertains. 29279 29280 29281 29282

(2) If a provider is paid a rate for an intermediate care facility for the mentally retarded calculated using a quarterly average case-mix score assigned under division (C)(1) of this section for more than six months in a calendar year, the department may assign the facility a cost per case-mix unit that is five per cent less than the facility's actual or assigned cost per case-mix unit for the preceding calendar year. The department may use the assigned cost per case-mix unit, instead of calculating the facility's actual cost per case-mix unit in accordance with section 5164.05 of the Revised Code, to establish the facility's rate for direct care costs for the following fiscal year. 29283 29284 29285 29286 29287 29288 29289 29290 29291 29292 29293 29294

(3) The department shall take action under division (C)(1) or (2) of this section only in accordance with rules authorized by division (D) of this section. The department shall not take an action that affects rates for prior payment periods except in accordance with sections 5164.38 and 5164.39 of the Revised Code. 29295 29296 29297 29298 29299

(D) The director shall adopt rules under section 5163.15 of the Revised Code that do all of the following: 29300 29301

(1) Specify the medium or media through which the completed assessment data shall be submitted; 29302 29303

(2) Establish procedures under which the assessment data shall be reviewed for accuracy and providers shall be notified of any data that requires correction; 29304 29305 29306

(3) Establish procedures for providers to correct assessment data and specify a reasonable period of time by which providers shall submit the corrections; 29307 29308 29309

(4) Specify when and how the department will assign case-mix 29310
scores or costs per case-mix unit under division (C) of this 29311
section if information necessary to calculate the facility's 29312
case-mix score is not provided or corrected in accordance with the 29313
procedures established by the rules. Notwithstanding any other 29314
provision of sections 5164.01 to 5164.47 of the Revised Code, the 29315
rules also may provide for excluding case-mix scores assigned 29316
under division (C) of this section from calculation of an 29317
intermediate care facility for the mentally retarded's annual 29318
average case-mix score and the maximum cost per case-mix unit for 29319
the facility's peer group. 29320

Sec. ~~5111.235~~ 5164.06. The department of ~~job and family~~ 29321
~~services~~ health care administration shall pay a provider for each 29322
of the provider's eligible intermediate care facilities for the 29323
mentally retarded a per resident per day rate for other protected 29324
costs established prospectively each fiscal year for each 29325
facility. The rate for each facility shall be the facility's 29326
desk-reviewed, actual, allowable, per diem other protected costs 29327
from the calendar year preceding the fiscal year in which the rate 29328
will be paid, all adjusted for the estimated inflation rate for 29329
the eighteen-month period beginning on the first day of July of 29330
the calendar year preceding the fiscal year in which the rate will 29331
be paid and ending on the thirty-first day of December of that 29332
fiscal year. The department shall estimate inflation using the 29333
consumer price index for all urban consumers for nonprescription 29334
drugs and medical supplies, as published by the United States 29335
bureau of labor statistics. If the estimated inflation rate for 29336
the eighteen-month period is different from the actual inflation 29337
rate for that period, the difference shall be added to or 29338
subtracted from the inflation rate estimated for the following 29339
year. 29340

Sec. ~~5111.241~~ 5164.07. (A) The department of ~~job and family services~~ health care administration shall pay a provider for each of the provider's eligible intermediate care facilities for the mentally retarded a per resident per day rate for indirect care costs established prospectively each fiscal year for each facility. The rate for each intermediate care facility for the mentally retarded shall be the sum of the following, but shall not exceed the maximum rate established for the facility's peer group under division (B) of this section: 29341 29342 29343 29344 29345 29346 29347 29348 29349

(1) The facility's desk-reviewed, actual, allowable, per diem indirect care costs from the calendar year preceding the fiscal year in which the rate will be paid, adjusted for the inflation rate estimated under division (C)(1) of this section; 29350 29351 29352 29353

(2) An efficiency incentive in the following amount: 29354

(a) For fiscal years ending in even-numbered calendar years: 29355

(i) In the case of intermediate care facilities for the mentally retarded with more than eight beds, seven and one-tenth per cent of the maximum rate established for the facility's peer group under division (B) of this section; 29356 29357 29358 29359

(ii) In the case of intermediate care facilities for the mentally retarded with eight or fewer beds, seven per cent of the maximum rate established for the facility's peer group under division (B) of this section; 29360 29361 29362 29363

(b) For fiscal years ending in odd-numbered calendar years, the amount calculated for the preceding fiscal year under division (A)(2)(a) of this section. 29364 29365 29366

(B)(1) The maximum rate for indirect care costs for each peer group of intermediate care facilities for the mentally retarded with more than eight beds specified in rules adopted under division (D) of this section shall be determined as follows: 29367 29368 29369 29370

(a) For fiscal years ending in even-numbered calendar years, the maximum rate for each peer group shall be the rate that is no less than twelve and four-tenths per cent above the median desk-reviewed, actual, allowable, per diem indirect care cost for all intermediate care facilities for the mentally retarded with more than eight beds in the group, excluding facilities in the group whose indirect care costs for that period are more than three standard deviations from the mean desk-reviewed, actual, allowable, per diem indirect care cost for all intermediate care facilities for the mentally retarded with more than eight beds, for the calendar year preceding the fiscal year in which the rate will be paid, adjusted by the inflation rate estimated under division (C)(1) of this section. 29371 29372 29373 29374 29375 29376 29377 29378 29379 29380 29381 29382 29383

(b) For fiscal years ending in odd-numbered calendar years, the maximum rate for each peer group is the group's maximum rate for the previous fiscal year, adjusted for the inflation rate estimated under division (C)(2) of this section. 29384 29385 29386 29387

(2) The maximum rate for indirect care costs for each peer group of intermediate care facilities for the mentally retarded with eight or fewer beds specified in rules adopted under division (D) of this section shall be determined as follows: 29388 29389 29390 29391

(a) For fiscal years ending in even-numbered calendar years, the maximum rate for each peer group shall be the rate that is no less than ten and three-tenths per cent above the median desk-reviewed, actual, allowable, per diem indirect care cost for all intermediate care facilities for the mentally retarded with eight or fewer beds in the group, excluding facilities in the group whose indirect care costs are more than three standard deviations from the mean desk-reviewed, actual, allowable, per diem indirect care cost for all intermediate care facilities for the mentally retarded with eight or fewer beds, for the calendar year preceding the fiscal year in which the rate will be paid, 29392 29393 29394 29395 29396 29397 29398 29399 29400 29401 29402

adjusted by the inflation rate estimated under division (C)(1) of this section. 29403 29404

(b) For fiscal years that end in odd-numbered calendar years, the maximum rate for each peer group is the group's maximum rate for the previous fiscal year, adjusted for the inflation rate estimated under division (C)(2) of this section. 29405 29406 29407 29408

(3) The department shall not recalculate a maximum rate for indirect care costs under division (B)(1) or (2) of this section based on additional information that it receives after the maximum rate is set. The department shall recalculate the maximum rate for indirect care costs only if it made an error in computing the maximum rate based on the information available at the time of the original calculation. 29409 29410 29411 29412 29413 29414 29415

(C)(1) When adjusting rates for inflation under divisions (A)(1), (B)(1)(a), and (B)(2)(a) of this section, the department shall estimate the rate of inflation for the eighteen-month period beginning on the first day of July of the calendar year preceding the fiscal year in which the rate will be paid and ending on the thirty-first day of December of the fiscal year in which the rate will be paid, using the consumer price index for all items for all urban consumers for the north central region, published by the United States bureau of labor statistics. 29416 29417 29418 29419 29420 29421 29422 29423 29424

(2) When adjusting rates for inflation under divisions (B)(1)(b) and (B)(2)(b) of this section, the department shall estimate the rate of inflation for the twelve-month period beginning on the first day of January of the fiscal year preceding the fiscal year in which the rate will be paid and ending on the thirty-first day of December of the fiscal year in which the rate will be paid, using the consumer price index for all items for all urban consumers for the north central region, published by the United States bureau of labor statistics. 29425 29426 29427 29428 29429 29430 29431 29432 29433

(3) If an inflation rate estimated under division (C)(1) or 29434
(2) of this section is different from the actual inflation rate 29435
for the relevant time period, as measured using the same index, 29436
the difference shall be added to or subtracted from the inflation 29437
rate estimated pursuant to this division for the following fiscal 29438
year. 29439

(D) The director of ~~job and family services~~ health care 29440
administration shall adopt rules under section ~~5111.02~~ 5163.15 of 29441
the Revised Code that specify peer groups of intermediate care 29442
facilities for the mentally retarded with more than eight beds, 29443
and peer groups of intermediate care facilities for the mentally 29444
retarded with eight or fewer beds, based on findings of 29445
significant per diem indirect care cost differences due to 29446
geography and facility bed-size. The rules also may specify peer 29447
groups based on findings of significant per diem indirect care 29448
cost differences due to other factors, including case-mix. 29449

Sec. ~~5111.251~~ 5164.08. (A) The department of ~~job and family~~ 29450
~~services~~ health care administration shall pay a provider for each 29451
of the provider's eligible intermediate care facilities for the 29452
mentally retarded for its reasonable capital costs, a per resident 29453
per day rate established prospectively each fiscal year for each 29454
intermediate care facility for the mentally retarded. Except as 29455
otherwise provided in sections ~~5111.20~~ 5164.01 to ~~5111.33~~ 5164.41 29456
of the Revised Code, the rate shall be based on the facility's 29457
capital costs for the calendar year preceding the fiscal year in 29458
which the rate will be paid. The rate shall equal the sum of the 29459
following: 29460

(1) The facility's desk-reviewed, actual, allowable, per diem 29461
cost of ownership for the preceding cost reporting period, limited 29462
as provided in divisions (C) and (F) of this section; 29463

(2) Any efficiency incentive determined under division (B) of 29464

this section; 29465

(3) Any amounts for renovations determined under division (D) 29466
of this section; 29467

(4) Any amounts for return on equity determined under 29468
division (I) of this section. 29469

Buildings shall be depreciated using the straight line method 29470
over forty years or over a different period approved by the 29471
department. Components and equipment shall be depreciated using 29472
the straight line method over a period designated by the director 29473
of ~~job and family services~~ health care administration in rules 29474
adopted under section ~~5111.02~~ 5163.15 of the Revised Code, 29475
consistent with the guidelines of the American hospital 29476
association, or over a different period approved by the department 29477
of ~~job and family services~~ health care administration. Any rules 29478
authorized by this division that specify useful lives of 29479
buildings, components, or equipment apply only to assets acquired 29480
on or after July 1, 1993. Depreciation for costs paid or 29481
reimbursed by any government agency shall not be included in costs 29482
of ownership or renovation unless that part of the payment under 29483
sections ~~5111.20~~ 5164.01 to ~~5111.33~~ 5164.41 of the Revised Code is 29484
used to reimburse the government agency. 29485

(B) The department of ~~job and family services~~ health care 29486
administration shall pay to a provider for each of the provider's 29487
eligible intermediate care facilities for the mentally retarded an 29488
efficiency incentive equal to fifty per cent of the difference 29489
between any desk-reviewed, actual, allowable cost of ownership and 29490
the applicable limit on cost of ownership payments under division 29491
(C) of this section. For purposes of computing the efficiency 29492
incentive, depreciation for costs paid or reimbursed by any 29493
government agency shall be considered as a cost of ownership, and 29494
the applicable limit under division (C) of this section shall 29495
apply both to facilities with more than eight beds and facilities 29496

with eight or fewer beds. The efficiency incentive paid to a provider for a facility with eight or fewer beds shall not exceed three dollars per patient day, adjusted annually for the inflation rate for the twelve-month period beginning on the first day of July of the calendar year preceding the calendar year that precedes the fiscal year for which the efficiency incentive is determined and ending on the thirtieth day of the following June, using the consumer price index for shelter costs for all urban consumers for the north central region, as published by the United States bureau of labor statistics. 29497 29498 29499 29500 29501 29502 29503 29504 29505 29506

(C) Cost of ownership payments for intermediate care facilities for the mentally retarded with more than eight beds shall not exceed the following limits: 29507 29508 29509

(1) For facilities with dates of licensure prior to January 1, 1958, not exceeding two dollars and fifty cents per patient day; 29510 29511 29512

(2) For facilities with dates of licensure after December 31, 1957, but prior to January 1, 1968, not exceeding: 29513 29514

(a) Three dollars and fifty cents per patient day if the cost of construction was three thousand five hundred dollars or more per bed; 29515 29516 29517

(b) Two dollars and fifty cents per patient day if the cost of construction was less than three thousand five hundred dollars per bed. 29518 29519 29520

(3) For facilities with dates of licensure after December 31, 1967, but prior to January 1, 1976, not exceeding: 29521 29522

(a) Four dollars and fifty cents per patient day if the cost of construction was five thousand one hundred fifty dollars or more per bed; 29523 29524 29525

(b) Three dollars and fifty cents per patient day if the cost 29526

of construction was less than five thousand one hundred fifty dollars per bed, but exceeds three thousand five hundred dollars per bed; 29527 29528 29529

(c) Two dollars and fifty cents per patient day if the cost of construction was three thousand five hundred dollars or less per bed. 29530 29531 29532

(4) For facilities with dates of licensure after December 31, 1975, but prior to January 1, 1979, not exceeding: 29533 29534

(a) Five dollars and fifty cents per patient day if the cost of construction was six thousand eight hundred dollars or more per bed; 29535 29536 29537

(b) Four dollars and fifty cents per patient day if the cost of construction was less than six thousand eight hundred dollars per bed but exceeds five thousand one hundred fifty dollars per bed; 29538 29539 29540 29541

(c) Three dollars and fifty cents per patient day if the cost of construction was five thousand one hundred fifty dollars or less per bed, but exceeds three thousand five hundred dollars per bed; 29542 29543 29544 29545

(d) Two dollars and fifty cents per patient day if the cost of construction was three thousand five hundred dollars or less per bed. 29546 29547 29548

(5) For facilities with dates of licensure after December 31, 1978, but prior to January 1, 1980, not exceeding: 29549 29550

(a) Six dollars per patient day if the cost of construction was seven thousand six hundred twenty-five dollars or more per bed; 29551 29552 29553

(b) Five dollars and fifty cents per patient day if the cost of construction was less than seven thousand six hundred twenty-five dollars per bed but exceeds six thousand eight hundred 29554 29555 29556

dollars per bed; 29557

(c) Four dollars and fifty cents per patient day if the cost of construction was six thousand eight hundred dollars or less per bed but exceeds five thousand one hundred fifty dollars per bed; 29558 29559 29560

(d) Three dollars and fifty cents per patient day if the cost of construction was five thousand one hundred fifty dollars or less but exceeds three thousand five hundred dollars per bed; 29561 29562 29563

(e) Two dollars and fifty cents per patient day if the cost of construction was three thousand five hundred dollars or less per bed. 29564 29565 29566

(6) For facilities with dates of licensure after December 31, 1979, but prior to January 1, 1981, not exceeding: 29567 29568

(a) Twelve dollars per patient day if the beds were originally licensed as residential facility beds by the department of mental retardation and developmental disabilities; 29569 29570 29571

(b) Six dollars per patient day if the beds were originally licensed as nursing home beds by the department of health. 29572 29573

(7) For facilities with dates of licensure after December 31, 1980, but prior to January 1, 1982, not exceeding: 29574 29575

(a) Twelve dollars per patient day if the beds were originally licensed as residential facility beds by the department of mental retardation and developmental disabilities; 29576 29577 29578

(b) Six dollars and forty-five cents per patient day if the beds were originally licensed as nursing home beds by the department of health. 29579 29580 29581

(8) For facilities with dates of licensure after December 31, 1981, but prior to January 1, 1983, not exceeding: 29582 29583

(a) Twelve dollars per patient day if the beds were originally licensed as residential facility beds by the department of mental retardation and developmental disabilities; 29584 29585 29586

(b) Six dollars and seventy-nine cents per patient day if the beds were originally licensed as nursing home beds by the department of health. 29587 29588 29589

(9) For facilities with dates of licensure after December 31, 1982, but prior to January 1, 1984, not exceeding: 29590 29591

(a) Twelve dollars per patient day if the beds were originally licensed as residential facility beds by the department of mental retardation and developmental disabilities; 29592 29593 29594

(b) Seven dollars and nine cents per patient day if the beds were originally licensed as nursing home beds by the department of health. 29595 29596 29597

(10) For facilities with dates of licensure after December 31, 1983, but prior to January 1, 1985, not exceeding: 29598 29599

(a) Twelve dollars and twenty-four cents per patient day if the beds were originally licensed as residential facility beds by the department of mental retardation and developmental disabilities; 29600 29601 29602 29603

(b) Seven dollars and twenty-three cents per patient day if the beds were originally licensed as nursing home beds by the department of health. 29604 29605 29606

(11) For facilities with dates of licensure after December 31, 1984, but prior to January 1, 1986, not exceeding: 29607 29608

(a) Twelve dollars and fifty-three cents per patient day if the beds were originally licensed as residential facility beds by the department of mental retardation and developmental disabilities; 29609 29610 29611 29612

(b) Seven dollars and forty cents per patient day if the beds were originally licensed as nursing home beds by the department of health. 29613 29614 29615

(12) For facilities with dates of licensure after December 29616

31, 1985, but prior to January 1, 1987, not exceeding: 29617

(a) Twelve dollars and seventy cents per patient day if the beds were originally licensed as residential facility beds by the department of mental retardation and developmental disabilities; 29618 29619 29620

(b) Seven dollars and fifty cents per patient day if the beds were originally licensed as nursing home beds by the department of health. 29621 29622 29623

(13) For facilities with dates of licensure after December 31, 1986, but prior to January 1, 1988, not exceeding: 29624 29625

(a) Twelve dollars and ninety-nine cents per patient day if the beds were originally licensed as residential facility beds by the department of mental retardation and developmental disabilities; 29626 29627 29628 29629

(b) Seven dollars and sixty-seven cents per patient day if the beds were originally licensed as nursing home beds by the department of health. 29630 29631 29632

(14) For facilities with dates of licensure after December 31, 1987, but prior to January 1, 1989, not exceeding thirteen dollars and twenty-six cents per patient day; 29633 29634 29635

(15) For facilities with dates of licensure after December 31, 1988, but prior to January 1, 1990, not exceeding thirteen dollars and forty-six cents per patient day; 29636 29637 29638

(16) For facilities with dates of licensure after December 31, 1989, but prior to January 1, 1991, not exceeding thirteen dollars and sixty cents per patient day; 29639 29640 29641

(17) For facilities with dates of licensure after December 31, 1990, but prior to January 1, 1992, not exceeding thirteen dollars and forty-nine cents per patient day; 29642 29643 29644

(18) For facilities with dates of licensure after December 31, 1991, but prior to January 1, 1993, not exceeding thirteen 29645 29646

dollars and sixty-seven cents per patient day; 29647

(19) For facilities with dates of licensure after December 31, 1992, not exceeding fourteen dollars and twenty-eight cents per patient day. 29648 29649 29650

(D) Beginning January 1, 1981, regardless of the original date of licensure, the department of ~~job and family services~~ health care administration shall pay a rate for the per diem capitalized costs of renovations to intermediate care facilities for the mentally retarded made after January 1, 1981, not exceeding six dollars per patient day using 1980 as the base year and adjusting the amount annually until June 30, 1993, for fluctuations in construction costs calculated by the department using the "Dodge building cost indexes, northeastern and north central states," published by Marshall and Swift. The payment provided for in this division is the only payment that shall be made for the capitalized costs of a nonextensive renovation of an intermediate care facility for the mentally retarded. Nonextensive renovation costs shall not be included in cost of ownership, and a nonextensive renovation shall not affect the date of licensure for purposes of division (C) of this section. This division applies to nonextensive renovations regardless of whether they are made by an owner or a lessee. If the tenancy of a lessee that has made renovations ends before the depreciation expense for the renovation costs has been fully reported, the former lessee shall not report the undepreciated balance as an expense. 29651 29652 29653 29654 29655 29656 29657 29658 29659 29660 29661 29662 29663 29664 29665 29666 29667 29668 29669 29670 29671

For a nonextensive renovation to qualify for payment under this division, both of the following conditions must be met: 29672 29673

(1) At least five years have elapsed since the date of licensure or date of an extensive renovation of the portion of the facility that is proposed to be renovated, except that this condition does not apply if the renovation is necessary to meet the requirements of federal, state, or local statutes, ordinances, 29674 29675 29676 29677 29678

rules, or policies. 29679

(2) The provider has obtained prior approval from the 29680
department of ~~job and family services~~ health care administration. 29681
The provider shall submit a plan that describes in detail the 29682
changes in capital assets to be accomplished by means of the 29683
renovation and the timetable for completing the project. The time 29684
for completion of the project shall be no more than eighteen 29685
months after the renovation begins. The director of ~~job and family~~ 29686
~~services~~ health care administration shall adopt rules under 29687
section ~~5111.02~~ 5163.15 of the Revised Code that specify criteria 29688
and procedures for prior approval of renovation projects. No 29689
provider shall separate a project with the intent to evade the 29690
characterization of the project as a renovation or as an extensive 29691
renovation. No provider shall increase the scope of a project 29692
after it is approved by the department of ~~job and family services~~ 29693
health care administration unless the increase in scope is 29694
approved by the department. 29695

(E) The amounts specified in divisions (C) and (D) of this 29696
section shall be adjusted beginning July 1, 1993, for the 29697
estimated inflation for the twelve-month period beginning on the 29698
first day of July of the calendar year preceding the calendar year 29699
that precedes the fiscal year for which rate will be paid and 29700
ending on the thirtieth day of the following June, using the 29701
consumer price index for shelter costs for all urban consumers for 29702
the north central region, as published by the United States bureau 29703
of labor statistics. 29704

(F)(1) For facilities of eight or fewer beds that have dates 29705
of licensure or have been granted project authorization by the 29706
department of mental retardation and developmental disabilities 29707
before July 1, 1993, and for facilities of eight or fewer beds 29708
that have dates of licensure or have been granted project 29709
authorization after that date if the providers of the facilities 29710

demonstrate that they made substantial commitments of funds on or 29711
before that date, cost of ownership shall not exceed eighteen 29712
dollars and thirty cents per resident per day. The eighteen-dollar 29713
and thirty-cent amount shall be increased by the change in the 29714
"Dodge building cost indexes, northeastern and north central 29715
states," published by Marshall and Swift, during the period 29716
beginning June 30, 1990, and ending July 1, 1993, and by the 29717
change in the consumer price index for shelter costs for all urban 29718
consumers for the north central region, as published by the United 29719
States bureau of labor statistics, annually thereafter. 29720

(2) For facilities with eight or fewer beds that have dates 29721
of licensure or have been granted project authorization by the 29722
department of mental retardation and developmental disabilities on 29723
or after July 1, 1993, for which substantial commitments of funds 29724
were not made before that date, cost of ownership payments shall 29725
not exceed the applicable amount calculated under division (F)(1) 29726
of this section, if the department of ~~job and family services~~ 29727
health care administration gives prior approval for construction 29728
of the facility. If the department does not give prior approval, 29729
cost of ownership payments shall not exceed the amount specified 29730
in division (C) of this section. 29731

(3) Notwithstanding divisions (D) and (F)(1) and (2) of this 29732
section, the total payment for cost of ownership, cost of 29733
ownership efficiency incentive, and capitalized costs of 29734
renovations for an intermediate care facility for the mentally 29735
retarded with eight or fewer beds shall not exceed the sum of the 29736
limitations specified in divisions (C) and (D) of this section. 29737

(G) Notwithstanding any provision of this section or section 29738
~~5111.241~~ 5164.07 of the Revised Code, the director of ~~job and~~ 29739
~~family services~~ health care administration may adopt rules under 29740
section ~~5111.02~~ 5163.15 of the Revised Code that provide for a 29741
calculation of a combined maximum payment limit for indirect care 29742

costs and cost of ownership for intermediate care facilities for the mentally retarded with eight or fewer beds. 29743 29744

(H) After the date on which a transaction of sale is closed, the provider shall refund to the department the amount of excess depreciation paid to the provider for the facility by the department for each year the provider has operated the facility under a provider agreement and prorated according to the number of medicaid patient days for which the provider has received payment for the facility. For the purposes of this division, "depreciation paid to the provider for the facility" means the amount paid to the provider for the intermediate care facility for the mentally retarded for cost of ownership pursuant to this section less any amount paid for interest costs. For the purposes of this division, "excess depreciation" is the intermediate care facility for the mentally retarded's depreciated basis, which is the provider's cost less accumulated depreciation, subtracted from the purchase price but not exceeding the amount of depreciation paid to the provider for the facility. 29745 29746 29747 29748 29749 29750 29751 29752 29753 29754 29755 29756 29757 29758 29759 29760

(I) The department of ~~job and family services~~ health care administration shall pay a provider for each of the provider's eligible proprietary intermediate care facilities for the mentally retarded a return on the facility's net equity computed at the rate of one and one-half times the average of interest rates on special issues of public debt obligations issued to the federal hospital insurance trust fund for the cost reporting period. No facility's return on net equity paid under this division shall exceed one dollar per patient day. 29761 29762 29763 29764 29765 29766 29767 29768 29769

In calculating the rate for return on net equity, the department shall use the greater of the facility's inpatient days during the applicable cost reporting period or the number of inpatient days the facility would have had during that period if its occupancy rate had been ninety-five per cent. 29770 29771 29772 29773 29774

(J)(1) Except as provided in division (J)(2) of this section, if a provider leases or transfers an interest in a facility to another provider who is a related party, the related party's allowable cost of ownership shall include the lesser of the following: 29775 29776 29777 29778 29779

(a) The annual lease expense or actual cost of ownership, whichever is applicable; 29780 29781

(b) The reasonable cost to the lessor or provider making the transfer. 29782 29783

(2) If a provider leases or transfers an interest in a facility to another provider who is a related party, regardless of the date of the lease or transfer, the related party's allowable cost of ownership shall include the annual lease expense or actual cost of ownership, whichever is applicable, subject to the limitations specified in divisions (B) to (I) of this section, if all of the following conditions are met: 29784 29785 29786 29787 29788 29789 29790

(a) The related party is a relative of owner; 29791

(b) In the case of a lease, if the lessor retains any ownership interest, it is, except as provided in division (J)(2)(d)(ii) of this section, in only the real property and any improvements on the real property; 29792 29793 29794 29795

(c) In the case of a transfer, the provider making the transfer retains, except as provided in division (J)(2)(d)(iv) of this section, no ownership interest in the facility; 29796 29797 29798

(d) The department of ~~job and family services~~ <u>health care administration</u> determines that the lease or transfer is an arm's length transaction pursuant to rules adopted under section ~~5111.02~~ <u>5163.15</u> of the Revised Code. The rules shall provide that a lease or transfer is an arm's length transaction if all of the following, as applicable, apply: 29799 29800 29801 29802 29803 29804

(i) In the case of a lease, once the lease goes into effect, the lessor has no direct or indirect interest in the lessee or, except as provided in division (J)(2)(b) of this section, the facility itself, including interest as an owner, officer, director, employee, independent contractor, or consultant, but excluding interest as a lessor. 29805 29806 29807 29808 29809 29810

(ii) In the case of a lease, the lessor does not reacquire an interest in the facility except through the exercise of a lessor's rights in the event of a default. If the lessor reacquires an interest in the facility in this manner, the department shall treat the facility as if the lease never occurred when the department calculates its reimbursement rates for capital costs. 29811 29812 29813 29814 29815 29816

(iii) In the case of a transfer, once the transfer goes into effect, the provider that made the transfer has no direct or indirect interest in the provider that acquires the facility or the facility itself, including interest as an owner, officer, director, employee, independent contractor, or consultant, but excluding interest as a creditor. 29817 29818 29819 29820 29821 29822

(iv) In the case of a transfer, the provider that made the transfer does not reacquire an interest in the facility except through the exercise of a creditor's rights in the event of a default. If the provider reacquires an interest in the facility in this manner, the department shall treat the facility as if the transfer never occurred when the department calculates its reimbursement rates for capital costs. 29823 29824 29825 29826 29827 29828 29829

(v) The lease or transfer satisfies any other criteria specified in the rules. 29830 29831

(e) Except in the case of hardship caused by a catastrophic event, as determined by the department, or in the case of a lessor or provider making the transfer who is at least sixty-five years of age, not less than twenty years have elapsed since, for the 29832 29833 29834 29835

same facility, allowable cost of ownership was determined most 29836
recently under this division. 29837

Sec. ~~5111.261~~ 5164.10. Except as otherwise provided in 29838
section ~~5111.264~~ 5164.372 of the Revised Code, the department of 29839
~~job and family services~~ health care administration, in determining 29840
whether an intermediate care facility for the mentally retarded's 29841
direct care costs and indirect care costs are allowable, shall 29842
place no limit on specific categories of reasonable costs other 29843
than compensation of owners, compensation of relatives of owners, 29844
compensation of administrators and costs for resident meals that 29845
are prepared and consumed outside the facility. 29846

Compensation cost limits for owners and relatives of owners 29847
shall be based on compensation costs for individuals who hold 29848
comparable positions but who are not owners or relatives of 29849
owners, as reported on facility cost reports. As used in this 29850
section, "comparable position" means the position that is held by 29851
the owner or the owner's relative, if that position is listed 29852
separately on the cost report form, or if the position is not 29853
listed separately, the group of positions that is listed on the 29854
cost report form and that includes the position held by the owner 29855
or the owner's relative. In the case of an owner or owner's 29856
relative who serves the facility in a capacity such as corporate 29857
officer, proprietor, or partner for which no comparable position 29858
or group of positions is listed on the cost report form, the 29859
compensation cost limit shall be based on civil service 29860
equivalents and shall be specified in rules adopted under section 29861
~~5111.02~~ 5163.15 of the Revised Code. 29862

Compensation cost limits for administrators shall be based on 29863
compensation costs for administrators who are not owners or 29864
relatives of owners, as reported on facility cost reports. 29865
Compensation cost limits for administrators of four or more 29866

intermediate care facilities for the mentally retarded shall be the same as the limits for administrators of intermediate care facilities for the mentally retarded with one hundred fifty or more beds.

Sec. ~~5111.255~~ 5164.12. (A) The department of ~~job and family services~~ health care administration shall establish initial rates for an intermediate care facility for the mentally retarded with a first date of licensure that is on or after January 1, 1993, including a facility that replaces one or more existing facilities, or for an intermediate care facility for the mentally retarded with a first date of licensure before that date that was initially certified for the medicaid program on or after that date, in the following manner:

(1) The rate for direct care costs shall be determined as follows:

(a) If there are no cost or resident assessment data as necessary to calculate a rate under section ~~5111.23~~ 5164.05 of the Revised Code, the rate shall be the median cost per case-mix unit calculated under division (B)(1) of that section for the relevant peer group for the calendar year preceding the fiscal year in which the rate will be paid, multiplied by the median annual average case-mix score for the peer group for that period and by the rate of inflation estimated under division (B)(3) of that section. This rate shall be recalculated to reflect the facility's actual quarterly average case-mix score, in accordance with that section, after it submits its first quarterly assessment data that qualifies for use in calculating a case-mix score in accordance with rules authorized by division ~~(E)~~(D) of section ~~5111.232~~ 5164.051 of the Revised Code. If the facility's first two quarterly submissions do not contain assessment data that qualifies for use in calculating a case-mix score, the department

shall continue to calculate the rate using the median annual 29898
case-mix score for the peer group in lieu of an assigned quarterly 29899
case-mix score. The department shall assign a case-mix score or, 29900
if necessary, a cost per case-mix unit under division ~~(D)~~(C) of 29901
section ~~5111.232~~ 5164.051 of the Revised Code for any subsequent 29902
submissions that do not contain assessment data that qualifies for 29903
use in calculating a case-mix score. 29904

(b) If the facility is a replacement facility and the 29905
facility or facilities that are being replaced are in operation 29906
immediately before the replacement facility opens, the rate shall 29907
be the same as the rate for the replaced facility or facilities, 29908
proportionate to the number of beds in each replaced facility. If 29909
one or more of the replaced facilities is not in operation 29910
immediately before the replacement facility opens, its proportion 29911
shall be determined under division (A)(1)(a) of this section. 29912

(2) The rate for other protected costs shall be one hundred 29913
fifteen per cent of the median rate for intermediate care 29914
facilities for the mentally retarded calculated for the fiscal 29915
year under section ~~5111.235~~ 5164.06 of the Revised Code. 29916

(3) The rate for indirect care costs shall be the applicable 29917
maximum rate for the facility's peer group as specified in 29918
division (B) of section ~~5111.241~~ 5164.07 of the Revised Code. 29919

(4) The rate for capital costs shall be determined under 29920
section ~~5111.251~~ 5164.08 of the Revised Code using the greater of 29921
actual inpatient days or an imputed occupancy rate of eighty per 29922
cent. 29923

(B) The department shall adjust the rates established under 29924
division (A) of this section at both of the following times: 29925

(1) Effective the first day of July, to reflect new rate 29926
calculations for all facilities under sections ~~5111.20~~ 5164.01 to 29927
~~5111.33~~ 5164.41 of the Revised Code; 29928

(2) Following the provider's submission of the facility's cost report under division (A)(1)(b) of section ~~5111.26~~ <u>5164.37</u> of the Revised Code. 29929 29930 29931

The department shall pay the rate adjusted based on the cost report beginning the first day of the calendar quarter that begins more than ninety days after the department receives the cost report. 29932 29933 29934 29935

Sec. ~~5111.291~~ <u>5164.13</u>. Notwithstanding sections ~~5111.20~~ <u>5164.01</u> to ~~5111.33~~ <u>5164.41</u> of the Revised Code, the department of ~~job and family services~~ <u>health care administration</u> may compute the rate for intermediate care facilities for the mentally retarded operated by the department of mental retardation and developmental disabilities or the department of mental health according to the reasonable cost principles of ~~Title XVIII~~ <u>the medicare program</u>. 29936 29937 29938 29939 29940 29941 29942

Sec. ~~5111.211~~ <u>5164.14</u>. (A) The department of mental retardation and developmental disabilities is responsible for the nonfederal share of claims submitted for services that are covered by the medicaid program and provided to an eligible medicaid recipient by an intermediate care facility for the mentally retarded if all of the following are the case: 29943 29944 29945 29946 29947 29948

(1) The services are provided on or after July 1, 2003; 29949

(2) The facility receives initial certification by the director of health as an intermediate care facility for the mentally retarded on or after June 1, 2003; 29950 29951 29952

(3) The facility, or a portion of the facility, is licensed by the director of mental retardation and developmental disabilities as a residential facility under section 5123.19 of the Revised Code; 29953 29954 29955 29956

(4) There is a valid provider agreement for the facility. 29957

(B) Each month, the department of ~~job and family services~~ <u>health care administration</u> shall invoice the department of mental retardation and developmental disabilities by interagency transfer voucher for the claims for which the department of mental retardation and developmental disabilities is responsible pursuant to this section. 29958 29959 29960 29961 29962 29963

Sec. ~~5111.222~~ <u>5164.18</u>. (A) Except as otherwise provided by sections ~~5111.20~~ <u>5164.01</u> to ~~5111.33~~ <u>5164.41</u> of the Revised Code and by division (B) of this section, the payments that the department of ~~job and family services~~ <u>health care administration</u> shall agree to make to the provider of a nursing facility pursuant to a provider agreement shall equal the sum of all of the following: 29964 29965 29966 29967 29968 29969 29970

(1) The rate for direct care costs determined for the nursing facility under section ~~5111.231~~ <u>5164.19</u> of the Revised Code; 29971 29972

(2) The rate for ancillary and support costs determined for the nursing facility's ancillary and support cost peer group under section ~~5111.24~~ <u>5164.20</u> of the Revised Code; 29973 29974 29975

(3) The rate for tax costs determined for the nursing facility under section ~~5111.242~~ <u>5164.21</u> of the Revised Code; 29976 29977

(4) The rate for franchise permit fees determined for the nursing facility under section ~~5111.243~~ <u>5164.22</u> of the Revised Code; 29978 29979 29980

(5) The quality incentive payment paid to the nursing facility under section ~~5111.244~~ <u>5164.23</u> of the Revised Code; 29981 29982

(6) The median rate for capital costs for the nursing facilities in the nursing facility's capital costs peer group as determined under section ~~5111.25~~ <u>5164.24</u> of the Revised Code. 29983 29984 29985

(B) The department shall adjust the rates otherwise determined under divisions (A)(1), (2), (3), and (6) of this 29986 29987

section as directed by the general assembly through the enactment 29988
of law governing medicaid payments to providers of nursing 29989
facilities, including any law that does either of the following: 29990

(1) Establishes factors by which the rates are to be 29991
adjusted; 29992

(2) Establishes a methodology for phasing in the rates 29993
determined for fiscal year 2006 under uncodified law the general 29994
assembly enacts to rates determined for subsequent fiscal years 29995
under sections ~~5111.20~~ 5164.01 to ~~5111.33~~ 5164.41 of the Revised 29996
Code. 29997

Sec. ~~5111.231~~ 5164.19. (A) As used in this section, 29998
"applicable calendar year" means the following: 29999

(1) For the purpose of the department of ~~job and family~~ 30000
~~services'~~ health care administration's initial determination under 30001
division (D) of this section of each peer group's cost per 30002
case-mix unit, calendar year 2003; 30003

(2) For the purpose of the department's subsequent 30004
determinations under division (D) of this section of each peer 30005
group's cost per case-mix unit, the calendar year the department 30006
selects. 30007

(B) The department of ~~job and family services~~ health care 30008
administration shall pay a provider for each of the provider's 30009
eligible nursing facilities a per resident per day rate for direct 30010
care costs determined semiannually by multiplying the cost per 30011
case-mix unit determined under division (D) of this section for 30012
the facility's peer group by the facility's semiannual case-mix 30013
score determined under section ~~5111.232~~ 5164.191 of the Revised 30014
Code. 30015

(C) For the purpose of determining nursing facilities' rate 30016
for direct care costs, the department shall establish three peer 30017

groups. 30018

Each nursing facility located in any of the following counties shall be placed in peer group one: Brown, Butler, Clermont, Clinton, Hamilton, and Warren. 30019 30020 30021

Each nursing facility located in any of the following counties shall be placed in peer group two: Ashtabula, Champaign, Clark, Cuyahoga, Darke, Delaware, Fairfield, Fayette, Franklin, Fulton, Geauga, Greene, Hancock, Knox, Lake, Licking, Lorain, Lucas, Madison, Marion, Medina, Miami, Montgomery, Morrow, Ottawa, Pickaway, Portage, Preble, Ross, Sandusky, Seneca, Summit, Union, and Wood. 30022 30023 30024 30025 30026 30027 30028

Each nursing facility located in any of the following counties shall be placed in peer group three: Adams, Allen, Ashland, Athens, Auglaize, Belmont, Carroll, Columbiana, Coshocton, Crawford, Defiance, Erie, Gallia, Guernsey, Hardin, Harrison, Henry, Highland, Hocking, Holmes, Huron, Jackson, Jefferson, Lawrence, Logan, Mahoning, Meigs, Mercer, Monroe, Morgan, Muskingum, Noble, Paulding, Perry, Pike, Putnam, Richland, Scioto, Shelby, Stark, Trumbull, Tuscarawas, Van Wert, Vinton, Washington, Wayne, Williams, and Wyandot. 30029 30030 30031 30032 30033 30034 30035 30036 30037

(D)(1) At least once every ten years, the department shall determine a cost per case-mix unit for each peer group established under division (C) of this section. A cost per case-mix unit determined under this division for a peer group shall be used for subsequent years until the department redetermines it. To determine a peer group's cost per case-mix unit, the department shall do all of the following: 30038 30039 30040 30041 30042 30043 30044

(a) Determine the cost per case-mix unit for each nursing facility in the peer group for the applicable calendar year by dividing each facility's desk-reviewed, actual, allowable, per diem direct care costs for the applicable calendar year by the 30045 30046 30047 30048

facility's annual average case-mix score determined under section 30049
~~5111.232~~ 5164.191 of the Revised Code for the applicable calendar 30050
year. 30051

(b) Subject to division (D)(2) of this section, identify 30052
which nursing facility in the peer group is at the twenty-fifth 30053
percentile of the cost per case-mix units determined under 30054
division (D)(1)(a) of this section. 30055

(c) Calculate the amount that is seven per cent above the 30056
cost per case-mix unit determined under division (D)(1)(a) of this 30057
section for the nursing facility identified under division 30058
(D)(1)(b) of this section. 30059

(d) Multiply the amount calculated under division (D)(1)(c) 30060
of this section by the rate of inflation for the eighteen-month 30061
period beginning on the first day of July of the applicable 30062
calendar year and ending the last day of December of the calendar 30063
year immediately following the applicable calendar year using the 30064
employment cost index for total compensation, health services 30065
component, published by the United States bureau of labor 30066
statistics. 30067

(2) In making the identification under division (D)(1)(b) of 30068
this section, the department shall exclude both of the following: 30069

(a) Nursing facilities that participated in the medicaid 30070
program under the same provider for less than twelve months in the 30071
applicable calendar year; 30072

(b) Nursing facilities whose cost per case-mix unit is more 30073
than one standard deviation from the mean cost per case-mix unit 30074
for all nursing facilities in the nursing facility's peer group 30075
for the applicable calendar year. 30076

(3) The department shall not redetermine a peer group's cost 30077
per case-mix unit under this division based on additional 30078
information that it receives after the peer group's per case-mix 30079

unit is determined. The department shall redetermine a peer group's cost per case-mix unit only if it made an error in determining the peer group's cost per case-mix unit based on information available to the department at the time of the original determination. 30080 30081 30082 30083 30084

Sec. ~~5111.232~~ 5164.191. (A)(1) The department of ~~job and family services~~ health care administration shall determine semiannual and annual average case-mix scores for nursing facilities by using all of the following: 30085 30086 30087 30088

(a) Data from a resident assessment instrument specified in rules adopted under section ~~5111.02~~ 5163.15 of the Revised Code pursuant to ~~section 1919(e)(5) of the "Social Security Act," 49 Stat. 620 (1935),~~ 42 U.S.C.~~A.~~ 1396r(e)(5)~~, as amended,~~ for the following residents: 30089 30090 30091 30092 30093

(i) When determining ~~semi-annual~~ semiannual case-mix scores, each resident who is a medicaid recipient; 30094 30095

(ii) When determining annual average case-mix scores, each resident regardless of payment source. 30096 30097

(b) Except as provided in rules authorized by ~~division~~ divisions (A)(2)(a) and (b) of this section, the case-mix values established by the United States department of health and human services; 30098 30099 30100 30101

(c) Except as modified in rules authorized by division (A)(2)(c) of this section, the grouper methodology used on June 30, 1999, by the United States department of health and human services for prospective payment of skilled nursing facilities under the medicare program ~~established by Title XVIII~~. 30102 30103 30104 30105 30106

(2) The director of ~~job and family services~~ health care administration may adopt rules under section ~~5111.02~~ 5163.15 of the Revised Code that do any of the following: 30107 30108 30109

(a) Adjust the case-mix values specified in division 30110
(A)(1)(b) of this section to reflect changes in relative wage 30111
differentials that are specific to this state; 30112

(b) Express all of those case-mix values in numeric terms 30113
that are different from the terms specified by the United States 30114
department of health and human services but that do not alter the 30115
relationship of the case-mix values to one another; 30116

(c) Modify the grouper methodology specified in division 30117
(A)(1)(c) of this section as follows: 30118

(i) Establish a different hierarchy for assigning residents 30119
to case-mix categories under the methodology; 30120

(ii) Prohibit the use of the index maximizer element of the 30121
methodology; 30122

(iii) Incorporate changes to the methodology the United 30123
States department of health and human services makes after June 30124
30, 1999; 30125

(iv) Make other changes the department determines are 30126
necessary. 30127

(B) ~~The department shall determine case-mix scores for~~ 30128
~~intermediate care facilities for the mentally retarded using data~~ 30129
~~for each resident, regardless of payment source, from a resident~~ 30130
~~assessment instrument and grouper methodology prescribed in rules~~ 30131
~~adopted under section 5111.02 of the Revised Code and expressed in~~ 30132
~~case-mix values established by the department in those rules.~~ 30133

~~(C)~~ Each calendar quarter, each provider of a nursing 30134
facility shall compile complete assessment data, from the resident 30135
assessment instrument specified in rules authorized by division 30136
(A) ~~or (B)~~ of this section, for each resident of each of the 30137
provider's nursing facilities, regardless of payment source, who 30138
was in the facility or on hospital or therapeutic leave from the 30139

facility on the last day of the quarter. Providers ~~of a nursing~~ 30140
~~facility~~ shall submit the data to the department of health and, if 30141
required by rules, the department of ~~job and family services~~ 30142
health care administration. ~~Providers of an intermediate care~~ 30143
~~facility for the mentally retarded shall submit the data to the~~ 30144
~~department of job and family services.~~ The data shall be submitted 30145
not later than fifteen days after the end of the calendar quarter 30146
for which the data is compiled. 30147

Except as provided in division ~~(D)~~(C) of this section, the 30148
department, every six months and after the end of each calendar 30149
year, shall calculate a semiannual and annual average case-mix 30150
score for each nursing facility using the facility's quarterly 30151
case-mix scores for that six-month period or calendar year. ~~Also~~ 30152
~~except as provided in division (D) of this section, the~~ 30153
~~department, after the end of each calendar year, shall calculate~~ 30154
~~an annual average case-mix score for each intermediate care~~ 30155
~~facility for the mentally retarded using the facility's quarterly~~ 30156
~~case-mix scores for that calendar year.~~ The department shall make 30157
the calculations pursuant to procedures specified in rules adopted 30158
under section ~~5111.02~~ 5163.15 of the Revised Code. 30159

~~(D)~~(C)(1) If a provider of a nursing facility does not timely 30160
submit information for a calendar quarter necessary to calculate a 30161
facility's case-mix score, or submits incomplete or inaccurate 30162
information for a calendar quarter, the department may assign the 30163
facility a quarterly average case-mix score that is five per cent 30164
less than the facility's quarterly average case-mix score for the 30165
preceding calendar quarter. If the facility was subject to an 30166
exception review under division (C) of section ~~5111.27~~ 5164.38 of 30167
the Revised Code for the preceding calendar quarter, the 30168
department may assign a quarterly average case-mix score that is 30169
five per cent less than the score determined by the exception 30170
review. If the facility was assigned a quarterly average case-mix 30171

score for the preceding quarter, the department may assign a 30172
quarterly average case-mix score that is five per cent less than 30173
that score assigned for the preceding quarter. 30174

The department may use a quarterly average case-mix score 30175
assigned under division ~~(D)~~(C)(1) of this section, instead of a 30176
quarterly average case-mix score calculated based on the 30177
provider's submitted information, to calculate the facility's rate 30178
for direct care costs being established under section ~~5111.23 or~~ 30179
~~5111.231~~ 5164.19 of the Revised Code for one or more months, as 30180
specified in rules authorized by division ~~(E)~~(D) of this section, 30181
of the quarter for which the rate established under section 30182
~~5111.23 or 5111.231~~ 5164.19 of the Revised Code will be paid. 30183

Before taking action under division ~~(D)~~(C)(1) of this 30184
section, the department shall permit the provider a reasonable 30185
period of time, specified in rules authorized by division ~~(E)~~(D) 30186
of this section, to correct the information. ~~In the case of an~~ 30187
~~intermediate care facility for the mentally retarded, the~~ 30188
~~department shall not assign a quarterly average case-mix score due~~ 30189
~~to late submission of corrections to assessment information unless~~ 30190
~~the provider fails to submit corrected information prior to the~~ 30191
~~eighty-first day after the end of the calendar quarter to which~~ 30192
~~the information pertains. In the case of a nursing facility, the~~ 30193
The department shall not assign a quarterly average case-mix score 30194
due to late submission of corrections to assessment information 30195
unless the provider fails to submit corrected information prior to 30196
the earlier of the eighty-first day after the end of the calendar 30197
quarter to which the information pertains or the deadline for 30198
submission of such corrections established by regulations adopted 30199
by the United States department of health and human services under 30200
Titles XVIII and XIX. 30201

(2) If a provider is paid a rate for a nursing facility 30202
calculated using a quarterly average case-mix score assigned under 30203

division ~~(D)~~(C)(1) of this section for more than six months in a calendar year, the department may assign the facility a cost per case-mix unit that is five per cent less than the facility's actual or assigned cost per case-mix unit for the preceding calendar year. The department may use the assigned cost per case-mix unit, instead of calculating the facility's actual cost per case-mix unit in accordance with section ~~5111.23 or 5111.231~~ 5164.19 of the Revised Code, to establish the facility's rate for direct care costs for the following fiscal year. 30204 30205 30206 30207 30208 30209 30210 30211 30212

(3) The department shall take action under division ~~(D)~~(C)(1) or (2) of this section only in accordance with rules authorized by division ~~(E)~~(D) of this section. The department shall not take an action that affects rates for prior payment periods except in accordance with sections ~~5111.27~~ 5164.38 and ~~5111.28~~ 5164.39 of the Revised Code. 30213 30214 30215 30216 30217 30218

~~(E)~~(D) The director shall adopt rules under section ~~5111.02~~ 5163.15 of the Revised Code that do all of the following: 30219 30220

(1) Specify whether providers of a nursing facility must submit the assessment data to the department of ~~job and family services~~ health care administration; 30221 30222 30223

(2) Specify the medium or media through which the completed assessment data shall be submitted; 30224 30225

(3) Establish procedures under which the assessment data shall be reviewed for accuracy and providers shall be notified of any data that requires correction; 30226 30227 30228

(4) Establish procedures for providers to correct assessment data and specify a reasonable period of time by which providers shall submit the corrections. The procedures may limit the content of corrections by providers of nursing facilities in the manner required by regulations adopted by the United States department of health and human services under Titles XVIII and XIX. 30229 30230 30231 30232 30233 30234

(5) Specify when and how the department will assign case-mix scores or costs per case-mix unit under division ~~(D)~~(C) of this section if information necessary to calculate the facility's case-mix score is not provided or corrected in accordance with the procedures established by the rules. Notwithstanding any other provision of sections ~~5111.20~~ 5164.01 to ~~5111.33~~ 5164.41 of the Revised Code, the rules also may provide for ~~the following:~~ 30235–30241

~~(a) Exclusion of case-mix scores assigned under division (D) of this section from calculation of an intermediate care facility for the mentally retarded's annual average case-mix score and the maximum cost per case-mix unit for the facility's peer group;~~ 30242–30245

~~(b) Exclusion of~~ excluding case-mix scores assigned under division ~~(D)~~(C) of this section from calculation of a nursing facility's semiannual or annual average case-mix score and the cost per case-mix unit for the facility's peer group. 30246–30249

Sec. ~~5111.24~~ 5164.20. (A) As used in this section, "applicable calendar year" means the following: 30250–30251

(1) For the purpose of the department of ~~job and family services'~~ health care administration's initial determination under division (D) of this section of each peer group's rate for ancillary and support costs, calendar year 2003; 30252–30255

(2) For the purpose of the department's subsequent determinations under division (D) of this section of each peer group's rate for ancillary and support costs, the calendar year the department selects. 30256–30259

(B) The department of ~~job and family services~~ health care administration shall pay a provider for each of the provider's eligible nursing facilities a per resident per day rate for ancillary and support costs determined for the nursing facility's peer group under division (D) of this section. 30260–30264

(C) For the purpose of determining nursing facilities' rate for ancillary and support costs, the department shall establish six peer groups. 30265 30266 30267

Each nursing facility located in any of the following counties shall be placed in peer group one or two: Brown, Butler, Clermont, Clinton, Hamilton, and Warren. Each nursing facility located in any of those counties that has fewer than one hundred beds shall be placed in peer group one. Each nursing facility located in any of those counties that has one hundred or more beds shall be placed in peer group two. 30268 30269 30270 30271 30272 30273 30274

Each nursing facility located in any of the following counties shall be placed in peer group three or four: Ashtabula, Champaign, Clark, Cuyahoga, Darke, Delaware, Fairfield, Fayette, Franklin, Fulton, Geauga, Greene, Hancock, Knox, Lake, Licking, Lorain, Lucas, Madison, Marion, Medina, Miami, Montgomery, Morrow, Ottawa, Pickaway, Portage, Preble, Ross, Sandusky, Seneca, Summit, Union, and Wood. Each nursing facility located in any of those counties that has fewer than one hundred beds shall be placed in peer group three. Each nursing facility located in any of those counties that has one hundred or more beds shall be placed in peer group four. 30275 30276 30277 30278 30279 30280 30281 30282 30283 30284 30285

Each nursing facility located in any of the following counties shall be placed in peer group five or six: Adams, Allen, Ashland, Athens, Auglaize, Belmont, Carroll, Columbiana, Coshocton, Crawford, Defiance, Erie, Gallia, Guernsey, Hardin, Harrison, Henry, Highland, Hocking, Holmes, Huron, Jackson, Jefferson, Lawrence, Logan, Mahoning, Meigs, Mercer, Monroe, Morgan, Muskingum, Noble, Paulding, Perry, Pike, Putnam, Richland, Scioto, Shelby, Stark, Trumbull, Tuscarawas, Van Wert, Vinton, Washington, Wayne, Williams, and Wyandot. Each nursing facility located in any of those counties that has fewer than one hundred beds shall be placed in peer group five. Each nursing facility 30286 30287 30288 30289 30290 30291 30292 30293 30294 30295 30296

located in any of those counties that has one hundred or more beds shall be placed in peer group six. 30297 30298

(D)(1) At least once every ten years, the department shall determine the rate for ancillary and support costs for each peer group established under division (C) of this section. The rate for ancillary and support costs determined under this division for a peer group shall be used for subsequent years until the department redetermines it. To determine a peer group's rate for ancillary and support costs, the department shall do all of the following: 30299 30300 30301 30302 30303 30304 30305

(a) Determine the rate for ancillary and support costs for each nursing facility in the peer group for the applicable calendar year by using the greater of the nursing facility's actual inpatient days for the applicable calendar year or the inpatient days the nursing facility would have had for the applicable calendar year if its occupancy rate had been ninety per cent. For the purpose of determining a nursing facility's occupancy rate under division (D)(1)(a) of this section, the department shall include any beds that the nursing facility removes from its medicaid-certified capacity unless the nursing facility also removes the beds from its licensed bed capacity. 30306 30307 30308 30309 30310 30311 30312 30313 30314 30315 30316

(b) Subject to division (D)(2) of this section, identify which nursing facility in the peer group is at the twenty-fifth percentile of the rate for ancillary and support costs for the applicable calendar year determined under division (D)(1)(a) of this section. 30317 30318 30319 30320 30321

(c) Calculate the amount that is three per cent above the rate for ancillary and support costs determined under division (D)(1)(a) of this section for the nursing facility identified under division (D)(1)(b) of this section. 30322 30323 30324 30325

(d) Multiply the amount calculated under division (D)(1)(c) of this section by the rate of inflation for the eighteen-month 30326 30327

period beginning on the first day of July of the applicable calendar year and ending the last day of December of the calendar year immediately following the applicable calendar year using the consumer price index for all items for all urban consumers for the north central region, published by the United States bureau of labor statistics.

(2) In making the identification under division (D)(1)(b) of this section, the department shall exclude both of the following:

(a) Nursing facilities that participated in the medicaid program under the same provider for less than twelve months in the applicable calendar year;

(b) Nursing facilities whose ancillary and support costs are more than one standard deviation from the mean desk-reviewed, actual, allowable, per diem ancillary and support cost for all nursing facilities in the nursing facility's peer group for the applicable calendar year.

(3) The department shall not redetermine a peer group's rate for ancillary and support costs under this division based on additional information that it receives after the rate is determined. The department shall redetermine a peer group's rate for ancillary and support costs only if it made an error in determining the rate based on information available to the department at the time of the original determination.

Sec. ~~5111.242~~ 5164.21. (A) As used in this section:

(1) "Applicable calendar year" means the following:

(a) For the purpose of the department of ~~job and family services'~~ health care administration's initial determination under this section of nursing facilities' rate for tax costs, calendar year 2003;

(b) For the purpose of the department's subsequent

determinations under division (D) of this section of nursing facilities' rate for tax costs, the calendar year the department selects. 30358 30359 30360

(2) "Tax costs" means the costs of taxes imposed under Chapter 5751. of the Revised Code, real estate taxes, personal property taxes, and corporate franchise taxes. 30361 30362 30363

(B) The department of ~~job and family services~~ health care administration shall pay a provider for each of the provider's eligible nursing facilities a per resident per day rate for tax costs determined under division (C) of this section. 30364 30365 30366 30367

(C) At least once every ten years, the department shall determine the rate for tax costs for each nursing facility. The rate for tax costs determined under this division for a nursing facility shall be used for subsequent years until the department redetermines it. To determine a nursing facility's rate for tax costs, the department shall divide the nursing facility's desk-reviewed, actual, allowable tax costs paid for the applicable calendar year by the number of inpatient days the nursing facility would have had if its occupancy rate had been one hundred per cent during the applicable calendar year. 30368 30369 30370 30371 30372 30373 30374 30375 30376 30377

Sec. ~~5111.243~~ 5164.22. The department of ~~job and family services~~ health care administration shall pay a provider for each of the provider's eligible nursing facilities a per resident per day rate for the franchise permit fees paid for the nursing facility. The rate shall be equal to the franchise permit fee for the fiscal year for which the rate is paid. 30378 30379 30380 30381 30382 30383

Sec. ~~5111.244~~ 5164.23. (A) As used in this section, "deficiency" and "standard survey" have the same meanings as in section ~~5111.35~~ 5164.50 of the Revised Code. 30384 30385 30386

(B) Each fiscal year, the department of ~~job and family~~ 30387

~~services~~ health care administration shall pay the provider of each nursing facility a quality incentive payment. The amount of a quality incentive payment paid to a provider for a fiscal year shall be based on the number of points the provider's nursing facility is awarded under division (C) of this section for that fiscal year. The amount of a quality incentive payment paid to a provider of a nursing facility that is awarded no points may be zero. The mean payment for fiscal year 2007, weighted by medicaid days, shall be three dollars per medicaid day. The department shall adjust the mean payment for subsequent fiscal years by the same adjustment factors the department uses to adjust, pursuant to division (B) of section ~~5111.222~~ 5164.18 of the Revised Code, nursing facilities' rates otherwise determined under divisions (A)(1), (2), (3), and (6) of that section. 30388 30389 30390 30391 30392 30393 30394 30395 30396 30397 30398 30399 30400 30401

(C)(1) Except as provided by division (C)(2) of this section, the department shall annually award each nursing facility participating in the medicaid program one point for each of the following accountability measures the facility meets: 30402 30403 30404 30405

(a) The facility had no health deficiencies on the facility's most recent standard survey. 30406 30407

(b) The facility had no health deficiencies with a scope and severity level greater than E, as determined under nursing facility certification standards established under Title XIX, on the facility's most recent standard survey. 30408 30409 30410 30411

(c) The facility's resident satisfaction is above the statewide average. 30412 30413

(d) The facility's family satisfaction is above the statewide average. 30414 30415

(e) The number of hours the facility employs nurses is above the statewide average. 30416 30417

(f) The facility's employee retention rate is above the 30418

average for the facility's peer group established in division (C) 30419
of section ~~5111.231~~ 5164.19 of the Revised Code. 30420

(g) The facility's occupancy rate is above the statewide 30421
average. 30422

(h) The facility's medicaid utilization rate is above the 30423
statewide average. 30424

(i) The facility's case-mix score is above the statewide 30425
average. 30426

(2) The department shall award points pursuant to division 30427
(C)(1)(c) or (d) of this section only for a fiscal year 30428
immediately following a calendar year for which a survey of 30429
resident or family satisfaction has been conducted under section 30430
173.47 of the Revised Code. 30431

(D) The director of ~~job and family services~~ health care 30432
administration shall adopt rules under section ~~5111.02~~ 5163.15 of 30433
the Revised Code as necessary to implement this section. The rules 30434
shall include rules establishing the system for awarding points 30435
under division (C) of this section. 30436

Sec. ~~5111.25~~ 5164.24. (A) As used in this section, 30437
"applicable calendar year" means the following: 30438

(1) For the purpose of the department of ~~job and family~~ 30439
~~services'~~ health care administration's initial determination under 30440
division (D) of this section of each peer group's median rate for 30441
capital costs, calendar year 2003; 30442

(2) For the purpose of the department's subsequent 30443
determinations under division (D) of this section of each peer 30444
group's median rate for capital costs, the calendar year the 30445
department selects. 30446

(B) The department of ~~job and family services~~ health care 30447
administration shall pay a provider for each of the provider's 30448

eligible nursing facilities a per resident per day rate for capital costs. A nursing facility's rate for capital costs shall be the median rate for capital costs for the nursing facilities in the nursing facility's peer group as determined under division (D) of this section. 30449 30450 30451 30452 30453

(C) For the purpose of determining nursing facilities' rate for capital costs, the department shall establish six peer groups. 30454 30455

Each nursing facility located in any of the following counties shall be placed in peer group one or two: Brown, Butler, Clermont, Clinton, Hamilton, and Warren. Each nursing facility located in any of those counties that has fewer than one hundred beds shall be placed in peer group one. Each nursing facility located in any of those counties that has one hundred or more beds shall be placed in peer group two. 30456 30457 30458 30459 30460 30461 30462

Each nursing facility located in any of the following counties shall be placed in peer group three or four: Ashtabula, Champaign, Clark, Cuyahoga, Darke, Delaware, Fairfield, Fayette, Franklin, Fulton, Geauga, Greene, Hancock, Knox, Lake, Licking, Lorain, Lucas, Madison, Marion, Medina, Miami, Montgomery, Morrow, Ottawa, Pickaway, Portage, Preble, Ross, Sandusky, Seneca, Summit, Union, and Wood. Each nursing facility located in any of those counties that has fewer than one hundred beds shall be placed in peer group three. Each nursing facility located in any of those counties that has one hundred or more beds shall be placed in peer group four. 30463 30464 30465 30466 30467 30468 30469 30470 30471 30472 30473

Each nursing facility located in any of the following counties shall be placed in peer group five or six: Adams, Allen, Ashland, Athens, Auglaize, Belmont, Carroll, Columbiana, Coshocton, Crawford, Defiance, Erie, Gallia, Guernsey, Hardin, Harrison, Henry, Highland, Hocking, Holmes, Huron, Jackson, Jefferson, Lawrence, Logan, Mahoning, Meigs, Mercer, Monroe, Morgan, Muskingum, Noble, Paulding, Perry, Pike, Putnam, Richland, 30474 30475 30476 30477 30478 30479 30480

Scioto, Shelby, Stark, Trumbull, Tuscarawas, Van Wert, Vinton, Washington, Wayne, Williams, and Wyandot. Each nursing facility located in any of those counties that has fewer than one hundred beds shall be placed in peer group five. Each nursing facility located in any of those counties that has one hundred or more beds shall be placed in peer group six. 30481 30482 30483 30484 30485 30486

(D)(1) At least once every ten years, the department shall determine the median rate for capital costs for each peer group established under division (C) of this section. The median rate for capital costs determined under this division for a peer group shall be used for subsequent years until the department redetermines it. To determine a peer group's median rate for capital costs, the department shall do both of the following: 30487 30488 30489 30490 30491 30492 30493

(a) Subject to division (D)(2) of this section, use the greater of each nursing facility's actual inpatient days for the applicable calendar year or the inpatient days the nursing facility would have had for the applicable calendar year if its occupancy rate had been one hundred per cent. 30494 30495 30496 30497 30498

(b) Exclude both of the following: 30499

(i) Nursing facilities that participated in the medicaid program under the same provider for less than twelve months in the applicable calendar year; 30500 30501 30502

(ii) Nursing facilities whose capital costs are more than one standard deviation from the mean desk-reviewed, actual, allowable, per diem capital cost for all nursing facilities in the nursing facility's peer group for the applicable calendar year. 30503 30504 30505 30506

(2) For the purpose of determining a nursing facility's occupancy rate under division (D)(1)(a) of this section, the department shall include any beds that the nursing facility removes from its medicaid-certified capacity after June 30, 2005, unless the nursing facility also removes the beds from its 30507 30508 30509 30510 30511

licensed bed capacity. 30512

(E) Buildings shall be depreciated using the straight line method over forty years or over a different period approved by the department. Components and equipment shall be depreciated using the straight-line method over a period designated in rules adopted under section ~~5111.02~~ 5163.15 of the Revised Code, consistent with the guidelines of the American hospital association, or over a different period approved by the department. Any rules authorized by this division that specify useful lives of buildings, components, or equipment apply only to assets acquired on or after July 1, 1993. Depreciation for costs paid or reimbursed by any government agency shall not be included in capital costs unless that part of the payment under sections ~~5111.20~~ 5164.01 to ~~5111.33~~ 5164.41 of the Revised Code is used to reimburse the government agency. 30513 30514 30515 30516 30517 30518 30519 30520 30521 30522 30523 30524 30525 30526

(F) The capital cost basis of nursing facility assets shall be determined in the following manner: 30527 30528

(1) Except as provided in division (F)(3) of this section, for purposes of calculating the rates to be paid for facilities with dates of licensure on or before June 30, 1993, the capital cost basis of each asset shall be equal to the desk-reviewed, actual, allowable, capital cost basis that is listed on the facility's cost report for the calendar year preceding the fiscal year during which the rate will be paid. 30529 30530 30531 30532 30533 30534 30535

(2) For facilities with dates of licensure after June 30, 1993, the capital cost basis shall be determined in accordance with the principles of the medicare program established under Title XVIII, except as otherwise provided in sections ~~5111.20~~ 5164.01 to ~~5111.33~~ 5164.41 of the Revised Code. 30536 30537 30538 30539 30540

(3) Except as provided in division (F)(4) of this section, if a provider transfers an interest in a facility to another provider 30541 30542

after June 30, 1993, there shall be no increase in the capital 30543
cost basis of the asset if the providers are related parties or 30544
the provider to which the interest is transferred authorizes the 30545
provider that transferred the interest to continue to operate the 30546
facility under a lease, management agreement, or other 30547
arrangement. If the previous sentence does not prohibit the 30548
adjustment of the capital cost basis under this division, the 30549
basis of the asset shall be adjusted by the lesser of the 30550
following: 30551

(a) One-half of the change in construction costs during the 30552
time that the transferor held the asset, as calculated by the 30553
department of ~~job and family services~~ health care administration 30554
using the "Dodge building cost indexes, northeastern and north 30555
central states," published by Marshall and Swift; 30556

(b) One-half of the change in the consumer price index for 30557
all items for all urban consumers, as published by the United 30558
States bureau of labor statistics, during the time that the 30559
transferor held the asset. 30560

(4) If a provider transfers an interest in a facility to 30561
another provider who is a related party, the capital cost basis of 30562
the asset shall be adjusted as specified in division (F)(3) of 30563
this section if all of the following conditions are met: 30564

(a) The related party is a relative of owner; 30565

(b) Except as provided in division (F)(4)(c)(ii) of this 30566
section, the provider making the transfer retains no ownership 30567
interest in the facility; 30568

(c) The department of ~~job and family services~~ health care 30569
administration determines that the transfer is an arm's length 30570
transaction pursuant to rules adopted under section ~~5111.02~~ 30571
5163.15 of the Revised Code. The rules shall provide that a 30572
transfer is an arm's length transaction if all of the following 30573

apply: 30574

(i) Once the transfer goes into effect, the provider that made the transfer has no direct or indirect interest in the provider that acquires the facility or the facility itself, including interest as an owner, officer, director, employee, independent contractor, or consultant, but excluding interest as a creditor. 30575 30576 30577 30578 30579 30580

(ii) The provider that made the transfer does not reacquire an interest in the facility except through the exercise of a creditor's rights in the event of a default. If the provider reacquires an interest in the facility in this manner, the department shall treat the facility as if the transfer never occurred when the department calculates its reimbursement rates for capital costs. 30581 30582 30583 30584 30585 30586 30587

(iii) The transfer satisfies any other criteria specified in the rules. 30588 30589

(d) Except in the case of hardship caused by a catastrophic event, as determined by the department, or in the case of a provider making the transfer who is at least sixty-five years of age, not less than twenty years have elapsed since, for the same facility, the capital cost basis was adjusted most recently under division (F)(4) of this section or actual, allowable cost of ownership was determined most recently under division (G)(9) of this section. 30590 30591 30592 30593 30594 30595 30596 30597

(G) As used in this division: 30598

"Imputed interest" means the lesser of the prime rate plus two per cent or ten per cent. 30599 30600

"Lease expense" means lease payments in the case of an operating lease and depreciation expense and interest expense in the case of a capital lease. 30601 30602 30603

"New lease" means a lease, to a different lessee, of a nursing facility that previously was operated under a lease. 30604 30605

(1) Subject to division (B) of this section, for a lease of a facility that was effective on May 27, 1992, the entire lease expense is an actual, allowable capital cost during the term of the existing lease. The entire lease expense also is an actual, allowable capital cost if a lease in existence on May 27, 1992, is renewed under either of the following circumstances: 30606 30607 30608 30609 30610 30611

(a) The renewal is pursuant to a renewal option that was in existence on May 27, 1992; 30612 30613

(b) The renewal is for the same lease payment amount and between the same parties as the lease in existence on May 27, 1992. 30614 30615 30616

(2) Subject to division (B) of this section, for a lease of a facility that was in existence but not operated under a lease on May 27, 1992, actual, allowable capital costs shall include the lesser of the annual lease expense or the annual depreciation expense and imputed interest expense that would be calculated at the inception of the lease using the lessor's entire historical capital asset cost basis, adjusted by the lesser of the following amounts: 30617 30618 30619 30620 30621 30622 30623 30624

(a) One-half of the change in construction costs during the time the lessor held each asset until the beginning of the lease, as calculated by the department using the "Dodge building cost indexes, northeastern and north central states," published by Marshall and Swift; 30625 30626 30627 30628 30629

(b) One-half of the change in the consumer price index for all items for all urban consumers, as published by the United States bureau of labor statistics, during the time the lessor held each asset until the beginning of the lease. 30630 30631 30632 30633

(3) Subject to division (B) of this section, for a lease of a 30634

facility with a date of licensure on or after May 27, 1992, that is initially operated under a lease, actual, allowable capital costs shall include the annual lease expense if there was a substantial commitment of money for construction of the facility after December 22, 1992, and before July 1, 1993. If there was not a substantial commitment of money after December 22, 1992, and before July 1, 1993, actual, allowable capital costs shall include the lesser of the annual lease expense or the sum of the following: 30635 30636 30637 30638 30639 30640 30641 30642 30643

(a) The annual depreciation expense that would be calculated at the inception of the lease using the lessor's entire historical capital asset cost basis; 30644 30645 30646

(b) The greater of the lessor's actual annual amortization of financing costs and interest expense at the inception of the lease or the imputed interest expense calculated at the inception of the lease using seventy per cent of the lessor's historical capital asset cost basis. 30647 30648 30649 30650 30651

(4) Subject to division (B) of this section, for a lease of a facility with a date of licensure on or after May 27, 1992, that was not initially operated under a lease and has been in existence for ten years, actual, allowable capital costs shall include the lesser of the annual lease expense or the annual depreciation expense and imputed interest expense that would be calculated at the inception of the lease using the entire historical capital asset cost basis of the lessor, adjusted by the lesser of the following: 30652 30653 30654 30655 30656 30657 30658 30659 30660

(a) One-half of the change in construction costs during the time the lessor held each asset until the beginning of the lease, as calculated by the department using the "Dodge building cost indexes, northeastern and north central states," published by Marshall and Swift; 30661 30662 30663 30664 30665

(b) One-half of the change in the consumer price index for all items for all urban consumers, as published by the United States bureau of labor statistics, during the time the lessor held each asset until the beginning of the lease. 30666 30667 30668 30669

(5) Subject to division (B) of this section, for a new lease of a facility that was operated under a lease on May 27, 1992, actual, allowable capital costs shall include the lesser of the annual new lease expense or the annual old lease payment. If the old lease was in effect for ten years or longer, the old lease payment from the beginning of the old lease shall be adjusted by the lesser of the following: 30670 30671 30672 30673 30674 30675 30676

(a) One-half of the change in construction costs from the beginning of the old lease to the beginning of the new lease, as calculated by the department using the "Dodge building cost indexes, northeastern and north central states," published by Marshall and Swift; 30677 30678 30679 30680 30681

(b) One-half of the change in the consumer price index for all items for all urban consumers, as published by the United States bureau of labor statistics, from the beginning of the old lease to the beginning of the new lease. 30682 30683 30684 30685

(6) Subject to division (B) of this section, for a new lease of a facility that was not in existence or that was in existence but not operated under a lease on May 27, 1992, actual, allowable capital costs shall include the lesser of annual new lease expense or the annual amount calculated for the old lease under division (G)(2), (3), (4), or (6) of this section, as applicable. If the old lease was in effect for ten years or longer, the lessor's historical capital asset cost basis shall be adjusted by the lesser of the following for purposes of calculating the annual amount under division (G)(2), (3), (4), or (6) of this section: 30686 30687 30688 30689 30690 30691 30692 30693 30694 30695

(a) One-half of the change in construction costs from the 30696

beginning of the old lease to the beginning of the new lease, as calculated by the department using the "Dodge building cost indexes, northeastern and north central states," published by Marshall and Swift; 30697 30698 30699 30700

(b) One-half of the change in the consumer price index for all items for all urban consumers, as published by the United States bureau of labor statistics, from the beginning of the old lease to the beginning of the new lease. 30701 30702 30703 30704

In the case of a lease under division (G)(3) of this section of a facility for which a substantial commitment of money was made after December 22, 1992, and before July 1, 1993, the old lease payment shall be adjusted for the purpose of determining the annual amount. 30705 30706 30707 30708 30709

(7) For any revision of a lease described in division (G)(1), (2), (3), (4), (5), or (6) of this section, or for any subsequent lease of a facility operated under such a lease, other than execution of a new lease, the portion of actual, allowable capital costs attributable to the lease shall be the same as before the revision or subsequent lease. 30710 30711 30712 30713 30714 30715

(8) Except as provided in division (G)(9) of this section, if a provider leases an interest in a facility to another provider who is a related party or previously operated the facility, the related party's or previous operator's actual, allowable capital costs shall include the lesser of the annual lease expense or the reasonable cost to the lessor. 30716 30717 30718 30719 30720 30721

(9) If a provider leases an interest in a facility to another provider who is a related party, regardless of the date of the lease, the related party's actual, allowable capital costs shall include the annual lease expense, subject to the limitations specified in divisions (G)(1) to (7) of this section, if all of the following conditions are met: 30722 30723 30724 30725 30726 30727

(a) The related party is a relative of owner; 30728

(b) If the lessor retains an ownership interest, it is, except as provided in division (G)(9)(c)(ii) of this section, in only the real property and any improvements on the real property; 30729 30730 30731

(c) The department of ~~job and family services~~ health care administration determines that the lease is an arm's length transaction pursuant to rules adopted under section ~~5111.02~~ 5163.15 of the Revised Code. The rules shall provide that a lease is an arm's length transaction if all of the following apply: 30732 30733 30734 30735 30736

(i) Once the lease goes into effect, the lessor has no direct or indirect interest in the lessee or, except as provided in division (G)(9)(b) of this section, the facility itself, including interest as an owner, officer, director, employee, independent contractor, or consultant, but excluding interest as a lessor. 30737 30738 30739 30740 30741

(ii) The lessor does not reacquire an interest in the facility except through the exercise of a lessor's rights in the event of a default. If the lessor reacquires an interest in the facility in this manner, the department shall treat the facility as if the lease never occurred when the department calculates its reimbursement rates for capital costs. 30742 30743 30744 30745 30746 30747

(iii) The lease satisfies any other criteria specified in the rules. 30748 30749

(d) Except in the case of hardship caused by a catastrophic event, as determined by the department, or in the case of a lessor who is at least sixty-five years of age, not less than twenty years have elapsed since, for the same facility, the capital cost basis was adjusted most recently under division (F)(4) of this section or actual, allowable capital costs were determined most recently under division (G)(9) of this section. 30750 30751 30752 30753 30754 30755 30756

(10) This division does not apply to leases of specific items of equipment. 30757 30758

(H) After the date on which a transaction of sale is closed, the provider shall refund to the department the amount of excess depreciation paid to the provider for the facility by the department for each year the provider has operated the facility under a provider agreement and prorated according to the number of medicaid patient days for which the provider has received payment for the facility. The provider of a facility that is sold or that voluntarily terminates participation in the medicaid program also shall refund any other amount that the department properly finds to be due after the audit conducted under this division. For the purposes of this division, "depreciation paid to the provider for the facility" means the amount paid to the provider for the nursing facility for capital costs pursuant to this section less any amount paid for interest costs, amortization of financing costs, and lease expenses. For the purposes of this division, "excess depreciation" is the nursing facility's depreciated basis, which is the provider's cost less accumulated depreciation, subtracted from the purchase price net of selling costs but not exceeding the amount of depreciation paid to the provider for the facility. 30759 30760 30761 30762 30763 30764 30765 30766 30767 30768 30769 30770 30771 30772 30773 30774 30775 30776 30777 30778

Sec. ~~5111.263~~ 5164.26. (A) As used in this section, "covered therapy services" means physical therapy, occupational therapy, audiology, and speech therapy services that are provided by appropriately licensed therapists or therapy assistants and that are covered for nursing facility residents either by the medicare program ~~established under Title XVIII~~ or the medicaid program as specified in rules adopted by the director of ~~job and family services~~ health care administration under section ~~5111.02~~ 5163.15 of the Revised Code. 30779 30780 30781 30782 30783 30784 30785 30786 30787

(B) Except as provided in division (G) of this section, the costs of therapy are not allowable costs for nursing facilities for the purpose of determining rates under sections ~~5111.20~~ 30788 30789 30790

5164.01 to ~~5111.33~~ 5164.41 of the Revised Code. 30791

(C) The department of ~~job and family services~~ health care administration shall process no claims for payment under the medicaid program for covered therapy services rendered to a resident of a nursing facility other than such claims submitted, in accordance with this section, by a nursing facility that has a valid provider agreement with the department. 30792 30793 30794 30795 30796 30797

(D) Providers of nursing facilities may bill the department of ~~job and family services~~ health care administration for covered therapy services the nursing facilities provide to residents of any nursing facility who are medicaid recipients and not eligible for the medicare program. 30798 30799 30800 30801 30802

(E) The department shall not process any claim for a covered therapy service provided to a nursing facility resident who is eligible for the medicare program unless the claim is for a copayment or deductible or the conditions in division (E)(1) or (2) of this section apply: 30803 30804 30805 30806 30807

(1) The covered therapy service provided is, under the federal statutes, regulations, or policies governing the medicare program, not covered by the medicare program and the service is, under the provisions of this chapter or the rules adopted under this chapter, covered by the medicaid program. 30808 30809 30810 30811 30812

(2) All of the following apply: 30813

(a) The individual or entity who provided the covered therapy service was eligible to bill the medicare program for the service. 30814 30815

(b) A complete, accurate, and timely claim was submitted to the medicare program and the program denied payment for the service as not medically necessary for the resident. For the purposes of division (E)(2)(b) of this section, a claim is not considered to have been denied by the medicare program until either a denial has been issued following a medicare fair hearing 30816 30817 30818 30819 30820 30821

or six months have elapsed since the request for a fair hearing was filed. 30822 30823

(c) The facility is required to provide or arrange for the provision of the service by a licensed therapist or therapy assistant to be in compliance with federal or state nursing facility certification requirements for the medicaid program. 30824 30825 30826 30827

(d) The claim for payment for the services under the medicaid program is accompanied by documentation that divisions (E)(2)(b) and (c) of this section apply to the service. 30828 30829 30830

(F) The reimbursement allowed by the department for covered therapy services provided to nursing facility residents and billed under division (D) or (E) of this section shall be fifteen per cent less than the fees it pays for the same services rendered to hospital outpatients. The director may adopt rules under section ~~5111.02~~ 5163.15 of the Revised Code establishing comparable fees for covered therapy services that are not included in its schedule of fees paid for services rendered to hospital outpatients. 30831 30832 30833 30834 30835 30836 30837 30838

(G) A nursing facility's reasonable costs for rehabilitative, restorative, or maintenance therapy services rendered to facility residents by nurses or nurse aides, and the facility's overhead costs to support provision of therapy services provided to nursing facility residents, are allowable costs for the purposes of establishing rates under sections ~~5111.20~~ 5164.01 to ~~5111.33~~ 5164.41 of the Revised Code. 30839 30840 30841 30842 30843 30844 30845

Sec. ~~5111.257~~ 5164.27. If a provider of a nursing facility adds or replaces one or more medicaid certified beds to or at the nursing facility, or renovates one or more of the nursing facility's beds, the rate for the added, replaced, or renovated beds shall be the same as the rate for the nursing facility's existing beds. 30846 30847 30848 30849 30850 30851

Sec. ~~5111.265~~ 5164.28. If one or more medicaid-certified beds 30852
are relocated from one nursing facility to another nursing 30853
facility owned by a different person or government entity and the 30854
application for the certificate of need authorizing the relocation 30855
is filed with the director of health on or after ~~the effective~~ 30856
~~date of this section~~ July 1, 2005, amortization of the cost of 30857
acquiring operating rights for the relocated beds is not an 30858
allowable cost for the purpose of determining the nursing 30859
facility's medicaid reimbursement rate. 30860

Sec. ~~5111.34~~ 5164.30. The director of ~~job and family services~~ 30861
health care administration shall prepare an annual report 30862
containing recommendations on the methodology that should be used 30863
to transition paying providers of nursing facilities the rate 30864
determined for nursing facilities for one fiscal year to the 30865
immediately succeeding fiscal year. The director shall submit a 30866
copy of the annual report to the governor, the president and 30867
minority leader of the senate, and the speaker and minority leader 30868
of the house of representatives not later than the first day of 30869
each October. 30870

Sec. ~~5111.254~~ 5164.32. (A) The department of ~~job and family~~ 30871
~~services~~ health care administration shall establish initial rates 30872
for a nursing facility with a first date of licensure that is on 30873
or after July 1, 2006, including a facility that replaces one or 30874
more existing facilities, or for a nursing facility with a first 30875
date of licensure before that date that was initially certified 30876
for the medicaid program on or after that date, in the following 30877
manner: 30878

(1) The rate for direct care costs shall be the product of 30879
the cost per case-mix unit determined under division (D) of 30880
section ~~5111.231~~ 5164.19 of the Revised Code for the facility's 30881

peer group and the nursing facility's case-mix score. For the purpose of division (A)(1) of this section, the nursing facility's case-mix score shall be the following: 30882 30883 30884

(a) Unless the nursing facility replaces an existing nursing facility that participated in the medicaid program immediately before the replacement nursing facility begins participating in the medicaid program, the median annual average case-mix score for the nursing facility's peer group; 30885 30886 30887 30888 30889

(b) If the nursing facility replaces an existing nursing facility that participated in the medicaid program immediately before the replacement nursing facility begins participating in the medicaid program, the semiannual case-mix score most recently determined under section ~~5111.232~~ 5164.191 of the Revised Code for the replaced nursing facility as adjusted, if necessary, to reflect any difference in the number of beds in the replaced and replacement nursing facilities. 30890 30891 30892 30893 30894 30895 30896 30897

(2) The rate for ancillary and support costs shall be the rate for the facility's peer group determined under division (D) of section ~~5111.24~~ 5164.20 of the Revised Code. 30898 30899 30900

(3) The rate for capital costs shall be the median rate for the facility's peer group determined under division (D) of section ~~5111.25~~ 5164.24 of the Revised Code. 30901 30902 30903

(4) The rate for tax costs as defined in section ~~5111.242~~ 5164.21 of the Revised Code shall be the median rate for tax costs for the facility's peer group in which the facility is placed under division (C) of section ~~5111.24~~ 5164.20 of the Revised Code. 30904 30905 30906 30907

(5) The quality incentive payment shall be the mean payment specified in division (B) of section ~~5111.244~~ 5164.23 of the Revised Code. 30908 30909 30910

(B) Subject to division (C) of this section, the department shall adjust the rates established under division (A) of this 30911 30912

section effective the first day of July, to reflect new rate 30913
calculations for all nursing facilities under sections ~~5111.20~~ 30914
5164.01 to ~~5111.33~~ 5164.41 of the Revised Code. 30915

(C) If a rate for direct care costs is determined under this 30916
section for a nursing facility using the median annual average 30917
case-mix score for the nursing facility's peer group, the rate 30918
shall be redetermined to reflect the replacement nursing 30919
facility's actual semiannual case-mix score determined under 30920
section ~~5111.232~~ 5164.191 of the Revised Code after the nursing 30921
facility submits its first two quarterly assessment data that 30922
qualify for use in calculating a case-mix score in accordance with 30923
rules authorized by division ~~(E)~~(D) of section ~~5111.232~~ 5164.191 30924
of the Revised Code. If the nursing facility's quarterly 30925
submissions do not qualify for use in calculating a case-mix 30926
score, the department shall continue to use the median annual 30927
average case-mix score for the nursing facility's peer group in 30928
lieu of the nursing facility's semiannual case-mix score until the 30929
nursing facility submits two consecutive quarterly assessment data 30930
that qualify for use in calculating a case-mix score. 30931

Sec. ~~5111.258~~ 5164.34. (A) Notwithstanding sections ~~5111.20~~ 30932
5164.01 to ~~5111.33~~ 5164.41 of the Revised Code, the director of 30933
~~job and family services~~ health care administration shall adopt 30934
rules under section ~~5111.02~~ 5163.15 of the Revised Code that 30935
establish a methodology for calculating the prospective rates that 30936
will be paid each fiscal year to a provider for each of the 30937
provider's eligible nursing facilities and intermediate care 30938
facilities for the mentally retarded, and discrete units of the 30939
provider's nursing facilities or intermediate care facilities for 30940
the mentally retarded, that serve residents who have diagnoses or 30941
special care needs that require direct care resources that are not 30942
measured adequately by the applicable assessment instrument 30943
specified in rules authorized by section ~~5111.232~~ 5164.051 or 30944

5164.191 of the Revised Code, or who have diagnoses or special care needs specified in the rules as otherwise qualifying for consideration under this section. The facilities and units of facilities whose rates are established under this division may include, but shall not be limited to, any of the following: 30945 30946 30947 30948 30949

(1) In the case of nursing facilities, facilities and units of facilities that serve medically fragile pediatric residents, residents who are dependent on ventilators, or residents who have severe traumatic brain injury, end-stage Alzheimer's disease, or end-stage acquired immunodeficiency syndrome; 30950 30951 30952 30953 30954

(2) In the case of intermediate care facilities for the mentally retarded, facilities and units of facilities that serve residents who have complex medical conditions or severe behavioral problems. 30955 30956 30957 30958

The department shall use the methodology established under this division to pay for services rendered by such facilities and units after June 30, 1993. 30959 30960 30961

The rules authorized by this division shall specify the criteria and procedures the department will apply when designating facilities and units that qualify for calculation of rates under this division. The criteria shall include consideration of whether all of the allowable costs of the facility or unit would be paid by rates established under sections ~~5111.20~~ 5164.01 to ~~5111.33~~ 5164.41 of the Revised Code, and shall establish a minimum bed size for a facility or unit to qualify to have its rates established under this division. The criteria shall not be designed to require that residents be served only in facilities located in large cities. The methodology established by the rules shall consider the historical costs of providing care to the residents of the facilities or units. 30962 30963 30964 30965 30966 30967 30968 30969 30970 30971 30972 30973 30974

The rules may require that a facility designated under this 30975

division or containing a unit designated under this division 30976
receive authorization from the department to admit or retain a 30977
resident to the facility or unit and shall specify the criteria 30978
and procedures the department will apply when granting that 30979
authorization. 30980

Notwithstanding any other provision of sections ~~5111.20~~ 30981
5164.01 to ~~5111.33~~ 5164.41 of the Revised Code, the costs incurred 30982
by facilities or units whose rates are established under this 30983
division shall not be considered in establishing payment rates for 30984
other facilities or units. 30985

(B) The director may adopt rules under section ~~5111.02~~ 30986
5163.15 of the Revised Code under which the department, 30987
notwithstanding any other provision of sections ~~5111.20~~ 5164.01 to 30988
~~5111.33~~ 5164.41 of the Revised Code, may adjust the rates 30989
determined under sections ~~5111.20~~ 5164.01 to ~~5111.33~~ 5164.41 of 30990
the Revised Code for a facility that serves a resident who has a 30991
diagnosis or special care need that, in the rules authorized by 30992
division (A) of this section, would qualify a facility or unit of 30993
a facility to have its rate determined under that division, but 30994
who is not in such a unit. The rules may require that a facility 30995
that qualifies for a rate adjustment under this division receive 30996
authorization from the department to admit or retain a resident 30997
who qualifies the facility for the rate adjustment and shall 30998
specify the criteria and procedures the department will apply when 30999
granting that authorization. 31000

Sec. ~~5111.33~~ 5164.35. Reimbursement to a provider under 31001
sections ~~5111.20~~ 5164.01 to ~~5111.32~~ 5164.41 of the Revised Code 31002
shall include payments to the provider, at a rate equal to the 31003
percentage of the per resident per day rates that the department 31004
of ~~job and family services~~ health care administration has 31005
established for the provider's nursing facility or intermediate 31006

care facility for the mentally retarded under sections ~~5111.20~~ 5164.01 to ~~5111.33~~ 5164.41 of the Revised Code for the fiscal year for which the cost of services is reimbursed, to reserve a bed for a recipient during a temporary absence under conditions prescribed by the department, to include hospitalization for an acute condition, visits with relatives and friends, and participation in therapeutic programs outside the facility, when the resident's plan of care provides for such absence and federal participation in the payments is available. The maximum period during which payments may be made to reserve a bed shall not exceed the maximum period specified under federal regulations, and shall not be more than thirty days during any calendar year for hospital stays, visits with relatives and friends, and participation in therapeutic programs. Recipients who have been identified by the department as requiring the level of care of an intermediate care facility for the mentally retarded shall not be subject to a maximum period during which payments may be made to reserve a bed if prior authorization of the department is obtained for hospital stays, visits with relatives and friends, and participation in therapeutic programs. The director of ~~job and family services~~ health care administration shall adopt rules under section ~~5111.02~~ 5163.15 of the Revised Code establishing conditions under which prior authorization may be obtained. 31007–31029

Sec. ~~5111.26~~ 5164.37. (A)(1)(a) Except as provided in division (A)(1)(b) of this section, each provider shall file with the department of ~~job and family services~~ health care administration an annual cost report for each of the provider's nursing facilities and intermediate care facilities for the mentally retarded that participate in the medicaid program. A provider shall prepare the reports in accordance with guidelines established by the department. A report shall cover a calendar year or the portion of a calendar year during which the facility 31030–31038

participated in the medicaid program. A provider shall file the 31039
reports within ninety days after the end of the calendar year. The 31040
department, for good cause, may grant a fourteen-day extension of 31041
the time for filing cost reports upon written request from a 31042
provider. The director of ~~job and family services~~ health care 31043
administration shall prescribe, in rules adopted under section 31044
~~5111.02~~ 5163.15 of the Revised Code, the cost reporting form and a 31045
uniform chart of accounts for the purpose of cost reporting, and 31046
shall distribute cost reporting forms or computer software for 31047
electronic submission of the cost report to each provider at least 31048
sixty days before the reporting date. 31049

(b) If rates for a provider's nursing facility or 31050
intermediate care facility for the mentally retarded were most 31051
recently established under section ~~5111.254~~ 5164.32 or ~~5111.255~~ 31052
5164.12 of the Revised Code, the provider shall submit a cost 31053
report for that facility no later than ninety days after the end 31054
of the facility's first three full calendar months of operation. 31055
If a nursing facility or intermediate care facility for the 31056
mentally retarded undergoes a change of provider that the 31057
department determines, in accordance with rules adopted under 31058
section ~~5111.02~~ 5163.15 of the Revised Code, is an arm's length 31059
transaction, the new provider shall submit a cost report for that 31060
facility not later than ninety days after the end of the 31061
facility's first three full calendar months of operation under the 31062
new provider. The provider of a facility that opens or undergoes a 31063
change of provider that is an arm's length transaction after the 31064
first day of October in any calendar year is not required to file 31065
a cost report for that calendar year. 31066

(c) If a nursing facility undergoes a change of provider that 31067
the department determines, in accordance with rules adopted under 31068
section ~~5111.02~~ 5163.15 of the Revised Code, is not an ~~arms~~ arm's 31069
length transaction, the new provider shall file a cost report 31070

under division (A)(1)(a) of this section for the facility. The cost report shall cover the portion of the calendar year during which the new provider operated the nursing facility and the portion of the calendar year during which the previous provider operated the nursing facility. 31071 31072 31073 31074 31075

(2) If a provider required to submit a cost report for a nursing facility or intermediate care facility for the mentally retarded does not file the report within the required time period or within fourteen days thereafter if an extension is granted under division (A)(1)(a) of this section, or files an incomplete or inadequate report for the facility, the department shall provide immediate written notice to the provider that the provider agreement for the facility will be terminated in thirty days unless the provider submits a complete and adequate cost report for the facility within thirty days. During the thirty-day termination period or any additional time allowed for an appeal of the proposed termination of a provider agreement, the provider shall be paid the facility's then current per resident per day rate, minus two dollars. On July 1, 1994, the department shall adjust the two-dollar reduction to reflect the rate of inflation during the preceding twelve months, as shown in the consumer price index for all items for all urban consumers for the north central region, published by the United States bureau of labor statistics. On July 1, 1995, and the first day of July of each year thereafter, the department shall adjust the amount of the reduction in effect during the previous twelve months to reflect the rate of inflation during the preceding twelve months, as shown in the same index. 31076 31077 31078 31079 31080 31081 31082 31083 31084 31085 31086 31087 31088 31089 31090 31091 31092 31093 31094 31095 31096 31097 31098

(B) No provider shall report fines paid under sections ~~5111.35~~ 5164.50 to ~~5111.62~~ 5164.78 or section ~~5111.99~~ 5164.99 of the Revised Code in any cost report filed under this section. 31099 31100 31101

(C) The department shall develop an addendum to the cost 31102

report form that a provider may use to set forth costs that the provider believes may be disputed by the department. Any costs reported by the provider on the addendum may be considered by the department in setting the facility's rate. If the department does not consider the costs listed on the addendum in setting the facility's rate, the provider may seek reconsideration of that determination under section ~~5111.29~~ 5164.41 of the Revised Code. If the department subsequently includes the costs listed in the addendum in the facility's rate, the department shall pay the provider interest at a reasonable rate established in rules adopted under section ~~5111.02~~ 5163.15 of the Revised Code for the time that the rate paid excluded the costs.

Sec. ~~5111.266~~ 5164.371. A provider of a nursing facility filing the facility's cost report with the department of ~~job and family services~~ health care administration under section ~~5111.26~~ 5164.37 of the Revised Code shall report as a nonreimbursable expense the cost of the nursing facility's franchise permit fee.

Sec. ~~5111.264~~ 5164.372. Except as provided in section ~~5111.25~~ 5164.24 or ~~5111.251~~ 5164.08 of the Revised Code, the costs of goods, services, and facilities, furnished to a provider by a related party are includable in the allowable costs of the provider at the reasonable cost to the related party.

Sec. ~~5111.27~~ 5164.38. (A) The department of ~~job and family services~~ health care administration shall conduct a desk review of each cost report it receives under section ~~5111.26~~ 5164.37 of the Revised Code. Based on the desk review, the department shall make a preliminary determination of whether the reported costs are allowable costs. The department shall notify each provider of whether any of the reported costs are preliminarily determined not to be allowable, the rate calculation under sections ~~5111.20~~

5164.01 to ~~5111.33~~ 5164.41 of the Revised Code that results from that determination, and the reasons for the determination and resulting rate. The department shall allow the provider to verify the calculation and submit additional information. 31133 31134 31135 31136

(B) The department may conduct an audit, as defined by rule adopted under section ~~5111.02~~ 5163.15 of the Revised Code, of any cost report and shall notify the provider of its findings. 31137 31138 31139

Audits shall be conducted by auditors under contract with or employed by the department. The decision whether to conduct an audit and the scope of the audit, which may be a desk or field audit, shall be determined based on prior performance of the provider and may be based on a risk analysis or other evidence that gives the department reason to believe that the provider has reported costs improperly. A desk or field audit may be performed annually, but is required whenever a provider does not pass the risk analysis tolerance factors. The department shall issue the audit report no later than three years after the cost report is filed, or upon the completion of a desk or field audit on the report or a report for a subsequent cost reporting period, whichever is earlier. During the time within which the department may issue an audit report, the provider may amend the cost report upon discovery of a material error or material additional information. The department shall review the amended cost report for accuracy and notify the provider of its determination. 31140 31141 31142 31143 31144 31145 31146 31147 31148 31149 31150 31151 31152 31153 31154 31155 31156

The department may establish a contract for the auditing of facilities by outside firms. Each contract entered into by bidding shall be effective for one to two years. The department shall establish an audit manual and program which shall require that all field audits, conducted either pursuant to a contract or by department employees: 31157 31158 31159 31160 31161 31162

(1) Comply with the applicable rules prescribed pursuant to Titles XVIII and XIX; 31163 31164

(2) Consider generally accepted auditing standards prescribed by the American institute of certified public accountants; 31165 31166

(3) Include a written summary as to whether the costs included in the report examined during the audit are allowable and are presented fairly in accordance with generally accepted accounting principles and department rules, and whether, in all material respects, allowable costs are documented, reasonable, and related to patient care; 31167 31168 31169 31170 31171 31172

(4) Are conducted by accounting firms or auditors who, during the period of the auditors' professional engagement or employment and during the period covered by the cost reports, do not have nor are committed to acquire any direct or indirect financial interest in the ownership, financing, or operation of a nursing facility or intermediate care facility for the mentally retarded in this state; 31173 31174 31175 31176 31177 31178 31179

(5) Are conducted by accounting firms or auditors who, as a condition of the contract or employment, shall not audit any facility that has been a client of the firm or auditor; 31180 31181 31182

(6) Are conducted by auditors who are otherwise independent as determined by the standards of independence established by the American institute of certified public accountants; 31183 31184 31185

(7) Are completed within the time period specified by the department; 31186 31187

(8) Provide to the provider complete written interpretations that explain in detail the application of all relevant contract provisions, regulations, auditing standards, rate formulae, and departmental policies, with explanations and examples, that are sufficient to permit the provider to calculate with reasonable certainty those costs that are allowable and the rate to which the provider's facility is entitled. 31188 31189 31190 31191 31192 31193 31194

For the purposes of division (B)(4) of this section, 31195

employment of a member of an auditor's family by a nursing 31196
facility or intermediate care facility for the mentally retarded 31197
that the auditor does not review does not constitute a direct or 31198
indirect financial interest in the ownership, financing, or 31199
operation of the facility. 31200

(C) The department, pursuant to rules adopted under section 31201
~~5111.02~~ 5163.15 of the Revised Code, may conduct an exception 31202
review of assessment data submitted under section ~~5111.232~~ 31203
5164.051 or 5164.191 of the Revised Code. The department may 31204
conduct an exception review based on the findings of a 31205
certification survey conducted by the department of health, a risk 31206
analysis, or prior performance of the provider. 31207

Exception reviews shall be conducted at the facility by 31208
appropriate health professionals under contract with or employed 31209
by the department of ~~job and family services~~ health care 31210
administration. The professionals may review resident assessment 31211
forms and supporting documentation, conduct interviews, and 31212
observe residents to identify any patterns or trends of inaccurate 31213
assessments and resulting inaccurate case-mix scores. 31214

The rules shall establish an exception review program that 31215
requires that exception reviews do all of the following: 31216

(1) Comply with Titles XVIII and XIX; 31217

(2) Provide a written summary that states whether the 31218
resident assessment forms have been completed accurately; 31219

(3) Are conducted by health professionals who, during the 31220
period of their professional engagement or employment with the 31221
department, neither have nor are committed to acquire any direct 31222
or indirect financial interest in the ownership, financing, or 31223
operation of a nursing facility or intermediate care facility for 31224
the mentally retarded in this state; 31225

(4) Are conducted by health professionals who, as a condition 31226

of their engagement or employment with the department, shall not review any provider that has been a client of the professional.

For the purposes of division (C)(3) of this section, employment of a member of a health professional's family by a nursing facility or intermediate care facility for the mentally retarded that the professional does not review does not constitute a direct or indirect financial interest in the ownership, financing, or operation of the facility.

If an exception review is conducted before the effective date of the rate that is based on the case-mix data subject to the review and the review results in findings that exceed tolerance levels specified in the rules adopted under this division, the department, in accordance with those rules, may use the findings to recalculate individual resident case-mix scores, quarterly average facility case-mix scores, and annual average facility case-mix scores. The department may use the recalculated quarterly and annual facility average case-mix scores to calculate the facility's rate for direct care costs for the appropriate calendar quarter or quarters.

(D) The department shall prepare a written summary of any audit disallowance or exception review finding that is made after the effective date of the rate that is based on the cost or case-mix data. Where the provider is pursuing judicial or administrative remedies in good faith regarding the disallowance or finding, the department shall not withhold from the provider's current payments any amounts the department claims to be due from the provider pursuant to section ~~5111.28~~ 5164.39 of the Revised Code.

(E) The department shall not reduce rates calculated under sections ~~5111.20~~ 5164.01 to ~~5111.33~~ 5164.41 of the Revised Code on the basis that the provider charges a lower rate to any resident who is not eligible for the medicaid program.

(F) The department shall adjust the rates calculated under sections ~~5111.20~~ 5164.01 to ~~5111.33~~ 5164.41 of the Revised Code to account for reasonable additional costs that must be incurred by intermediate care facilities for the mentally retarded to comply with requirements of federal or state statutes, rules, or policies enacted or amended after January 1, 1992, or with orders issued by state or local fire authorities. 31259 31260 31261 31262 31263 31264 31265

Sec. ~~5111.28~~ 5164.39. (A) If a provider properly amends its cost report under section ~~5111.27~~ 5164.38 of the Revised Code and the amended report shows that the provider received a lower rate under the original cost report than it was entitled to receive, the department of ~~job and family services~~ health care administration shall adjust the provider's rate prospectively to reflect the corrected information. The department shall pay the adjusted rate beginning two months after the first day of the month after the provider files the amended cost report. If the department finds, from an exception review of resident assessment information conducted after the effective date of the rate for direct care costs that is based on the assessment information, that inaccurate assessment information resulted in the provider receiving a lower rate than it was entitled to receive, the department prospectively shall adjust the provider's rate accordingly and shall make payments using the adjusted rate for the remainder of the calendar quarter for which the assessment information is used to determine the rate, beginning one month after the first day of the month after the exception review is completed. 31266 31267 31268 31269 31270 31271 31272 31273 31274 31275 31276 31277 31278 31279 31280 31281 31282 31283 31284 31285

(B) If the provider properly amends its cost report under section ~~5111.27~~ 5164.38 of the Revised Code, the department makes a finding based on an audit under that section, or the department makes a finding based on an exception review of resident assessment information conducted under that section after the 31286 31287 31288 31289 31290

effective date of the rate for direct care costs that is based on the assessment information, any of which results in a determination that the provider has received a higher rate than it was entitled to receive, the department shall recalculate the provider's rate using the revised information. The department shall apply the recalculated rate to the periods when the provider received the incorrect rate to determine the amount of the overpayment. The provider shall refund the amount of the overpayment. 31291 31292 31293 31294 31295 31296 31297 31298 31299

In addition to requiring a refund under this division, the department may charge the provider interest at the applicable rate specified in this division from the time the overpayment was made. 31300 31301 31302

(1) If the overpayment resulted from costs reported for calendar year 1993, the interest shall be no greater than one and one-half times the average bank prime rate. 31303 31304 31305

(2) If the overpayment resulted from costs reported for subsequent calendar years: 31306 31307

(a) The interest shall be no greater than two times the average bank prime rate if the overpayment was equal to or less than one per cent of the total medicaid payments to the provider for the fiscal year for which the incorrect information was used to establish a rate. 31308 31309 31310 31311 31312

(b) The interest shall be no greater than two and one-half times the current average bank prime rate if the overpayment was greater than one per cent of the total medicaid payments to the provider for the fiscal year for which the incorrect information was used to establish a rate. 31313 31314 31315 31316 31317

(C) The department also may impose the following penalties: 31318

(1) If a provider does not furnish invoices or other documentation that the department requests during an audit within sixty days after the request, no more than the greater of one 31319 31320 31321

thousand dollars per audit or twenty-five per cent of the cumulative amount by which the costs for which documentation was not furnished increased the total medicaid payments to the provider during the fiscal year for which the costs were used to establish a rate; 31322 31323 31324 31325 31326

(2) If an exiting operator or owner fails to provide notice of a facility closure, voluntary termination, or voluntary withdrawal of participation in the medicaid program as required by section ~~5111.66~~ <u>5164.83</u> of the Revised Code, or an exiting operator or owner and entering operator fail to provide notice of a change of operator as required by section ~~5111.67~~ <u>5164.84</u> of the Revised Code, no more than the current average bank prime rate plus four per cent of the last two monthly payments. 31327 31328 31329 31330 31331 31332 31333 31334

(D) If the provider continues to participate in the medicaid program, the department shall deduct any amount that the provider is required to refund under this section, and the amount of any interest charged or penalty imposed under this section, from the next available payment from the department to the provider. The department and the provider may enter into an agreement under which the amount, together with interest, is deducted in installments from payments from the department to the provider. 31335 31336 31337 31338 31339 31340 31341 31342

(E) The department shall transmit refunds and penalties to the treasurer of state for deposit in the general revenue fund. 31343 31344

(F) For the purpose of this section, the department shall determine the average bank prime rate using statistical release H.15, "selected interest rates," a weekly publication of the federal reserve board, or any successor publication. If statistical release H.15, or its successor, ceases to contain the bank prime rate information or ceases to be published, the department shall request a written statement of the average bank prime rate from the federal reserve bank of Cleveland or the federal reserve board. 31345 31346 31347 31348 31349 31350 31351 31352 31353

Sec. ~~5111.221~~ 5164.40. The department of ~~job and family services~~ health care administration shall make its best efforts each year to calculate rates under sections ~~5111.20~~ 5164.01 to ~~5111.33~~ 5164.41 of the Revised Code in time to use them to make the payments due to providers by the fifteenth day of August. If the department is unable to calculate the rates so that they can be paid by that date, the department shall pay each provider the rate calculated for the provider's nursing facilities and intermediate care facilities for the mentally retarded under those sections at the end of the previous fiscal year. If the department also is unable to calculate the rates to make the payments due by the fifteenth day of September and the fifteenth day of October, the department shall pay the previous fiscal year's rate to make those payments. The department may increase by five per cent the previous fiscal year's rate paid for any facility pursuant to this section at the request of the provider. The department shall use rates calculated for the current fiscal year to make the payments due by the fifteenth day of November. 31354 31355 31356 31357 31358 31359 31360 31361 31362 31363 31364 31365 31366 31367 31368 31369 31370 31371

If the rate paid to a provider for a facility pursuant to this section is lower than the rate calculated for the facility for the current fiscal year, the department shall pay the provider the difference between the two rates for the number of days for which the provider was paid for the facility pursuant to this section. If the rate paid for a facility pursuant to this section is higher than the rate calculated for it for the current fiscal year, the provider shall refund to the department the difference between the two rates for the number of days for which the provider was paid for the facility pursuant to this section. 31372 31373 31374 31375 31376 31377 31378 31379 31380 31381

Sec. ~~5111.29~~ 5164.41. (A) The director of ~~job and family services~~ health care administration shall adopt rules under section ~~5111.02~~ 5163.15 of the Revised Code that establish a 31382 31383 31384

process under which a provider, or a group or association of providers, may seek reconsideration of rates established under sections ~~5111.20~~ 5164.01 to ~~5111.33~~ 5164.41 of the Revised Code, including a rate for direct care costs recalculated before the effective date of the rate as a result of an exception review of resident assessment information conducted under section ~~5111.27~~ 5164.38 of the Revised Code. 31385 31386 31387 31388 31389 31390 31391

(1) Except as provided in divisions (A)(2) to (4) of this section, the only issue that a provider, group, or association may raise in the rate reconsideration shall be whether the rate was calculated in accordance with sections ~~5111.20~~ 5164.01 to ~~5111.33~~ 5164.41 of the Revised Code and the rules adopted under section ~~5111.02~~ 5163.15 of the Revised Code. The rules shall permit a provider, group, or association to submit written arguments or other materials that support its position. The rules shall specify time frames within which the provider, group, or association and the department must act. If the department determines, as a result of the rate reconsideration, that the rate established for one or more facilities of a provider is less than the rate to which the facility is entitled, the department shall increase the rate. If the department has paid the incorrect rate for a period of time, the department shall pay the provider the difference between the amount the provider was paid for that period for the facility and the amount the provider should have been paid for the facility. 31392 31393 31394 31395 31396 31397 31398 31399 31400 31401 31402 31403 31404 31405 31406 31407 31408

(2) The rules shall provide that during a fiscal year, the department, by means of the rate reconsideration process, may increase the rate determined for an intermediate care facility for the mentally retarded as calculated under sections ~~5111.20~~ 5164.01 to ~~5111.33~~ 5164.41 of the Revised Code if the provider of the facility demonstrates that the facility's actual, allowable costs have increased because of extreme circumstances. A facility may qualify for a rate increase only if the facility's per diem, 31409 31410 31411 31412 31413 31414 31415 31416

actual, allowable costs have increased to a level that exceeds its total rate. The rules shall specify the circumstances that would justify a rate increase under division (A)(2) of this section. The rules shall provide that the extreme circumstances include natural disasters, renovations approved under division (D) of section ~~5111.251~~ 5164.08 of the Revised Code, an increase in workers' compensation experience rating of greater than five per cent for a facility that has an appropriate claims management program, increased security costs for an inner-city facility, and a change of ownership that results from bankruptcy, foreclosure, or findings of violations of certification requirements by the department of health. An increase under division (A)(2) of this section is subject to any rate limitations or maximum rates established by sections ~~5111.20~~ 5164.01 to ~~5111.33~~ 5164.41 of the Revised Code for specific cost centers. Any rate increase granted under division (A)(2) of this section shall take effect on the first day of the first month after the department receives the request. 31417–31434

(3) The rules shall provide that the department, through the rate reconsideration process, may increase an intermediate care facility for the mentally retarded's rate as calculated under sections ~~5111.20~~ 5164.01 to ~~5111.33~~ 5164.41 of the Revised Code if the department, in the department's sole discretion, determines that the rate as calculated under those sections works an extreme hardship on the facility. 31435–31441

(4) The rules shall provide that when beds certified for the medicaid program are added to an existing intermediate care facility for the mentally retarded or replaced at the same site, the department, through the rate reconsideration process, shall increase the intermediate care facility for the mentally retarded's rate for capital costs proportionately, as limited by any applicable limitation under section ~~5111.251~~ 5164.08 of the 31442–31448

Revised Code, to account for the costs of the beds that are added or replaced. The department shall make this increase one month after the first day of the month after the department receives sufficient documentation of the costs. Any rate increase granted under division (A)(4) of this section after June 30, 1993, shall remain in effect until the effective date of a rate calculated under section ~~5111.251~~ 5164.08 of the Revised Code that includes costs incurred for a full calendar year for the bed addition or bed replacement. The facility shall report double accumulated depreciation in an amount equal to the depreciation included in the rate adjustment on its cost report for the first year of operation. During the term of any loan used to finance a project for which a rate adjustment is granted under division (A)(4) of this section, if the facility is operated by the same provider, the provider shall subtract from the interest costs it reports on its cost report an amount equal to the difference between the following: 31449–31465

(a) The actual, allowable interest costs for the loan during the calendar year for which the costs are being reported; 31466–31467

(b) The actual, allowable interest costs attributable to the loan that were used to calculate the rates paid to the provider for the facility during the same calendar year. 31468–31470

(5) The department's decision at the conclusion of the reconsideration process shall not be subject to any administrative proceedings under Chapter 119. or any other provision of the Revised Code. 31471–31474

(B) All of the following are subject to an adjudication conducted in accordance with Chapter 119. of the Revised Code: 31475–31476

(1) Any audit disallowance that the department makes as the result of an audit under section ~~5111.27~~ 5164.38 of the Revised Code; 31477–31479

(2) Any adverse finding that results from an exception review of resident assessment information conducted under section ~~5111.27~~ 5164.38 of the Revised Code after the effective date of the facility's rate that is based on the assessment information;

(3) Any medicaid payment deemed an overpayment under section ~~5111.683~~ 5164.853 of the Revised Code;

(4) Any penalty the department imposes under division (C) of section ~~5111.28~~ 5164.39 of the Revised Code or section ~~5111.683~~ 5164.853 of the Revised Code.

Sec. ~~5111.202~~ 5164.45. (A) As used in this section:

(1) "Dementia" includes Alzheimer's disease or a related disorder.

(2) "Serious mental illness" means "serious mental illness," as defined by the United States department of health and human services in regulations adopted under ~~section 1919(e)(7)(G)(i) of the "Social Security Act," 49 Stat. 620 (1935),~~ 42 U.S.C.~~A. 301, as amended~~ 1396r(e)(7)(G)(i).

(3) "Mentally ill individual" means an individual who has a serious mental illness other than either of the following:

(a) A primary diagnosis of dementia;

(b) A primary diagnosis that is not a primary diagnosis of dementia and a primary diagnosis of something other than a serious mental illness.

(4) "Mentally retarded individual" means an individual who is mentally retarded or has a related condition, as described in ~~section 1905(d) of the "Social Security Act~~ 42 U.S.C. 1396d(d).~~"~~

(5) "Specialized services" means the services specified by the United States department of health and human services in regulations adopted under ~~section 1919(e)(7)(G)(iii) of the~~

~~"Social Security Act~~ 42 U.S.C. 1396r(e)(7)(G)(iii).~~"~~ 31509

(B)(1) Except as provided in division (D) of this section, no nursing facility shall admit as a resident any mentally ill individual unless the facility has received evidence that the department of mental health has determined both of the following under section 5119.061 of the Revised Code: 31510 31511 31512 31513 31514

(a) That the individual requires the level of services provided by a nursing facility because of the individual's physical and mental condition; 31515 31516 31517

(b) Whether the individual requires specialized services for mental illness. 31518 31519

(2) Except as provided in division (D) of this section, no nursing facility shall admit as a resident any mentally retarded individual unless the facility has received evidence that the department of mental retardation and developmental disabilities has determined both of the following under section 5123.021 of the Revised Code: 31520 31521 31522 31523 31524 31525

(a) That the individual requires the level of services provided by a nursing facility because of the individual's physical and mental condition; 31526 31527 31528

(b) Whether the individual requires specialized services for mental retardation. 31529 31530

(C) The department of ~~job and family services~~ health care administration shall not make payments under the ~~medical assistance~~ medicaid program to a nursing facility on behalf of any individual who is admitted to the facility in violation of division (B) of this section for the period beginning on the date of admission and ending on the date the requirements of division (B) of this section are met. 31531 31532 31533 31534 31535 31536 31537

(D) A determination under division (B) of this section is not 31538

required for any individual who is exempted from the requirement that a determination be made by division (B)(2) of section 5119.061 of the Revised Code or rules adopted by the department of mental health under division (E)(3) of that section, or by division (B)(2) of section 5123.021 of the Revised Code or rules adopted by the department of mental retardation and developmental disabilities under division (E)(3) of that section.

Sec. ~~5111.203~~ 5164.46. Regardless of whether or not an applicant for admission to a nursing facility or resident of a nursing facility is an applicant for or recipient of ~~medical assistance~~ medicaid, the department of ~~job and family services~~ health care administration shall provide notice and an opportunity for a hearing to any applicant for admission to a nursing facility or resident of a nursing facility who is adversely affected by a determination made by the department of mental health under section 5119.061 of the Revised Code or by the department of mental retardation and developmental disabilities under section 5123.021 of the Revised Code. The hearing shall be conducted in the same manner as hearings conducted under section ~~5101.35~~ 5160.34 of the Revised Code. Any decision made by the department of ~~job and family services~~ health care administration on the basis of the hearing is binding on the department of mental health and the department of mental retardation and developmental disabilities.

Sec. ~~5111.204~~ 5164.47. (A) As used in this section, "representative" means a person acting on behalf of an applicant for or recipient of medicaid. A representative may be a family member, attorney, hospital social worker, or any other person chosen to act on behalf of an applicant or recipient.

(B) The department of ~~job and family services~~ health care administration may require each applicant for or recipient of

medicaid who applies or intends to apply for admission to a 31570
nursing facility or resides in a nursing facility to undergo an 31571
assessment to determine whether the applicant or recipient needs 31572
the level of care provided by a nursing facility. The assessment 31573
may be performed concurrently with a long-term care consultation 31574
provided under section 173.42 of the Revised Code. 31575

To the maximum extent possible, the assessment shall be based 31576
on information from the resident assessment instrument specified 31577
in rules adopted by the director of ~~job and family services~~ health 31578
care administration under division ~~(E)~~(D) of section ~~5111.232~~ 31579
5164.191 of the Revised Code. The assessment shall also be based 31580
on criteria and procedures established in rules adopted under 31581
division (F) of this section and information provided by the 31582
person being assessed or the person's representative. 31583

The department of ~~job and family services~~ health care 31584
administration, or if the assessment is performed by an agency 31585
under contract with the department pursuant to division (G) of 31586
this section, the agency, shall, not later than the time the level 31587
of care determination based on the assessment is required to be 31588
provided under division (C) of this section, give written notice 31589
of its conclusions and the basis for them to the person assessed 31590
and, if the department of ~~job and family services~~ health care 31591
administration or agency under contract with the department has 31592
been informed that the person has a representative, to the 31593
representative. 31594

(C) The department of ~~job and family services~~ health care 31595
administration or agency under contract with the department, 31596
whichever performs the assessment, shall provide a level of care 31597
determination based on the assessment as follows: 31598

(1) In the case of a person applying or intending to apply 31599
for admission to a nursing facility while hospitalized, not later 31600
than one of the following: 31601

(a) One working day after the person or the person's representative submits the application or notifies the department of the person's intention to apply and submits all information required for providing the level of care determination, as specified in rules adopted under division (F)(2) of this section; 31602 31603 31604 31605 31606

(b) A later date requested by the person or the person's representative. 31607 31608

(2) In the case of a person applying or intending to apply for admission to a nursing facility who is not hospitalized, not later than one of the following: 31609 31610 31611

(a) Five calendar days after the person or the person's representative submits the application or notifies the department of the person's intention to apply and submits all information required for providing the level of care determination, as specified in rules adopted under division (F)(2) of this section; 31612 31613 31614 31615 31616

(b) A later date requested by the person or the person's representative. 31617 31618

(3) In the case of a person who resides in a nursing facility, not later than one of the following: 31619 31620

(a) Five calendar days after the person or the person's representative submits an application for ~~medical assistance~~ <u>medicaid</u> and submits all information required for providing the level of care determination, as specified in rules adopted under division (F)(2) of this section; 31621 31622 31623 31624 31625

(b) A later date requested by the person or the person's representative. 31626 31627

(4) In the case of an emergency, as specified in rules adopted under division (F)(4) of this section, within the number of days specified in the rules. 31628 31629 31630

(D) A person assessed under this section or the person's 31631

representative may request a state hearing to dispute the conclusions reached by the department of ~~job and family services~~ <u>health care administration</u> or agency under contract with the department on the basis of the assessment. The request for a state hearing shall be made in accordance with section ~~5101.35~~ <u>5160.34</u> of the Revised Code. The department of ~~job and family services~~ <u>health care administration</u> or agency under contract with the department shall provide to the person or the person's representative and the nursing facility written notice of the person's right to request a state hearing. The notice shall include an explanation of the procedure for requesting a state hearing. If a state hearing is requested, the state shall be represented in the hearing by the department of ~~job and family services~~ <u>health care administration</u> or the agency under contract with the department, whichever performed the assessment. 31632 31633 31634 31635 31636 31637 31638 31639 31640 31641 31642 31643 31644 31645 31646

(E) A nursing facility that admits or retains a person determined pursuant to an assessment required under this section not to need the level of care provided by the nursing facility shall not be reimbursed under the medicaid program for the person's care. 31647 31648 31649 31650 31651

(F) The director of ~~job and family services~~ <u>health care administration</u> shall adopt rules in accordance with Chapter 119. of the Revised Code to implement and administer this section. The rules shall include all of the following: 31652 31653 31654 31655

(1) Criteria and procedures to be used in determining whether admission to a nursing facility or continued stay in a nursing facility is appropriate for the person being assessed; 31656 31657 31658

(2) Information the person being assessed or the person's representative must provide to the department or agency under contract with the department for purposes of the assessment and providing a level of care determination based on the assessment; 31659 31660 31661 31662

(3) Circumstances under which a person is not required to be assessed;

(4) Circumstances that constitute an emergency for purposes of division (C)(4) of this section and the number of days within which a level of care determination must be provided in the case of an emergency.

(G) Pursuant to section ~~5111.91~~ 5161.05 of the Revised Code, the department of ~~job and family services~~ health care administration may enter into contracts in the form of interagency agreements with one or more other state agencies to perform the assessments required under this section. The interagency agreements shall specify the responsibilities of each agency in the performance of the assessments.

Sec. ~~5111.35~~ 5164.50. As used in this section "a resident's rights" means the rights of a nursing facility resident under sections 3721.10 to 3721.17 of the Revised Code and subsection (c) of section 1819 or 1919 of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended, and regulations issued under those subsections.

As used in sections ~~5111.35~~ 5164.50 to ~~5111.62~~ 5164.78 of the Revised Code:

(A) "Certification requirements" means the requirements for nursing facilities established under sections 1819 and 1919 of the "Social Security Act."

(B) "Compliance" means substantially meeting all applicable certification requirements.

(C) "Contracting agency" means a state agency that has entered into a contract with the department of ~~job and family services~~ health care administration under section ~~5111.38~~ 5164.53 of the Revised Code.

(D)(1) "Deficiency" means a finding cited by the department of health during a survey, on the basis of one or more actions, practices, situations, or incidents occurring at a nursing facility, that constitutes a severity level three finding, severity level four finding, scope level three finding, or scope level four finding. Whenever the finding is a repeat finding, "deficiency" also includes any finding that is a severity level two and scope level one finding, a severity level two and scope level two finding, or a severity level one and scope level two finding. 31693 31694 31695 31696 31697 31698 31699 31700 31701 31702

(2) "Cluster of deficiencies" means deficiencies that result from noncompliance with two or more certification requirements and are causing or resulting from the same action, practice, situation, or incident. 31703 31704 31705 31706

(E) "Emergency" means either of the following: 31707

(1) A deficiency or cluster of deficiencies that creates a condition of immediate jeopardy; 31708 31709

(2) An unexpected situation or sudden occurrence of a serious or urgent nature that creates a substantial likelihood that one or more residents of a nursing facility may be seriously harmed if allowed to remain in the facility, including the following: 31710 31711 31712 31713

(a) A flood or other natural disaster, civil disaster, or similar event; 31714 31715

(b) A labor strike that suddenly causes the number of staff members in a nursing facility to be below that necessary for resident care. 31716 31717 31718

(F) "Finding" means a finding of noncompliance with certification requirements determined by the department of health under section ~~5111.41~~ 5164.56 of the Revised Code. 31719 31720 31721

(G) "Immediate jeopardy" means that one or more residents of 31722

a nursing facility are in imminent danger of serious physical or life-threatening harm. 31723 31724

(H) "Medicaid eligible resident" means a person who is a resident of a nursing facility, or is applying for admission to a nursing facility, and is eligible to receive financial assistance under the ~~medical assistance~~ medicaid program for the care the person receives in such a facility. 31725 31726 31727 31728 31729

(I) "Noncompliance" means failure to substantially meet all applicable certification requirements. 31730 31731

(J) "Nursing facility" has the same meaning as in section ~~5111.20~~ 5164.01 of the Revised Code. 31732 31733

(K) "Provider" means a person, institution, or entity that furnishes nursing facility services under a ~~medical assistance program~~ medicaid provider agreement. 31734 31735 31736

(L) "Repeat finding" or "repeat deficiency" means a finding or deficiency cited pursuant to a survey, to which both of the following apply: 31737 31738 31739

(1) The finding or deficiency involves noncompliance with the same certification requirement, and the same kind of actions, practices, situations, or incidents caused by or resulting from the noncompliance, as were cited in the immediately preceding standard survey or another survey conducted subsequent to the immediately preceding standard survey of the facility. For purposes of this division, actions, practices, situations, or incidents may be of the same kind even though they involve different residents, staff, or parts of the facility. 31740 31741 31742 31743 31744 31745 31746 31747 31748

(2) The finding or deficiency is cited subsequent to a determination by the department of health that the finding or deficiency cited on the immediately preceding standard survey, or another survey conducted subsequent to the immediately preceding standard survey, had been corrected. 31749 31750 31751 31752 31753

(M)(1) "Scope level one finding" means a finding of noncompliance by a nursing facility in which the actions, situations, practices, or incidents causing or resulting from the noncompliance affect one or a very limited number of facility residents and involve one or a very limited number of facility staff members. 31754 31755 31756 31757 31758 31759

(2) "Scope level two finding" means a finding of noncompliance by a nursing facility in which the actions, situations, practices, or incidents causing or resulting from the noncompliance affect more than a limited number of facility residents or involve more than a limited number of facility staff members, but the number or percentage of facility residents affected or staff members involved and the number or frequency of the actions, situations, practices, or incidents in short succession does not establish any reasonable degree of predictability of similar actions, situations, practices, or incidents occurring in the future. 31760 31761 31762 31763 31764 31765 31766 31767 31768 31769 31770

(3) "Scope level three finding" means a finding of noncompliance by a nursing facility in which the actions, situations, practices, or incidents causing or resulting from the noncompliance affect more than a limited number of facility residents or involve more than a limited number of facility staff members, and the number or percentage of facility residents affected or staff members involved or the number or frequency of the actions, situations, practices, or incidents in short succession establishes a reasonable degree of predictability of similar actions, situations, practices, or incidents occurring in the future. 31771 31772 31773 31774 31775 31776 31777 31778 31779 31780 31781

(4) "Scope level four finding" means a finding of noncompliance by a nursing facility causing or resulting from actions, situations, practices, or incidents that involve a sufficient number or percentage of facility residents or staff 31782 31783 31784 31785

members or occur with sufficient regularity over time that the noncompliance can be considered systemic or pervasive in the facility. 31786 31787 31788

(N)(1) "Severity level one finding" means a finding of noncompliance by a nursing facility that has not caused and, if continued, is unlikely to cause physical harm to a facility resident, mental or emotional harm to a resident, or a violation of a resident's rights that results in physical, mental, or emotional harm to the resident. 31789 31790 31791 31792 31793 31794

(2) "Severity level two finding" means a finding of noncompliance by a nursing facility that, if continued over time, will cause, or is likely to cause, physical harm to a facility resident, mental or emotional harm to a resident, or a violation of a resident's rights that results in physical, mental, or emotional harm to the resident. 31795 31796 31797 31798 31799 31800

(3) "Severity level three finding" means a finding of noncompliance by a nursing facility that has caused physical harm to a facility resident, mental or emotional harm to a resident, or a violation of a resident's rights that results in physical, mental, or emotional harm to the resident. 31801 31802 31803 31804 31805

(4) "Severity level four finding" means a finding of noncompliance by a nursing facility that has caused life-threatening harm to a facility resident or caused a resident's death. 31806 31807 31808 31809

(O) "State agency" has the same meaning as in section 1.60 of the Revised Code. 31810 31811

(P) "Substandard care" means care furnished in a facility in which the department of health has cited a deficiency or deficiencies that constitute one of the following: 31812 31813 31814

(1) A severity level four finding, regardless of scope; 31815

(2) A severity level three and scope level four finding, in the quality of care provided to residents; 31816 31817

(3) A severity level three and scope level three finding, in the quality of care provided to residents. 31818 31819

(Q)(1) "Survey" means a survey of a nursing facility conducted under section ~~5111.39~~ 5164.54 of the Revised Code. 31820 31821

(2) "Standard survey" means a survey conducted by the department of health under division (A) of section ~~5111.39~~ 5164.54 of the Revised Code and includes an extended survey. 31822 31823 31824

(3) "Follow-up survey" means a survey conducted by the department of health to determine whether a nursing facility has substantially corrected deficiencies cited in a previous survey. 31825 31826 31827

Sec. ~~5111.36~~ 5164.51. The director of ~~job and family services~~ health care administration may adopt rules under Chapter 119. of the Revised Code that are consistent with regulations, guidelines, and procedures issued by the United States secretary of health and human services under ~~sections 1819 and 1919 of the "Social Security Act," 49 Stat. 620 (1935),~~ 42 U.S.C.~~A. 301, as amended,~~ 1395i-3 and 1396r and necessary for administration and enforcement of sections ~~5111.35~~ 5164.50 to ~~5111.62~~ 5164.78 of the Revised Code. If the secretary does not issue appropriate regulations for enforcement of ~~sections 1819 and 1919 of the "Social Security Act"~~ 42 U.S.C. 1395i-3 and 1396r on or before December 13, 1990, the director of ~~job and family services~~ health care administration may adopt, under Chapter 119. of the Revised Code, rules that are consistent with those sections and with sections ~~5111.35~~ 5164.50 to ~~5111.62~~ 5164.78 of the Revised Code. 31828 31829 31830 31831 31832 31833 31834 31835 31836 31837 31838 31839 31840 31841 31842

Sec. ~~5111.37~~ 5164.52. The department of ~~job and family services~~ health care administration is hereby authorized to enforce sections ~~5111.35~~ 5164.50 to ~~5111.62~~ 5164.78 of the Revised 31843 31844 31845

Code. The department may enforce the sections directly or through 31846
contracting agencies. The department and agencies shall enforce 31847
the sections in accordance with the requirements of ~~sections 1819~~ 31848
~~and 1919 of the "Social Security Act," 49 Stat. 620 (1935),~~ 42 31849
U.S.C.~~A. 301, as amended,~~ 1395i-3 and 1396r that apply to nursing 31850
facilities; with regulations, guidelines, and procedures adopted 31851
by the United States secretary of health and human services for 31852
the enforcement of ~~sections 1819 and 1919 of the "Social Security~~ 31853
~~Act"~~ 42 U.S.C. 1395i-3 and 1396r; and with the rules adopted under 31854
section ~~5111.36~~ 5164.51 of the Revised Code. The department and 31855
agencies shall enforce sections ~~5111.35~~ 5164.50 to ~~5111.62~~ 5164.78 31856
of the Revised Code for purposes of the medicare program~~, Title~~ 31857
~~XVIII of the "Social Security Act,"~~ only to the extent prescribed 31858
by the regulations, guidelines, and procedures issued by the 31859
secretary under ~~section 1819 of that act~~ 42 U.S.C. 1395i-3. 31860

Sec. ~~5111.38~~ 5164.53. The department of ~~job and family~~ 31861
~~services~~ health care administration may enter into contracts with 31862
other state agencies that authorize the agencies to perform all or 31863
part of the duties assigned to the department of ~~job and family~~ 31864
~~services~~ health care administration under sections ~~5111.35~~ 5164.50 31865
to ~~5111.62~~ 5164.78 of the Revised Code. Each contract shall 31866
specify the duties the agency is authorized to perform and the 31867
sections of the Revised Code under which the agency is authorized 31868
to perform those duties. 31869

Sec. ~~5111.39~~ 5164.54. (A) The department of health shall 31870
conduct a survey, titled a standard survey, of every nursing 31871
facility in this state on a statewide average of not more than 31872
once every twelve months. Each nursing facility shall undergo a 31873
standard survey at least once every fifteen months as a condition 31874
of meeting certification requirements. The department may extend a 31875
standard survey; such a survey is titled an extended survey. 31876

(B) The department may conduct surveys in addition to standard surveys when it considers them necessary. 31877 31878

(C) The department shall conduct surveys in accordance with the regulations, guidelines, and procedures issued by the United States secretary of health and human services ~~under Titles XVIII and XIX of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended~~ for the medicare and medicaid programs, sections ~~5111.40~~ 5164.55 to ~~5111.42~~ 5164.58 of the Revised Code, and rules adopted under section 3721.022 of the Revised Code. 31879 31880 31881 31882 31883 31884 31885

Sec. ~~5111.40~~ 5164.55. (A) At the conclusion of each survey, the department of health survey team shall conduct an exit interview with the administrator or other person in charge of the nursing facility and any other facility staff members designated by the administrator or person in charge of the facility. During the exit interview, at the request of the administrator or other person in charge of the facility, the survey team shall provide one of the following, as selected by the survey team: 31886 31887 31888 31889 31890 31891 31892 31893

(1) Copies of all survey notes and any other written materials created during the survey; 31894 31895

(2) A written summary of the survey team's recommendations regarding findings of noncompliance with certification requirements; 31896 31897 31898

(3) An audio or audiovisual recording of the interview. If the survey team selects this option, at least two copies of the recording shall be made and the survey team shall select one copy to be kept by the survey team for use by the department of health. 31899 31900 31901 31902

(B) All expenses of copying under division (A)(1) of this section or recording under division (A)(3) of this section, including the cost of the copy of the recording kept by the survey team, shall be paid by the facility. 31903 31904 31905 31906

Sec. ~~5111.41~~ 5164.56. (A) Except as provided in section 3721.17 of the Revised Code, a finding shall be cited only on the basis of a survey and a determination that one or more actions, practices, situations, or incidents at a nursing facility caused or resulted from the facility's failure to comply with one or more certification requirements. The department of health shall determine whether the actions, practices, situations, or incidents can be justified by either of the following: 31907 31908 31909 31910 31911 31912 31913 31914

(1) The actions, practices, situations, or incidents resulted from a resident exercising the resident's rights guaranteed under the laws of the United States or of this state; 31915 31916 31917

(2) The actions, practices, situations, or incidents resulted from a facility following the orders of a person licensed under Chapter 4731. of the Revised Code to practice medicine or surgery or osteopathic medicine and surgery. 31918 31919 31920 31921

(B) If the department of health determines both that the actions, practices, situations, or incidents cannot be justified by the factors identified in division (A) of this section and that one or more of the following are applicable, the department shall declare that the actions, practices, situations, or incidents constitute a finding: 31922 31923 31924 31925 31926 31927

(1) The actions, practices, situations, or incidents could have been prevented by one or more persons involved in the facility's operation; 31928 31929 31930

(2) No person involved in the facility's operation identified the actions, practices, situations, or incidents prior to the survey; 31931 31932 31933

(3) Prior to the survey, no person involved in the facility's operation initiated action to correct the noncompliance caused by or resulting in the actions, practices, situations, or incidents; 31934 31935 31936

(4) The facility does not have in effect, if needed, a 31937
contingency plan that is reasonably calculated to prevent 31938
physical, mental, or emotional harm to residents while permanent 31939
corrective action is being taken. 31940

(C) The department of health shall determine the severity 31941
level and scope level of each finding. 31942

(D) A deficiency that is substantially corrected within the 31943
time limits specified in sections ~~5111.52~~ 5164.68 to ~~5111.56~~ 31944
5164.72 of the Revised Code and for which no remedy is imposed, 31945
shall be counted as a deficiency for the purpose of determining 31946
whether a deficiency is a repeat deficiency. 31947

(E) Whenever the department of health determines that during 31948
the period between two surveys a finding existed at the facility, 31949
but the facility substantially corrected it prior to the second 31950
survey, the department shall cite it. However, the department of 31951
~~job and family services~~ health care administration or a 31952
contracting agency shall impose a remedy only as provided in 31953
division (C) of section ~~5111.46~~ 5164.62 of the Revised Code. 31954

(F) Immediately upon determining the severity and scope of a 31955
finding at a nursing facility, the department of health shall 31956
notify the department of ~~job and family services~~ health care 31957
administration and any contracting agency of the finding, the 31958
severity and scope of the finding, and whether the finding creates 31959
immediate jeopardy. Immediately upon determining that an emergency 31960
exists at a facility that does not result from a deficiency that 31961
creates immediate jeopardy, the department of health shall notify 31962
the department of ~~job and family services~~ health care 31963
administration and any contracting agency. 31964

Sec. ~~5111.411~~ 5164.57. The results of a survey of a nursing 31965
facility that is conducted under section ~~5111.39~~ 5164.54 of the 31966
Revised Code, including any statement of deficiencies and all 31967

findings and deficiencies cited in the statement on the basis of 31968
the survey, shall be used solely to determine the nursing 31969
facility's compliance with certification requirements or with this 31970
chapter or another chapter of the Revised Code. Those results of a 31971
survey, that statement of deficiencies, and the findings and 31972
deficiencies cited in that statement shall not be used in any 31973
court or in any action or proceeding that is pending in any court 31974
and are not admissible in evidence in any action or proceeding 31975
unless that action or proceeding is an appeal of an administrative 31976
action by the department of ~~job and family services~~ health care 31977
administration or contracting agency under this chapter or is an 31978
action by any department or agency of the state to enforce this 31979
chapter or another chapter of the Revised Code. 31980

Nothing in this section prohibits the results of a survey, a 31981
statement of deficiencies, or the findings and deficiencies cited 31982
in that statement on the basis of the survey under this section 31983
from being used in a criminal investigation or prosecution. 31984

Sec. ~~5111.42~~ 5164.58. (A) Not later than ten days after an 31985
exit interview, the department of health shall deliver to the 31986
nursing facility a detailed statement, titled a statement of 31987
deficiencies, setting forth all findings and deficiencies cited on 31988
the basis of the survey, including any finding cited pursuant to 31989
division (E) of section ~~5111.41~~ 5164.56 of the Revised Code. The 31990
statement shall indicate the severity and scope level of each 31991
finding and fully describe the incidents or other facts that form 31992
the basis of the department's determination of the existence of 31993
each finding and deficiency. A failure by the survey team to 31994
completely disclose in the exit interview every finding that may 31995
result from the survey does not affect the validity of any finding 31996
or deficiency cited in the statement of deficiencies. On request 31997
of the facility, the department shall provide a copy of any 31998
written worksheet or other document produced by the survey team in 31999

making recommendations regarding scope and severity levels of findings and deficiencies.

(B) At the same time the department of health delivers a statement of deficiencies, it also shall deliver to the facility a separate written notice that states all of the following:

(1) That the department of ~~job and family services~~ health care administration or a contracting agency will issue an order under section ~~5111.57~~ 5164.73 of the Revised Code denying payment for any medicaid eligible residents admitted on and after the effective date of the order if the facility does not substantially correct, within ninety days after the exit interview, the deficiency or deficiencies cited in the statement of deficiencies in accordance with the plan of correction it submitted under section ~~5111.43~~ 5164.59 of the Revised Code;

(2) If a condition of substandard care has been cited on the basis of a standard survey and a condition of substandard care was also cited on the immediately preceding standard survey, that the department of ~~job and family services~~ health care administration or a contracting agency will issue an order under section ~~5111.57~~ 5164.73 of the Revised Code denying payment for any medicaid eligible residents admitted on and after the effective date of the order if a condition of substandard care is cited on the basis of the next standard survey;

(3) That the department of ~~job and family services~~ health care administration or a contracting agency will issue an order under section ~~5111.58~~ 5164.74 of the Revised Code terminating the facility's participation in the ~~medical assistance~~ medicaid program if either of the following applies:

(a) The facility does not substantially correct the deficiency or deficiencies in accordance with the plan of correction it submitted under section ~~5111.43~~ 5164.59 of the

Revised Code within six months after the exit interview. 32031

(b) The facility substantially corrects the deficiency or deficiencies within the six-month period, but after correcting it, the department of health, based on a follow-up survey conducted during the remainder of the six-month period, determines that the facility has failed to maintain compliance with certification requirements. 32032 32033 32034 32035 32036 32037

Sec. ~~5111.43~~ 5164.59. Whenever a nursing facility receives a statement of deficiencies under section ~~5111.42~~ 5164.58 of the Revised Code, the facility shall submit to the department of health for its approval a plan of correction for each finding cited in the statement. The plan shall describe the actions the facility will take to correct each finding and specify the date by which each finding will be corrected. In the case of a finding cited pursuant to division (E) of section ~~5111.41~~ 5164.56 of the Revised Code, the plan shall describe the actions the facility took to correct the finding and the date on which it was corrected. 32038 32039 32040 32041 32042 32043 32044 32045 32046 32047 32048

The department shall approve any plan that conforms to the requirements for approval of plans of corrections established in the regulations, guidelines, and procedures issued by the United States secretary of health and human services ~~under Titles XVIII and XIX of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended~~ for the medicare and medicaid programs. The department also shall approve any modification of an existing plan submitted by a facility, if the plan as modified conforms to those regulations, guidelines, and procedures. The department shall not reject a facility's plan of correction or modification on the ground that the facility disputes the finding, if the plan is reasonably calculated to correct the finding. 32049 32050 32051 32052 32053 32054 32055 32056 32057 32058 32059 32060

A facility that complies with this section shall not be 32061

considered to have admitted the existence of a finding cited by the department.

Sec. ~~5111.44~~ 5164.60. The department of health may appoint employees of the department to conduct on-site monitoring of a nursing facility whenever a finding is cited, including any finding cited pursuant to division (E) of section ~~5111.41~~ 5164.56 of the Revised Code, or an emergency is found to exist. Appointment of monitors under this section is not subject to appeal under section ~~5111.60~~ 5164.76 or any other section of the Revised Code. No employee of a facility for which monitors are appointed, no person employed by the facility within the previous two years, and no person who currently has a consulting or other contract with the department or the facility, shall be appointed as a monitor under this section. Every monitor appointed under this section shall have the professional qualifications necessary to monitor correction of the finding or elimination of the emergency.

Sec. ~~5111.45~~ 5164.61. (A) If the department of health cites a deficiency or deficiencies that was not substantially corrected before a survey and that does not constitute a severity level four finding or create immediate jeopardy, the department of ~~job and family services~~ health care administration or a contracting agency shall permit the nursing facility to continue participating in the ~~medical assistance~~ medicaid program for up to six months after the exit interview, if all of the following apply:

(1) The facility meets the requirements, established in regulations issued by the United States secretary of health and human services under ~~Title XIX of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended,~~ the medicaid program for certification of nursing facilities that have a deficiency.

(2) The department of health has approved a plan of correction submitted by the facility under section ~~5111.43~~ 5164.59 of the Revised Code for each deficiency.

(3) The provider agrees to repay the department of ~~job and family services~~ health care administration, in accordance with section ~~5111.58~~ 5164.74 of the Revised Code, the federal share of all payments made by the department to the facility during the six-month period following the exit interview if the facility does not within the six-month period substantially correct the deficiency or deficiencies in accordance with the plan of correction submitted under section ~~5111.43~~ 5164.59 of the Revised Code.

(B) If any of the conditions in divisions (A)(1) to (3) of this section do not apply, the department of ~~job and family services~~ health care administration or contracting agency shall issue an order terminating the facility's participation in the ~~medical assistance~~ medicaid program. An order issued under this division is subject to appeal under Chapter 119. of the Revised Code. The order shall not take effect prior to the later of the thirtieth day after it is delivered to the facility or, if the order is appealed, the date on which a final adjudication order upholding the termination becomes effective pursuant to Chapter 119. of the Revised Code.

(C) At the time the department of ~~job and family services~~ health care administration or contracting agency issues an order under division (B) of this section terminating a nursing facility's participation in the ~~medical assistance~~ medicaid program, it may also impose, subject to section ~~5111.50~~ 5164.66 of the Revised Code, other remedies under sections ~~5111.46~~ 5164.62 to ~~5111.48~~ 5164.64 of the Revised Code.

Sec. ~~5111.46~~ 5164.62. (A) If the department of health cites a

deficiency, or cluster of deficiencies, that was not substantially corrected before a survey and constitutes a severity level four finding, the department of ~~job and family services~~ health care administration or contracting agency shall, subject to sections ~~5111.52~~ 5164.68 to ~~5111.56~~ 5164.72 of the Revised Code, impose a remedy for the deficiency or cluster of deficiencies. The department or agency may act under either division (A)(1) or (2) of this section: 32124 32125 32126 32127 32128 32129 32130 32131

(1) The department or agency may impose one or more of the following remedies: 32132 32133

(a) Issue an order terminating the nursing facility's participation in the ~~medical assistance~~ medicaid program. 32134 32135

(b) Do either of the following: 32136

(i) Regardless of whether the provider consents, appoint a temporary manager of the facility. 32137 32138

(ii) Apply to the common pleas court of the county in which the facility is located for such injunctive or other equitable relief as is necessary for the appointment of a special master with such powers and authority over the facility and length of appointment as the court considers necessary. 32139 32140 32141 32142 32143

(c) Do either of the following: 32144

(i) Issue an order denying payment to the facility under the ~~medical assistance~~ medicaid program for all medicaid eligible residents admitted after the effective date of the order; 32145 32146 32147

(ii) Impose a fine. 32148

(d) Issue an order denying payment to the facility under the ~~medical assistance~~ medicaid program for medicaid eligible residents admitted after the effective date of the order who have certain diagnoses or special care needs specified by the department or agency. 32149 32150 32151 32152 32153

(2) The department or agency may impose one or more of the following remedies: 32154 32155

(a) Appoint, subject to the continuing consent of the provider, a temporary manager of the facility; 32156 32157

(b) Do either of the following: 32158

(i) Regardless of whether the provider consents, appoint a temporary manager of the facility; 32159 32160

(ii) Apply to the common pleas court of the county in which the facility is located for such injunctive or other equitable relief as is necessary for the appointment of a special master with such powers and authority over the facility and length of appointment as the court considers necessary. 32161 32162 32163 32164 32165

(c) Do either of the following: 32166

(i) Issue an order denying payment to the facility under the ~~medical assistance~~ medicaid program for all medicaid eligible residents admitted after the effective date of the order; 32167 32168 32169

(ii) Impose a fine. 32170

(d) Issue an order denying payment to the facility under the ~~medical assistance~~ medicaid program for medicaid eligible residents admitted after the effective date of the order who have certain diagnoses or special care needs specified by the department or agency; 32171 32172 32173 32174 32175

(e) Issue an order requiring the facility to correct the deficiency or cluster of deficiencies under the plan of correction submitted by the facility and approved by the department of health under section ~~5111.43~~ 5164.59 of the Revised Code. 32176 32177 32178 32179

(B) The department of ~~job and family services~~ health care administration or contracting agency shall deliver a written order issued under division (A)(1) of this section terminating a nursing facility's participation in the ~~medical assistance~~ medicaid 32180 32181 32182 32183

program to the facility within five days after the exit interview. 32184
If the facility alleges, at any time prior to the later of the 32185
twentieth day after the exit interview or the fifteenth day after 32186
it receives the order, that the deficiency or cluster of 32187
deficiencies for which the order was issued has been substantially 32188
corrected, the department of health shall conduct a follow-up 32189
survey to determine whether the deficiency or cluster of 32190
deficiencies has been substantially corrected. The order shall 32191
take effect and the facility's participation shall terminate on 32192
the twentieth day after the exit interview, unless the facility 32193
has substantially corrected the deficiency or cluster of 32194
deficiencies that constituted a severity level four finding or did 32195
not receive notice from the department of ~~job and family services~~ 32196
health care administration or contracting agency within five days 32197
after the exit interview. In the latter case, the order shall take 32198
effect and the facility's participation shall terminate on the 32199
fifteenth day after the facility received the order. 32200

(C) If the department of health cites a deficiency or cluster 32201
of deficiencies pursuant to division (E) of section ~~5111.41~~ 32202
5164.56 of the Revised Code that constituted a severity level four 32203
finding, the department of ~~job and family services~~ health care 32204
administration or a contracting agency shall, subject to section 32205
~~5111.56~~ 5164.72 of the Revised Code, impose a fine. The fine shall 32206
be in effect for a period equal to the number of days the 32207
deficiency or cluster of deficiencies existed at the facility. 32208

Sec. ~~5111.47~~ 5164.63. If the department of health cites a 32209
deficiency, or cluster of deficiencies, that was not substantially 32210
corrected before a survey and constitutes a severity level three 32211
and scope level three or four finding, the department of ~~job and~~ 32212
~~family services~~ health care administration or a contracting agency 32213
may, subject to sections ~~5111.55~~ 5164.71 and ~~5111.56~~ 5164.72 of 32214
the Revised Code, impose one or more of the following remedies: 32215

(A) Do either of the following: 32216

(1) Issue an order denying payment to the facility under the 32217
~~medical assistance~~ medicaid program for all medicaid eligible 32218
residents admitted after the effective date of the order; 32219

(2) Impose a fine. 32220

(B) Issue an order denying payment to the facility under the 32221
~~medical assistance~~ medicaid program for medicaid eligible 32222
residents admitted after the effective date of the order who have 32223
certain diagnoses or special care needs specified by the 32224
department or agency; 32225

(C) Issue an order requiring the facility to correct the 32226
deficiency or cluster of deficiencies under the plan of correction 32227
submitted by the facility and approved by the department of health 32228
under section ~~5111.43~~ 5164.59 of the Revised Code. 32229

Sec. ~~5111.48~~ 5164.64. (A) If the department of health cites a 32230
deficiency, or cluster of deficiencies, that was not substantially 32231
corrected before a survey and constitutes a severity level three 32232
and scope level two finding, the department of ~~job and family~~ 32233
~~services~~ health care administration or a contracting agency may, 32234
subject to sections ~~5111.55~~ 5164.71 and ~~5111.56~~ 5164.72 of the 32235
Revised Code, impose one or more of the following remedies: 32236

(1) Do either of the following: 32237

(a) Issue an order denying payment to the facility under the 32238
~~medical assistance~~ medicaid program for all medicaid eligible 32239
residents admitted after the effective date of the order; 32240

(b) Impose a fine. 32241

(2) Issue an order denying payment to the facility under the 32242
~~medical assistance~~ medicaid program for medicaid eligible 32243
residents admitted after the effective date of the order who have 32244
certain diagnoses or special care needs specified by the 32245

department or agency; 32246

(3) Issue an order requiring the facility to correct the 32247
deficiency or cluster of deficiencies under the plan of correction 32248
proposed by the facility and approved by the department of health 32249
under section ~~5111.43~~ 5164.59 of the Revised Code. 32250

(B) If the department of health cites a deficiency, or 32251
cluster of deficiencies, that was not substantially corrected 32252
before a survey and constitutes a severity level three and scope 32253
level one finding, the department of ~~job and family services~~ 32254
health care administration or a contracting agency may, subject to 32255
sections ~~5111.55~~ 5164.71 and ~~5111.56~~ 5164.72 of the Revised Code, 32256
impose one or more of the following remedies: 32257

(1) Impose a fine; 32258

(2) Issue an order denying payment to the facility under the 32259
~~medical assistance~~ medicaid program for medicaid eligible 32260
residents admitted after the effective date of the order who have 32261
certain diagnoses or special care needs specified by the 32262
department or agency; 32263

(3) Issue an order requiring the facility to correct the 32264
deficiency or cluster of deficiencies under the plan of correction 32265
proposed by the facility and approved by the department of health 32266
under section ~~5111.43~~ 5164.59 of the Revised Code. 32267

(C) If the department of health cites a deficiency, or 32268
cluster of deficiencies, that was not substantially corrected 32269
before a survey and constitutes a severity level two and a scope 32270
level three or four finding, the department of ~~job and family~~ 32271
~~services~~ health care administration or a contracting agency may, 32272
subject to sections ~~5111.55~~ 5164.71 and ~~5111.56~~ 5164.72 of the 32273
Revised Code, impose one or more of the following remedies: 32274

(1) Impose a fine; 32275

(2) Issue an order denying payment to the facility under the ~~medical assistance~~ medicaid program for medicaid eligible residents admitted after the effective date of the order who have certain diagnoses or special care needs specified by the department or agency; 32276 32277 32278 32279 32280

(3) Issue an order requiring the facility to correct the deficiency or cluster of deficiencies under the plan of correction submitted by the facility and approved by the department of health under section ~~5111.43~~ 5164.59 of the Revised Code. 32281 32282 32283 32284

(D) If the department of health cites a deficiency, or cluster of deficiencies, that was not substantially corrected before a survey, constitutes a severity level two and scope level one or two finding, and is a repeat finding, the department of ~~job and family services~~ health care administration or a contracting agency may issue an order requiring the facility to correct the deficiency or cluster of deficiencies under the plan of correction submitted by the facility and approved by the department of health under section ~~5111.43~~ 5164.59 of the Revised Code. 32285 32286 32287 32288 32289 32290 32291 32292 32293

(E) If the department of health cites a deficiency, or cluster of deficiencies, that was not substantially corrected before a survey and constitutes a severity level one and scope level three or four finding, the department of ~~job and family services~~ health care administration or a contracting agency may issue an order requiring the facility to correct the deficiency or cluster of deficiencies under the plan of correction submitted by the facility and approved by the department of health under section ~~5111.43~~ 5164.59 of the Revised Code. 32294 32295 32296 32297 32298 32299 32300 32301 32302

(F) If the department of health cites a deficiency, or cluster of deficiencies, that was not substantially corrected before a survey, constitutes a severity level one and scope level two finding, and is a repeat finding, the department of ~~job and family services~~ health care administration or a contracting agency 32303 32304 32305 32306 32307

may issue an order requiring the facility to correct the deficiency or cluster of deficiencies under the plan of correction submitted by the facility and approved by the department of health under section ~~5111.43~~ 5164.59 of the Revised Code. 32308 32309 32310 32311

Sec. ~~5111.49~~ 5164.65. (A) In determining which remedies to impose under section ~~5111.46~~ 5164.62, ~~5111.47~~ 5164.63, or ~~5111.48~~ 5164.64 of the Revised Code, including whether a fine should be imposed, the department of ~~job and family services~~ health care administration or a contracting agency shall do both of the following: 32312 32313 32314 32315 32316 32317

(1) Impose the remedies that are most likely to achieve correction of deficiencies, encourage sustained compliance with certification requirements, and protect the health, safety, and rights of facility residents, but that are not directed at punishment of the facility; 32318 32319 32320 32321 32322

(2) Consider all of the following: 32323

(a) The presence or absence of immediate jeopardy; 32324

(b) The relationships of groups of deficiencies to each other; 32325 32326

(c) The facility's history of compliance with certification requirements generally and in the specific area of the deficiency or deficiencies; 32327 32328 32329

(d) Whether the deficiency or deficiencies are directly related to resident care; 32330 32331

(e) The corrective, long-term compliance, resident protective, and nonpunitive outcomes sought by the department or agency; 32332 32333 32334

(f) The nature, scope, and duration of the noncompliance with certification requirements; 32335 32336

(g) The existence of repeat deficiencies; 32337

(h) The category of certification requirements with which the 32338
facility is out of compliance; 32339

(i) Any period of noncompliance with certification 32340
requirements that occurred between two certifications by the 32341
department of health that the facility was in compliance with 32342
certification requirements; 32343

(j) The facility's degree of culpability; 32344

(k) The accuracy, extent, and availability of facility 32345
records; 32346

(l) The facility's financial condition, exclusive of any 32347
moneys donated to a facility that is an organization described in 32348
subsection 501(c)(3) and is tax exempt under subsection 501(a) of 32349
the "Internal Revenue Code of 1986," 100 Stat. 2085, 26 U.S.C.A. 32350
1; 32351

(m) Any adverse effect that the action or fine would have on 32352
the health and safety of facility residents; 32353

(n) If the noncompliance that resulted in the citation of a 32354
deficiency or cluster of deficiencies existed before a change in 32355
ownership of the facility, whether the new owner or owners have 32356
had sufficient time to correct the noncompliance. 32357

(B) Whenever the department or agency imposes remedies under 32358
section ~~5111.46~~ 5164.62, ~~5111.47~~ 5164.63, or ~~5111.48~~ 5164.64 of 32359
the Revised Code, it shall provide a written statement to the 32360
nursing facility that specifies all of the following: 32361

(1) The effective date of each remedy; 32362

(2) The deficiency or cluster of deficiencies for which each 32363
remedy is imposed; 32364

(3) The severity and scope of the deficiency or cluster of 32365
deficiencies; 32366

(4) The rationale, including all applicable factors specified in division (A) of this section, for imposing the remedies. 32367 32368

Sec. ~~5111.50~~ 5164.66. At the time the department of ~~job and family services~~ health care administration or a contracting agency, under section ~~5111.45~~ 5164.61, ~~5111.46~~ 5164.62, or ~~5111.51~~ 5164.67 of the Revised Code, issues an order terminating a nursing facility's participation in the ~~medical assistance~~ medicaid program, the department or agency may also impose a fine, in accordance with sections ~~5111.46~~ 5164.62 to ~~5111.48~~ 5164.64 and ~~5111.56~~ 5164.72 of the Revised Code, to be collected in the event the termination order does not take effect. The department or agency shall not collect this fine if the termination order takes effect. 32369 32370 32371 32372 32373 32374 32375 32376 32377 32378 32379

Sec. ~~5111.51~~ 5164.67. (A) If the department of health finds during a survey that an emergency exists at a nursing facility, as the result of a deficiency or cluster of deficiencies that creates immediate jeopardy, the department of ~~job and family services~~ health care administration or a contracting agency shall impose one or more of the remedies described in division (A)(1) of this section and, in addition, may take one or both of the actions described in division (A)(2) of this section. 32380 32381 32382 32383 32384 32385 32386 32387

(1) The department or agency shall impose one or more of the following remedies: 32388 32389

(a) Appoint, subject to the continuing consent of the provider, a temporary manager of the facility; 32390 32391

(b) Apply to the common pleas court of the county in which the facility is located for a temporary restraining order, preliminary injunction, or such other injunctive or equitable relief as is necessary to close the facility, transfer one or more residents to other nursing facilities or other appropriate care 32392 32393 32394 32395 32396

settings, or otherwise eliminate the condition of immediate 32397
jeopardy. If the court grants such an order, injunction, or 32398
relief, it may appoint a special master empowered to implement the 32399
court's judgment under the court's direct supervision. 32400

(c) Issue an order terminating the facility's participation 32401
in the medical assistance program; 32402

(d) Regardless of whether the provider consents, appoint a 32403
temporary manager of the facility. 32404

(2) The department or agency may do one or both of the 32405
following: 32406

(a) Issue an order denying payment to the facility for all 32407
medicaid eligible residents admitted after the effective date of 32408
the order; 32409

(b) Impose remedies under sections ~~5111.46~~ 5164.62 to ~~5111.48~~ 32410
5164.64 of the Revised Code appropriate to the severity and scope 32411
of the deficiency or cluster of deficiencies, except that the 32412
department or agency shall not impose a fine for the same 32413
deficiency for which the department or agency has issued an order 32414
under division (A)(2)(a) of this section. 32415

(B) If the department of health, department of ~~job and family~~ 32416
~~services~~ health care administration, or a contracting agency finds 32417
on the basis of a survey or other visit to the facility by 32418
representatives of that department or agency that an emergency 32419
exists at a facility that is not the result of a deficiency or 32420
cluster of deficiencies that constitutes immediate jeopardy, the 32421
department of ~~job and family services~~ health care administration 32422
or contracting agency may do either of the following: 32423

(1) Appoint, subject to the continuing consent of the 32424
provider, a temporary manager of the facility; 32425

(2) Apply to the common pleas court of the county in which 32426

the facility is located for a temporary restraining order, preliminary injunction, or such other injunctive or equitable relief as is necessary to close the facility, transfer one or more residents to other nursing facilities or other appropriate care settings, or otherwise eliminate the emergency. If the court grants such an order, injunction, or relief, it may appoint a special master empowered to implement the court's judgment under the court's direct supervision. 32427 32428 32429 32430 32431 32432 32433 32434

(C)(1) Prior to acting under division (A)(1)(b), (c), (d), or (2), or (B)(2) of this section, the department of ~~job and family services~~ health care administration or contracting agency shall give written notice to the facility specifying all of the following: 32435 32436 32437 32438 32439

(a) The nature of the emergency, including the nature of any deficiency or deficiencies that caused the emergency; 32440 32441

(b) The nature of the action the department or agency intends to take unless the department of health determines that the facility, in the absence of state intervention, possesses the capacity to eliminate the emergency; 32442 32443 32444 32445

(c) The rationale for taking the action. 32446

(2) If the department of health determines that the facility does not possess the capacity to eliminate the emergency in the absence of state intervention, the department of ~~job and family services~~ health care administration or contracting agency may immediately take action under division (A) or (B) of this section. If the department of health determines that the facility possesses the capacity to eliminate the emergency, the department of ~~job and family services~~ health care administration or contracting agency shall direct the facility to eliminate the emergency within five days after the facility's receipt of the notice. At the end of the five-day period, the department of health shall conduct a 32447 32448 32449 32450 32451 32452 32453 32454 32455 32456 32457

follow-up survey that focuses on the emergency. If the department of health determines that the facility has eliminated the emergency within the time period, the department of ~~job and family services~~ health care administration or contracting agency shall not act under division (A)(1)(b), (c), (d), or (2)(a), or (B)(2) of this section. If the department of health determines that the facility has failed to eliminate the emergency within the five-day period, the department of job and family services or contracting agency shall take appropriate action under division (A)(1)(b), (c), (d), or (2), or (B)(2) of this section. 32458 32459 32460 32461 32462 32463 32464 32465 32466 32467

(3) Until the written notice required by division (C)(1) of this section is actually delivered, no action taken by the department of ~~job and family services~~ health care administration or contracting agency under division (A)(1)(b), (c), (d), or (2), or (B)(2) of this section shall have any legal effect. In addition to the written notice, the department of health survey team shall give oral notice to the facility, at the time of the survey, concerning any recommendations the survey team intends to make that could form the basis of a determination that an emergency exists. 32468 32469 32470 32471 32472 32473 32474 32475 32476 32477

(D) The department of ~~job and family services~~ health care administration or contracting agency shall deliver a written order issued under division (A)(1) of this section terminating a nursing facility's participation in the ~~medical assistance~~ medicaid program to the facility within five days after the exit interview. If the facility alleges, at any time prior to the later of the twentieth day after the exit interview or the fifteenth day after it receives the order, that the condition of immediate jeopardy for which the order was issued has been eliminated, the department of health shall conduct a follow-up survey to determine whether the immediate jeopardy has been eliminated. The order shall take effect and the facility's participation shall terminate on the 32478 32479 32480 32481 32482 32483 32484 32485 32486 32487 32488 32489

twentieth day after the exit interview, unless the facility has eliminated the immediate jeopardy or did not receive notice from the department of ~~job and family services~~ health care administration or contracting agency within five days after the exit interview. In the latter case, the order shall take effect and the facility's participation shall terminate on the fifteenth day after the facility received the order.

(E) Any action taken by the department of ~~job and family services~~ health care administration or a contracting agency under division (A)(1)(c), (d), or (2)(a) of this section is subject to appeal under Chapter 119. of the Revised Code, except that the department or agency may take such action prior to and during the pendency of any proceeding under that chapter. No action taken by a facility under division (C) of this section to eliminate an emergency cited by the department of health shall be considered an admission by the facility of the existence of an emergency.

Sec. ~~5111.52~~ 5164.68. (A) As used in this section:

(1) "Provider agreement" means a contract between the department of ~~job and family services~~ health care administration and a nursing facility for the provision of nursing facility services under the ~~medical assistance~~ medicaid program.

(2) "Terminating" includes not renewing.

(B) A nursing facility's participation in the ~~medical assistance~~ medicaid program shall be terminated under sections ~~5111.35~~ 5164.50 to ~~5111.62~~ 5164.78 of the Revised Code as follows:

(1) If the department of ~~job and family services~~ health care administration is terminating the facility's participation, it shall issue an order terminating the facility's provider agreement.

(2) If the department of health, acting as a contracting

agency, is terminating the facility's participation, it shall issue an order terminating certification of the facility's compliance with certification requirements. When the department of health terminates certification, the department of ~~job and family services~~ health care administration shall terminate the facility's provider agreement. The department of ~~job and family services~~ health care administration is not required to provide an adjudication hearing when it terminates a provider agreement following termination of certification by the department of health.

(3) If a state agency other than the department of health, acting as a contracting agency, is terminating the facility's participation, it shall notify the department of ~~job and family services~~ health care administration, and the department of ~~job and family services~~ health care administration shall issue an order terminating the facility's provider agreement. The contracting agency shall conduct any administrative proceedings concerning the order.

(C) If the following conditions are met, the department of ~~job and family services~~ health care administration may make ~~medical assistance~~ medicaid payments to a nursing facility for a period not exceeding thirty days after the effective date of termination under sections ~~5111.35~~ 5164.50 to ~~5111.62~~ 5164.78 of the Revised Code of the facility's participation in the ~~medical assistance~~ medicaid program:

(1) The payments are for medicaid eligible residents admitted to the facility prior to the effective date of the termination;

(2) The provider is making reasonable efforts to transfer medicaid eligible residents to other care settings.

The period during which payments may be made under this division begins on the later of the effective date of the

termination or, if the facility has appealed a termination order, the date of issuance of the adjudication order upholding termination. 32551 32552 32553

Sec. ~~5111.53~~ 5164.69. (A) Whenever a nursing facility is closed under sections ~~5111.35~~ 5164.50 to ~~5111.62~~ 5164.78 of the Revised Code, the department of ~~job and family services~~ health care administration or contracting agency shall arrange for the safe and orderly transfer of all residents, including residents who are not medicaid eligible residents, to other appropriate care settings. Whenever a facility's participation in the ~~medical assistance~~ medicaid program is terminated under sections ~~5111.35~~ 5164.50 to ~~5111.62~~ 5164.78 of the Revised Code, the department or agency shall arrange for the safe and orderly transfer of all medicaid eligible residents or, if the termination results in the closure of the facility, of all residents. The provider and all persons involved in the facility's operation shall cooperate with and assist in the transfer of residents. 32554 32555 32556 32557 32558 32559 32560 32561 32562 32563 32564 32565 32566 32567

(B) After a nursing facility's participation in the ~~medical assistance~~ medicaid program is terminated under section ~~5111.45~~ 5164.61, ~~5111.46~~ 5164.62, ~~5111.51~~ 5164.67, or ~~5111.58~~ 5164.74 of the Revised Code, the department of ~~job and family services~~ health care administration or contracting agency may appoint a temporary manager subject to the continuing consent of the provider, or may apply to the common pleas court of the county in which the facility is located for such injunctive relief as is necessary for the appointment of a special master, to ensure the transfer of medicaid eligible residents to other appropriate care settings and, if applicable, the orderly closure of the facility. 32568 32569 32570 32571 32572 32573 32574 32575 32576 32577 32578

Sec. ~~5111.54~~ 5164.70. (A) A temporary manager of a nursing facility appointed by the department of ~~job and family services~~ health care administration or a contracting agency under sections 32579 32580 32581

~~5111.35~~ 5164.50 to ~~5111.62~~ 5164.78 of the Revised Code shall meet all of the following qualifications: 32582 32583

(1) Be licensed as a nursing home administrator under Chapter 4751. of the Revised Code; 32584 32585

(2) Have demonstrated competence as a nursing home administrator; 32586 32587

(3) Have had no disciplinary action taken against the temporary manager by any licensing board or professional society in this state. 32588 32589 32590

(B) The salary of a temporary manager or special master appointed under sections ~~5111.35~~ 5164.50 to ~~5111.62~~ 5164.78 of the Revised Code shall be paid by the facility and set by the department of ~~job and family services~~ health care administration or contracting agency, in the case of a temporary manager, or by the court, in the case of a special master, at a rate not to exceed the maximum allowable compensation for an administrator under the ~~medical assistance~~ medicaid program. The extent to which this compensation is allowable under the ~~medical assistance~~ medicaid program is subject to and limited by this chapter and rules of the department. 32591 32592 32593 32594 32595 32596 32597 32598 32599 32600 32601

Subject to division (C) of this section, any costs incurred on behalf of a nursing facility by a temporary manager or special master appointed under sections ~~5111.35~~ 5164.50 to ~~5111.62~~ 5164.78 of the Revised Code shall be paid by the facility. The allowability of these costs under the ~~medical assistance~~ medicaid program shall be subject to and governed by this chapter and the rules of the department. This division does not prohibit a facility from applying for or receiving any waiver of cost ceilings available under rules of the department. 32602 32603 32604 32605 32606 32607 32608 32609 32610

(C) No temporary manager or special master appointed under sections ~~5111.35~~ 5164.50 to ~~5111.62~~ 5164.78 of the Revised Code 32611 32612

shall enter into any employment contract on behalf of a facility, or purchase any capital goods using facility funds totaling more than ten thousand dollars, unless the temporary manager or special master has obtained prior approval for the contract or purchase from either the provider or the court. 32613 32614 32615 32616 32617

(D)(1) A temporary manager appointed for a nursing facility under section ~~5111.46~~ 5164.62 of the Revised Code is hereby vested, subject to division (C) of this section, with the legal authority necessary to correct any deficiency or cluster of deficiencies at a facility, bring the facility into compliance with certification requirements, and otherwise ensure the health and safety of the residents. 32618 32619 32620 32621 32622 32623 32624

(2) A temporary manager appointed under section ~~5111.51~~ 5164.67 of the Revised Code is hereby vested, subject to division (C) of this section, with the authority necessary to eliminate the emergency, bring the facility into compliance with certification requirements, and otherwise ensure the health and safety of the residents. 32625 32626 32627 32628 32629 32630

(3) A temporary manager appointed under section ~~5111.53~~ 5164.69 of the Revised Code is hereby vested, subject to division (C) of this section, with the authority necessary to ensure the transfer of medicaid eligible residents to other appropriate care settings and, if applicable, the orderly closure of the facility, and to otherwise ensure the health and safety of the residents. 32631 32632 32633 32634 32635 32636

(E) Prior to acting under division (A)(1)(b) or (2)(b) of section ~~5111.46~~ 5164.62 of the Revised Code to appoint a temporary manager or apply for a special master, the department of ~~job and family services~~ health care administration or contracting agency shall order the facility to substantially correct the deficiency or deficiencies within five days after receiving the statement and inform the facility, in the statement it provides pursuant to division (B) of section ~~5111.49~~ 5164.65 of the Revised Code, of 32637 32638 32639 32640 32641 32642 32643 32644

the order and that it will not take that action unless the facility fails to substantially correct the deficiency or deficiencies within that five-day period. At the end of the five-day period, the department of health shall conduct a follow-up survey that focuses on the deficiency or deficiencies. If the department of health determines that the facility has substantially corrected the deficiency or deficiencies within that time, the department of ~~job and family services~~ health care administration or contracting agency shall not appoint a temporary manager or apply for a special master. If the department of health determines that the facility has failed to substantially correct the deficiency or deficiencies within that time, the department of ~~job and family services~~ health care administration or contracting agency may proceed with appointment of the temporary manager or application for a special master. Until the statement required under division (B) of section ~~5111.49~~ 5164.65 of the Revised Code is actually delivered, no action taken by the department or agency to appoint a temporary manager or apply for a temporary manager under division (A)(1)(b) or (2)(b) of section ~~5111.46~~ 5164.62 of the Revised Code shall have any legal effect. No action taken by a facility under this division to substantially correct a deficiency or deficiencies shall be considered an admission by the facility of the existence of a deficiency or deficiencies.

(F) Appointment of a temporary manager under division (A)(1)(b) or (2)(b) of section ~~5111.46~~ 5164.62 or division (A)(1)(d) of section ~~5111.51~~ 5164.67 of the Revised Code shall expire at the end of the seventh day following the appointment. If the department of ~~job and family services~~ health care administration or contracting agency finds that the deficiency or deficiencies that prompted the appointment under division (A)(1)(b) or (2)(b) of section ~~5111.46~~ 5164.62 of the Revised Code cannot be substantially corrected, or the condition of immediate jeopardy that prompted the appointment under division (A)(1)(d) of

section ~~5111.51~~ 5164.67 of the Revised Code cannot be eliminated, prior to the expiration of the appointment, it may take one of the following actions: 32678 32679 32680

(1) Appoint, subject to the continuing consent of the provider, a temporary manager for the facility; 32681 32682

(2) Apply to the common pleas court of the county in which the facility is located for an order appointing a special master who, under the authority and direct supervision of the court and subject to divisions (B) and (C) of this section, may take such additional actions as are necessary to correct the deficiency or deficiencies or eliminate the condition of immediate jeopardy and bring the facility into compliance with certification requirements. 32683 32684 32685 32686 32687 32688 32689 32690

(G) The court, on finding that the deficiency or deficiencies for which a special master was appointed under division (F)(2) of this section or division (A)(1)(b) or (2)(b) of section ~~5111.46~~ 5164.62 of the Revised Code has been substantially corrected, or the emergency for which a special master was appointed under division (F)(2) of this section or division (A)(1)(b) or (B)(2) of section ~~5111.51~~ 5164.67 of the Revised Code has been eliminated, that the facility has been brought into compliance with certification requirements, and that the provider has established the management capability to ensure continued compliance with the certification requirements, shall immediately terminate its jurisdiction over the facility and return control and management of the facility to the provider. If the deficiency or deficiencies cannot be substantially corrected, or the emergency cannot be eliminated practicably within a reasonable time following appointment of the special master, the court may order the special master to close the facility and transfer all residents to other nursing facilities or other appropriate care settings. 32691 32692 32693 32694 32695 32696 32697 32698 32699 32700 32701 32702 32703 32704 32705 32706 32707 32708

Sec. ~~5111.55~~ <u>5164.71</u>. (A) An order issued under section ~~5111.46~~ <u>5164.62</u>, ~~5111.47~~ <u>5164.63</u>, ~~5111.48~~ <u>5164.64</u>, ~~5111.51~~ <u>5164.67</u>, or ~~5111.57~~ <u>5164.73</u> of the Revised Code denying payment to a nursing facility for all medicaid eligible residents admitted after its effective date, or an order issued under section ~~5111.46~~ <u>5164.62</u>, ~~5111.47~~ <u>5164.63</u>, or ~~5111.48~~ <u>5164.64</u> of the Revised Code denying payment to a nursing facility for medicaid eligible residents admitted after the effective date of the order who have specified diagnoses or special care needs, shall also apply to individuals admitted to the facility on and after the effective date of the order who are not medicaid eligible residents but become medicaid eligible residents after admission. Such an order shall not apply to any of the following: 32709 32710 32711 32712 32713 32714 32715 32716 32717 32718 32719 32720 32721

(1) An individual who was a medicaid eligible resident of the facility on the day immediately preceding the effective date of the order and continues to be a medicaid eligible resident on and after that date; 32722 32723 32724 32725

(2) An individual who was a resident of the facility on the day immediately preceding the effective date of the order, continues to be a resident on and after that date, and becomes medicaid eligible on or after that date; 32726 32727 32728 32729

(3) An individual who was a medicaid eligible resident of the facility prior to the effective date of the order, is temporarily absent from the facility on that or a subsequent date due to hospitalization or participation in therapeutic programs outside the facility, and chooses to return to the facility; 32730 32731 32732 32733 32734

(4) An individual who was a resident of the facility prior to the effective date of the order, is temporarily absent from the facility on that or a subsequent date due to hospitalization or participation in therapeutic programs outside the facility, becomes medicaid eligible on or after that date, and chooses to 32735 32736 32737 32738 32739

return to the facility. 32740

(B) An order issued under section ~~5111.46~~ 5164.62 of the Revised Code denying payment to a nursing facility for all medicaid eligible residents admitted after its effective date, or denying payment to a facility for medicaid eligible residents admitted after the effective date of the order who have specified diagnoses or special care needs shall not take effect prior to the fifth day after the order is delivered to the facility. Such an order issued under section ~~5111.47~~ 5164.63 or ~~5111.48~~ 5164.64 of the Revised Code shall not take effect prior to the twentieth day after it is delivered to the facility. 32741 32742 32743 32744 32745 32746 32747 32748 32749 32750

(C) No nursing facility that has received an order under section ~~5111.46~~ 5164.62, ~~5111.47~~ 5164.63, ~~5111.48~~ 5164.64, ~~5111.51~~ 5164.67, or ~~5111.57~~ 5164.73 of the Revised Code denying payment for all new admissions of medicaid eligible residents shall admit a medicaid eligible resident on or after the effective date of the order, unless the resident is described in division (A)(3) or (4) of this section, until the order is terminated pursuant to this section. No nursing facility that has received an order under section ~~5111.46~~ 5164.62, ~~5111.47~~ 5164.63, or ~~5111.48~~ 5164.64 of the Revised Code denying payment to a nursing facility for new admissions of medicaid eligible residents with specified diagnoses or special care needs shall admit such a resident on or after the effective date of the order, unless the resident is described in division (A)(3) or (4) of this section, until the order is terminated pursuant to this section. 32751 32752 32753 32754 32755 32756 32757 32758 32759 32760 32761 32762 32763 32764 32765

(D) In the case of an order imposed under division (B) of section ~~5111.57~~ 5164.73 of the Revised Code, the department of health care administration or contracting agency shall appoint monitors in accordance with section ~~5111.44~~ 5164.60 of the Revised Code to conduct on-site monitoring. 32766 32767 32768 32769 32770

(E)(1) A facility may give written notice to the department 32771

of health whenever any of the following apply: 32772

(a) With respect to an order denying payment issued under section ~~5111.46~~ 5164.62, ~~5111.47~~ 5164.63, or ~~5111.48~~ 5164.64 of the Revised Code, either of the following is the case: 32773 32774 32775

(i) The facility has completed implementation of the plan of correction it submitted under section ~~5111.43~~ 5164.59 of the Revised Code and substantially corrected all deficiencies for which the order was issued. 32776 32777 32778 32779

(ii) The facility has reduced the severity or scope of all of the deficiencies to a level at which sections ~~5111.46~~ 5164.62 to ~~5111.48~~ 5164.64 of the Revised Code do not authorize the order. 32780 32781 32782

(b) With respect to an order denying payment issued under section ~~5111.51~~ 5164.67 of the Revised Code, the facility has eliminated the immediate jeopardy. 32783 32784 32785

(c) With respect to an order denying payment issued under division (A) of section ~~5111.57~~ 5164.73 of the Revised Code, the facility has completed implementation of the plan of correction it submitted under section ~~5111.43~~ 5164.59 of the Revised Code and substantially corrected all deficiencies for which the order was issued. 32786 32787 32788 32789 32790 32791

(d) With respect to an order denying payment issued under division (B) of section ~~5111.57~~ 5164.73 of the Revised Code, both of the following are the case: 32792 32793 32794

(i) The facility has completed implementation of the plan of correction it submitted under section ~~5111.43~~ 5164.59 of the Revised Code and substantially corrected all deficiencies for which the order was issued. 32795 32796 32797 32798

(ii) The facility is in compliance with certification requirements and has provided adequate assurance that it will remain in compliance with them. 32799 32800 32801

(2) Within ten working days after it receives the notice under division (E)(1) of this section, the department of health shall conduct a follow-up survey that focuses on the cited deficiency or deficiencies, unless the department is able to determine, on the basis of documentation provided by the facility, that the facility has completed the applicable action described in divisions (E)(1)(a) to (d) of this section. If the department of health makes that determination on the basis of the documentation, the department of ~~job and family services~~ health care administration or contracting agency shall terminate the order denying payment as of the date the facility completed the applicable action, as subsequently verified by the department of health. If the department of health conducts a follow-up survey, the department of ~~job and family services~~ health care administration or contracting agency shall terminate the order denying payment as of the date the department of health makes the determination that the facility completed the applicable action.

(F) The department of ~~job and family services~~ health care administration or contracting agency shall provide public notice implementing an order under section ~~5111.46~~ 5164.62, ~~5111.47~~ 5164.63, ~~5111.48~~ 5164.64, ~~5111.51~~ 5164.67, or ~~5111.57~~ 5164.73 of the Revised Code denying payment to a nursing facility under the ~~medical assistance~~ medicaid program for all medicaid eligible residents by publishing in a newspaper of general circulation in the county in which the facility is located an announcement stating: "By order of the (Ohio Department of ~~Job and Family Services~~ Health Care Administration or name of contracting agency), effective on and after (effective date of order), (name of facility) is no longer authorized to admit Medicaid eligible residents." Immediately following termination of any such order, the department or agency shall publish in a newspaper of general circulation in the county in which the facility is located an announcement stating: "By order of the (Ohio Department of ~~Job and~~

Family Services Health Care Administration or name of contracting agency), effective on and after (effective date of termination), (name of facility) is hereby authorized to admit Medicaid eligible residents." Neither the department nor the contracting agency shall issue public notice of an order under section 5111.46 5164.62, 5111.47 5164.63, or 5111.48 5164.64 of the Revised Code denying payment to a nursing facility for medicaid eligible residents with specified diagnoses or special care needs; public notice is not required for such an order to take effect. 32835 32836 32837 32838 32839 32840 32841 32842 32843

(G) A facility that complies with division (E) of this section shall not be considered to have admitted to the existence of the deficiency that constitutes the basis of the department's or agency's order. 32844 32845 32846 32847

Sec. 5111.56 5164.72. (A) As used in this section, "certified beds" means beds certified under Title XVIII or XIX of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended the medicare or medicaid program. 32848 32849 32850 32851

(B) If the department of job and family services health care administration or a contracting agency imposes a fine on a nursing facility under section 5111.46 5164.62, 5111.47 5164.63, or 5111.48 5164.64 of the Revised Code, it may impose one or more of the following: 32852 32853 32854 32855 32856

(1) One hundred sixty per cent of the amount calculated under division (C) of this section for any deficiency or cluster of deficiencies that constitutes a severity level four and scope level four finding; 32857 32858 32859 32860

(2) One hundred forty per cent of the amount calculated under division (C) of this section for any deficiency or cluster of deficiencies that constitutes a severity level four and scope level three finding; 32861 32862 32863 32864

(3) One hundred twenty per cent of the amount calculated under division (C) of this section for any deficiency or cluster of deficiencies that constitutes a severity level four and scope level two finding; 32865 32866 32867 32868

(4) The amount calculated under division (C) of this section for any deficiency or cluster of deficiencies that constitutes a severity level four and scope level one finding or any deficiency or cluster of deficiencies that constitutes a severity level three and scope level four finding; 32869 32870 32871 32872 32873

(5) Ninety per cent of the amount calculated under division (C) of this section for any deficiency or cluster of deficiencies that constitutes a severity level three and scope level three finding; 32874 32875 32876 32877

(6) Eighty per cent of the amount calculated under division (C) of this section for any deficiency or cluster of deficiencies that constitutes a severity level three and scope level two finding; 32878 32879 32880 32881

(7) Seventy per cent of the amount calculated under division (C) of this section for any deficiency or cluster of deficiencies that constitutes a severity level three and scope level one finding; 32882 32883 32884 32885

(8) Fifty per cent of the amount calculated under division (C) of this section for any deficiency or cluster of deficiencies that constitutes a severity level two and scope level four finding; 32886 32887 32888 32889

(9) Forty per cent of the amount calculated under division (C) of this section for any deficiency or cluster of deficiencies that constitutes a severity level two and scope level three finding. 32890 32891 32892 32893

(C) The amount subject to division (B) of this section shall be the product of multiplying two dollars and fifty cents for each 32894 32895

day the fine is in effect by the total number of licensed nursing 32896
home beds or certified beds, whichever is greater, in the facility 32897
as of the date the deficiency or cluster of deficiencies that is 32898
the reason for the fine was cited. 32899

(D)(1) The department of ~~job and family services~~ <u>health care</u> 32900
<u>administration</u> or contracting agency shall not impose on a 32901
facility, at any one time, more than four fines as a result of any 32902
one survey. 32903

(2) The department of ~~job and family services~~ <u>health care</u> 32904
<u>administration</u> or contracting agency shall not impose more than 32905
one fine based on a deficiency or cluster of deficiencies. 32906
However, if the department of health, in a follow-up or other 32907
subsequent survey, finds a change in the scope or severity of the 32908
deficiency or cluster of deficiencies, the department of ~~job and~~ 32909
~~family services~~ <u>health care administration</u> or contracting agency 32910
may increase or decrease the fine in accordance with division (B) 32911
of this section to reflect the change in scope or severity. The 32912
department or agency shall give the facility written notice of the 32913
change in the amount of the fine. The change shall take effect on 32914
the date the follow-up or other subsequent survey is completed. 32915

If the department of health finds that a deficiency is a 32916
repeat deficiency, the department of ~~job and family services~~ 32917
<u>health care administration</u> or contracting agency may impose a fine 32918
that is one hundred per cent greater than the fine specified in 32919
division (B) of this section for the deficiency. 32920

(E) The total amount of fines the department of ~~job and~~ 32921
~~family services~~ <u>health care administration</u> or contracting agency 32922
may impose on a facility in a single calendar year shall not 32923
exceed five hundred dollars for each licensed nursing home bed or 32924
certified bed, whichever is greater in number, in the facility. 32925

(F)(1) Except as provided in division (F)(2) of this section, 32926

the department of ~~job and family services~~ <u>health care administration</u> or contracting agency shall not impose a fine under section ~~5111.46~~ <u>5164.62</u>, ~~5111.47~~ <u>5164.63</u>, or ~~5111.48~~ <u>5164.64</u> of the Revised Code if the deficiency or cluster of deficiencies is substantially corrected within twenty days after the nursing facility receives the statement provided under division (B) of section ~~5111.49~~ <u>5164.65</u> of the Revised Code. The department or agency shall inform the nursing facility in that statement that the fine will not be imposed if the deficiency or cluster of deficiencies is substantially corrected within the twenty-day period. 32927 32928 32929 32930 32931 32932 32933 32934 32935 32936 32937

(2) If a nursing facility has substantially corrected a deficiency or cluster of deficiencies within six months after the exit interview of a survey that was the basis for citing a deficiency or cluster of deficiencies, but after correcting it has been cited for the same deficiency or cluster of deficiencies by the department of health on the basis of a subsequent survey conducted during the remainder of the six-month period, the department of ~~job and family services~~ <u>health care administration</u> or contracting agency may impose a fine beginning on the date of the exit interview of the subsequent survey. 32938 32939 32940 32941 32942 32943 32944 32945 32946 32947

(G) Whenever a facility believes that it has completed implementation of the plan of correction it submitted under section ~~5111.43~~ <u>5164.59</u> of the Revised Code and substantially corrected the cited deficiency or cluster of deficiencies that is the basis for a fine, it may give written notice to that effect to the department of health. After receiving the notice, the department shall conduct a follow-up survey of the facility that focuses on the deficiency or cluster, unless the department is able to determine, on the basis of documentation provided by the facility, that the facility has substantially corrected the deficiency or cluster. If, based on the follow-up survey, the 32948 32949 32950 32951 32952 32953 32954 32955 32956 32957 32958

department establishes that the facility had not completed implementation of the plan of correction at the time the department received the notice, any fine based on the deficiency or cluster shall be doubled effective from the date the department received the notice. A facility that complies with this division shall not be considered to have admitted the existence of the deficiency or cluster that is the basis for the fine. 32959 32960 32961 32962 32963 32964 32965

(H) Except for a fine imposed under division (C) of section ~~5111.46~~ 5164.62 of the Revised Code and as provided in division (F)(2) of this section, the department of ~~job and family services~~ health care administration or contracting agency shall impose a fine only if the facility fails to give notice under division (G) of this section within twenty days after it receives the statement required by division (B) of section ~~5111.49~~ 5164.65 of the Revised Code or if the department of health determines, based on a follow-up survey, that the deficiency or cluster of deficiencies for which the fine is proposed has not been substantially corrected within the twenty-day period. The fine shall be imposed effective on the twenty-first day after the facility receives the statement under division (B) of section ~~5111.49~~ 5164.65 of the Revised Code. The fine shall remain in effect until the earliest of the following: 32966 32967 32968 32969 32970 32971 32972 32973 32974 32975 32976 32977 32978 32979 32980

(1) The date the department of health receives notice under division (G) of this section, unless the department determines, on the basis of a follow-up survey, that the deficiency or cluster of deficiencies that is the basis for the fine has not been substantially corrected as of that date; 32981 32982 32983 32984 32985

(2) The date on which the department of health makes a determination, on the basis of a follow-up survey, that the deficiency or cluster of deficiencies has been substantially corrected; 32986 32987 32988 32989

(3) The date the facility substantially corrected the 32990

deficiency or cluster, as subsequently determined by the department of health on the basis of documentation provided by the facility. 32991 32992 32993

(I) Any fine imposed by the department of ~~job and family services~~ health care administration or contracting agency under this section is subject to appeal under Chapter 119. of the Revised Code. If the facility does not request a hearing under Chapter 119. of the Revised Code and either pays or agrees in writing to pay the fine when payment becomes due under division (J) of this section, the department or agency shall reduce the fine by fifty per cent. The department or agency may compromise any claim for payment of a fine under sections ~~5111.35~~ 5164.50 to ~~5111.62~~ 5164.78 of the Revised Code. 32994 32995 32996 32997 32998 32999 33000 33001 33002 33003

(J) The department of ~~job and family services~~ health care administration or contracting agency shall collect interest on fines, at the rate per calendar month that equals one-twelfth of the rate per year prescribed by section 5703.47 of the Revised Code for the calendar year that includes the month for which the interest charge accrues. Payment of a fine is due, and interest begins to accrue on the unpaid fine or balance, on the thirty-first day after the department or agency issues a final adjudication order imposing the fine. If the deficiency or deficiencies on which the fine is based have not been corrected when the final adjudication order is issued, the payment is due, and interest begins to accrue on the unpaid fine or balance, on the thirty-first day after the deficiency or deficiencies are corrected and the department or agency mails a notice specifying the amount of the fine to the facility. 33004 33005 33006 33007 33008 33009 33010 33011 33012 33013 33014 33015 33016 33017 33018

(K) The department of ~~job and family services~~ health care administration or contracting agency shall collect fines and interest imposed under this section through one of the following means: 33019 33020 33021 33022

(1) A lump sum payment from the provider; 33023

(2) Periodic payments for a period not to exceed twelve months, in accordance with a schedule approved by the department or agency; 33024 33025 33026

(3) Appropriately reducing the amounts of payments made to the facility for care provided to medicaid eligible residents for a period not to exceed twelve months following the date on which payment of the fine becomes due under division (J) of this section. An amount equal to the amount by which each payment is reduced shall be deposited to the credit of the residents protection fund in accordance with section ~~5111.62~~ 5164.78 of the Revised Code. 33027 33028 33029 33030 33031 33032 33033 33034

Sec. ~~5111.57~~ 5164.73. (A) The department of ~~job and family services~~ health care administration or a contracting agency shall issue an order denying payment to a nursing facility for all medicaid eligible residents admitted to the facility on or after the effective date of the order, if the facility has failed to substantially correct within ninety days after the exit interview a deficiency or cluster of deficiencies in accordance with the plan of correction it submitted under section ~~5111.43~~ 5164.59 of the Revised Code, as determined by the department of health on the basis of a follow-up survey. 33035 33036 33037 33038 33039 33040 33041 33042 33043 33044

(B) The department of ~~job and family services~~ health care administration or contracting agency shall issue an order denying payment to a nursing facility for all medicaid eligible residents admitted to the facility on or after the effective date of the order, if during three consecutive standard surveys conducted after December 13, 1990, the department of health has found a condition of substandard care in a facility. 33045 33046 33047 33048 33049 33050 33051

(C) An order issued under division (A) or (B) of this section shall take effect on the later of the date the facility receives 33052 33053

the order or the date the public notice required under division (F) of section ~~5111.55~~ <u>5164.71</u> of the Revised Code is published. The order is subject to appeal under Chapter 119. of the Revised Code; however the order may take effect prior to or during the pendency of any hearing under that chapter. In that case, the department or agency shall provide the facility an opportunity for a hearing in accordance with section ~~5111.60~~ <u>5164.76</u> of the Revised Code. 33054 33055 33056 33057 33058 33059 33060 33061

Sec. ~~5111.58~~ <u>5164.74</u>. (A) If a nursing facility notifies the department of ~~job and family services~~ <u>health care administration</u> or a contracting agency, at any time during the six-month period following the exit interview of a survey that was the basis for citing a deficiency or deficiencies, that the deficiency or deficiencies have been substantially corrected in accordance with the plan of correction submitted and approved under section ~~5111.43~~ <u>5164.59</u> of the Revised Code, the department of health shall conduct a follow-up survey to determine whether the deficiency or deficiencies have been substantially corrected in accordance with the plan. 33062 33063 33064 33065 33066 33067 33068 33069 33070 33071 33072

(B) The department of ~~job and family services~~ <u>health care administration</u> or a contracting agency shall terminate a nursing facility's participation in the ~~medical assistance~~ <u>medicaid</u> program whenever the facility has not substantially corrected, within six months after the exit interview of the survey on the basis of which it was cited, a deficiency or deficiencies in accordance with the plan of correction submitted under section ~~5111.43~~ <u>5164.59</u> of the Revised Code, as determined by the department of health on the basis of a follow-up survey. 33073 33074 33075 33076 33077 33078 33079 33080 33081

(C) Unless the facility has substantially corrected the deficiency or deficiencies in accordance with the plan of correction, as determined by the department of health on the basis 33082 33083 33084

of a follow-up survey, the department of ~~job and family services~~ health care administration or contracting agency shall deliver to the facility, at least thirty days prior to the day that is six months after the exit interview, a written order terminating the facility's participation in the ~~medical assistance~~ medicaid program. The order shall take effect and the facility's participation shall terminate on the day that is six months after the exit interview. The order shall not take effect if, after it is delivered to the facility and prior to the effective date of the order, the department of health determines on the basis of a follow-up survey that the facility has corrected the deficiency or deficiencies. 33085 33086 33087 33088 33089 33090 33091 33092 33093 33094 33095 33096

An order issued under this section is subject to appeal under Chapter 119. of the Revised Code; however, the order may take effect prior to or during the pendency of any hearing under that chapter. In that case, the department of ~~job and family services~~ health care administration or contracting agency shall provide the facility an opportunity for a hearing in accordance with section ~~5111.60~~ 5164.76 of the Revised Code. 33097 33098 33099 33100 33101 33102 33103

(D) Except as provided in division (E) of this section, whenever the department of ~~job and family services~~ health care administration or a contracting agency terminates a facility's participation in the ~~medical assistance~~ medicaid program pursuant to this section, the provider shall repay the department the federal share of all payments made by the department to the facility under the ~~medical assistance~~ medicaid program during the six-month period following the exit interview of the survey that was the basis for citing the deficiency or cluster of deficiencies. The provider shall repay the department within thirty days after the department repays to the federal government the federal share of payments made to the facility during that six-month period. 33104 33105 33106 33107 33108 33109 33110 33111 33112 33113 33114 33115 33116

(E) A provider is not required to repay the department of ~~job~~ 33117
~~and family services~~ health care administration if either of the 33118
following is the case: 33119

(1) The facility has brought an appeal under Chapter 119. of 33120
the Revised Code of termination of its participation in the 33121
~~medical assistance~~ medicaid program, except that the provider 33122
shall repay the department of ~~job and family services~~ health care 33123
administration within thirty days after the facility exhausts its 33124
right to appeal under that chapter. 33125

(2) The facility complied with the plan of correction 33126
approved by the department of health and the obligation to repay 33127
resulted from the department's failure to provide timely 33128
verification to the United States department of health and human 33129
services of the facility's compliance with the plan of correction. 33130

(F) If a provider's obligation to repay the department of ~~job~~ 33131
~~and family services~~ health care administration under division (D) 33132
of this section results from disallowance of federal financial 33133
participation by the United States department of health and human 33134
services, the provider shall not be required to repay the 33135
department of ~~job and family services~~ health care administration 33136
until the federal disallowance becomes final. 33137

(G) Any fines paid under sections ~~5111.35~~ 5164.50 to ~~5111.62~~ 33138
5164.78 of the Revised Code during any period for which the 33139
facility is required to repay the department of ~~job and family~~ 33140
~~services~~ health care administration under division (D) of this 33141
section shall be offset against the amount the provider is 33142
required to repay the department for that period. 33143

(H) Prior to a change of ownership of a facility for which a 33144
provider has an obligation to repay the department of ~~job and~~ 33145
~~family services~~ health care administration under division (D) of 33146
this section that has not become final, or has become final but 33147

not been paid, the department may do one or more of the following: 33148

(1) Require the provider to place money in escrow, or obtain a bond, in sufficient amount to indemnify the state against the provider's failure to repay the department after the change of ownership occurs; 33149 33150 33151 33152

(2) Place a lien on the facility's real property; 33153

(3) Use any method to recover the payments that is available to the attorney general to recover payments on behalf of the department of ~~job and family services~~ <u>health care administration</u>. 33154 33155 33156

Sec. ~~5111.59~~ <u>5164.75</u>. The department of ~~job and family services~~ <u>health care administration</u>, the department of health, and any contracting agency shall deliver a written notice, statement, or order to a nursing facility under sections ~~5111.35~~ <u>5164.50</u> to ~~5111.41~~ <u>5164.56</u> and ~~5111.43~~ <u>5164.59</u> to ~~5111.62~~ <u>5164.78</u> of the Revised Code by certified mail or hand delivery. If the notice, statement, or order is mailed, it shall be addressed to the administrator of the facility as indicated in the department's or agency's records. If it is hand delivered, it shall be delivered to a person at the facility who would appear to the average prudent person to have authority to accept it. 33157 33158 33159 33160 33161 33162 33163 33164 33165 33166 33167

Delivery of written notice by a nursing facility to the department of health, the department of ~~job and family services~~ <u>health care administration</u>, or a contracting agency under sections ~~5111.35~~ <u>5164.50</u> to ~~5111.62~~ <u>5164.78</u> of the Revised Code shall be by certified mail or hand delivery to the appropriate department or the agency. 33168 33169 33170 33171 33172 33173

Sec. ~~5111.60~~ <u>5164.76</u>. (A) Except as provided in division (B) of this section, the following remedies are subject to appeal under Chapter 119. of the Revised Code: 33174 33175 33176

(1) An order issued under section ~~5111.45~~ <u>5164.61</u>, ~~5111.46~~ 33177

5164.62, ~~5111.51~~ 5164.67, or ~~5111.58~~ 5164.74 of the Revised Code 33178
terminating a nursing facility's participation in the ~~medical~~ 33179
~~assistance~~ medicaid program; 33180

(2) Appointment of a temporary manager of a facility under 33181
division (A)(1)(b) or (2)(b) of section ~~5111.46~~ 5164.62, or 33182
division (A)(1)(d) of section ~~5111.51~~ 5164.67 of the Revised Code; 33183

(3) An order issued under section ~~5111.46~~ 5164.62, ~~5111.47~~ 33184
5164.63, ~~5111.48~~ 5164.64, ~~5111.51~~ 5164.67, or ~~5111.57~~ 5164.73 of 33185
the Revised Code denying payment to a facility under the ~~medical~~ 33186
~~assistance~~ medicaid program for all medicaid eligible residents 33187
admitted after the effective date of the order; 33188

(4) An order issued under section ~~5111.46~~ 5164.62, ~~5111.47~~ 33189
5164.63, or ~~5111.48~~ 5164.64 of the Revised Code denying payment to 33190
a facility under the ~~medical assistance~~ medicaid program for 33191
medicaid eligible residents admitted after the effective date of 33192
the order who have certain diagnoses or special care needs 33193
specified by the department or agency; 33194

(5) A fine imposed under section ~~5111.46~~ 5164.62, ~~5111.47~~ 33195
5164.63, or ~~5111.48~~ 5164.64 of the Revised Code. 33196

(B) The department of ~~job and family services~~ health care 33197
administration or contracting agency may do any of the following 33198
prior to or during the pendency of any proceeding under Chapter 33199
119. of the Revised Code: 33200

(1) Issue and execute an order under section ~~5111.46~~ 5164.62, 33201
~~5111.51~~ 5164.67, or ~~5111.58~~ 5164.74 of the Revised Code 33202
terminating a nursing facility's participation in the ~~medical~~ 33203
~~assistance~~ medicaid program; 33204

(2) Appoint a temporary manager under division (A)(1)(b) or 33205
(2)(b) of section ~~5111.46~~ 5164.62 or division (A)(1)(d) of section 33206
~~5111.51~~ 5164.67 of the Revised Code; 33207

(3) Issue and execute an order under section ~~5111.46~~ 5164.62, ~~5111.47~~ 5164.63, ~~5111.51~~ 5164.67, or ~~5111.57~~ 5164.73 of the Revised Code denying payment to a facility for all medicaid eligible residents admitted after the effective date of the order;

(4) Issue and execute an order under section ~~5111.46~~ 5164.62 or ~~5111.47~~ 5164.63 or division (A), (B), or (C) of section ~~5111.48~~ 5164.64 of the Revised Code denying payment to a facility for medicaid eligible residents admitted after the effective date of the order who have specified diagnoses or special care needs.

(C) Whenever the department or agency imposes a remedy listed in division (B) of this section prior to or during the pendency of a proceeding, all of the following apply:

(1) The provider against whom the action is taken shall have ten days after the date the facility actually receives the notice specified in section 119.07 of the Revised Code to request a hearing.

(2) The hearing shall commence within thirty days after the date the department or agency receives the provider's request for a hearing.

(3) The hearing shall continue uninterrupted from day to day, except for Saturdays, Sundays, and legal holidays, unless other interruptions are agreed to by the provider and the department or agency.

(4) If the hearing is conducted by a hearing examiner, the hearing examiner shall file a report and recommendations within ten days after the close of the hearing.

(5) The provider shall have five days after the date the hearing officer files the report and recommendations within which to file objections to the report and recommendations.

(6) Not later than fifteen days after the date the hearing

officer files the report and recommendations, the director of ~~job and family services~~ health care administration or the director of the contracting agency shall issue an order approving, modifying, or disapproving the report and recommendations of the hearing examiner. 33238 33239 33240 33241 33242

(D) If the department or agency imposes more than one remedy as the result of deficiencies cited in a single survey, the proceedings for all of the remedies shall be consolidated. If any of the remedies are imposed during the pendency of a hearing, as permitted by division (B) of this section, the consolidated hearing shall be conducted in accordance with division (C) of this section. The consolidation of the remedies for purposes of a hearing does not affect the effective dates prescribed in sections ~~5111.35~~ 5164.50 to ~~5111.58~~ 5164.74 of the Revised Code. 33243 33244 33245 33246 33247 33248 33249 33250 33251

(E) If a contracting agency conducts administrative proceedings pertaining to remedies imposed under sections ~~5111.35~~ 5164.50 to ~~5111.62~~ 5164.78 of the Revised Code, the department of ~~job and family services~~ health care administration shall not be considered a party to the proceedings. 33252 33253 33254 33255 33256

Sec. ~~5111.61~~ 5164.77. (A)(1) Except as required by court order, as necessary for the administration or enforcement of any statute relating to nursing facilities, or as provided in division (C) of this section, the department of ~~job and family services~~ health care administration and any contracting agency shall not release any of the following information without the permission of the individual or the individual's legal representative: 33257 33258 33259 33260 33261 33262 33263

(a) The identity of any resident of a nursing facility; 33264

(b) The identity of any individual who submits a complaint about a nursing facility; 33265 33266

(c) The identity of any individual who provides the 33267

department or agency with information about a nursing facility and has requested confidentiality; 33268 33269

(d) Any information that reasonably would tend to disclose the identity of any individual described in division (A)(1)(a) to (c) of this section. 33270 33271 33272

(2) An agency or individual to whom the department or contracting agency is required, by court order or for the administration or enforcement of a statute relating to nursing facilities, to release information described in division (A)(1) of this section shall not release the information without the permission of the individual who would be or would reasonably tend to be identified, or of the individual's legal representative, unless the agency or individual is required to release it by division (C) of this section, by court order, or for the administration or enforcement of a statute relating to nursing facilities. 33273 33274 33275 33276 33277 33278 33279 33280 33281 33282 33283

(B) Except as provided in division (C) of this section, any record that identifies an individual described in division (A)(1) of this section or that reasonably would tend to identify such an individual is not a public record for the purposes of section 149.43 of the Revised Code, and is not subject to inspection and copying under section 1347.08 of the Revised Code. 33284 33285 33286 33287 33288 33289

(C) If the department or a contracting agency, or an agency or individual to whom the department or contracting agency was required by court order or for administration or enforcement of a statute relating to nursing facilities to release information described in division (A)(1) of this section, uses information in any administrative or judicial proceeding against a facility that reasonably would tend to identify an individual described in division (A)(1) of this section, the department, agency, or individual shall disclose that information to the facility. However, the department, agency, or individual shall not disclose 33290 33291 33292 33293 33294 33295 33296 33297 33298 33299

information that directly identifies an individual described in divisions (A)(1)(a) to (c) of this section, unless the individual is to testify in the proceedings. 33300 33301 33302

(D) No person shall knowingly register a false complaint about a nursing facility with the department or a contracting agency, or knowingly swear or affirm the truth of a false complaint, when the allegation is made for the purpose of incriminating another. 33303 33304 33305 33306 33307

Sec. ~~5111.62~~ 5164.78. The proceeds of all fines, including interest, collected under sections ~~5111.35~~ 5164.50 to ~~5111.62~~ 5164.78 of the Revised Code shall be deposited in the state treasury to the credit of the residents protection fund, which is hereby created. The proceeds of all fines, including interest, collected under section 173.42 of the Revised Code shall be deposited in the state treasury to the credit of the residents protection fund. 33308 33309 33310 33311 33312 33313 33314 33315

Moneys in the fund shall be used for the protection of the health or property of residents of nursing facilities in which the department of health finds deficiencies, including payment for the costs of relocation of residents to other facilities, maintenance of operation of a facility pending correction of deficiencies or closure, and reimbursement of residents for the loss of money managed by the facility under section 3721.15 of the Revised Code. 33316 33317 33318 33319 33320 33321 33322

The fund shall be maintained and administered by the department of ~~job and family services~~ health care administration under rules developed in consultation with the departments of health and aging and adopted by the director of ~~job and family services~~ health care administration under Chapter 119. of the Revised Code. 33323 33324 33325 33326 33327 33328

Sec. ~~5111.63~~ 5164.79. For the purposes of this section, 33329

"facility~~,~~" ~~"medicare," and "medicaid" have~~ has the same ~~meanings~~ meaning as in section 3721.10 of the Revised Code. 33330 33331

The department of health shall be the designee of the department of ~~job and family services~~ health care administration for the purpose of conducting a hearing pursuant to section 3721.162 of the Revised Code concerning a facility's decision to transfer or discharge a resident if the resident is a medicaid recipient or medicare beneficiary. 33332 33333 33334 33335 33336 33337

Sec. ~~5111.65~~ 5164.82. As used in sections ~~5111.65~~ 5164.82 to ~~5111.688~~ 5164.858 of the Revised Code: 33338 33339

(A) "Change of operator" means an entering operator becoming the operator of a nursing facility or intermediate care facility for the mentally retarded in the place of the exiting operator. 33340 33341 33342

(1) Actions that constitute a change of operator include the following: 33343 33344

(a) A change in an exiting operator's form of legal organization, including the formation of a partnership or corporation from a sole proprietorship; 33345 33346 33347

(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; 33348 33349 33350 33351 33352

(c) A lease of the facility to the entering operator or the exiting operator's termination of the exiting operator's lease; 33353 33354

(d) If the exiting operator is a partnership, dissolution of the partnership; 33355 33356

(e) If the exiting operator is a partnership, a change in composition of the partnership unless both of the following apply: 33357 33358

(i) The change in composition does not cause the partnership's dissolution under state law. 33359 33360

(ii) The partners agree that the change in composition does not constitute a change in operator. 33361 33362

(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. 33363 33364 33365 33366

(2) The following, alone, do not constitute a change of operator: 33367 33368

(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; 33369 33370 33371 33372

(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; 33373 33374 33375 33376 33377

(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. 33378 33379 33380 33381

(B) "Effective date of a change of operator" means the day the entering operator becomes the operator of the nursing facility or intermediate care facility for the mentally retarded. 33382 33383 33384

(C) "Effective date of a facility closure" means the last day that the last of the residents of the nursing facility or intermediate care facility for the mentally retarded resides in the facility. 33385 33386 33387 33388

(D) "Effective date of a voluntary termination" means the day the intermediate care facility for the mentally retarded ceases to accept medicaid patients. 33389 33390 33391

(E) "Effective date of a voluntary withdrawal of participation" means the day the nursing facility ceases to accept new medicaid patients other than the individuals who reside in the nursing facility on the day before the effective date of the voluntary withdrawal of participation. 33392 33393 33394 33395 33396

(F) "Entering operator" means the person or government entity that will become the operator of a nursing facility or intermediate care facility for the mentally retarded when a change of operator occurs. 33397 33398 33399 33400

(G) "Exiting operator" means any of the following: 33401

(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; 33402 33403 33404

(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; 33405 33406 33407

(3) An operator of an intermediate care facility for the mentally retarded that is undergoing or has undergone a voluntary termination; 33408 33409 33410

(4) An operator of a nursing facility that is undergoing or has undergone a voluntary withdrawal of participation. 33411 33412

(H)(1) "Facility closure" means discontinuance of the use of the building, or part of the building, that houses the facility as a nursing facility or intermediate care facility for the mentally retarded that results in the relocation of all of the facility's residents. A facility closure occurs regardless of any of the following: 33413 33414 33415 33416 33417 33418

(a) The operator completely or partially replacing the 33419
facility by constructing a new facility or transferring the 33420
facility's license to another facility; 33421

(b) The facility's residents relocating to another of the 33422
operator's facilities; 33423

(c) Any action the department of health takes regarding the 33424
facility's certification ~~under Title XIX of the "Social Security~~ 33425
~~Act," 79 Stat. 286 (1965), 42 U.S.C. 1396, as amended,~~ for 33426
participation in the medicaid program that may result in the 33427
transfer of part of the facility's survey findings to another of 33428
the operator's facilities; 33429

(d) Any action the department of health takes regarding the 33430
facility's license under Chapter 3721. of the Revised Code; 33431

(e) Any action the department of mental retardation and 33432
developmental disabilities takes regarding the facility's license 33433
under section 5123.19 of the Revised Code. 33434

(2) A facility closure does not occur if all of the 33435
facility's residents are relocated due to an emergency evacuation 33436
and one or more of the residents return to a medicaid-certified 33437
bed in the facility not later than thirty days after the 33438
evacuation occurs. 33439

(I) "Fiscal year," "intermediate care facility for the 33440
mentally retarded," "nursing facility," "operator," "owner," and 33441
"provider agreement" have the same meanings as in section ~~5111.20~~ 33442
5164.01 of the Revised Code. 33443

(J) "Voluntary termination" means an operator's voluntary 33444
election to terminate the participation of an intermediate care 33445
facility for the mentally retarded in the medicaid program but to 33446
continue to provide service of the type provided by a residential 33447
facility as defined in section 5123.19 of the Revised Code. 33448

(K) "Voluntary withdrawal of participation" means an operator's voluntary election to terminate the participation of a nursing facility in the medicaid program but to continue to provide service of the type provided by a nursing facility. 33449 33450 33451 33452

Sec. ~~5111.651~~ 5164.821. Sections ~~5111.65~~ 5164.82 to ~~5111.688~~ 5164.858 of the Revised Code do not apply to a nursing facility or intermediate care facility for the mentally retarded that undergoes a facility closure, voluntary termination, voluntary withdrawal of participation, or change of operator on or before September 30, 2005, if the exiting operator provided written notice of the facility closure, voluntary termination, voluntary withdrawal of participation, or change of operator to the department of job and family services on or before June 30, 2005. 33453 33454 33455 33456 33457 33458 33459 33460 33461

Sec. ~~5111.66~~ 5164.83. An exiting operator or owner of a nursing facility or intermediate care facility for the mentally retarded participating in the medicaid program shall provide the department of ~~job and family services~~ health care administration written notice of a facility closure, voluntary termination, or voluntary withdrawal of participation not less than ninety days before the effective date of the facility closure, voluntary termination, or voluntary withdrawal of participation. The written notice shall include all of the following: 33462 33463 33464 33465 33466 33467 33468 33469 33470

(A) The name of the exiting operator and, if any, the exiting operator's authorized agent; 33471 33472

(B) The name of the nursing facility or intermediate care facility for the mentally retarded that is the subject of the written notice; 33473 33474 33475

(C) The exiting operator's medicaid provider agreement number for the facility that is the subject of the written notice; 33476 33477

(D) The effective date of the facility closure, voluntary 33478

termination, or voluntary withdrawal of participation; 33479

(E) The signature of the exiting operator's or owner's representative. 33480 33481

Sec. ~~5111.67~~ 5164.84. (A) An exiting operator or owner and entering operator shall provide the department of ~~job and family services~~ health care administration written notice of a change of operator if the nursing facility or intermediate care facility for the mentally retarded participates in the medicaid program and the entering operator seeks to continue the facility's participation. The written notice shall be provided to the department not later than forty-five days before the effective date of the change of operator if the change of operator does not entail the relocation of residents. The written notice shall be provided to the department not later than ninety days before the effective date of the change of operator if the change of operator entails the relocation of residents. The written notice shall include all of the following: 33482 33483 33484 33485 33486 33487 33488 33489 33490 33491 33492 33493 33494 33495

(1) The name of the exiting operator and, if any, the exiting operator's authorized agent; 33496 33497

(2) The name of the nursing facility or intermediate care facility for the mentally retarded that is the subject of the change of operator; 33498 33499 33500

(3) The exiting operator's medicaid provider agreement number for the facility that is the subject of the change of operator; 33501 33502

(4) The name of the entering operator; 33503

(5) The effective date of the change of operator; 33504

(6) The manner in which the entering operator becomes the facility's operator, including through sale, lease, merger, or other action; 33505 33506 33507

(7) If the manner in which the entering operator becomes the 33508

facility's operator involves more than one step, a description of 33509
each step; 33510

(8) Written authorization from the exiting operator or owner 33511
and entering operator for the department to process a provider 33512
agreement for the entering operator; 33513

(9) The signature of the exiting operator's or owner's 33514
representative. 33515

(B) The entering operator shall include a completed 33516
application for a provider agreement with the written notice to 33517
the department. The entering operator shall attach to the 33518
application the following: 33519

(1) If the written notice is provided to the department 33520
before the date the exiting operator or owner and entering 33521
operator complete the transaction for the change of operator, all 33522
the proposed leases, management agreements, merger agreements and 33523
supporting documents, and sales contracts and supporting documents 33524
relating to the facility's change of operator; 33525

(2) If the written notice is provided to the department on or 33526
after the date the exiting operator or owner and entering operator 33527
complete the transaction for the change of operator, copies of all 33528
the executed leases, management agreements, merger agreements and 33529
supporting documents, and sales contracts and supporting documents 33530
relating to the facility's change of operator. 33531

Sec. ~~5111.671~~ 5164.841. The department of ~~job and family~~ 33532
~~services~~ health care administration may enter into a provider 33533
agreement with an entering operator that goes into effect at 12:01 33534
a.m. on the effective date of the change of operator if all of the 33535
following requirements are met: 33536

(A) The department receives a properly completed written 33537
notice required by section ~~5111.67~~ 5164.84 of the Revised Code on 33538

or before the date required by that section. 33539

(B) The entering operator furnishes to the department copies of all the fully executed leases, management agreements, merger agreements and supporting documents, and sales contracts and supporting documents relating to the change of operator not later than ten days after the effective date of the change of operator. 33540 33541 33542 33543 33544

(C) The entering operator is eligible for medicaid payments as provided in section ~~5111.21~~ 5164.02 of the Revised Code. 33545 33546

Sec. ~~5111.672~~ 5164.842. (A) The department of ~~job and family services~~ health care administration may enter into a provider agreement with an entering operator that goes into effect at 12:01 a.m. on the date determined under division (B) of this section if all of the following are the case: 33547 33548 33549 33550 33551

(1) The department receives a properly completed written notice required by section ~~5111.67~~ 5164.84 of the Revised Code. 33552 33553

(2) The entering operator furnishes to the department copies of all the fully executed leases, management agreements, merger agreements and supporting documents, and sales contracts and supporting documents relating to the change of operator. 33554 33555 33556 33557

(3) The requirement of division (A)(1) of this section is met after the time required by section ~~5111.67~~ 5164.84 of the Revised Code, the requirement of division (A)(2) of this section is met more than ten days after the effective date of the change of operator, or both. 33558 33559 33560 33561 33562

(4) The entering operator is eligible for medicaid payments as provided in section ~~5111.21~~ 5164.02 of the Revised Code. 33563 33564

(B) The department shall determine the date a provider agreement entered into under this section is to go into effect as follows: 33565 33566 33567

(1) The effective date shall give the department sufficient 33568

time to process the change of operator, assure no duplicate payments are made, make the withholding required by section ~~5111.681~~ <u>5164.851</u> of the Revised Code, and withhold the final payment to the exiting operator until one hundred eighty days after either of the following: 33569 33570 33571 33572 33573

(a) The date that the exiting operator submits to the department a properly completed cost report under section ~~5111.682~~ <u>5164.852</u> of the Revised Code; 33574 33575 33576

(b) The date that the department waives the cost report requirement of section ~~5111.682~~ <u>5164.852</u> of the Revised Code. 33577 33578

(2) The effective date shall be not earlier than the later of the effective date of the change of operator or the date that the exiting operator or owner and entering operator comply with section ~~5111.67~~ <u>5164.84</u> of the Revised Code. 33579 33580 33581 33582

(3) The effective date shall be not later than the following after the later of the dates specified in division (B)(2) of this section: 33583 33584 33585

(a) Forty-five days if the change of operator does not entail the relocation of residents; 33586 33587

(b) Ninety days if the change of operator entails the relocation of residents. 33588 33589

Sec. ~~5111.673~~ <u>5164.843</u>. A provider that enters into a provider agreement with the department of ~~job and family services~~ <u>health care administration</u> under section ~~5111.671~~ <u>5164.841</u> or ~~5111.672~~ <u>5164.842</u> of the Revised Code shall do all of the following: 33590 33591 33592 33593 33594

(A) Comply with all applicable federal statutes and regulations; 33595 33596

(B) Comply with section ~~5111.22~~ <u>5164.03</u> of the Revised Code and all other applicable state statutes and rules; 33597 33598

(C) Comply with all the terms and conditions of the exiting operator's provider agreement, including, but not limited to, all of the following: 33599 33600 33601

(1) Any plan of correction; 33602

(2) Compliance with health and safety standards; 33603

(3) Compliance with the ownership and financial interest disclosure requirements of 42 C.F.R. 455.104, 455.105, and 1002.3; 33604 33605

(4) Compliance with the civil rights requirements of 45 C.F.R. parts 80, 84, and 90; 33606 33607

(5) Compliance with additional requirements imposed by the department; 33608 33609

(6) Any sanctions relating to remedies for violation of the provider agreement, including deficiencies, compliance periods, accountability periods, monetary penalties, notification for correction of contract violations, and history of deficiencies. 33610 33611 33612 33613

Sec. ~~5111.674~~ 5164.844. In the case of a change of operator, the exiting operator shall be considered to be the operator of the nursing facility or intermediate care facility for the mentally retarded for purposes of the medicaid program, including medicaid payments, until the effective date of the entering operator's provider agreement if the provider agreement is entered into under section ~~5111.671~~ 5164.841 or ~~5111.672~~ 5164.842 of the Revised Code. 33614 33615 33616 33617 33618 33619 33620 33621

Sec. ~~5111.675~~ 5164.845. The department of ~~job and family services~~ health care administration may enter into a provider agreement as provided in section ~~5111.22~~ 5164.03 of the Revised Code, rather than section ~~5111.671~~ 5164.841 or ~~5111.672~~ 5164.842 of the Revised Code, with an entering operator if the entering operator does not agree to a provider agreement that satisfies the 33622 33623 33624 33625 33626 33627

requirements of division (C) of section ~~5111.673~~ 5164.843 of the Revised Code. The department may not enter into the provider agreement unless the department of health certifies the nursing facility or intermediate care facility for the mentally retarded ~~under Title XIX of the "Social Security Act," 79 Stat. 286 (1965), 42 U.S.C. 1396, as amended~~ for participation in the medicaid program. The effective date of the provider agreement shall not precede any of the following: 33628 33629 33630 33631 33632 33633 33634 33635

(A) The date that the department of health certifies the facility; 33636 33637

(B) The effective date of the change of operator; 33638

(C) The date the requirement of section ~~5111.67~~ 5164.84 of the Revised Code is satisfied. 33639 33640

Sec. ~~5111.676~~ 5164.846. The director of ~~job and family services~~ health care administration may adopt rules in accordance with Chapter 119. of the Revised Code governing adjustments to the medicaid reimbursement rate for a nursing facility or intermediate care facility for the mentally retarded that undergoes a change of operator. No rate adjustment resulting from a change of operator shall be effective before the effective date of the entering operator's provider agreement. This is the case regardless of whether the provider agreement is entered into under section ~~5111.671~~ 5164.841, section ~~5111.672~~ 5164.842, or, pursuant to section ~~5111.675~~ 5164.845, section ~~5111.22~~ 5164.03 of the Revised Code. 33641 33642 33643 33644 33645 33646 33647 33648 33649 33650 33651 33652

Sec. ~~5111.677~~ 5164.847. Neither of the following shall affect the department of ~~job and family services'~~ health care administration's determination of whether or when a change of operator occurs or the effective date of an entering operator's provider agreement under section ~~5111.671~~ 5164.841, section 33653 33654 33655 33656 33657

~~5111.672~~ 5164.842, or, pursuant to section ~~5111.675~~ 5164.845, section ~~5111.22~~ 5164.03 of the Revised Code: 33658 33659

(A) The department of health's determination that a change of operator has or has not occurred for purposes of licensure under Chapter 3721. of the Revised Code; 33660 33661 33662

(B) The department of mental retardation and developmental disabilities' determination that a change of operator has or has not occurred for purposes of licensure under section 5123.19 of the Revised Code. 33663 33664 33665 33666

Sec. ~~5111.68~~ 5164.85. (A) On receipt of a written notice under section ~~5111.66~~ 5164.83 of the Revised Code of a facility closure, voluntary termination, or voluntary withdrawal of participation or a written notice under section ~~5111.67~~ 5164.84 of the Revised Code of a change of operator, the department of ~~job and family services~~ health care administration shall determine the amount of any overpayments made under the medicaid program to the exiting operator, including overpayments the exiting operator disputes, and other actual and potential debts the exiting operator owes or may owe to the department and United States centers for medicare and medicaid services under the medicaid program. In determining the exiting operator's other actual and potential debts to the department under the medicaid program, the department shall include all of the following that the department determines is applicable: 33667 33668 33669 33670 33671 33672 33673 33674 33675 33676 33677 33678 33679 33680 33681

(1) Refunds due the department under section ~~5111.27~~ 5164.38 of the Revised Code; 33682 33683

(2) Interest owed to the department and United States centers for medicare and medicaid services; 33684 33685

(3) Final civil monetary and other penalties for which all right of appeal has been exhausted; 33686 33687

(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. 33688 33689 33690 33691 33692

(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. 33693 33694 33695 33696 33697 33698 33699 33700 33701

Sec. ~~5111.681~~ 5164.851. (A) Except as provided in division (B) of this section, the department of ~~job and family services~~ health care administration shall withhold the greater of the following from payment due an exiting operator under the medicaid program: 33702 33703 33704 33705 33706

(1) The total amount of any overpayments made under the medicaid program to the exiting operator, including overpayments the exiting operator disputes, and other actual and potential debts, including any unpaid penalties, the exiting operator owes or may owe to the department and United States centers for medicare and medicaid services under the medicaid program; 33707 33708 33709 33710 33711 33712

(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. 33713 33714 33715 33716 33717 33718

(B) The department may choose not to make the withholding under division (A) of this section if an entering operator does both of the following: 33719 33720 33721

(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; 33722 33723 33724

(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. 33725 33726 33727

Sec. ~~5111.682~~ 5164.852. (A) Except as provided in division (B) of this section, an exiting operator shall file with the department of ~~job and family services~~ health care administration a cost report not later than ninety days after the last day the exiting operator's provider agreement is in effect or, in the case of a voluntary withdrawal of participation, the effective date of the voluntary withdrawal of participation. The cost report shall cover the period that begins with the day after the last day covered by the operator's most recent previous cost report required by section ~~5111.26~~ 5164.37 of the Revised Code and ends on the last day the exiting operator's provider agreement is in effect or, in the case of a voluntary withdrawal of participation, the effective date of the voluntary withdrawal of participation. The cost report shall include, as applicable, all of the following: 33728 33729 33730 33731 33732 33733 33734 33735 33736 33737 33738 33739 33740 33741 33742

(1) The sale price of the nursing facility or intermediate care facility for the mentally retarded; 33743 33744

(2) A final depreciation schedule that shows which assets are transferred to the buyer and which assets are not transferred to the buyer; 33745 33746 33747

(3) Any other information the department requires. 33748

(B) The department, at its sole discretion, may waive the requirement that an exiting operator file a cost report in accordance with division (A) of this section. 33749 33750 33751

Sec. ~~5111.683~~ 5164.853. If an exiting operator required by section ~~5111.682~~ 5164.852 of the Revised Code to file a cost report with the department of ~~job and family services~~ health care administration fails to file the cost report in accordance with that section, all payments under the medicaid program for the period the cost report is required to cover are deemed overpayments until the date the department receives the properly completed cost report. The department may impose on the exiting operator a penalty of one hundred dollars for each calendar day the properly completed cost report is late. 33752 33753 33754 33755 33756 33757 33758 33759 33760 33761

Sec. ~~5111.684~~ 5164.854. The department of ~~job and family services~~ health care administration may not provide an exiting operator final payment under the medicaid program until the department receives all properly completed cost reports the exiting operator is required to file under sections ~~5111.26~~ 5164.37 and ~~5111.682~~ 5164.852 of the Revised Code. 33762 33763 33764 33765 33766 33767

Sec. ~~5111.685~~ 5164.855. The department of ~~job and family services~~ health care administration shall determine the actual amount of debt an exiting operator owes the department under the medicaid program by completing all final fiscal audits not already completed and performing all other appropriate actions the department determines to be necessary. The department shall issue a debt summary report on this matter not later than ninety days after the date the exiting operator files the properly completed cost report required by section ~~5111.682~~ 5164.852 of the Revised Code with the department or, if the department waives the cost report requirement for the exiting operator, ninety days after the 33768 33769 33770 33771 33772 33773 33774 33775 33776 33777 33778

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~~ <u>5164.032</u> of the Revised Code are subject to an adjudication conducted in accordance with Chapter 119. of the Revised Code.

Sec. ~~5111.686~~ <u>5164.856</u>. The department of ~~job and family services~~ <u>health care administration</u> shall release the actual amount withheld under division (A) of section ~~5111.681~~ <u>5164.851</u> 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~~ <u>5164.852</u> of the Revised Code unless the department issues the report required by section ~~5111.685~~ <u>5164.855</u> of the Revised Code not later than ninety days after the date the exiting operator files the properly completed cost report;

(B) Not later than thirty days after the exiting operator agrees to a final fiscal audit resulting from the report required by section ~~5111.685~~ <u>5164.855</u> of the Revised Code if the department issues the report not later than ninety days after the date the exiting operator files a properly completed cost report required by section ~~5111.682~~ <u>5164.852</u> of the Revised Code;

(C) Ninety-one days after the date the department waives the cost report requirement of section ~~5111.682~~ <u>5164.852</u> of the Revised Code unless the department issues the report required by section ~~5111.685~~ <u>5164.855</u> of the Revised Code not later than ninety days after the date the department waives the cost report

requirement; 33810

(D) Not later than thirty days after the exiting operator agrees to a final fiscal audit resulting from the report required by section ~~5111.685~~ 5164.855 of the Revised Code if the department issues the report not later than ninety days after the date the department waives the cost report requirement of section ~~5111.682~~ 5164.852 of the Revised Code. 33811 33812 33813 33814 33815 33816

Sec. ~~5111.687~~ 5164.857. The department of ~~job and family services~~ health care administration, at its sole discretion, may release the amount withheld under division (A) of section ~~5111.681~~ 5164.851 of the Revised Code if the exiting operator submits to the department written notice of a postponement of a change of operator, facility closure, voluntary termination, or voluntary withdrawal of participation and the transactions leading to the change of operator, facility closure, voluntary termination, or voluntary withdrawal of participation are postponed for at least thirty days but less than ninety days after the date originally proposed for the change of operator, facility closure, voluntary termination, or voluntary withdrawal of participation as reported in the written notice required by section ~~5111.66~~ 5164.83 or ~~5111.67~~ 5164.84 of the Revised Code. The department shall release the amount withheld if the exiting operator submits to the department written notice of a cancellation or postponement of a change of operator, facility closure, voluntary termination, or voluntary withdrawal of participation and the transactions leading to the change of operator, facility closure, voluntary termination, or voluntary withdrawal of participation are canceled or postponed for more than ninety days after the date originally proposed for the change of operator, facility closure, voluntary termination, or voluntary withdrawal of participation as reported in the written notice required by section ~~5111.66~~ 5164.83 or ~~5111.67~~ 5164.84 of the Revised Code. 33817 33818 33819 33820 33821 33822 33823 33824 33825 33826 33827 33828 33829 33830 33831 33832 33833 33834 33835 33836 33837 33838 33839 33840 33841

After the department receives a written notice regarding a cancellation or postponement of a facility closure, voluntary termination, or voluntary withdrawal of participation, the exiting operator or owner shall provide new written notice to the department under section ~~5111.66~~ 5164.83 of the Revised Code regarding any transactions leading to a facility closure, voluntary termination, or voluntary withdrawal of participation at a future time. After the department receives a written notice regarding a cancellation or postponement of a change of operator, the exiting operator or owner and entering operator shall provide new written notice to the department under section ~~5111.67~~ 5164.84 of the Revised Code regarding any transactions leading to a change of operator at a future time. 33842 33843 33844 33845 33846 33847 33848 33849 33850 33851 33852 33853 33854

Sec. ~~5111.688~~ 5164.858. The director of ~~job and family services~~ health care administration may adopt rules under section ~~5111.02~~ 5163.15 of the Revised Code to implement sections ~~5111.65~~ 5164.82 to ~~5111.688~~ 5164.858 of the Revised Code, including rules applicable to an exiting operator that provides written notification under section ~~5111.66~~ 5164.83 of the Revised Code of a voluntary withdrawal of participation. Rules adopted under this section shall comply with ~~section 1919(c)(2)(F) of the "Social Security Act," 79 Stat. 286 (1965),~~ 42 U.S.C. 1396r(c)(2)(F), regarding restrictions on transfers or discharges of nursing facility residents in the case of a voluntary withdrawal of participation. The rules may prescribe a medicaid reimbursement methodology and other procedures that are applicable after the effective date of a voluntary withdrawal of participation that differ from the reimbursement methodology and other procedures that would otherwise apply. 33855 33856 33857 33858 33859 33860 33861 33862 33863 33864 33865 33866 33867 33868 33869 33870

Sec. ~~5111.99~~ 5164.99. (A) Whoever violates division (B) of section ~~5111.26~~ 5164.37 or division (E) of section ~~5111.31~~ 33871 33872

5164.033 of the Revised Code shall be fined not less than five hundred dollars nor more than one thousand dollars for the first offense and not less than one thousand dollars nor more than five thousand dollars for each subsequent offense. Fines paid under this section shall be deposited in the state treasury to the credit of the general revenue fund.

(B) Whoever violates division (D) of section ~~5111.61~~ 5164.77 of the Revised Code is guilty of registering a false complaint, a misdemeanor of the first degree.

Sec. 5165.01. As used in this chapter:

"Care management system" means the medicaid managed care program established under section 5165.02 of the Revised Code.

"Emergency services" has the same meaning as in 42 U.S.C. 1396u-2(b)(2).

"Medicaid managed care organization" means a managed care organization that has entered into a contract with the department of health care administration under section 5165.05 of the Revised Code.

"Provider" has the same meaning as in section 5163.01 of the Revised Code.

Sec. 5165.02. The department of health care administration shall establish a care management system as part of the medicaid program. The department shall submit, if necessary, applications to the United States department of health and human services for waivers of federal medicaid requirements that would otherwise be violated in the implementation of the system.

Sec. ~~5111.16~~ 5165.03. ~~(A) As part of the medicaid program, the department of job and family services shall establish a care management system. The department shall submit, if necessary,~~

~~applications to the United States department of health and human services for waivers of federal medicaid requirements that would otherwise be violated in the implementation of the system.~~ 33902 33903 33904

~~(B)~~ The department of health care administration shall implement the care management system in some or all counties and shall designate the medicaid recipients who are required or permitted to participate in the system. In the department's implementation of the system and designation of participants, all of the following apply: 33905 33906 33907 33908 33909 33910

~~(1)~~(A) In the case of individuals who receive medicaid on the basis of being included in the category identified by the department as covered families and children, the department shall implement the care management system in all counties. All individuals included in the category shall be designated for participation, except for ~~indivduals~~ individuals included in one or more of the medicaid recipient groups specified in 42 C.F.R. 438.50(d). The department shall designate the participants not later than January 1, 2006. Beginning not later than December 31, 2006, the department shall ensure that all participants are enrolled in health insuring corporations under contract with the department pursuant to section ~~5111.17~~ 5165.05 of the Revised Code. 33911 33912 33913 33914 33915 33916 33917 33918 33919 33920 33921 33922 33923

~~(2)~~(B) In the case of individuals who receive medicaid on the basis of being aged, blind, or disabled, as specified in division ~~(A)(2)~~(B) of section ~~5111.01~~ 5162.01 of the Revised Code, the department shall implement the care management system in all counties. All individuals included in the category shall be designated for participation, except for the individuals specified in divisions (B)~~(2)(a) to (e)~~ of this section. Beginning not later than December 31, 2006, the department shall ensure that all participants are enrolled in health insuring corporations under contract with the department pursuant to section ~~5111.17~~ 5165.05 33924 33925 33926 33927 33928 33929 33930 33931 33932 33933

of the Revised Code. 33934

In designating participants who receive medicaid on the basis 33935
of being aged, blind, or disabled, the department shall not 33936
include any of the following: 33937

~~(a)~~(1) Individuals who are under twenty-one years of age; 33938

~~(b)~~(2) Individuals who are institutionalized; 33939

~~(c)~~(3) Individuals who become eligible for medicaid by 33940
spending down their income or resources to a level that meets the 33941
medicaid program's financial eligibility requirements; 33942

~~(d)~~(4) Individuals who are dually eligible under the medicaid 33943
program and the medicare program ~~established under Title XVIII of~~ 33944
~~the "Social Security Act," 79 Stat. 286 (1965), 42 U.S.C. 1395, as~~ 33945
~~amended~~; 33946

~~(e)~~(5) Individuals to the extent that they are receiving 33947
medicaid services through a medicaid waiver component, as defined 33948
in section ~~5111.85~~ 5163.50 of the Revised Code. 33949

~~(3)~~(C) Alcohol, drug addiction, and mental health services 33950
covered by medicaid shall not be included in any component of the 33951
care management system when the nonfederal share of the cost of 33952
those services is provided by a board of alcohol, drug ~~adiction~~ 33953
addiction, and mental health services or a state agency other than 33954
the department of ~~job and family services~~ health care 33955
administration, but the recipients of those services may otherwise 33956
be designated for participation in the system. 33957

~~(C) Subject to division (B) of this section, the department~~ 33958
~~may do both of the following under the care management system:~~ 33959

~~(1) Require or permit participants in the system to obtain~~ 33960
~~health care services from providers designated by the department;~~ 33961

~~(2) Require or permit participants in the system to obtain~~ 33962
~~health care services through managed care organizations under~~ 33963

~~contract with the department pursuant to section 5111.17 of the Revised Code.~~

~~(D)(1) The department shall prepare an annual report on the care management system. The report shall address the department's ability to implement the system, including all of the following components:~~

~~(a) The required designation of participants included in the category identified by the department as covered families and children;~~

~~(b) The required designation of participants included in the aged, blind, or disabled category of medicaid recipients;~~

~~(c) The conduct of the pilot program for chronically ill children established under section 5111.163 of the Revised Code;~~

~~(d) The use of any programs for enhanced care management.~~

~~(2) The department shall submit each annual report to the general assembly. The first report shall be submitted not later than October 1, 2007.~~

~~(E) The director of job and family services may adopt rules in accordance with Chapter 119. of the Revised Code to implement this section.~~

Sec. 5165.04. Subject to section 5165.03 of the Revised Code, the department of health care administration may do both of the following under the care management system:

(A) Require or permit participants in the system to obtain health care services from providers designated by the department;

(B) Require or permit participants in the system to obtain health care services through managed care organizations under contract with the department pursuant to section 5165.05 of the Revised Code.

Sec. ~~5111.17~~ 5165.05. ~~(A)~~ The department of ~~job and family services~~ health care administration may enter into contracts with managed care organizations, including health insuring corporations, under which the organizations are authorized to provide, or arrange for the provision of, health care services to ~~medical assistance~~ medicaid recipients who are required or permitted to obtain health care services through managed care organizations as part of the care management system ~~established under section 5111.16 of the Revised Code~~.

~~(B) The director of job and family services may adopt rules in accordance with Chapter 119. of the Revised Code to implement this section.~~

~~(C)~~ The department of ~~job and family services~~ health care administration shall allow managed care plans to use providers to render care upon completion of the managed care plan's credentialing process.

Sec. 5165.06. The department of health care administration shall develop and implement a financial incentive program to improve and reward positive health outcomes through the managed care organization contracts entered into under section 5165.05 of the Revised Code. In developing and implementing the program, the department may take into consideration the recommendations regarding the program made by the medicaid care management working group created under section 5165.19 of the Revised Code.

Sec. ~~5111.171~~ 5165.07. ~~(A)~~ The department of ~~job and family services~~ health care administration may provide financial incentive awards to medicaid managed care organizations ~~under contract with the department pursuant to section 5111.17 of the Revised Code~~ that meet or exceed performance standards specified in provider agreements or rules adopted ~~by the department~~ under

section 5165.18 of the Revised Code. The department may specify in 34023
a contract with a managed care organization the amounts of 34024
financial incentive awards, methodology for distributing awards, 34025
types of awards, and standards for administration by the 34026
department. 34027

~~(B) There is hereby created in the state treasury the health~~ 34028
~~care compliance fund. The fund shall consist of all fines imposed~~ 34029
~~on and collected from managed care organizations for failure to~~ 34030
~~meet performance standards or other requirements specified in~~ 34031
~~provider agreements or rules adopted by the department. All~~ 34032
~~investment earnings of the fund shall be credited to the fund.~~ 34033
~~Moneys credited to the fund shall be used solely for the following~~ 34034
~~purposes:~~ 34035

~~(1) To reimburse managed care organizations that have paid~~ 34036
~~fines for failures to meet performance standards or other~~ 34037
~~requirements and that have come into compliance by meeting~~ 34038
~~requirements as specified by the department;~~ 34039

~~(2) To provide financial incentive awards established~~ 34040
~~pursuant to division (A) of this section and specified in~~ 34041
~~contracts between managed care organizations and the department.~~ 34042

Sec. 5165.08. There is hereby created in the state treasury 34043
the health care compliance fund. The fund shall consist of all 34044
fines imposed on and collected from medicaid managed care 34045
organizations for failure to meet performance standards or other 34046
requirements specified in provider agreements or rules under 34047
section 5165.18 of the Revised Code. All investment earnings of 34048
the fund shall be credited to the fund. Moneys credited to the 34049
fund shall be used solely for the following purposes: 34050

(A) To reimburse medicaid managed care organizations that 34051
have paid fines for failures to meet performance standards or 34052
other requirements and that have come into compliance by meeting 34053

requirements as specified by the department; 34054

(B) To provide financial incentive awards established pursuant to section 5165.06 of the Revised Code and specified in contracts between medicaid managed care organizations and the department. 34055 34056 34057 34058

Sec. ~~5111.172~~ 5165.09. (A) When contracting under section ~~5111.17~~ 5165.05 of the Revised Code with a managed care organization that is a health insuring corporation, the department of ~~job and family services~~ health care administration may require the health insuring corporation to provide coverage of prescription drugs for medicaid recipients enrolled in the health insuring corporation. In providing the required coverage, the health insuring corporation may, subject to the department's approval, use strategies for the management of drug utilization. 34059 34060 34061 34062 34063 34064 34065 34066 34067

(B) As used in this division, "controlled substance" has the same meaning as in section 3719.01 of the Revised Code. 34068 34069

If a health insuring corporation is required under this section to provide coverage of prescription drugs, the department shall permit the health insuring corporation to develop and implement a pharmacy utilization management program under which prior authorization through the program is established as a condition of obtaining a controlled substance pursuant to a prescription. The program may include processes for requiring medicaid recipients at high risk for fraud or abuse involving controlled substances to have their prescriptions for controlled substances filled by a pharmacy, medical provider, or health care facility designated by the program. 34070 34071 34072 34073 34074 34075 34076 34077 34078 34079 34080

Sec. ~~5111.173~~ 5165.10. The department of ~~job and family services~~ health care administration shall appoint a temporary manager for a medicaid managed care organization ~~under contract~~ 34081 34082 34083

~~with the department pursuant to section 5111.17 of the Revised~~ 34084
~~Code~~ if the department determines that the medicaid managed care 34085
organization has repeatedly failed to meet substantive 34086
requirements specified in ~~section 1903(m) of the "Social Security~~ 34087
~~Act," 79 Stat. 286 (1965),~~ 42 U.S.C. 1396b(m), ~~as amended; section~~ 34088
~~1932 of the Social Security Act,~~ 42 U.S.C. 1396u-2, ~~as amended;~~ or 34089
42 C.F.R. 438 Part I. The appointment of a temporary manager does 34090
not preclude the department from imposing other sanctions 34091
available to the department against the medicaid managed care 34092
organization. 34093

The medicaid managed care organization shall pay all costs of 34094
having the temporary manager perform the temporary manager's 34095
duties, including all costs the temporary manager incurs in 34096
performing those duties. If the temporary manager incurs costs or 34097
liabilities on behalf of the medicaid managed care organization, 34098
the medicaid managed care organization shall pay those costs and 34099
be responsible for those liabilities. 34100

The appointment of a temporary manager is not subject to 34101
Chapter 119. of the Revised Code, but the medicaid managed care 34102
organization may request a reconsideration of the appointment. 34103
Reconsiderations shall be requested and conducted in accordance 34104
with rules ~~the director of job and family services shall adopt in~~ 34105
~~accordance with Chapter 119.~~ adopted under section 5165.18 of the 34106
Revised Code. 34107

The appointment of a temporary manager does not cause the 34108
medicaid managed care organization to lose the right to appeal, in 34109
accordance with Chapter 119. of the Revised Code, any proposed 34110
termination or any decision not to renew the medicaid managed care 34111
organization's medicaid provider agreement or the right to 34112
initiate the sale of the medicaid managed care organization or its 34113
assets. 34114

~~In addition to the rules required to be adopted under this~~ 34115

~~section, the director may adopt any other rules necessary to~~ 34116
~~implement this section. The rules shall be adopted in accordance~~ 34117
~~with Chapter 119. of the Revised Code.~~ 34118

Sec. ~~5111.177~~ 5165.11. When contracting under section ~~5111.17~~ 34119
5165.05 of the Revised Code with a health insuring corporation 34120
that holds a certificate of authority under Chapter 1751. of the 34121
Revised Code, the department of ~~job and family services~~ health 34122
care administration shall require the health insuring corporation 34123
to provide a grievance process for medicaid recipients in 34124
accordance with 42 C.F.R. 438, subpart F. 34125

Sec. ~~5111.174~~ 5165.12. The department of ~~job and family~~ 34126
~~services~~ health care administration may disenroll some or all 34127
medicaid recipients enrolled in a medicaid managed care 34128
organization ~~under contract with the department pursuant to~~ 34129
~~section 5111.17 of the Revised Code~~ if the department proposes to 34130
terminate or not to renew the contract and determines that the 34131
recipients' access to medically necessary services is jeopardized 34132
by the proposal to terminate or not to renew the contract. The 34133
disenrollment is not subject to Chapter 119. of the Revised Code, 34134
but the medicaid managed care organization may request a 34135
reconsideration of the disenrollment. Reconsiderations shall be 34136
requested and conducted in accordance with rules ~~the director of~~ 34137
~~job and family services shall adopt in accordance with Chapter~~ 34138
~~119.~~ adopted under section 5165.18 of the Revised Code. The 34139
request for, or conduct of, a reconsideration regarding a proposed 34140
disenrollment shall not delay the disenrollment. 34141

~~In addition to the rules required to be adopted under this~~ 34142
~~section, the director may adopt any other rules necessary to~~ 34143
~~implement this section. The rules shall be adopted in accordance~~ 34144
~~with Chapter 119. of the Revised Code.~~ 34145

Sec. ~~5111.175~~ 5165.13. For the purpose of determining the amount the department of ~~job and family services~~ health care administration pays hospitals under section ~~5112.08~~ 5166.07 of the Revised Code and the amount of disproportionate share hospital payments paid by the medicare program ~~established under Title XVIII of the "Social Security Act," 79 Stat. 286 (1965), 42 U.S.C. 1396n, as amended~~, a medicaid managed care organization ~~under contract with the department pursuant to section 5111.17 of the Revised Code authorizing the organization~~ authorized to provide, or arrange for the provision of, hospital services to medicaid recipients shall keep detailed records for each hospital with which it contracts about the cost to the hospital of providing the services, payments made by the organization to the hospital for the services, utilization of hospital services by medicaid recipients enrolled in the organization, and other utilization data required by the department.

Sec. ~~5111.162~~ 5165.14. (A) ~~As used in this section:~~

~~(1) "Emergency services" has the same meaning as in section 1932(b)(2) of the "Social Security Act," 79 Stat. 286 (1965), 42 U.S.C. 1396u-2(b)(2), as amended.~~

~~(2) "Medicaid managed care organization" means a managed care organization that has entered into a contract with the department of job and family services pursuant to section 5111.17 of the Revised Code.~~

~~(B)~~ Except as provided in division ~~(C)~~(B) of this section, when a participant in the care management system ~~established under section 5111.16 of the Revised Code~~ is enrolled in a medicaid managed care organization and the organization refers the participant to receive services, other than emergency services provided on or after January 1, 2007, at a hospital that

participates in the medicaid program but is not under contract 34176
with the organization, the hospital shall provide the service for 34177
which the referral was made and shall accept from the 34178
organization, as payment in full, the amount derived from the 34179
reimbursement rate used by the department to reimburse other 34180
hospitals of the same type for providing the same service to a 34181
medicaid recipient who is not enrolled in a medicaid managed care 34182
organization. 34183

~~(C)~~(B) A hospital is not subject to division ~~(B)~~(A) of this 34184
section if all of the following are the case: 34185

(1) The hospital is located in a county in which participants 34186
in the care management system are required before January 1, 2006, 34187
to be enrolled in a medicaid managed care organization that is a 34188
health insuring corporation; 34189

(2) The hospital has entered into a contract before January 34190
1, 2006, with at least one health insuring corporation serving the 34191
participants specified in division ~~(C)~~(B)(1) of this section; 34192

(3) The hospital remains under contract with at least one 34193
health insuring corporation serving participants in the care 34194
management system who are required to be enrolled in a health 34195
insuring corporation. 34196

~~(D) The director of job and family services shall adopt rules~~ 34197
~~specifying the circumstances under which a medicaid managed care~~ 34198
~~organization is permitted to refer a participant in the care~~ 34199
~~management system to a hospital that is not under contract with~~ 34200
~~the organization. The director may adopt any other rules necessary~~ 34201
~~to implement this section. All rules adopted under this section~~ 34202
~~shall be adopted in accordance with Chapter 119. of the Revised~~ 34203
~~Code.~~ 34204

Sec. ~~5111.163~~ 5165.15. ~~(A) As used in this section:~~ 34205

~~(1) "Emergency services" has the same meaning as in section 1932(b)(2) of the "Social Security Act," 79 Stat. 286 (1965), 42 U.S.C. 1396u-2(b)(2), as amended.~~

~~(2) "Medicaid managed care organization" has the same meaning as in section 5111.162 of the Revised Code.~~

~~(3) "Provider" means any person, institution, or entity that furnishes emergency services to a medicaid recipient enrolled in a medicaid managed care organization, regardless of whether the person, institution, or entity has a provider agreement with the department of job and family services pursuant to Title XIX of the "Social Security Act."~~

~~(B)~~ When a participant in the care management system ~~established under section 5111.16 of the Revised Code~~ is enrolled in a medicaid managed care organization and receives emergency services on or after January 1, 2007, from a provider that is not under contract with the organization, the provider shall accept from the organization, as payment in full, not more than the amounts (less any payments for indirect costs of medical education and direct costs of graduate medical education) that the provider could collect if the participant received medicaid other than through enrollment in a managed care organization.

Sec. ~~5111.178~~ 5165.16. (A) The director of ~~job and family services~~ health care administration shall determine whether a waiver of federal medicaid requirements is necessary to fulfill the requirements of section 3901.3814 of the Revised Code. If the director determines a waiver is necessary, the department of ~~job and family services~~ health care administration shall apply to the United States secretary of health and human services for the waiver.

(B)(1) If the director determines that section 3901.3814 of the Revised Code can be implemented without a waiver or a waiver

is granted, the department shall notify the department of insurance that the section can be implemented. Implementation of the section shall be effective eighteen months after the notice is sent. 34237 34238 34239 34240

(2) At the time the notice is given under division (B)(1) of this section, the department shall also give notice to each health insuring corporation that provides coverage to medicaid recipients. The notice shall inform the corporation that sections 3901.38 and 3901.381 to 3901.3814 of the Revised Code apply to claims for services rendered to recipients on the date determined under division (B)(1) of this section, instead of the prompt payment requirements of 42 C.F.R. 447.46. That date shall be specified in the notice. 34241 34242 34243 34244 34245 34246 34247 34248 34249

Sec. 5165.17. (A) The department of health care administration shall prepare an annual report on the care management system. The report shall address the department's ability to implement the system, including all of the following components: 34250 34251 34252 34253 34254

(1) The required designation of participants included in the category identified by the department as covered families and children; 34255 34256 34257

(2) The required designation of participants included in the aged, blind, or disabled category of medicaid recipients; 34258 34259

(3) The use of any programs for enhanced care management. 34260

(B) The department shall submit each annual report to the general assembly. The first report shall be submitted not later than October 1, 2007. 34261 34262 34263

Sec. 5165.18. The director of health care administration shall adopt rules in accordance with Chapter 119. of the Revised Code to implement care management system, including rules that do 34264 34265 34266

all of the following:

(A) Specify the circumstances under which a medicaid managed care organization is permitted to refer a participant in the care management system to a hospital that is not under contract with the organization;

(B) Specify performance standards for medicaid managed care organizations;

(C) The method by which a medicaid managed care organization may request a reconsideration of the appointment of a temporary manager under section 5165.10 of the Revised Code and the method by which the reconsideration is to be conducted;

(D) The method by which a medicaid managed care organization may request a reconsideration of a disenrollment under section 5165.12 of the Revised Code and the method by which the reconsideration is to be conducted.

Sec. ~~5111.13~~ 5165.30. (A) As used in this section, "cost-effective" and "group health plan" have the same meanings as in ~~section 1906 of the "Social Security Act," 49 Stat. 620 (1935),~~ 42 U.S.C.~~A.~~ 1396e~~, as amended,~~ and any regulations adopted under that section.

(B) The department of ~~job and family services~~ health care administration, pursuant to guidelines issued by the United States secretary of health and human services, shall identify cases in which enrollment of an individual otherwise eligible for ~~medical assistance under this chapter~~ the medicaid program in a group health plan in which the individual is eligible to enroll and payment of the individual's premiums, deductibles, coinsurance, and other cost-sharing expenses is cost effective.

The department shall require, as a condition of eligibility for ~~medical assistance~~ the medicaid program, individuals

identified under this division, or in the case of a child, the 34297
child's parent, to apply for enrollment in the group health plan, 34298
except that the failure of a parent to enroll self or the parent's 34299
child in a group health plan does not affect the child's 34300
eligibility under the ~~medical assistance~~ medicaid program. 34301

The department shall pay enrollee premiums and deductibles, 34302
coinsurance, and other cost-sharing obligations for services and 34303
items otherwise covered under the ~~medical assistance~~ medicaid 34304
program. The department shall treat coverage under the group 34305
health plan in the same manner as any other third-party liability 34306
under the program. If not all members of a family are eligible for 34307
~~medical assistance~~ the medicaid program and enrollment of the 34308
eligible members in a group health plan is not possible without 34309
also enrolling the members who are ineligible for ~~medical~~ 34310
~~assistance~~ the medicaid program, the department shall pay the 34311
premiums for the ineligible members if the payments are cost 34312
effective. The department shall not pay deductibles, coinsurance, 34313
or other cost-sharing obligations of enrolled members who are not 34314
eligible for ~~medical assistance~~ the medicaid program. 34315

The department may make payments under this section to 34316
employers, insurers, or other entities. The department may make 34317
the payments without entering into a contract with employers, 34318
insurers, or other entities. 34319

(C) To the extent permitted by federal law and regulations, 34320
the department of ~~job and family services~~ health care 34321
administration shall coordinate the ~~medical assistance~~ medicaid 34322
program with group health plans in such a manner that the ~~medical~~ 34323
~~assistance~~ medicaid program serves as a supplement to the group 34324
health plans. In its coordination efforts, the department shall 34325
consider cost-effectiveness and quality of care. The department 34326
may enter into agreements with group health plans as necessary to 34327
implement this division. 34328

(D) The director of ~~job and family services~~ health care 34329
administration shall adopt rules in accordance with Chapter 119. 34330
of the Revised Code to implement this section. 34331

Sec. ~~5112.01~~ 5166.01. As used in sections ~~5112.03~~ 5166.02 to 34332
~~5112.21~~ 5166.14 of the Revised Code: 34333

(A)(1) "Hospital" means a nonfederal hospital to which either 34334
of the following applies: 34335

(a) The hospital is registered under section 3701.07 of the 34336
Revised Code as a general medical and surgical hospital or a 34337
pediatric general hospital, and provides inpatient hospital 34338
services, as defined in 42 C.F.R. 440.10; 34339

(b) The hospital is recognized under the medicare program 34340
~~established by Title XVIII of the "Social Security Act," 49 Stat.~~ 34341
~~620 (1935), 42 U.S.C.A. 301, as amended,~~ as a cancer hospital and 34342
is exempt from the medicare prospective payment system. 34343

"Hospital" does not include a hospital operated by a health 34344
insuring corporation that has been issued a certificate of 34345
authority under section 1751.05 of the Revised Code or a hospital 34346
that does not charge patients for services. 34347

(2) "Disproportionate share hospital" means a hospital that 34348
meets the definition of a disproportionate share hospital in rules 34349
adopted under section ~~5112.03~~ 5166.02 of the Revised Code. 34350

(B) "Bad debt," "charity care," "courtesy care," and 34351
"contractual allowances" have the same meanings given these terms 34352
in regulations ~~adopted under Title XVIII of the "Social Security~~ 34353
~~Act~~ governing the medicare program.~~"~~ 34354

(C) "Cost reporting period" means the twelve-month period 34355
used by a hospital in reporting costs for purposes of ~~Title XVIII~~ 34356
~~of the "Social Security Act~~ the medicare program.~~"~~ 34357

(D) "Governmental hospital" means a county hospital with more 34358

than five hundred registered beds or a state-owned and -operated 34359
hospital with more than five hundred registered beds. 34360

(E) "Indigent care pool" means the sum of the following: 34361

(1) The total of assessments to be paid in a program year by 34362
all hospitals under section ~~5112.06~~ 5166.05 of the Revised Code, 34363
less the assessments deposited into the legislative budget 34364
services fund under section ~~5112.19~~ 5166.13 of the Revised Code 34365
and into the health care services administration fund created 34366
under section ~~5111.94~~ 5161.15 of the Revised Code; 34367

(2) The total amount of intergovernmental transfers required 34368
to be made in the same program year by governmental hospitals 34369
under section ~~5112.07~~ 5166.06 of the Revised Code, less the amount 34370
of transfers deposited into the legislative budget services fund 34371
under section ~~5112.19~~ 5166.13 of the Revised Code and into the 34372
health care services administration fund created under section 34373
~~5111.94~~ 5161.15 of the Revised Code; 34374

(3) The total amount of federal matching funds that will be 34375
made available in the same program year as a result of funds 34376
distributed by the department of ~~job and family services~~ health 34377
care administration to hospitals under section ~~5112.08~~ 5166.07 of 34378
the Revised Code. 34379

(F) "Intergovernmental transfer" means any transfer of money 34380
by a governmental hospital under section ~~5112.07~~ 5166.06 of the 34381
Revised Code. 34382

(G) ~~"Medical assistance program" means the program of medical~~ 34383
~~assistance established under section 5111.01 of the Revised Code~~ 34384
~~and Title XIX of the "Social Security Act."~~ 34385

~~(H)~~ "Program year" means a period beginning the first day of 34386
October, or a later date designated in rules adopted under section 34387
~~5112.03~~ 5166.02 of the Revised Code, and ending the thirtieth day 34388
of September, or an earlier date designated in rules adopted under 34389

that section. 34390

~~(I)~~(H) "Registered beds" means the total number of hospital 34391
beds registered with the department of health, as reported in the 34392
most recent "directory of registered hospitals" published by the 34393
department of health. 34394

~~(J)~~(I) "Total facility costs" means the total costs for all 34395
services rendered to all patients, including the direct, indirect, 34396
and overhead cost to the hospital of all services, supplies, 34397
equipment, and capital related to the care of patients, regardless 34398
of whether patients are enrolled in a health insuring corporation, 34399
excluding costs associated with providing skilled nursing services 34400
in distinct-part nursing facility units, as shown on the 34401
hospital's cost report filed under section ~~5112.04~~ 5166.03 of the 34402
Revised Code. Effective October 1, 1993, if rules adopted under 34403
section ~~5112.03~~ 5166.02 of the Revised Code so provide, "total 34404
facility costs" may exclude costs associated with providing care 34405
to recipients of any of the governmental programs listed in 34406
division (B) of that section. 34407

~~(K)~~(J) "Uncompensated care" means bad debt and charity care. 34408

Sec. ~~5112.03~~ 5166.02. (A) The director of ~~job and family~~ 34409
~~services~~ health care administration shall adopt, and may amend and 34410
rescind, rules in accordance with Chapter 119. of the Revised Code 34411
for the purpose of administering sections ~~5112.01~~ 5166.01 to 34412
~~5112.21~~ 5166.14 of the Revised Code, including rules that do all 34413
of the following: 34414

(1) Define as a "disproportionate share hospital" any 34415
hospital included under subsection (b) of section 1923 of the 34416
"Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 34417
1396r-4(b), as amended, and any other hospital the director 34418
determines appropriate; 34419

(2) Prescribe the form for submission of cost reports under section ~~5112.04~~ 5166.03 of the Revised Code; 34420 34421

(3) Establish, in accordance with division (A) of section ~~5112.06~~ 5166.05 of the Revised Code, the assessment rate or rates to be applied to hospitals under that section; 34422 34423 34424

(4) Establish schedules for hospitals to pay installments on their assessments under section ~~5112.06~~ 5166.05 of the Revised Code and for governmental hospitals to pay installments on their intergovernmental transfers under section ~~5112.07~~ 5166.06 of the Revised Code; 34425 34426 34427 34428 34429

(5) Establish procedures to notify hospitals of adjustments made under division (B)(2)(b) of section ~~5112.06~~ 5166.05 of the Revised Code in the amount of installments on their assessment; 34430 34431 34432

(6) Establish procedures to notify hospitals of adjustments made under division (D) of section ~~5112.09~~ 5166.08 of the Revised Code in the total amount of their assessment and to adjust for the remainder of the program year the amount of the installments on the assessments; 34433 34434 34435 34436 34437

(7) Establish, in accordance with section ~~5112.08~~ 5166.07 of the Revised Code, the methodology for paying hospitals under that section. 34438 34439 34440

The director shall consult with hospitals when adopting the rules required by divisions (A)(4) and (5) of this section in order to minimize hospitals' cash flow difficulties. 34441 34442 34443

(B) Rules adopted under this section may provide that "total facility costs" excludes costs associated with any of the following: 34444 34445 34446

(1) Recipients of the ~~medical assistance~~ medicaid program; 34447

(2) Recipients of financial assistance provided under Chapter 5115. of the Revised Code; 34448 34449

(3) Recipients of the disability medical assistance ~~provided~~ 34450
~~under Chapter 5115. of the Revised Code~~ program; 34451

(4) Recipients of the program for medically handicapped 34452
children established under section 3701.023 of the Revised Code; 34453

(5) Recipients of the medicare program ~~established under~~ 34454
~~Title XVIII of the "Social Security Act," 49 Stat. 620 (1935), 42~~ 34455
~~U.S.C.A. 301, as amended:~~; 34456

(6) Recipients of Title V of the "Social Security Act of 34457
1935"; 34458

(7) Any other category of costs deemed appropriate by the 34459
director in accordance with ~~Title XIX of the "Social Security Act"~~ 34460
~~and the rules adopted under that title~~ federal law, including 34461
administrative regulations, governing the medicaid program. 34462

Sec. ~~5112.04~~ 5166.03. (A) Except as provided in division (C) 34463
of this section, each hospital, on or before the first day of July 34464
of each year or at a later date approved by the director of ~~job~~ 34465
~~and family services~~ health care administration, shall submit to 34466
the department of ~~job and family services~~ health care 34467
administration a financial statement for the preceding calendar 34468
year that accurately reflects the income, expenses, assets, 34469
liabilities, and net worth of the hospital, and accompanying 34470
notes. A hospital that has a fiscal year different from the 34471
calendar year shall file its financial statement within one 34472
hundred eighty days of the end of its fiscal year or at a later 34473
date approved by the director of ~~job and family services~~ health 34474
care administration. The financial statement shall be prepared by 34475
an independent certified public accountant and reflect an official 34476
audit report prepared in a manner consistent with generally 34477
accepted accounting principles. The financial statement shall, to 34478
the extent that the hospital has sufficient financial records, 34479
show bad debt and charity care separately from courtesy care and 34480

contractual allowances.

(B) Except as provided in division (C) of this section, each hospital, within one hundred eighty days after the end of the hospital's cost reporting period, shall submit to the department a cost report in a format prescribed in rules adopted ~~by the director of job and family services~~ under section ~~5112.03~~ 5166.02 of the Revised Code. The department shall grant a hospital an extension of the one hundred eighty day period if the health care financing administration of the United States department of health and human services extends the date by which the hospital must submit its cost report for the hospital's cost reporting period.

(C) The director of ~~job and family services~~ health care administration may adopt rules under section ~~5112.03~~ 5166.02 of the Revised Code specifying financial information that must be submitted by hospitals for which no financial statement or cost report is available. The rules shall specify deadlines for submitting the information. Each such hospital shall submit the information specified in the rules not later than the deadline specified in the rules.

Sec. ~~5112.05~~ 5166.04. The requirements of sections ~~5112.06~~ 5166.05 to ~~5112.09~~ 5166.08 of the Revised Code apply only as long as the United States ~~health care financing administration~~ department of health and human services determines that the assessment imposed under section ~~5112.06~~ 5166.05 of the Revised Code is a permissible health care-related tax pursuant to ~~section 1903(w) of the "Social Security Act," 49 Stat. 620 (1935),~~ 42 U.S.C.~~A.~~ 1396b(w)~~, as amended~~. Whenever the department of ~~job and family services~~ health care administration is informed that the assessment is an impermissible health care-related tax, the department shall promptly refund to each hospital the amount of money currently in the hospital care assurance program fund

created by section ~~5112.18~~ 5166.12 of the Revised Code that has been paid by the hospital under section ~~5112.06~~ 5166.05 or ~~5112.07~~ 5166.06 of the Revised Code, plus any investment earnings on that amount. 34512 34513 34514 34515

Sec. ~~5112.06~~ 5166.05. (A) For the purpose of distributing funds to hospitals under the ~~medical assistance~~ medicaid program pursuant to sections ~~5112.01~~ 5166.01 to ~~5112.21~~ 5166.14 of the Revised Code and depositing funds into the legislative budget services fund under section ~~5112.19~~ 5166.13 of the Revised Code and into the health care services administration fund created under section ~~5111.94~~ 5161.15 of the Revised Code, there is hereby imposed an assessment on all hospitals. Each hospital's assessment shall be based on total facility costs. All hospitals shall be assessed according to the rate or rates established each program year by the department of ~~job and family services~~ health care administration in rules adopted under section ~~5112.03~~ 5166.02 of the Revised Code. The department shall assess all hospitals uniformly and in a manner consistent with federal statutes and regulations. During any program year, the department shall not assess any hospital more than two per cent of the hospital's total facility costs. 34516 34517 34518 34519 34520 34521 34522 34523 34524 34525 34526 34527 34528 34529 34530 34531 34532

The department shall establish an assessment rate or rates each program year that will do both of the following: 34533 34534

(1) Yield funds that, when combined with intergovernmental transfers and federal matching funds, will produce a program of sufficient size to pay a substantial portion of the indigent care provided by hospitals; 34535 34536 34537 34538

(2) Yield funds that, when combined with intergovernmental transfers and federal matching funds, will produce amounts for distribution to disproportionate share hospitals that do not exceed, in the aggregate, the limits prescribed by the United 34539 34540 34541 34542

States ~~health care financing administration~~ department of health and human services under ~~subsection (f) of section 1923 of the "Social Security Act," 49 Stat. 620 (1935),~~ 42 U.S.C.~~A.~~ 1396r-4(f)~~, as amended~~. 34543–34546

(B)(1) Except as provided in division (B)(3) of this section, each hospital shall pay its assessment in periodic installments in accordance with a schedule established by the director of ~~job and family services~~ health care administration in rules adopted under section ~~5112.03~~ 5166.02 of the Revised Code. 34547–34551

(2) The installments shall be equal in amount, unless either of the following applies: 34552–34553

(a) The department makes adjustments during a program year under division (D) of section ~~5112.09~~ 5166.08 of the Revised Code in the total amount of hospitals' assessments; 34554–34556

(b) The director of ~~job and family services~~ health care administration determines that adjustments in the amounts of installments are necessary for the administration of sections ~~5112.01~~ 5166.01 to ~~5112.21~~ 5166.14 of the Revised Code and that unequal installments will not create cash flow difficulties for hospitals. 34557–34562

(3) The director may adopt rules under section ~~5112.03~~ 5166.02 of the Revised Code establishing alternate schedules for hospitals to pay assessments under this section in order to reduce hospitals' cash flow difficulties. 34563–34566

Sec. ~~5112.07~~ 5166.06. (A) The department of ~~job and family services~~ health care administration may require governmental hospitals to make intergovernmental transfers each program year for the purpose of distributing funds to hospitals under the ~~medical assistance~~ medicaid program pursuant to sections ~~5112.01~~ 5166.01 to ~~5112.21~~ 5166.14 of the Revised Code and depositing 34567–34572

funds into the legislative budget services fund under section ~~5112.19~~ 5166.13 of the Revised Code and into the health care services administration fund created under section ~~5111.94~~ 5161.15 of the Revised Code. The department shall not require transfers in an amount that, when combined with hospital assessments paid under section ~~5112.06~~ 5166.05 of the Revised Code and federal matching funds, produce amounts for distribution to disproportionate share hospitals that, in the aggregate, exceed limits prescribed by the United States ~~health care financing administration~~ department of health and human services under ~~subsection (f) of section 1923 of the "Social Security Act," 49 Stat. 620 (1935),~~ 42 U.S.C.~~A.~~ 1396r-4(f)~~, as amended~~. 34573–34584

(B) Before or during each program year, the department shall notify each governmental hospital of the amount of the intergovernmental transfer it is required to make during the program year. Each governmental hospital shall make intergovernmental transfers as required by the department under this section in periodic installments, executed by electronic fund transfer, in accordance with a schedule established in rules adopted under section ~~5112.03~~ 5166.02 of the Revised Code. 34585–34592

Sec. ~~5112.08~~ 5166.07. The director of ~~job and family services~~ health care administration shall adopt rules under section ~~5112.03~~ 5166.02 of the Revised Code establishing a methodology to pay hospitals that is sufficient to expend all money in the indigent care pool. Under the rules: 34593–34597

(A) The department of ~~job and family services~~ health care administration may classify similar hospitals into groups and allocate funds for distribution within each group. 34598–34600

(B) The department shall establish a method of allocating funds to hospitals, taking into consideration the relative amount of indigent care provided by each hospital or group of hospitals. 34601–34603

The amount to be allocated shall be based on any combination of 34604
the following indicators of indigent care that the director 34605
considers appropriate: 34606

(1) Total costs, volume, or proportion of services to 34607
medicaid recipients ~~of the medical assistance program~~, including 34608
recipients enrolled in health insuring corporations; 34609

(2) Total costs, volume, or proportion of services to 34610
low-income patients in addition to medicaid recipients ~~of the~~ 34611
~~medical assistance program~~, which may include recipients of Title 34612
V of the "Social Security Act of 1935," ~~49 Stat. 620 (1935), 42~~ 34613
~~U.S.C.A. 301, as amended, and~~ recipients of financial ~~or medical~~ 34614
assistance provided under Chapter 5115. of the Revised Code, and 34615
recipients of the disability medical assistance program; 34616

(3) The amount of uncompensated care provided by the hospital 34617
or group of hospitals; 34618

(4) Other factors that the director considers to be 34619
appropriate indicators of indigent care. 34620

(C) The department shall distribute funds to each hospital or 34621
group of hospitals in a manner that first may provide for an 34622
additional distribution to individual hospitals that provide a 34623
high proportion of indigent care in relation to the total care 34624
provided by the hospital or in relation to other hospitals. The 34625
department shall establish a formula to distribute the remainder 34626
of the funds. The formula shall be consistent with ~~section 1923 of~~ 34627
~~the "Social Security Act,"~~ 42 U.S.C.~~A.~~ 1396r-4~~, as amended, shall~~ 34628
~~be~~ and based on any combination of the indicators of indigent care 34629
listed in division (B) of this section that the director considers 34630
appropriate. 34631

(D) The department shall distribute funds to each hospital in 34632
installments not later than ten working days after the deadline 34633
established in rules for each hospital to pay an installment on 34634

its assessment under section ~~5112.06~~ 5166.05 of the Revised Code. In the case of a governmental hospital that makes intergovernmental transfers, the department shall pay an installment under this section not later than ten working days after the earlier of that deadline or the deadline established in rules for the governmental hospital to pay an installment on its intergovernmental transfer. If the amount in the hospital care assurance program fund created under section ~~5112.18~~ 5166.12 of the Revised Code and the portion of the health care - federal fund created under section ~~5111.943~~ 5161.18 of the Revised Code that is credited to that fund pursuant to division (B) of section ~~5112.18~~ 5166.12 of the Revised Code are insufficient to make the total distributions for which hospitals are eligible to receive in any period, the department shall reduce the amount of each distribution by the percentage by which the amount and portion are insufficient. The department shall distribute to hospitals any amounts not distributed in the period in which they are due as soon as moneys are available in the funds.

Sec. ~~5112.09~~ 5166.08. (A) Before or during each program year, the department of ~~job and family services~~ health care administration shall mail to each hospital by certified mail, return receipt requested, the preliminary determination of the amount that the hospital is assessed under section ~~5112.06~~ 5166.05 of the Revised Code during the program year. The preliminary determination of a hospital's assessment shall be calculated for a cost-reporting period that is specified in rules adopted under section ~~5112.03~~ 5166.02 of the Revised Code.

The department shall consult with hospitals each year when determining the date on which it will mail the preliminary determinations in order to minimize hospitals' cash flow difficulties.

If no hospital submits a request for reconsideration under division (B) of this section, the preliminary determination constitutes the final reconciliation of each hospital's assessment under section ~~5112.06~~ 5166.05 of the Revised Code. The final reconciliation is subject to adjustments under division (D) of this section. 34666 34667 34668 34669 34670 34671

(B) Not later than fourteen days after the preliminary determinations are mailed, any hospital may submit to the department a written request to reconsider the preliminary determinations. The request shall be accompanied by written materials setting forth the basis for the reconsideration. If one or more hospitals submit a request, the department shall hold a public hearing not later than thirty days after the preliminary determinations are mailed to reconsider the preliminary determinations. The department shall mail to each hospital a written notice of the date, time, and place of the hearing at least ten days prior to the hearing. On the basis of the evidence submitted to the department or presented at the public hearing, the department shall reconsider and may adjust the preliminary determinations. The result of the reconsideration is the final reconciliation of the hospital's assessment under section ~~5112.06~~ 5166.05 of the Revised Code. The final reconciliation is subject to adjustments under division (D) of this section. 34672 34673 34674 34675 34676 34677 34678 34679 34680 34681 34682 34683 34684 34685 34686 34687 34688

(C) The department shall mail to each hospital a written notice of its assessment for the program year under the final reconciliation. A hospital may appeal the final reconciliation of its assessment to the court of common pleas of Franklin county. While a judicial appeal is pending, the hospital shall pay, in accordance with the schedules required by division (B) of section ~~5112.06~~ 5166.05 of the Revised Code, any amount of its assessment that is not in dispute into the hospital care assurance program fund created in section ~~5112.18~~ 5166.12 of the Revised Code. 34689 34690 34691 34692 34693 34694 34695 34696 34697

(D) In the course of any program year, the department may adjust the assessment rate or rates established in rules pursuant to section ~~5112.06~~ 5166.05 of the Revised Code or adjust the amounts of intergovernmental transfers required under section ~~5112.07~~ 5166.06 of the Revised Code and, as a result of the adjustment, adjust each hospital's assessment and intergovernmental transfer, to reflect refinements made by the United States ~~health care financing administration~~ department of health and human services during that program year to the limits it prescribed under ~~subsection (f) of section 1923 of the "Social Security Act," 49 Stat. 620 (1935),~~ 42 U.S.C.~~A.~~ 1396r-4(f)~~, as amended~~. When adjusted, the assessment rate or rates must comply with division (A) of section ~~5112.06~~ 5166.05 of the Revised Code. An adjusted intergovernmental transfer must comply with division (A) of section ~~5112.07~~ 5166.06 of the Revised Code. The department shall notify hospitals of adjustments made under this division and adjust for the remainder of the program year the installments paid by hospitals under sections ~~5112.06~~ 5166.05 and ~~5112.07~~ 5166.06 of the Revised Code in accordance with rules adopted under section ~~5112.03~~ 5166.02 of the Revised Code.

Sec. ~~5112.10~~ 5166.09. The department of ~~job and family services~~ health care administration shall operate the hospital care assurance program established by sections ~~5112.01~~ 5166.01 to ~~5112.21~~ 5166.14 of the Revised Code on a program year basis. The department shall complete all program requirements on or before the thirtieth day of September each year.

Sec. ~~5112.11~~ 5166.10. Except for moneys deposited into the legislative budget services fund under section ~~5112.19~~ 5166.13 of the Revised Code and the health care services administration fund created under section ~~5111.94~~ 5161.15 of the Revised Code, the department of ~~job and family services~~ health care administration

shall not use money paid to the department under sections ~~5112.06~~ 5166.05 and ~~5112.07~~ 5166.06 of the Revised Code or money that the department pays to hospitals under section ~~5112.08~~ 5166.07 of the Revised Code to replace any funds appropriated by the general assembly for the ~~medical assistance~~ medicaid program. 34729 34730 34731 34732 34733

Sec. ~~5112.17~~ 5166.11. (A) As used in this section: 34734

(1) "Federal poverty guideline" means the official poverty guideline as revised annually by the United States secretary of health and human services in accordance with section 673 of the "Community Service Block Grant Act," 95 Stat. 511 (1981), 42 U.S.C.A. 9902, as amended, for a family size equal to the size of the family of the person whose income is being determined. 34735 34736 34737 34738 34739 34740

(2) "Third-party payer" means any private or public entity or program that may be liable by law or contract to make payment to or on behalf of an individual for health care services. "Third-party payer" does not include a hospital. 34741 34742 34743 34744

(B) Each hospital that receives funds distributed under sections ~~5112.01~~ 5166.01 to ~~5112.21~~ 5166.14 of the Revised Code shall provide, without charge to the individual, basic, medically necessary hospital-level services to individuals who are residents of this state, are not recipients of the ~~medical assistance~~ medicaid program, and whose income is at or below the federal poverty guideline. Recipients of disability financial assistance ~~and recipients of disability medical assistance~~ provided under Chapter 5115. of the Revised Code and recipients of the disability medical assistance program qualify for services under this section. The director of ~~job and family services~~ health care administration shall adopt rules under section ~~5112.03~~ 5166.02 of the Revised Code specifying the hospital services to be provided under this section. 34745 34746 34747 34748 34749 34750 34751 34752 34753 34754 34755 34756 34757 34758

(C) Nothing in this section shall be construed to prevent a 34759

hospital from requiring an individual to apply for eligibility under the ~~medical assistance~~ medicaid program before the hospital processes an application under this section. Hospitals may bill any third-party payer for services rendered under this section. Hospitals may bill the ~~medical assistance~~ medicaid program, in accordance with Chapter ~~5111.~~ 5163. of the Revised Code and the rules adopted under ~~that chapter~~ section 5163.15 of the Revised Code, for services rendered under this section if the individual becomes a recipient of the program. Hospitals may bill individuals for services under this section if all of the following apply: 34760 34761 34762 34763 34764 34765 34766 34767 34768 34769

(1) The hospital has an established post-billing procedure for determining the individual's income and canceling the charges if the individual is found to qualify for services under this section. 34770 34771 34772 34773

(2) The initial bill, and at least the first follow-up bill, is accompanied by a written statement that does all of the following: 34774 34775 34776

(a) Explains that individuals with income at or below the federal poverty guideline are eligible for services without charge; 34777 34778 34779

(b) Specifies the federal poverty guideline for individuals and families of various sizes at the time the bill is sent; 34780 34781

(c) Describes the procedure required by division (C)(1) of this section. 34782 34783

(3) The hospital complies with any additional rules the department adopts under section ~~5112.03~~ 5166.02 of the Revised Code. 34784 34785 34786

Notwithstanding division (B) of this section, a hospital providing care to an individual under this section is subrogated to the rights of any individual to receive compensation or benefits from any person or governmental entity for the hospital 34787 34788 34789 34790

goods and services rendered.

(D) Each hospital shall collect and report to the department, in the form and manner prescribed by the department, information on the number and identity of patients served pursuant to this section.

(E) This section applies beginning May 22, 1992, regardless of whether the department has adopted rules specifying the services to be provided. Nothing in this section alters the scope or limits the obligation of any governmental entity or program, including the program awarding reparations to victims of crime under sections 2743.51 to 2743.72 of the Revised Code and the program for medically handicapped children established under section 3701.023 of the Revised Code, to pay for hospital services in accordance with state or local law.

Sec. ~~5112.18~~ 5166.12. (A) Except as provided in section ~~5112.19~~ 5166.13 of the Revised Code, all payments of assessments by hospitals under section ~~5112.06~~ 5166.05 of the Revised Code and all intergovernmental transfers under section ~~5112.07~~ 5166.06 of the Revised Code shall be deposited in the state treasury to the credit of the hospital care assurance program fund, hereby created. All investment earnings of the hospital care assurance program fund shall be credited to the fund. The department of ~~job and family services~~ health care administration shall maintain records that show the amount of money in the hospital care assurance program fund at any time that has been paid by each hospital and the amount of any investment earnings on that amount. All moneys credited to the hospital care assurance program fund shall be used solely to make payments to hospitals under division (D) of this section and section ~~5112.08~~ 5166.07 of the Revised Code.

(B) All federal matching funds received as a result of the

department distributing funds from the hospital care assurance 34822
program fund to hospitals under section ~~5112.08~~ 5166.07 of the 34823
Revised Code shall be credited to the health care - federal fund 34824
created under section ~~5111.943~~ 5161.18 of the Revised Code. 34825

(C) All distributions of funds to hospitals under section 34826
~~5112.08~~ 5166.07 of the Revised Code are conditional on: 34827

(1) Expiration of the time for appeals under section ~~5112.09~~ 34828
5166.08 of the Revised Code without the filing of an appeal, or on 34829
court determinations, in the event of appeals, that the hospital 34830
is entitled to the funds; 34831

(2) The sum of the following being sufficient to distribute 34832
the funds after the final determination of any appeals: 34833

(a) The available money in the hospital care assurance 34834
program fund; 34835

(b) The available portion of the money in the health care - 34836
federal fund that is credited to that fund pursuant to division 34837
(B) of this section. 34838

(3) The hospital's compliance with section ~~5112.17~~ 5166.11 of 34839
the Revised Code. 34840

(D) If an audit conducted by the department of the amounts of 34841
payments made and funds received by hospitals under sections 34842
~~5112.06, 5112.07, and 5112.08~~ 5166.05, 5166.06, and 5166.07 of the 34843
Revised Code identifies amounts that, due to errors by the 34844
department, a hospital should not have been required to pay but 34845
did pay, should have been required to pay but did not pay, should 34846
not have received but did receive, or should have received but did 34847
not receive, the department shall: 34848

(1) Make payments to any hospital that the audit reveals paid 34849
amounts it should not have been required to pay or did not receive 34850
amounts it should have received; 34851

(2) Take action to recover from a hospital any amounts that the audit reveals it should have been required to pay but did not pay or that it should not have received but did receive. 34852 34853 34854

Payments made under division (D)(1) of this section shall be made from the hospital care assurance program fund. Amounts recovered under division (D)(2) of this section shall be deposited to the credit of that fund. Any hospital may appeal the amount the hospital is to be paid under division (D)(1) or the amount that is to be recovered from the hospital under division (D)(2) of this section to the court of common pleas of Franklin county. 34855 34856 34857 34858 34859 34860 34861

Sec. ~~5112.19~~ 5166.13. From the first installment of assessments paid under section ~~5112.06~~ 5166.05 of the Revised Code and intergovernmental transfers made under section ~~5112.07~~ 5166.06 of the Revised Code during each program year beginning in an odd-numbered calendar year, the department of ~~job and family services~~ health care administration shall deposit into the state treasury to the credit of the legislative budget services fund, which is hereby created, a total amount equal to the amount by which the biennial appropriation from that fund exceeds the amount of unexpended, unencumbered moneys in that fund. All investment earnings of the legislative budget services fund shall be credited to that fund. Money in the legislative budget services fund shall be used solely to pay the expenses of the legislative budget office of the legislative service commission. 34862 34863 34864 34865 34866 34867 34868 34869 34870 34871 34872 34873 34874 34875

Sec. ~~5112.21~~ 5166.14. Except as specifically required by sections ~~5112.01~~ 5166.01 to ~~5112.19~~ 5166.13 of the Revised Code, information filed under those sections shall not include any patient-identifying material. Information that includes patient-identifying material is not a public record under section 149.43 of the Revised Code, and no patient-identifying material shall be released publicly by the department of ~~job and family~~ 34876 34877 34878 34879 34880 34881 34882

~~services~~ health care administration or by any person under contract with the department who has access to such information. 34883 34884

Sec. ~~3721.50~~ 5166.20. As used in sections ~~3721.50~~ 5166.20 to ~~3721.58~~ 5166.30 of the Revised Code: 34885 34886

(A) "Hospital" has the same meaning as in section 3727.01 of the Revised Code. 34887 34888

(B) "Inpatient days" means all days during which a resident of a nursing facility, regardless of payment source, occupies a bed in the nursing facility that is included in the facility's certified capacity under ~~Title XIX~~ the medicaid program. Therapeutic or hospital leave days for which payment is made under section ~~5111.26~~ 5164.37 of the Revised Code are considered inpatient days proportionate to the percentage of the facility's per resident per day rate paid for those days. 34889 34890 34891 34892 34893 34894 34895 34896

(C) ~~"Medicaid" has the same meaning as in section 5111.01 of the Revised Code.~~ 34897 34898

~~(D)~~ "Medicaid day" means all days during which a resident who is a medicaid recipient occupies a bed in a nursing facility that is included in the facility's certified capacity under ~~Title XIX~~ the medicaid program. Therapeutic or hospital leave days for which payment is made under section ~~5111.26~~ 5164.37 of the Revised Code are considered medicaid days proportionate to the percentage of the nursing facility's per resident per day rate for those days. 34899 34900 34901 34902 34903 34904 34905

~~(E)~~(D) "Nursing facility" has the same meaning as in section ~~5111.20~~ 5164.01 of the Revised Code. 34906 34907

~~(F)~~(E)(1) "Nursing home" means all of the following: 34908

(a) A nursing home licensed under section 3721.02 or 3721.09 of the Revised Code, including any part of a home for the aging licensed as a nursing home; 34909 34910 34911

(b) A facility or part of a facility, other than a hospital, 34912

that is certified as a skilled nursing facility under ~~Title XVIII~~ 34913
the medicare program; 34914

(c) A nursing facility, other than a portion of a hospital 34915
certified as a nursing facility. 34916

(2) "Nursing home" does not include any of the following: 34917

(a) A county home, county nursing home, or district home 34918
operated pursuant to Chapter 5155. of the Revised Code; 34919

(b) A nursing home maintained and operated by the Ohio 34920
veterans' home agency under section 5907.01 of the Revised Code; 34921

(c) A nursing home or part of a nursing home licensed under 34922
section 3721.02 or 3721.09 of the Revised Code that is certified 34923
as an intermediate care facility for the mentally retarded under 34924
~~Title XIX~~ the medicaid program. 34925

~~(G) "Title XIX" means Title XIX of the "Social Security Act,"~~ 34926
~~79 Stat. 286 (1965), 42 U.S.C. 1396, as amended.~~ 34927

~~(H) "Title XVIII" means Title XVIII of the "Social Security~~ 34928
~~Act," 79 Stat. 286 (1965), 42 U.S.C. 1395, as amended.~~ 34929

Sec. ~~3721.51~~ 5166.21. The department of ~~job and family~~ 34930
~~services~~ health care administration shall do all of the following: 34931

(A) Subject to division (C) of this section and for the 34932
purposes specified in sections ~~3721.56~~ 5166.27 and ~~3721.561~~ 34933
5166.28 of the Revised Code, determine an annual franchise permit 34934
fee on each nursing home in an amount equal to six dollars and 34935
twenty-five cents, multiplied by the product of the following: 34936

(1) The number of beds licensed as nursing home beds, plus 34937
any other beds certified as skilled nursing facility beds under 34938
~~Title XVIII~~ the medicare program or nursing facility beds under 34939
~~Title XIX~~ the medicaid program on the first day of May of the 34940
calendar year in which the fee is determined pursuant to division 34941

(A) of section ~~3721.53~~ 5166.23 of the Revised Code; 34942

(2) The number of days in the fiscal year beginning on the 34943
first day of July of the calendar year in which the fee is 34944
determined pursuant to division (A) of section ~~3721.53~~ 5166.23 of 34945
the Revised Code. 34946

(B) Subject to division (C) of this section and for the 34947
purposes specified in sections ~~3721.56~~ 5166.27 and ~~3721.561~~ 34948
5166.28 of the Revised Code, determine an annual franchise permit 34949
fee on each hospital in an amount equal to six dollars and 34950
twenty-five cents, multiplied by the product of the following: 34951
34952

(1) The number of beds registered pursuant to section 3701.07 34953
of the Revised Code as skilled nursing facility beds or long-term 34954
care beds, plus any other beds licensed as nursing home beds under 34955
section 3721.02 or 3721.09 of the Revised Code, on the first day 34956
of May of the calendar year in which the fee is determined 34957
pursuant to division (A) of section ~~3721.53~~ 5166.23 of the Revised 34958
Code; 34959

(2) The number of days in the fiscal year beginning on the 34960
first day of July of the calendar year in which the fee is 34961
determined pursuant to division (A) of section ~~3721.53~~ 5166.23 of 34962
the Revised Code. 34963

(C) If the United States centers for medicare and medicaid 34964
services determines that the franchise permit fee established by 34965
sections ~~3721.50~~ 5166.20 to ~~3721.58~~ 5166.30 of the Revised Code is 34966
an impermissible health care-related tax under ~~section 1903(w) of~~ 34967
~~the "Social Security Act," 49 Stat. 620 (1935),~~ 42 U.S.C. 34968
1396b(w), ~~as amended,~~ take all necessary actions to cease 34969
implementation of sections ~~3721.50~~ 5166.20 to ~~3721.58~~ 5166.30 of 34970
the Revised Code in accordance with rules adopted under section 34971
~~3721.58~~ 5166.30 of the Revised Code. 34972

Sec. ~~3721.52~~ 5166.22. (A) For the purpose of the fee under 34973
division (A) of section ~~3721.51~~ 5166.21 of the Revised Code, the 34974
department of health shall, not later than the first day of each 34975
June, report to the department of ~~job and family services~~ health 34976
care administration the number of beds in each nursing home 34977
licensed on the preceding first day of May under section 3721.02 34978
or 3721.09 of the Revised Code or certified on that date under 34979
~~Title XVIII or XIX~~ the medicare or medicaid program. 34980

(B) For the purpose of the fee under division (B) of section 34981
~~3721.51~~ 5166.21 of the Revised Code, the department of health 34982
shall, not later than the first day of each June, report to the 34983
department of ~~job and family services~~ health care administration 34984
the number of beds in each hospital registered on the preceding 34985
first day of May pursuant to section 3701.07 of the Revised Code 34986
as skilled nursing facility or long-term care beds or licensed on 34987
that date under section 3721.02 or 3721.09 of the Revised Code as 34988
nursing home beds. 34989

Sec. ~~3721.53~~ 5166.23. (A) Not later than the fifteenth day of 34990
August of each year, the department of ~~job and family services~~ 34991
health care administration shall determine the annual franchise 34992
permit fee for each nursing home in accordance with division (A) 34993
of section ~~3721.51~~ 5166.21 of the Revised Code and the annual 34994
franchise permit fee for each hospital in accordance with division 34995
(B) of that section. 34996

(B) Not later than the first day of September of each year, 34997
the department shall mail to each nursing home and hospital notice 34998
of the amount of the franchise permit fee that has been determined 34999
for the nursing home or hospital. 35000

(C) Each nursing home and hospital shall pay its fee under 35001
section ~~3721.51~~ 5166.21 of the Revised Code to the department in 35002

quarterly installment payments not later than forty-five days after the last day of each September, December, March, and June. 35003 35004

(D) No nursing home or hospital shall directly bill its residents for the fee paid under this section, or otherwise directly pass the fee through to its residents. 35005 35006 35007

Sec. ~~3721.54~~ <u>5166.24</u>. If a nursing home or hospital fails to pay the full amount of a franchise permit fee installment when due, the department of ~~job and family services~~ <u>health care administration</u> may assess a five per cent penalty on the amount due for each month or fraction thereof the installment is overdue. 35008 35009 35010 35011 35012

Sec. ~~3721.541~~ <u>5166.25</u>. (A) In addition to assessing a penalty pursuant to section ~~3721.54~~ <u>5166.24</u> of the Revised Code, the department of ~~job and family services~~ <u>health care administration</u> may do any of the following if a nursing facility or hospital fails to pay the full amount of a franchise permit fee installment when due: 35013 35014 35015 35016 35017 35018

(1) Withhold an amount less than or equal to the installment and penalty assessed under section ~~3721.54~~ <u>5166.24</u> of the Revised Code from a medicaid payment due the nursing facility or hospital until the nursing facility or hospital pays the installment and penalty; 35019 35020 35021 35022 35023

(2) Offset an amount less than or equal to the installment and penalty assessed under section ~~3721.54~~ <u>5166.24</u> of the Revised Code from a ~~Medicaid~~ <u>medicaid</u> payment due the nursing facility or hospital; 35024 35025 35026 35027

(3) Terminate the nursing facility or hospital's medicaid provider agreement. 35028 35029

(B) The department may offset a medicaid payment under division (A) of this section without providing notice to the nursing facility or hospital and without conducting an 35030 35031 35032

adjudication under Chapter 119. of the Revised Code. 35033

Sec. ~~3721.55~~ 5166.26. (A) A nursing home or hospital may 35034
appeal the fee imposed under section ~~3721.51~~ 5166.21 of the 35035
Revised Code solely on the grounds that the department of ~~job and~~ 35036
~~family services~~ health care administration committed a material 35037
error in determining the amount of the fee. A request for an 35038
appeal must be received by the department not later than fifteen 35039
days after the date the department mails the notice of the fee and 35040
must include written materials setting forth the basis for the 35041
appeal. 35042

(B) If a nursing home or hospital submits a request for an 35043
appeal within the time required under division (A) of this 35044
section, the department of ~~job and family services~~ health care 35045
administration shall hold a public hearing in Columbus not later 35046
than thirty days after the date the department receives the 35047
request for an appeal. The department shall, not later than ten 35048
days before the date of the hearing, mail a notice of the date, 35049
time, and place of the hearing to the nursing home or hospital. 35050
The department may hear all the requested appeals in one public 35051
hearing. 35052

(C) On the basis of the evidence presented at the hearing or 35053
any other evidence submitted by the nursing home or hospital, the 35054
department may adjust a fee. The department's decision is final. 35055

Sec. ~~3721.56~~ 5166.27. There is hereby created in the state 35056
treasury the home- and community-based services for the aged fund. 35057
Sixteen per cent of all payments and penalties paid by nursing 35058
homes and hospitals under sections ~~3721.53~~ 5166.23 and ~~3721.54~~ 35059
5166.24 of the Revised Code shall be deposited into the fund. The 35060
departments of ~~job and family services~~ health care administration 35061
and aging shall use the moneys in the fund to fund the following 35062

in accordance with rules adopted under section ~~3721.58~~ 5166.30 of the Revised Code:

(A) The medicaid program ~~established under Chapter 5111. of the Revised Code~~, including the PASSPORT program established under section 173.40 of the Revised Code;

(B) The residential state supplement program established under section ~~173.35~~ 5160.80 of the Revised Code.

Sec. ~~3721.561~~ 5166.28. (A) There is hereby created in the state treasury the nursing facility stabilization fund. All payments and penalties paid by nursing homes and hospitals under sections ~~3721.53~~ 5166.23 and ~~3721.54~~ 5166.24 of the Revised Code that are not deposited into the home and community-based services for the aged fund shall be deposited into the fund. The department of ~~job and family services~~ health care administration shall use the money in the fund to make medicaid payments to nursing facilities.

(B) Any money remaining in the nursing facility stabilization fund after payments specified in division (A) of this section are made shall be retained in the fund. Any interest or other investment proceeds earned on money in the fund shall be credited to the fund and used to make medicaid payments in accordance with division (A) of this section.

Sec. ~~3721.57~~ 5166.29. The department of ~~job and family services~~ health care administration may make any investigation it considers appropriate to obtain information necessary to fulfill its duties under sections ~~3721.50~~ 5166.20 to ~~3721.58~~ 5166.30 of the Revised Code. At the request of the department, the attorney general shall aid in any such investigations. The attorney general shall institute and prosecute all necessary actions for the enforcement of sections ~~3721.50~~ 5166.20 to ~~3721.58~~ 5166.30 of the

Revised Code, except that at the request of the attorney general, the county prosecutor of the county in which a nursing home or hospital that has failed to comply with sections ~~3721.50~~ 5166.20 to ~~3721.58~~ 5166.30 of the Revised Code is located shall institute and prosecute any necessary action against the nursing home or hospital.

Sec. ~~3721.58~~ 5166.30. The director of ~~job and family services~~ health care administration shall adopt rules in accordance with Chapter 119. of the Revised Code to do all of the following:

(A) Prescribe the actions the department of ~~job and family services~~ health care administration will take to cease implementation of sections ~~3721.50~~ 5166.20 through ~~3721.57~~ 5166.29 of the Revised Code if the United States centers for medicare and medicaid services determines that the franchise permit fee established by those sections is an impermissible health-care related tax under ~~section 1903(w) of the "Social Security Act," 49 Stat. 620 (1935),~~ 42 U.S.C. 1396b(w)~~, as amended~~;

(B) Establish the method of distributing moneys in the home and community-based services for the aged fund created under section ~~3721.56~~ 5166.27 of the Revised Code;

(C) Establish any requirements or procedures the director considers necessary to implement sections ~~3721.50~~ 5166.20 to ~~3721.58~~ 5166.30 of the Revised Code.

Sec. ~~5112.30~~ 5166.40. As used in sections ~~5112.30~~ 5166.40 to ~~5112.39~~ 5166.50 of the Revised Code~~:~~

~~(A) "Intermediate~~, "intermediate care facility for the mentally retarded" has the same meaning as in section ~~5111.20~~ 5164.01 of the Revised Code, except that it does not include any such facility operated by the department of mental retardation and

developmental disabilities. 35123

~~(B) "Medicaid" has the same meaning as in section 5111.01 of~~ 35124
~~the Revised Code.~~ 35125

Sec. ~~5112.31~~ 5166.41. The department of ~~job and family~~ 35126
~~services~~ health care administration shall do all of the following: 35127
35128

(A) For the purposes specified in sections ~~5112.37~~ 5166.48 35129
and ~~5112.371~~ 5166.481 of the Revised Code, annually assess each 35130
intermediate care facility for the mentally retarded a franchise 35131
permit fee equal to eleven dollars and ninety-eight cents 35132
multiplied by the product of the following: 35133

(1) The number of beds certified ~~under Title XIX of the~~ 35134
~~"Social Security Act"~~ for the medicaid program on the first day of 35135
May of the calendar year in which the assessment is determined 35136
pursuant to division (A) of section ~~5112.33~~ 5166.44 of the Revised 35137
Code; 35138

(2) The number of days in the fiscal year beginning on the 35139
first day of July of the same calendar year. 35140

(B) Beginning July 1, 2009, and the first day of each July 35141
thereafter, adjust fees determined under division (A) of this 35142
section in accordance with the composite inflation factor 35143
established in rules adopted under section ~~5112.39~~ 5166.50 of the 35144
Revised Code. 35145

(C) If the United States secretary of health and human 35146
services determines that the franchise permit fee established by 35147
sections ~~5112.30~~ 5166.40 to ~~5112.39~~ 5166.50 of the Revised Code 35148
would be an impermissible health care-related tax under ~~section~~ 35149
~~1903(w) of the "Social Security Act,"~~ 42 U.S.C.~~A.~~ 1396b(w), ~~as~~ 35150
~~amended,~~ take all necessary actions to cease implementation of 35151
those sections in accordance with rules adopted under section 35152

~~5112.39~~ 5166.50 of the Revised Code. 35153

Sec. ~~5112.32~~ 5166.43. For the purpose of the franchise permit fee imposed under section ~~5112.31~~ 5166.41 of the Revised Code, the department of mental retardation and developmental disabilities shall: 35154 35155 35156 35157

(A) Not later than August 1, 1993, report to the department of ~~job and family services~~ health care administration the number of beds in each intermediate care facility for the mentally retarded certified on July 1, 1993, ~~under Title XIX of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended~~ for the medicaid program; 35158 35159 35160 35161 35162 35163

(B) Not later than June 1, 1994, and the first day of each June thereafter, report to the department of ~~job and family services~~ health care administration the number of beds in each such facility certified on the preceding first day of May under that title. 35164 35165 35166 35167 35168

Sec. ~~5112.33~~ 5166.44. (A) Not later than the fifteenth day of August of each year, the department of ~~job and family services~~ health care administration shall determine the annual franchise permit fee for each intermediate care facility for the mentally retarded in accordance with section ~~5112.31~~ 5166.41 of the Revised Code. 35169 35170 35171 35172 35173 35174

(B) Not later than the first day of September of each year, the department shall mail to each intermediate care facility for the mentally retarded notice of the amount of the franchise permit fee the facility has been assessed under section ~~5112.31~~ 5166.41 of the Revised Code. 35175 35176 35177 35178 35179

(C) Each intermediate care facility for the mentally retarded shall pay its fee under section ~~5112.31~~ 5166.41 of the Revised Code to the department in quarterly installment payments not later 35180 35181 35182

than forty-five days after the last day of each September, 35183
December, March, and June. 35184

Sec. ~~5112.34~~ 5166.45. If an intermediate care facility for 35185
the mentally retarded fails to pay the full amount of an 35186
installment when due, the department of ~~job and family services~~ 35187
health care administration may assess a five per cent penalty on 35188
the amount due for each month or fraction thereof the installment 35189
is overdue. 35190

Sec. ~~5112.341~~ 5166.46. (A) In addition to assessing a penalty 35191
pursuant to section ~~5112.34~~ 5166.45 of the Revised Code, the 35192
department of ~~job and family services~~ health care administration 35193
may do any of the following if an intermediate care facility for 35194
the mentally retarded fails to pay the full amount of a franchise 35195
permit fee installment when due: 35196

(1) Withhold an amount less than or equal to the installment 35197
and penalty assessed under section ~~5112.34~~ 5166.45 of the Revised 35198
Code from a medicaid payment due the facility until the facility 35199
pays the installment and penalty; 35200

(2) Offset an amount less than or equal to the installment 35201
and penalty assessed under section ~~5112.34~~ 5166.45 of the Revised 35202
Code from a ~~Medicaid~~ medicaid payment due the nursing facility or 35203
hospital; 35204

(3) Terminate the facility's medicaid provider agreement. 35205

(B) The department may offset a medicaid payment under 35206
division (A) of this section without providing notice to the 35207
intermediate care facility for the mentally retarded and without 35208
conducting an adjudication under Chapter 119. of the Revised Code. 35209
35210

Sec. ~~5112.35~~ 5166.47. (A) An intermediate care facility for 35211

the mentally retarded may appeal the franchise permit fee imposed 35212
under section ~~5112.31~~ 5166.41 of the Revised Code solely on the 35213
grounds that the department of ~~job and family services~~ health care 35214
administration committed a material error in determining the 35215
amount of the fee. A request for an appeal must be received by the 35216
department not later than fifteen days after the date the 35217
department mails the notice of the fee and must include written 35218
materials setting forth the basis for the appeal. 35219

(B) If an intermediate care facility for the mentally 35220
retarded submits a request for an appeal within the time required 35221
under division (A) of this section, the department shall hold a 35222
public hearing in Columbus not later than thirty days after the 35223
date the department receives the request for an appeal. The 35224
department shall, not later than ten days before the date of the 35225
hearing, mail a notice of the date, time, and place of the hearing 35226
to the facility. The department may hear all requested appeals in 35227
one public hearing. 35228

(C) On the basis of the evidence presented at the hearing or 35229
any other evidence submitted by the intermediate care facility for 35230
the mentally retarded, the department may adjust a fee. The 35231
department's decision is final. 35232

Sec. ~~5112.37~~ 5166.48. There is hereby created in the state 35233
treasury the home and community-based services for the mentally 35234
retarded and developmentally disabled fund. Ninety-four and 35235
twenty-eight hundredths per cent of all installment payments and 35236
penalties paid by an intermediate care facility for the mentally 35237
retarded under sections ~~5112.33~~ 5166.44 and ~~5112.34~~ 5166.45 of the 35238
Revised Code shall be deposited into the fund. The department of 35239
~~job and family services~~ health care administration shall 35240
distribute the money in the fund in accordance with rules adopted 35241
under section ~~5112.39~~ 5166.50 of the Revised Code. The departments 35242

of ~~job and family services~~ health care administration and mental retardation and developmental disabilities shall use the money for the medicaid program ~~established under Chapter 5111. of the Revised Code and~~, including home and community-based services to ~~mentally retarded and developmentally disabled~~ persons with mental retardation or a developmental disability. 35243 35244 35245 35246 35247 35248

Sec. ~~5112.371~~ 5166.481. There is hereby created in the state treasury the children with intensive behavioral needs programs fund. Five and seventy-two hundredths per cent of all installment payments and penalties paid by an intermediate care facility for the mentally retarded under sections ~~5112.33~~ 5166.44 and ~~5112.34~~ 5166.45 of the Revised Code shall be deposited in the fund. The money in the fund shall be used for the programs the director of mental retardation and developmental disabilities establishes under section 5123.0417 of the Revised Code. 35249 35250 35251 35252 35253 35254 35255 35256 35257

Sec. ~~5112.38~~ 5166.49. The department of ~~job and family services~~ health care administration may make any investigation it considers appropriate to obtain information necessary to fulfill its duties under sections ~~5112.30~~ 5166.40 to ~~5112.39~~ 5166.50 of the Revised Code. At the request of the department, the attorney general shall aid in any such investigations. The attorney general shall institute and prosecute all necessary actions for the enforcement of sections ~~5112.30~~ 5166.40 to ~~5112.39~~ 5166.50 of the Revised Code, except that at the request of the attorney general, the county prosecutor of the county in which an intermediate care facility for the mentally retarded that has failed to comply with those sections is located shall institute and prosecute any necessary action against the facility. 35258 35259 35260 35261 35262 35263 35264 35265 35266 35267 35268 35269 35270

Sec. ~~5112.39~~ 5166.50. The director of ~~job and family services~~ health care administration shall adopt rules in accordance with 35271 35272

Chapter 119. of the Revised Code to do all of the following: 35273

35274

(A) Establish a composite inflation factor with which to adjust franchise permit fees under section ~~5112.31~~ 5166.41 of the Revised Code; 35275 35276 35277

(B) Prescribe the actions the department will take to cease implementation of sections ~~5112.30~~ 5166.40 to ~~5112.39~~ 5166.50 of the Revised Code if the United States secretary of health and human services determines that the franchise permit fee imposed under section ~~5112.31~~ 5166.41 of the Revised Code is an impermissible health care-related tax under ~~section 1903(w) of the "Social Security Act," 49 Stat. 620 (1935),~~ 42 U.S.C.~~A.~~ 1396b(w)~~, as amended~~; 35278 35279 35280 35281 35282 35283 35284 35285

(C) Establish the method of distributing the money in the home and community-based services for the mentally retarded and developmentally disabled fund created by section ~~5112.37~~ 5166.48 of the Revised Code; 35286 35287 35288 35289

(D) Establish any other requirements or procedures the director considers necessary to implement sections ~~5112.30~~ 5166.40 to ~~5112.39~~ 5166.50 of the Revised Code. 35290 35291 35292

Sec. ~~5111.176~~ 5166.60. (A) As used in this section: 35293

(1) "Medicaid health insuring corporation" means a health insuring corporation that holds a certificate of authority under Chapter 1751. of the Revised Code and has entered into a contract with the department of ~~job and family services~~ health care administration pursuant to section ~~5111.17~~ 5165.05 of the Revised Code. 35294 35295 35296 35297 35298 35299

(2) "Managed care premium" means any premium payment, capitation payment, or other payment a medicaid health insuring corporation receives for providing, or arranging for the provision 35300 35301 35302

of, health care services to its members or enrollees residing in this state. 35303 35304

(B) Except as provided in division (C) of this section, all of the following apply: 35305 35306

(1) Each medicaid health insuring corporation shall pay to the department of ~~job and family services~~ health care administration a franchise permit fee for the period December 1, 2005, through December 31, 2005, and each calendar quarter occurring thereafter. 35307 35308 35309 35310 35311

(2) The fee to be paid is an amount that is equal to a percentage of the managed care premiums the medicaid health insuring corporation received in the period December 1, 2005, through December 31, 2005, and in the subsequent quarter to which the fee applies, excluding the amount of any managed care premiums the corporation returned or refunded to enrollees, members, or premium payers during the period December 1, 2005, through December 31, 2005, or the subsequent quarter to which the fee applies. 35312 35313 35314 35315 35316 35317 35318 35319 35320

(3) The percentage to be used in calculating the fee shall be four and one-half per cent, unless the department adopts rules under division (L) of this section decreasing the percentage below four and one-half per cent or increasing the percentage to not more than six per cent. 35321 35322 35323 35324 35325

(C) The department shall reduce the franchise permit fee imposed under this section or terminate its collection of the fee if the department determines either of the following: 35326 35327 35328

(1) That the reduction or termination is required to comply with federal statutes or regulations; 35329 35330

(2) That the fee does not qualify as a state share of medicaid expenditures eligible for federal financial participation. 35331 35332 35333

(D) The franchise permit fee shall be paid on or before the thirtieth day following the end of the period December 1, 2005, through December 31, 2005, or the calendar quarter to which the fee applies. At the time the fee is submitted, the medicaid health insuring corporation shall file with the department a report on a form prescribed by the department. The corporation shall provide on the form all information required by the department and shall include with the form any necessary supporting documentation. 35334 35335 35336 35337 35338 35339 35340 35341

(E) The department may audit the records of any medicaid health insuring corporation to determine whether the corporation is in compliance with this section. The department may audit the records that pertain to the period December 1, 2005, through December 31, 2005, or a particular calendar quarter, at any time during the five years following the date the franchise permit fee payment for that period or quarter was due. 35342 35343 35344 35345 35346 35347 35348

(F)(1) A medicaid health insuring corporation that does not pay the franchise permit fee in full by the date the payment is due is subject to any or all of the following: 35349 35350 35351

(a) A monetary penalty in the amount of five hundred dollars for each day any part of the fee remains unpaid, except that the penalty shall not exceed an amount equal to five per cent of the total fee that was due; 35352 35353 35354 35355

(b) Withholdings from future managed care premiums pursuant to division (G) of this section; 35356 35357

(c) Termination of the corporation's medicaid provider agreement pursuant to division (H) of this section. 35358 35359

(2) Penalties imposed under division (F)(1)(a) of this section are in addition to and not in lieu of the franchise permit fee. 35360 35361 35362

(G) If a medicaid health insuring corporation fails to pay the full amount of its franchise permit fee when due, or the full 35363 35364

amount of a penalty imposed under division (F)(1)(a) of this section, the department may withhold an amount equal to the remaining amount due from any future managed care premiums to be paid to the corporation under the medicaid program. The department may withhold amounts under this division without providing notice to the corporation. The amounts may be withheld until the amount due has been paid. 35365 35366 35367 35368 35369 35370 35371

(H) The department may commence actions to terminate a medicaid health insuring corporation's medicaid provider agreement, and may terminate the agreement subject to division (I) of this section, if the corporation does any of the following: 35372 35373 35374 35375

(1) Fails to pay its franchise permit fee or fails to pay the fee promptly; 35376 35377

(2) Fails to pay a penalty imposed under division (F)(1)(a) of this section or fails to pay the penalty promptly; 35378 35379

(3) Fails to cooperate with an audit conducted under division (E) of this section. 35380 35381

(I) At the request of a medicaid health insuring corporation, the department shall grant the corporation a hearing in accordance with Chapter 119. of the Revised Code, if either of the following is the case: 35382 35383 35384 35385

(1) The department has determined that the corporation owes an additional franchise permit fee or penalty as the result of an audit conducted under division (E) of this section. 35386 35387 35388

(2) The department is proposing to terminate the corporation's medicaid provider agreement and the provisions of section ~~5111.06~~ 5163.01 of the Revised Code requiring an adjudication in accordance with Chapter 119. of the Revised Code are applicable. 35389 35390 35391 35392 35393

(J)(1) At the request of a medicaid corporation, the 35394

department shall grant the corporation a reconsideration of any issue that arises out of the provisions of this section and is not subject to division (I) of this section. The department's decision at the conclusion of the reconsideration is not subject to appeal under Chapter 119. of the Revised Code or any other provision of the Revised Code. 35395 35396 35397 35398 35399 35400

(2) In conducting a reconsideration, the department shall do at least the following: 35401 35402

(a) Specify the time frames within which a corporation must act in order to exercise its opportunity for a reconsideration; 35403 35404

(b) Permit the corporation to present written arguments or other materials that support the corporation's position. 35405 35406

(K) There is hereby created in the state treasury the managed care assessment fund. Money collected from the franchise permit fees and penalties imposed under this section shall be credited to the fund. The department shall use the money in the fund to pay for medicaid services, the department's administrative costs, and contracts with medicaid health insuring corporations. 35407 35408 35409 35410 35411 35412

(L) The director of ~~job and family services~~ health care administration may adopt rules to implement and administer this section. The rules shall be adopted in accordance with Chapter 119. of the Revised Code. 35413 35414 35415 35416

Sec. ~~5112.99~~ 5166.99. (A) The director of ~~job and family services~~ health care administration shall impose a penalty for each day that a hospital fails to report the information required under section ~~5112.04~~ 5166.03 of the Revised Code on or before the dates specified in that section. The amount of the penalty shall be established by the director in rules adopted under section ~~5112.03~~ 5166.02 of the Revised Code. 35417 35418 35419 35420 35421 35422 35423

(B) In addition to any other remedy available to the 35424

department of ~~job and family services~~ health care administration under law to collect unpaid assessments and transfers, the director shall impose a penalty of ten per cent of the amount due on any hospital that fails to pay assessments or make intergovernmental transfers by the dates required by rules adopted under section ~~5112.03~~ 5166.02 of the Revised Code.

(C) The director shall waive the penalties provided for in divisions (A) and (B) of this section for good cause shown by the hospital.

(D) All penalties imposed under this section shall be deposited into the health care administration fund created by section ~~5111.94~~ 5161.15 of the Revised Code.

Sec. 5167.01. As used in this chapter, "federal poverty guidelines" has the same meaning as in section 5101.46 of the Revised Code.

Sec. ~~5101.50~~ 5167.05. (A) ~~As used in sections 5101.50 to 5101.529 of the Revised Code:~~

~~(1) "Children's health insurance program" means the program authorized by Title XXI of the "Social Security Act," 111 Stat. 552 (1997), 42 U.S.C.A. 1397aa.~~

~~(2) "Federal poverty guidelines" has the same meaning as in section 5101.46 of the Revised Code.~~

~~(B)~~ The director of ~~job and family services~~ health care administration may continue to operate the children's health insurance program initially authorized by an executive order issued under section 107.17 of the Revised Code as long as federal financial participation is available for the program. If operated, the program shall provide health assistance to uninsured individuals under nineteen years of age with family incomes not exceeding one hundred fifty per cent of the federal poverty

guidelines. In accordance with 42 U.S.C.~~A.~~ 1397aa, the director may provide for the health assistance to meet the requirements of 42 U.S.C.~~A.~~ 1397cc, to be provided under the medicaid program ~~established under Chapter 5111. of the Revised Code~~, or to be a combination of both. 35455 35456 35457 35458 35459

Sec. ~~5101.501~~ 5167.06. Health assistance provided under section ~~5101.50~~ 5167.05 of the Revised Code shall be known as the children's health insurance program part I. 35460 35461 35462

Sec. ~~5101.502~~ 5167.07. The director of ~~job and family services~~ health care administration may adopt rules in accordance with Chapter 119. of the Revised Code as necessary for the efficient administration of the children's health insurance program part I, including rules that establish all of the following: 35463 35464 35465 35466 35467 35468

(A) The conditions under which health assistance services will be reimbursed; 35469 35470

(B) The method of reimbursement applicable to services reimbursable under the program; 35471 35472

(C) The amount of reimbursement, or the method by which the amount is to be determined, for each reimbursable service. 35473 35474

Sec. ~~5101.503~~ 5167.08. A completed application for ~~medical assistance under Chapter 5111. of the Revised Code~~ the medicaid program shall be treated as an application for health assistance under the children's health insurance program part I if the application is for an assistance group that includes a child under nineteen years of age and is denied. 35475 35476 35477 35478 35479 35480

Sec. ~~5101.51~~ 5167.10. In accordance with federal law governing the children's health insurance program, the director of 35481 35482

~~job and family services~~ health care administration may submit a state child health plan to the United States secretary of health and human services to provide, except as provided in section ~~5101.516~~ 5167.16 of the Revised Code, health assistance to uninsured individuals under nineteen years of age with family incomes above one hundred fifty per cent of the federal poverty guidelines but not exceeding two hundred per cent of the federal poverty guidelines. If the director submits the plan, the director shall include both of the following in the plan:

(A) The health assistance will not begin before January 1, 2000.

(B) The health assistance will be available only while federal financial participation is available for it.

Sec. ~~5101.511~~ 5167.11. Health assistance provided under section ~~5101.51~~ 5167.10 of the Revised Code shall be known as the children's health insurance program part II.

Sec. ~~5101.512~~ 5167.12. If the director of ~~job and family services~~ health care administration submits a state child health plan to the United States secretary of health and human services under section ~~5101.51~~ 5167.10 of the Revised Code and the secretary approves the plan, the director shall implement the children's health insurance program part II in accordance with the plan. The director may adopt rules in accordance with Chapter 119. of the Revised Code as necessary for the efficient administration of the program, including rules that establish all of the following:

(A) The conditions under which health assistance services will be reimbursed;

(B) The method of reimbursement applicable to services reimbursable under the program;

(C) The amount of reimbursement, or the method by which the 35513
amount is to be determined, for each reimbursable service. 35514

Sec. ~~5101.513~~ 5167.13. The director of ~~job and family~~ 35515
~~services~~ health care administration may contract with a government 35516
entity or person to perform the director's administrative duties 35517
regarding the children's health insurance program part II, other 35518
than the duty to submit a state child health plan to the United 35519
States secretary of health and human services under section 35520
~~5101.51~~ 5167.10 of the Revised Code and the duty to adopt rules 35521
under section ~~5101.512~~ 5167.12 of the Revised Code. 35522

Sec. ~~5101.514~~ 5167.14. In accordance with 42 U.S.C.~~A.~~ 1397aa, 35523
the director of health care administration may provide for health 35524
assistance under the children's health insurance program part II 35525
to meet the requirements of 42 U.S.C.~~A.~~ 1397cc, to be provided 35526
under the medicaid program ~~established under Chapter 5111. of the~~ 35527
~~Revised Code~~, or to be a combination of both. 35528

Sec. ~~5101.515~~ 5167.15. The director of ~~job and family~~ 35529
~~services~~ health care administration may determine applicants' 35530
eligibility for the children's health insurance program part II by 35531
any of the following means: 35532

(A) Using employees of the department of ~~job and family~~ 35533
~~services~~ health care administration; 35534

(B) Assigning the duty to county departments of job and 35535
family services; 35536

(C) Contracting with a government entity or person. 35537

Sec. ~~5101.516~~ 5167.16. If the director of ~~job and family~~ 35538
~~services~~ health care administration determines that federal 35539
financial participation for the children's health insurance 35540

program part II is insufficient to provide health assistance to all the individuals the director anticipates are eligible for the program, the director may refuse to accept new applications for the program or may make the program's eligibility requirements more restrictive. 35541-35545

Sec. ~~5101.517~~ <u>5167.17</u>. To the extent permitted by 42 U.S.C.~~A.~~ 1397cc(e), the director of ~~job and family services~~ <u>health care administration</u> may require an individual receiving health assistance under the children's health insurance program part II to pay a premium, deductible, coinsurance payment, or other cost-sharing expense. 35546-35551

Sec. ~~5101.518~~ <u>5167.18</u>. The director of ~~job and family services~~ <u>health care administration</u> shall establish an appeal process for individuals aggrieved by a decision made regarding eligibility for the children's health insurance program part II. The process may be identical to, similar to, or different from the appeal process established by section ~~5101.35~~ <u>5160.34</u> of the Revised Code. 35552-35558

Sec. ~~5101.519~~ <u>5167.19</u>. A completed application for ~~medical assistance under Chapter 5111. of the Revised Code~~ <u>the medicaid program</u> shall be treated as an application for health assistance under the children's health insurance program part II if the application is for an assistance group that includes a child under nineteen years of age and is denied. 35559-35564

Sec. ~~5101.52~~ <u>5167.21</u>. In accordance with federal law governing the children's health insurance program, the director of ~~job and family services~~ <u>health care administration</u> may submit a request for a federal waiver to the United States secretary of health and human services to provide, except as provided in 35565-35569

section ~~5101.526~~ 5167.27 of the Revised Code, health assistance to individuals under nineteen years of age with family incomes above two hundred per cent of the federal poverty guidelines but not exceeding three hundred per cent of the federal poverty guidelines. If the director submits the plan, the director shall stipulate in the plan that the health assistance will be available only while federal financial participation is available for it and that health assistance shall not begin before January 1, 2008.

Sec. ~~5101.521~~ 5167.22. Health assistance provided under section ~~5101.52~~ 5167.21 of the Revised Code shall be known as the children's health insurance program part III.

Sec. ~~5101.522~~ 5167.23. If the director of ~~job and family services~~ health care administration submits a waiver request to the United States secretary of health and human services under section ~~5101.52~~ 5167.21 of the Revised Code and the secretary grants the waiver, the director shall implement the children's health insurance program part III in accordance with the waiver. The director may adopt rules in accordance with Chapter 119. of the Revised Code as necessary for the efficient administration of the program, including rules that establish all of the following:

(A) The conditions under which health assistance services will be reimbursed;

(B) The method of reimbursement applicable to services reimbursable under the program;

(C) The amount of reimbursement, or the method by which the amount is to be determined, for each reimbursable service.

Sec. ~~5101.523~~ 5167.24. The director of ~~job and family services~~ health care administration may contract with a government

entity or person to perform the director's administrative duties regarding the children's health insurance program part III, other than the duty to submit a waiver request to the United States secretary of health and human services under section ~~5101.52~~ 5167.21 of the Revised Code and the duty to adopt rules under section ~~5101.522~~ 5167.23 of the Revised Code. 35599 35600 35601 35602 35603 35604

Sec. ~~5101.524~~ 5167.25. In accordance with 42 U.S.C. 1397aa, the director of ~~job and family services~~ health care administration shall provide for health assistance under the children's health insurance program part III to meet the requirements of 42 U.S.C. 1397cc, to be provided under the medicaid program ~~established under Chapter 5111. of the Revised Code~~, or to be a combination of both. 35605 35606 35607 35608 35609 35610 35611

Sec. ~~5101.525~~ 5167.26. The director of ~~job and family services~~ health care administration may determine applicants' eligibility for the children's health insurance program part III by any of the following means: 35612 35613 35614 35615

(A) Using employees of the department of ~~job and family services~~ health care administration; 35616 35617

(B) Assigning the duty to county departments of job and family services; 35618 35619

(C) Contracting with a government entity or person. 35620

Sec. ~~5101.526~~ 5167.27. If the director of ~~job and family services~~ health care administration determines that federal financial participation for the children's health insurance program part III is insufficient to provide health assistance to all the individuals the director anticipates are eligible for the program, the director may refuse to accept new applications for the program or may make the program's eligibility requirements 35621 35622 35623 35624 35625 35626 35627

more restrictive.

Sec. ~~5101.527~~ 5167.28. To the extent permitted by 42 U.S.C. 1397cc(e), the director of ~~job and family services~~ health care administration shall require an individual receiving health assistance under the children's health insurance program part III to pay the following as a term of participation in the program:

(A) A premium of not less than forty dollars per month for a family with one individual receiving health assistance under the program;

(B) A premium of not less than eighty dollars per month for a family with two individuals receiving health assistance under the program;

(C) A premium of not less than one hundred twenty dollars per month for a family with three or more individuals receiving health assistance under the program.

Sec. ~~5101.528~~ 5167.29. If the children's health insurance program part III is not provided under the medicaid program ~~established under Chapter 5111. of the Revised Code~~, the director of ~~job and family services~~ health care administration shall establish an appeal process for individuals aggrieved by a decision made regarding eligibility for the children's health insurance program part III. The process may be identical to, similar to, or different from the appeal process established by section ~~5101.35~~ 5160.34 of the Revised Code.

Sec. ~~5101.529~~ 5167.30. A completed application for the medicaid program ~~under Chapter 5111. of the Revised Code~~ shall be treated as an application for health assistance under the children's health insurance program part III.

Sec. ~~5101.5110~~ 5167.32. (A) The director of ~~job and family~~ 35656
~~services~~ health care administration may submit a waiver request to 35657
the United States secretary of health and human services to 35658
provide health assistance to any individual who meets all of the 35659
following requirements: 35660

(1) Is the parent of a child under nineteen years of age who 35661
resides with the parent and is eligible for health assistance 35662
under the children's health insurance program part I or II or the 35663
medicaid program ~~established under Chapter 5111. of the Revised~~ 35664
~~Code~~; 35665

(2) Is uninsured; 35666

(3) Has a family income that does not exceed one hundred per 35667
cent of the federal poverty guidelines. 35668

(B) A waiver request the director submits under division (A) 35669
of this section may seek federal funds allotted to the state under 35670
~~Title XXI of the "Social Security Act," 111 Stat. 558 (1997),~~ 42 35671
U.S.C.~~A.~~ 1397dd~~, as amended,~~ that are not otherwise used to fund 35672
the children's health insurance program parts I and II. 35673

(C) If a waiver request the director submits under division 35674
(A) of this section is granted, the director may adopt rules in 35675
accordance with Chapter 119. of the Revised Code as necessary for 35676
the efficient administration of the program authorization by the 35677
waiver. 35678

Sec. ~~5101.5211~~ 5167.35. (A) As used in sections ~~5101.5211~~ 35679
5167.35 to ~~5101.5216~~ 5167.40 of the Revised Code: 35680

~~"Children's buy-in program" means the program established~~ 35681
~~under sections 5101.5211 to 5101.5216 of the Revised Code.~~ 35682

"Countable family income" has the meaning established in 35683
rules adopted under section ~~5101.5215~~ 5167.39 of the Revised Code. 35684

35685

"Creditable coverage" has the same meaning as in 42 U.S.C. 300gg(c)(1), except that it does not mean medical assistance available under the children's buy-in program or the program for medically handicapped children. 35686 35687 35688 35689

"Family" has the meaning established in rules adopted under section ~~5101.5215~~ 5167.39 of the Revised Code. 35690 35691

"Federal poverty guidelines" has the same meaning as in section 5101.46 of the Revised Code. 35692 35693

"Program for medically handicapped children" means the program established under sections 3701.021 to 3701.0210 of the Revised Code. 35694 35695 35696

(B) The director of ~~job and family services~~ health care administration shall establish the children's buy-in program in accordance with sections ~~5101.5211~~ 5167.35 to ~~5101.5216~~ 5167.40 of the Revised Code. The director shall submit to the United States secretary of health and human services an amendment to the state medicaid plan, an amendment to the state child health plan, one or more requests for a federal waiver, or such an amendment and waiver requests as necessary to seek federal matching funds for the children's buy-in program. The director shall not begin implementation of the program until after submitting the amendment, waiver request, or both. The director may begin implementation of the program before receiving approval of the amendment, waiver request, or both using state funds only. The director shall implement the program regardless of whether the amendment, waiver request, or both are denied. The program shall be funded with state funds only if the United States secretary denies federal matching funds for the program. If the United States secretary approves federal matching funds for the program and if permitted under the terms of the approval, the program 35697 35698 35699 35700 35701 35702 35703 35704 35705 35706 35707 35708 35709 35710 35711 35712 35713 35714 35715

shall be operated as part of the medicaid program, the children's 35716
health insurance program, or both. 35717

Sec. ~~5101.5212~~ 5167.36. Under the children's buy-in program 35718
and subject to section ~~5101.5213~~ 5167.37 of the Revised Code, an 35719
individual who does both of the following in accordance with rules 35720
adopted under section ~~5101.5215~~ 5167.39 of the Revised Code 35721
qualifies for medical assistance under the program, unless the 35722
director of ~~job and family services~~ health care administration has 35723
adopted rules under division (B) of section ~~5101.5215~~ 5167.39 of 35724
the Revised Code to limit the number of individuals who may 35725
participate in the program at one time and the program is serving 35726
the maximum number of individuals specified in the rules: 35727
35728

(A) Applies for the children's buy-in program; 35729

(B) Provides satisfactory evidence of all of the following: 35730

(1) That the individual is under nineteen years of age; 35731

(2) That the individual's countable family income exceeds two 35732
hundred fifty per cent of the federal poverty guidelines; 35733

(3) That the individual has not had creditable coverage for 35734
at least six months before enrolling in the children's buy-in 35735
program, unless the individual lost the only creditable coverage 35736
available to the individual because the individual exhausted a 35737
lifetime benefit limitation; 35738

(4) That one or more of the following apply to the 35739
individual: 35740

(a) The individual is unable to obtain creditable coverage 35741
due to a pre-existing condition of the individual; 35742

(b) The individual lost the only creditable coverage 35743
available to the individual because the individual has exhausted a 35744
lifetime benefit limitation; 35745

(c) The premium for the only creditable coverage available to the individual is greater than two hundred per cent of the premium applicable to the individual under the children's buy-in program; 35746 35747 35748

(d) The individual participates in the program for medically handicapped children. 35749 35750

(5) That the individual meets the additional eligibility requirements for the children's buy-in program established in rules adopted under section ~~5101.5215~~ 5167.39 of the Revised Code. 35751 35752 35753 35754

Sec. ~~5101.5213~~ 5167.37. (A) An individual participating in the children's buy-in program shall be charged a monthly premium established by rules adopted under section ~~5101.5215~~ 5167.39 of the Revised Code. The amount of the monthly premium shall not be less than the following: 35755 35756 35757 35758 35759

(1) In the case of an individual with countable family income exceeding two hundred fifty per cent but not exceeding four hundred per cent of the federal poverty guidelines, the following amount: 35760 35761 35762 35763

(a) If no other member of the individual's family receives medical assistance under the program with the individual, one hundred dollars; 35764 35765 35766

(b) If one or more members of the individual's family receive medical assistance under the program with the individual, one hundred fifty dollars. 35767 35768 35769

(2) In the case of an individual with countable family income exceeding four hundred per cent but not exceeding five hundred per cent of the federal poverty guidelines, the following amount: 35770 35771 35772 35773

(a) If no other member of the individual's family receives medical assistance under the program with the individual, one 35774 35775

hundred twenty-five dollars; 35776

(b) If one or more members of the individual's family receive medical assistance under the program with the individual, one hundred seventy-five dollars. 35777 35778 35779

(3) In the case of an individual with countable family income exceeding five hundred per cent of the federal poverty guidelines, the full amount of the actuarially determined cost of the premium. 35780 35781 35782 35783

(B) If the premium for the children's buy-in program is not paid for two consecutive months, the individual shall lose eligibility for the program. The individual may not resume participation in the program until the unpaid premiums that accrued before the individual lost eligibility are paid. 35784 35785 35786 35787 35788

Sec. ~~5101.5214~~ 5167.38. (A) An individual participating in the children's buy-in program shall be charged co-payments established by rules adopted under section ~~5101.5215~~ 5167.39 of the Revised Code. 35789 35790 35791 35792

(B) Notwithstanding division (B) of section ~~5111.0112~~ 5162.35 of the Revised Code, if applicable, and to the extent permitted by federal law, a provider may refuse to provide a service to an individual if a co-payment required by this section is not paid. 35793 35794 35795 35796 35797

Sec. ~~5101.5215~~ 5167.39. (A) The director of ~~job and family services~~ health care administration shall adopt rules in accordance with Chapter 119. of the Revised Code as necessary to implement the children's buy-in program, including rules that do all of the following: 35798 35799 35800 35801 35802

(1) Establish the meaning of "countable family income" and "family"; 35803 35804

(2) For the purpose of section ~~5101.5212~~ 5167.36 of the 35805
Revised Code, establish additional eligibility requirements for 35806
the program; 35807

(3) For the purpose of section ~~5101.5213~~ 5167.37 of the 35808
Revised Code, establish monthly premiums for the children's buy-in 35809
program; 35810

(4) For the purpose of section ~~5101.5214~~ 5167.38 of the 35811
Revised Code, establish copayment requirements for the children's 35812
buy-in program. 35813

(B) The director may adopt rules in accordance with Chapter 35814
119. of the Revised Code to limit the number of individuals who 35815
may participate in the children's buy-in program at one time. 35816

Sec. ~~5101.5216~~ 5167.40. The director of ~~job and family~~ 35817
~~services~~ health care administration shall prepare a report on the 35818
children's buy-in program that examines the program's 35819
effectiveness and includes the number of individuals participating 35820
in the program and the costs of the program. The director shall 35821
submit the report to the governor and general assembly not later 35822
than December 31, 2008. 35823

Sec. ~~5115.10~~ 5168.01. (A) The director of ~~job and family~~ 35824
~~services~~ health care administration shall establish a disability 35825
medical assistance program. 35826

(B) Subject to all other eligibility requirements established 35827
by this chapter and the rules adopted under it for the disability 35828
medical assistance program, a person may be eligible for 35829
disability medical assistance only if the person is medication 35830
dependent, as determined by the department of ~~job and family~~ 35831
~~services~~ health care administration. 35832

(C) The director shall adopt rules under section 111.15 of 35833
the Revised Code for purposes of implementing division (B) of this 35834

section. The rules may specify or establish any or all of the following: 35835 35836

(1) Standards for determining whether a person is medication dependent, including standards under which a person may qualify as being medication dependent only if it is determined that both of the following are the case: 35837 35838 35839 35840

(a) The person is receiving ongoing treatment for a chronic medical condition that requires continuous prescription medication for an indefinite, long-term period of time; 35841 35842 35843

(b) Loss of the medication would result in a significant risk of medical emergency and loss of employability lasting at least nine months. 35844 35845 35846

(2) A requirement that a person's medical condition be certified by an individual authorized under Chapter 4731. of the Revised Code to practice medicine and surgery or osteopathic medicine and surgery; 35847 35848 35849 35850

(3) Limitations on the chronic medical conditions and prescription medications that may qualify a person as being medication dependent. 35851 35852 35853

Sec. ~~5115.11~~ 5168.02. An individual who qualifies for the ~~medical assistance~~ medicaid program ~~established under Chapter 5111. of the Revised Code~~ shall receive medical assistance through that program rather than through the disability medical assistance program. 35854 35855 35856 35857 35858

An individual is ineligible for disability medical assistance if, for the purpose of avoiding consideration of property in determinations of the individual's eligibility for disability medical assistance or a greater amount of assistance, the person has transferred property during the two years preceding application for or most recent redetermination of eligibility for 35859 35860 35861 35862 35863 35864

disability medical assistance. 35865

Sec. 5168.03. Each applicant for or recipient of disability medical assistance who, in the judgment of the department of health care administration or a county department of job and family services might be eligible for benefits under the supplemental security program, shall, as a condition of eligibility for assistance, apply for such benefits if directed to do so by the department or county department. 35866 35867 35868 35869 35870 35871 35872

Sec. 5168.04. As a condition of eligibility for disability medical assistance, and as a means of preventing or reducing the provision of assistance at public expense, each applicant for or recipient of the assistance shall make reasonable efforts to secure support from persons responsible for the applicant's or recipient's support, and from other sources, including any federal program designed to provide assistance to individuals with disabilities. The department of health care administration or county department of job and family services may provide assistance to the applicant or recipient in securing other forms of assistance. 35873 35874 35875 35876 35877 35878 35879 35880 35881 35882 35883

Sec. ~~5115.12~~ 5168.05. (A) The director of ~~job and family services~~ health care administration shall adopt rules in accordance with section 111.15 of the Revised Code governing the disability medical assistance program. The rules may establish or specify any or all of the following: 35884 35885 35886 35887 35888

(1) Income, resource, citizenship, age, residence, living arrangement, and other eligibility requirements; 35889 35890

(2) Health services to be included in the program; 35891

(3) The maximum authorized amount, scope, duration, or limit of payment for services; 35892 35893

(4) Limits on the length of time an individual may receive disability medical assistance; 35894 35895

(5) Limits on the total number of individuals in the state who may receive disability medical assistance; 35896 35897

(6) Limits on the number and types of providers eligible to be reimbursed for services provided to individuals enrolled in the program. 35898 35899 35900

(B) For purposes of limiting the cost of the disability medical assistance program, the director may do either of the following: 35901 35902 35903

(1) Adopt rules in accordance with section 111.15 of the Revised Code that revise the program's eligibility requirements; the maximum authorized amount, scope, duration, or limit of payment for services included in the program; or any other requirement or standard established or specified by rules adopted under division (A) of this section or under section ~~5115.10~~ 5168.01 of the Revised Code; 35904 35905 35906 35907 35908 35909 35910

(2) Suspend acceptance of applications for disability medical assistance. While a suspension is in effect, no person shall receive a determination or redetermination of eligibility for disability medical assistance unless the person was receiving the assistance during the month immediately preceding the suspension's effective date or the person submitted an application prior to the suspension's effective date and receives a determination of eligibility based on that application. The director may adopt rules in accordance with section 111.15 of the Revised Code establishing requirements and specifying procedures applicable to the suspension of acceptance of applications. 35911 35912 35913 35914 35915 35916 35917 35918 35919 35920 35921

Sec. ~~5115.14~~ 5168.06. (A) The director of ~~job and family services~~ health care administration shall adopt rules in 35922 35923

accordance with section 111.15 of the Revised Code establishing application and verification procedures, reapplication procedures, and other requirements the director considers necessary in the administration of the application process for disability medical assistance. 35924 35925 35926 35927 35928

(B) Any person who applies for disability medical assistance shall receive a voter registration application under section 3503.10 of the Revised Code. 35929 35930 35931

Sec. ~~5115.13~~ <u>5168.07</u>. (A) The department of ~~job and family services~~ <u>health care administration</u> shall supervise and administer the disability medical program, except as follows: 35932 35933 35934

(1) The department may require county departments of job and family services to perform any administrative function specified in rules adopted by the director of ~~job and family services~~ <u>health care administration</u>. 35935 35936 35937 35938

(2) The director may contract with any private or public entity in this state to perform any administrative function or to administer any or all of the program. 35939 35940 35941

(B) If the department requires county departments to perform administrative functions, the director of ~~job and family services~~ <u>health care administration</u> shall adopt rules in accordance with section 111.15 of the Revised Code governing the performance of the functions to be performed by county departments. County departments shall perform the functions in accordance with the rules. 35942 35943 35944 35945 35946 35947 35948

If the director contracts with a private or public entity to perform administrative functions or to administer any or all of the program, the director may either adopt rules in accordance with section 111.15 of the Revised Code or include provisions in the contract governing the performance of the functions by the 35949 35950 35951 35952 35953

private or public entity. Entities under contract shall perform the functions in accordance with the requirements established by the director. 35954 35955 35956

(C) Whenever division (A)(1) or (2) of this section is implemented, the director shall conduct investigations to determine whether disability medical assistance is being administered in compliance with the Revised Code and rules adopted by the director or in accordance with the terms of the contract. 35957 35958 35959 35960 35961

Sec. 5168.08. If a recipient of disability medical assistance, or an individual whose income and resources are included in determining the recipient's eligibility for the assistance, becomes possessed of resources or income in excess of the amount allowed to retain eligibility, or if other changes occur that affect the recipient's eligibility or need for assistance, the recipient shall notify the department of health care administration or county department of job and family services within the time limits specified in rules adopted by the director of health care administration in accordance with section 111.15 of the Revised Code. Failure of a recipient to report possession of excess resources or income or a change affecting eligibility or need within those time limits shall be considered prima-facie evidence of intent to defraud under section 5168.09 of the Revised Code. 35962 35963 35964 35965 35966 35967 35968 35969 35970 35971 35972 35973 35974 35975 35976

Sec. 5168.09. As used in this section, "erroneous payments" means disability medical assistance payments made to persons who are not entitled to receive them, including payments made as a result of misrepresentation or fraud, and payments made due to an error by the recipient or by the county department of job and family services that made the payment. 35977 35978 35979 35980 35981 35982

The department of health care administration shall adopt 35983

rules in accordance with section 111.15 of the Revised Code specifying the circumstances under which action is to be taken under this section to recover erroneous payments. The department, or a county department of job and family services at the request of the department, shall take action to recover erroneous payments in the circumstances specified in the rules. The department or county department may institute a civil action to recover erroneous payments.

Each county department of job and family services shall retain fifty per cent of the erroneous payments it recovers under this section. The department of health care administration shall receive the remaining fifty per cent.

Sec. 5168.10. Whenever disability medical assistance has been furnished to a recipient for whose support another person is responsible, the other person shall, in addition to the liability otherwise imposed, as a consequence of failure to support the recipient, be liable for all assistance furnished the recipient. The value of the assistance so furnished may be recovered in a civil action brought by the county department of job and family services.

Sec. ~~173.71~~ 5169.01. As used in ~~sections 173.71 to 173.91 of the Revised Code~~ this chapter:

~~(A) "Children's health insurance program" means the children's health insurance program part I, part II, and part III established under sections 5101.50 to 5101.529 of the Revised Code.~~

~~(B) "Disability medical assistance program" means the program established under section 5115.10 of the Revised Code.~~

~~(C) "Medicaid program" or "medicaid" means the medical assistance program established under Chapter 5111. of the Revised~~

~~Code.~~ 36014

~~(D)~~ "National drug code number" means the number registered 36015
for a drug pursuant to the listing system established by the 36016
United States food and drug administration under the "Drug Listing 36017
Act of 1972," 86 Stat. 559, 21 U.S.C. 360, as amended. 36018

~~(E)~~(B) "Ohio's best Rx program participant" or "participant" 36019
means an individual determined eligible for the Ohio's best Rx 36020
program and included under an Ohio's best Rx program enrollment 36021
card. 36022

~~(F)~~(C) "Participating manufacturer" means a drug manufacturer 36023
participating in the Ohio's best Rx program pursuant to a 36024
manufacturer agreement entered into under section 173.81 of the 36025
Revised Code. 36026

~~(G)~~(D) "Participating terminal distributor" means a terminal 36027
distributor of dangerous drugs participating in the Ohio's best Rx 36028
program pursuant to an agreement entered into under section 173.79 36029
of the Revised Code. 36030

~~(H)~~(E) "Political subdivision" has the same meaning as in 36031
section 9.23 of the Revised Code. 36032

~~(I)~~(F) "State agency" has the same meaning as in section 9.23 36033
of the Revised Code. 36034

~~(J)~~(G) "Terminal distributor of dangerous drugs" has the same 36035
meaning as in section 4729.01 of the Revised Code. 36036

~~(K)~~(H) "Third-party payer" has the same meaning as in section 36037
3901.38 of the Revised Code. 36038

~~(L)~~(I) "Trade secret" has the same meaning as in section 36039
1333.61 of the Revised Code. 36040

~~(M)~~(J) "Usual and customary charge" means the amount a 36041
participating terminal distributor or the drug mail order system 36042
included in the Ohio's best Rx program pursuant to section 173.78 36043

of the Revised Code charges when a drug included in the program is purchased by an individual who does not receive a discounted price for the drug pursuant to any drug discount program, including the Ohio's best Rx program or a pharmacy assistance program established by any person or government entity, and for whom no third-party payer or program funded in whole or part with state or federal funds is responsible for all or part of the cost of the drug.

Sec. ~~173.72~~ 5169.02. There is hereby established the Ohio's best Rx program for the purpose of providing outpatient prescription drug discounts to individuals residing in this state who are enrolled in the program by meeting the eligibility requirements specified in section ~~173.76~~ 5169.06 of the Revised Code, including eligible individuals who are sixty years of age or older, eligible individuals who have low incomes but are not eligible for medicaid, and other eligible individuals who do not have health benefits that cover outpatient drugs. The program shall include all drugs that are included in a manufacturer agreement entered into under section ~~173.81~~ 5169.11 of the Revised Code and all other drugs that may be dispensed only pursuant to a prescription issued by a licensed health professional authorized to prescribe drugs, as defined in section 4729.01 of the Revised Code.

Sec. ~~173.721~~ 5169.021. (A) Except as provided in division (B) of this section, the Ohio's best Rx program shall be administered by the department of ~~aging~~ health care administration.

(B)(1) The department may enter into a contract with any person under which the person serves as the administrator of the Ohio's best Rx program. Before entering into a contract for a program administrator, the department shall issue a request for proposals from persons seeking to be considered. The department

shall develop a process to be used in issuing the request for 36075
proposals, receiving responses to the request, and evaluating the 36076
responses on a competitive basis. In accordance with that process, 36077
the department shall select the person to be awarded the contract. 36078

(2) Subject to divisions (B)(5) and (6) of this section, the 36079
department may delegate to the person awarded the contract any of 36080
the department's powers or duties specified in sections ~~173.71~~ 36081
5169.01 to ~~173.91~~ 5169.21 of the Revised Code or any other 36082
provision of the Revised Code pertaining to the Ohio's best Rx 36083
program. The terms of the contract shall specify the extent to 36084
which the powers or duties are delegated to the program 36085
administrator. 36086

(3) In exercising powers or performing duties delegated under 36087
the contract, the program administrator is subject to the same 36088
provisions of sections ~~173.71~~ 5169.01 to ~~173.91~~ 5169.21 of the 36089
Revised Code or other provisions of the Revised Code that grant 36090
the powers or duties to the department, as well as any limitations 36091
or restrictions that are applicable to or associated with those 36092
powers or duties. 36093

(4) Wherever the department is referred to in sections ~~173.71~~ 36094
5169.01 to ~~173.91~~ 5169.21 of the Revised Code or another provision 36095
of the Revised Code relative to a power or duty delegated to the 36096
program administrator, both of the following apply: 36097

(a) If the department has delegated the power or duty in 36098
whole to the program administrator, the reference to the 36099
department is, instead, a reference to the administrator. 36100

(b) If the department retains any part of the power or duty 36101
that is delegated to the program administrator, the reference to 36102
the department is a reference to both the department and the 36103
administrator. 36104

(5) The terms of a contract for a program administrator shall 36105

include provisions for offering the drug mail order system 36106
included in the Ohio's best Rx program pursuant to section ~~173.78~~ 36107
5169.08 of the Revised Code. The terms of the contract may permit 36108
the administrator to offer the drug mail order system by 36109
contracting with another person. 36110

(6) The department shall not delegate to a program 36111
administrator the department's powers or duties to do any of the 36112
following: 36113

(a) Enter into contracts under this section other than a 36114
contract to offer a drug mail order system; 36115

(b) Receive verification of drug pricing information under 36116
section ~~173.742~~ 5169.042 of the Revised Code or verification of 36117
drug manufacturer payment information under section ~~173.814~~ 36118
5169.114 of the Revised Code from the pharmacy benefit manager 36119
selected under section ~~173.731~~ 5169.031 of the Revised Code to 36120
serve as the Ohio's best Rx program's consulting pharmacy benefit 36121
manager; 36122

(c) Request the program's consulting pharmacy benefit manager 36123
to provide for an audit under section ~~173.732~~ 5169.032 of the 36124
Revised Code; 36125

(d) Review or use any information contained in or pertaining 36126
to an audit provided for by the program's consulting pharmacy 36127
benefit manager other than the audit's findings of whether the 36128
consulting pharmacy benefit manager provided valid information 36129
when providing drug pricing verification services or drug 36130
manufacturer payment verification services; 36131

(e) Adopt rules under section ~~173.83~~ 5169.13 or ~~173.84~~ 36132
5169.14 of the Revised Code; 36133

(f) Employ an ombudsperson pursuant to section ~~173.723~~ 36134
5169.023 of the Revised Code. 36135

Sec. ~~173.722~~ 5169.022. The department of ~~aging~~ health care 36136
administration shall undertake outreach efforts to publicize the 36137
Ohio's best Rx program and maximize participation in the program. 36138

Sec. ~~173.723~~ 5169.023. The department of ~~aging~~ health care 36139
administration shall employ an ombudsperson to assist terminal 36140
distributors of dangerous drugs with grievances regarding the 36141
Ohio's best Rx program. 36142

Sec. ~~173.724~~ 5169.024. The department of ~~aging~~ health care 36143
administration may coordinate the Ohio's best Rx program with 36144
either of the following: 36145

(A) ~~The~~ In cooperation with the department of aging, the 36146
golden buckeye card program established under section 173.06 of 36147
the Revised Code. In coordinating the programs, the ~~department~~ 36148
departments may establish a card that serves as both a golden 36149
buckeye card provided under section 173.06 of the Revised Code and 36150
an Ohio's best Rx program enrollment card issued under section 36151
~~173.773~~ 5169.073 of the Revised Code. The ~~department~~ departments 36152
may identify the card by including the names of both programs on 36153
the card or by selecting a combined name for inclusion on the 36154
card. 36155

(B) Any health benefit plan offered to the employees of state 36156
agencies and the eligible dependents of those employees, for 36157
purposes of enhancing efficiency, reducing the cost of drugs, and 36158
maximizing the benefits of the Ohio's best Rx program and the 36159
health benefit plan. 36160

Sec. ~~173.73~~ 5169.03. (A) Any entity that provides services as 36161
a pharmacy benefit manager relative to the outpatient drug 36162
coverage included in a health benefit plan offered to the 36163
employees or retirees of a state agency or political subdivision 36164

and the eligible dependents of those employees or retirees shall provide drug pricing verification services under section ~~173.742~~ 5169.042 of the Revised Code and drug manufacturer payment verification services under section ~~173.814~~ 5169.114 of the Revised Code if the entity is selected under section ~~173.731~~ 5169.031 of the Revised Code by the department of ~~aging~~ health care administration to serve as the Ohio's best Rx program's consulting pharmacy benefit manager for purposes of providing the verification services. 36165 36166 36167 36168 36169 36170 36171 36172 36173

(B) Both of the following apply to the entity selected to serve as the Ohio's best Rx program's consulting pharmacy benefit manager: 36174 36175 36176

(1) The entity shall provide the drug pricing verification services and drug manufacturer payment verification services without charge, either to the Ohio's best Rx program or to the state agency or political subdivision for which it provides services as a pharmacy benefit manager. 36177 36178 36179 36180 36181

(2) The entity shall provide the verification services for the entire year for which it is selected to serve as the program's consulting pharmacy benefit manager, regardless of the duration or termination of its responsibility to the state agency or political subdivision for which it provides services as a pharmacy benefit manager. 36182 36183 36184 36185 36186 36187

(C) If the entity selected to serve as the consulting pharmacy benefit manager fails to provide the program with drug pricing verification services or drug manufacturer payment verification services, or fails to provide for an audit when requested to do so under section ~~173.732~~ 5169.032 of the Revised Code, the department may ask the attorney general to bring an action for injunctive relief in any court of competent jurisdiction. On the filing of an appropriate petition in the court, the court shall conduct a hearing on the petition. If it is 36188 36189 36190 36191 36192 36193 36194 36195 36196

demonstrated in the proceedings that the pharmacy benefit manager has failed to provide the verification services or has failed to provide for the audit, the court shall grant a temporary or permanent injunction enjoining the pharmacy benefit manager from continuing to fail to provide the verification services or from continuing to fail to provide for the audit. 36197 36198 36199 36200 36201 36202

(D) This section does not impose any duty on the state agency or political subdivision for which an entity provides services as a pharmacy benefit manager. 36203 36204 36205

Sec. ~~173.731~~ 5169.031. Annually, the department of ~~aging~~ health care administration shall select a pharmacy benefit manager, from among the pharmacy benefit managers subject to section ~~173.73~~ 5169.03 of the Revised Code, to serve as the Ohio's best Rx program's consulting pharmacy benefit manager for purposes of providing drug pricing verification services under section ~~173.742~~ 5169.042 of the Revised Code and drug manufacturer payment verification services under section ~~173.814~~ 5169.114 of the Revised Code. The department shall select the pharmacy benefit manager that the department considers to be the most appropriate pharmacy benefit manager to provide the verification services for the Ohio's best Rx program. In making the selection, the department shall consider the pharmacy benefit manager that provides services relative to the outpatient drug coverage included in the health benefit plan offered to the greatest number of employees or retirees of a state agency or political subdivision and the eligible dependents of those employees or retirees. 36206 36207 36208 36209 36210 36211 36212 36213 36214 36215 36216 36217 36218 36219 36220 36221 36222 36223

The department shall provide written notice to the pharmacy benefit manager that it has been selected to serve as the Ohio's best Rx program's consulting pharmacy benefit manager. The notice shall specify the date on which the pharmacy benefit manager is to 36224 36225 36226 36227

begin serving as the program's consulting pharmacy benefit manager 36228
for the ensuing year. 36229

Before the end of the one-year period during which a pharmacy 36230
benefit manager is to serve as the program's consulting pharmacy 36231
benefit manager, the department shall make another selection in 36232
accordance with this section. In making the selection, the 36233
department may select the same pharmacy benefit manager to serve 36234
as the program's consulting pharmacy benefit manager or may select 36235
another pharmacy benefit manager. 36236

Sec. ~~173.732~~ 5169.032. (A) To determine whether the pharmacy 36237
benefit manager selected under section ~~173.731~~ 5169.031 of the 36238
Revised Code to serve as the Ohio's best Rx program's consulting 36239
pharmacy benefit manager has provided valid information when 36240
providing drug pricing verification services under section ~~173.742~~ 36241
5169.042 of the Revised Code or drug manufacturer payment 36242
verification services under section ~~173.814~~ 5169.114 of the 36243
Revised Code, the department of ~~aging~~ health care administration 36244
may request that the consulting pharmacy benefit manager provide 36245
for an audit of its relevant contracts with drug manufacturers and 36246
terminal distributors of dangerous drugs. 36247

In making audit requests under this section, both of the 36248
following apply: 36249

(1) The department may request an audit on a regularly 36250
occurring basis, but not more frequently than once every three 36251
years. 36252

(2) The department may request an audit at any time it has a 36253
reasonable basis to believe that the consulting pharmacy benefit 36254
manager is not acting in good faith in providing drug pricing 36255
verification services or drug manufacturer payment verification 36256
services. Notice of the request shall be made in writing and 36257
signed by the director of ~~aging~~ health care administration. The 36258

notice may specify the basis for the belief that the consulting pharmacy benefit manager is not acting in good faith. If the basis for the belief is not specified and the audit findings demonstrate that the consulting pharmacy benefit manager acted in good faith, the department shall pay the cost incurred by the consulting pharmacy benefit manager in providing for the audit. 36259 36260 36261 36262 36263 36264

(B) An audit provided for under this section shall be performed only by an auditor that is mutually satisfactory to the department and consulting pharmacy benefit manager and independent of both the department and consulting pharmacy benefit manager. 36265 36266 36267 36268

(C) If the findings of an audit provided for under this section demonstrate that the verification services provided by the consulting pharmacy benefit manager did not result in valid information, the department shall use the audit findings for purposes of confirming the validity of the one or more drug pricing formulas designated under section ~~173.741~~ 5169.041 of the Revised Code and entering into agreements with drug manufacturers under section ~~173.81~~ 5169.11 of the Revised Code. 36269 36270 36271 36272 36273 36274 36275 36276

Sec. ~~173.74~~ 5169.04. Annually, the department of ~~aging~~ health care administration shall establish a base price for each drug included in the Ohio's best Rx program. In the case of drugs dispensed by a terminal distributor of dangerous drugs that has entered into an agreement under section ~~173.79~~ 5169.09 of the Revised Code, the base price shall be established by using the one or more formulas designated under section ~~173.741~~ 5169.041 of the Revised Code. In the case of the drug mail order system included in the program pursuant to section ~~173.78~~ 5169.08 of the Revised Code, the base price shall be established in accordance with the rules adopted under section ~~173.83~~ 5169.13 of the Revised Code governing the drug mail order system. 36277 36278 36279 36280 36281 36282 36283 36284 36285 36286 36287 36288

Sec. ~~173.741~~ 5169.041. Annually, the department of ~~aging~~ 36289
health care administration shall designate one or more formulas 36290
for use in establishing under section ~~173.74~~ 5169.04 of the 36291
Revised Code the Ohio's best Rx program's base price for drugs 36292
dispensed by a terminal distributor of dangerous drugs that has 36293
entered into an agreement under section ~~173.79~~ 5169.09 of the 36294
Revised Code. Each formula shall include a drug pricing discount 36295
component that is expressed as a percentage discount. The formula 36296
used for generic drugs may include the maximum allowable cost 36297
limits that apply to generic drugs under the medicaid program. 36298

In designating the one or more formulas, the department shall 36299
use the best information on drug pricing that is available to the 36300
department, including information obtained through the drug 36301
pricing verification services provided under section ~~173.742~~ 36302
5169.042 of the Revised Code by the Ohio's best Rx program's 36303
consulting pharmacy benefit manager selected under section ~~173.731~~ 36304
5169.031 of the Revised Code. Based on the available information, 36305
the department shall modify the one or more formulas as it 36306
considers appropriate to maximize the benefits provided to Ohio's 36307
best Rx program participants. 36308

Sec. ~~173.742~~ 5169.042. For purposes of section ~~173.741~~ 36309
5169.041 of the Revised Code, the department of ~~aging~~ health care 36310
administration shall obtain verification of drug pricing 36311
information from the Ohio's best Rx program's consulting pharmacy 36312
benefit manager selected under section ~~173.731~~ 5169.031 of the 36313
Revised Code. The information shall be obtained in accordance with 36314
the following procedures: 36315

(A) For brand name drugs, excluding generic drugs marketed 36316
under brand names, the department shall submit to the consulting 36317
pharmacy benefit manager the formula the department proposes to 36318
use to establish the program's base price for brand name drugs 36319

during the year. 36320

The consulting pharmacy benefit manager shall review the formula submitted by the department. In conducting the review, the consulting pharmacy benefit manager shall compare the drug pricing discount percentage included in the department's formula to the drug pricing discount percentage included in the formula most commonly used by the consulting pharmacy benefit manager to establish part of its payment rate for brand name drugs dispensed by terminal distributors of dangerous drugs other than drug mail order systems. If the formulas are not expressed in equivalent terms, the consulting pharmacy benefit manager shall make all accommodations necessary to make the comparison of the discount percentages. 36321 36322 36323 36324 36325 36326 36327 36328 36329 36330 36331 36332

After conducting the review, the consulting pharmacy benefit manager shall provide information to the department verifying whether the discount percentage included in the department's formula is more than two percentage points below the discount percentage included in the formula used by the consulting pharmacy benefit manager. The information provided to the department shall be certified by signature of an officer of the consulting pharmacy benefit manager. 36333 36334 36335 36336 36337 36338 36339 36340

(B) For generic drugs, the department shall identify the fifty generic drugs most frequently purchased by Ohio's best Rx program participants in the immediately preceding year from terminal distributors of dangerous drugs other than the drug mail order system included in the program pursuant to section ~~173.78~~ 5169.08 of the Revised Code. The department shall submit to the consulting pharmacy benefit manager the names of the fifty drugs, the number of prescriptions filled for each of the drugs, the formula used to compute the base price for the drugs during the year, and the weighted average base price for the drugs that resulted for the year. 36341 36342 36343 36344 36345 36346 36347 36348 36349 36350 36351

The consulting pharmacy benefit manager shall review the submitted information. In conducting the review, the consulting pharmacy benefit manager shall compare the department's weighted average base price to the equivalent part of the consulting pharmacy benefit manager's weighted average payment rate for the same drugs when dispensed by terminal distributors of dangerous drugs other than drug mail order systems. For purposes of the comparison, the department and consulting pharmacy benefit manager shall express the weighted average base price and payment rate in terms of a discount percentage that is taken from the drugs' average wholesale price, as identified by a national drug price reporting service selected by the department and the consulting pharmacy benefit manager. 36352 36353 36354 36355 36356 36357 36358 36359 36360 36361 36362 36363 36364

After conducting the review, the consulting pharmacy benefit manager shall provide information to the department verifying whether the discount percentage reflected in the department's weighted average base price for the drugs is more than two percentage points below the equivalent part of the consulting pharmacy benefit manager's weighted average payment rate for the same drugs. The information provided to the department shall be certified by signature of an officer of the consulting pharmacy benefit manager. 36365 36366 36367 36368 36369 36370 36371 36372 36373

Sec. ~~173.75~~ 5169.05. (A) Subject to division (B) of this section, the amount that an Ohio's best Rx program participant is to be charged for a quantity of a drug purchased under the program shall be established in accordance with all of the following: 36374 36375 36376 36377

(1) If the drug is not included in a manufacturer agreement entered into under section ~~173.81~~ 5169.11 of the Revised Code, the participant shall be charged an amount that is computed according to the drug's base price established under section ~~173.74~~ 5169.04 of the Revised Code. 36378 36379 36380 36381 36382

(2) If the drug is included in a manufacturer agreement entered into under section ~~173.81~~ 5169.11 of the Revised Code, the participant shall be charged an amount that is computed by subtracting from the drug's base price established under section ~~173.74~~ 5169.04 of the Revised Code the amount of the manufacturer payment that applies to the transaction, as established under section ~~173.812~~ 5169.112 of the Revised Code.

(3) If an administrative fee is specified in rules adopted under section ~~173.83~~ 5169.13 of the Revised Code, the participant shall be charged the amount of the administrative fee.

(4) If the drug is dispensed by a terminal distributor of dangerous drugs under an agreement entered into under section ~~173.79~~ 5169.09 of the Revised Code, and the terminal distributor charges a professional fee pursuant to the agreement, the participant shall be charged the amount of the professional fee.

(5) If the drug is dispensed through the drug mail order system included in the program pursuant to section ~~173.78~~ 5169.08 of the Revised Code, the participant shall not be charged a professional fee.

(B) When a quantity of a drug is purchased by an Ohio's best Rx program participant, the participating terminal distributor or drug mail order system dispensing the drug shall charge the lesser of the amount that applies to the transaction, as established in accordance with division (A) of this section, or the usual and customary charge that otherwise would apply to the transaction. When a drug is purchased at the usual and customary charge pursuant to this division, the transaction is not subject to sections ~~173.71~~ 5169.01 to ~~173.91~~ 5169.21 of the Revised Code as the purchase or dispensing of a drug under the program.

Sec. ~~173.751~~ 5169.051. The department of ~~aging~~ health care administration shall report the following to each participating

terminal distributor and the drug mail order system included in the Ohio's best Rx program pursuant to section ~~173.78~~ 5169.08 of the Revised Code in a manner enabling the distributor and system to comply with section ~~173.75~~ 5169.05 of the Revised Code: 36414 36415 36416 36417

(A) For each drug included in the program, the amount to be charged under division (A)(1) or (2) of section ~~173.75~~ 5169.05 of the Revised Code; 36418 36419 36420

(B) The administrative fee, if any, specified by the department in rules adopted under section ~~173.83~~ 5169.13 of the Revised Code. 36421 36422 36423

Sec. ~~173.752~~ 5169.052. The amount that an Ohio's best Rx program participant saves when a drug is purchased under the program shall be determined by subtracting the amount that the participant is charged in accordance with division (A) of section ~~173.75~~ 5169.05 of the Revised Code from the usual and customary charge that otherwise would apply to the transaction. 36424 36425 36426 36427 36428 36429

Sec. ~~173.753~~ 5169.053. Not later than the first day of March of each year, the department of ~~aging~~ health care administration shall do all of the following: 36430 36431 36432

(A) Create a list of the twenty-five drugs most often dispensed to Ohio's best Rx program participants under the program, using data from the most recent six-month period for which the data is available; 36433 36434 36435 36436

(B) Determine the average amount that participants are charged under the program, on a date selected by the department, for each drug included on the list created under division (A) of this section; 36437 36438 36439 36440

(C) Determine, for the date selected for division (B) of this section, the average usual and customary charge for each drug included on the list created under division (A) of this section; 36441 36442 36443

(D) By comparing the average charges determined under divisions (B) and (C) of this section, determine the average percentage savings Ohio's best Rx program participants receive for each drug included on the list created under division (A) of this section. 36444 36445 36446 36447 36448

Sec. ~~173.76~~ 5169.06. (A) To be eligible for the Ohio's best Rx program, an individual must meet all of the following requirements at the time of application for the program: 36449 36450 36451

(1) The individual must be a resident of this state. 36452

(2) One of the following must be the case: 36453

(a) The individual has family income, as determined under rules adopted pursuant to section ~~173.83~~ 5169.13 of the Revised Code, that does not exceed three hundred per cent of the federal poverty guidelines, as revised annually by the United States department of health and human services in accordance with section 673(2) of the "Omnibus Budget Reconciliation Act of 1981," 95 Stat. 511, 42 U.S.C. 9902, as amended; 36454 36455 36456 36457 36458 36459 36460

(b) The individual is sixty years of age or older; 36461

(c) The individual is a person with a disability, as defined in section 173.06 of the Revised Code. 36462 36463

(3) Except as provided in division (B) of this section, the individual must not have coverage for outpatient drugs paid for in whole or in part by any of the following: 36464 36465 36466

(a) A third-party payer, including an employer; 36467

(b) The medicaid program; 36468

(c) The children's health insurance program; 36469

(d) The disability medical assistance program; 36470

(e) Another health plan or pharmacy assistance program that uses state or federal funds to pay part or all of the cost of the 36471 36472

individual's outpatient drugs. 36473

(4) The individual must not have had coverage for outpatient drugs paid for by any of the entities or programs specified in division (A)(3) of this section during any of the four months preceding the month in which the application for the Ohio's best Rx program is made, unless any of the following applies: 36474 36475 36476 36477 36478

(a) The individual is sixty years of age or older. 36479

(b) The third-party payer, including an employer, that paid for the coverage filed for bankruptcy under federal bankruptcy laws. 36480 36481 36482

(c) The individual is no longer eligible for coverage provided through a retirement plan subject to protection under the "Employee Retirement Income Security Act of 1974," 88 Stat. 832, 29 U.S.C. 1001, as amended. 36483 36484 36485 36486

(d) The individual is no longer eligible for the medicaid program, children's health insurance program, or disability medical assistance program. 36487 36488 36489

(e) The individual is either temporarily or permanently discharged from employment due to a business reorganization. 36490 36491

(B) An individual is not subject to division (A)(3) of this section if the individual has coverage for outpatient drugs paid for in whole or in part by either of the following: 36492 36493 36494

(1) The workers' compensation program; 36495

(2) A medicare prescription drug plan offered pursuant to the "Medicare Prescription Drug, Improvement, and Modernization Act of 2003," 117 Stat. 2071, 42 U.S.C. 1395w-101, as amended, but only if all of the following are the case with respect to the particular drug being purchased through the Ohio's best Rx program: 36496 36497 36498 36499 36500 36501

(a) The individual is responsible for the full cost of the 36502

drug. 36503

(b) The drug is not subject to a rebate from the manufacturer under the individual's medicare prescription drug plan. 36504 36505

(c) The manufacturer of the drug has agreed to the Ohio's best Rx program's inclusion of individuals who have coverage through a medicare prescription drug plan. 36506 36507 36508

Sec. ~~173.77~~ 5169.07. Application for participation in the Ohio's best Rx program shall be made in accordance with rules adopted by the department of ~~aging~~ health care administration under section ~~173.83~~ 5169.13 of the Revised Code. When applying for participation, an individual may include application for participation by the individual's spouse and children. An individual's guardian or custodian may apply on behalf of the individual. 36509 36510 36511 36512 36513 36514 36515 36516

When submitting an application, the applicant shall include the information and documentation specified in the department's rules as necessary to verify eligibility for the program. The application may be submitted on a paper form prescribed and supplied by the department or pursuant to any other application method the department makes available for the program, including methods that permit an individual to apply by telephone or through the internet. 36517 36518 36519 36520 36521 36522 36523 36524

An applicant shall attest that the information and documentation the applicant submits with an application is accurate to the best knowledge and belief of the applicant. In the case of a paper application form, the applicant's signature shall be used to certify that the applicant has attested to the accuracy of the information and documentation. In the case of other application methods, the application certification process specified in the department's rules shall be used to certify that the applicant has attested to the accuracy of the information and 36525 36526 36527 36528 36529 36530 36531 36532 36533

documentation. 36534

The department shall inform each applicant that knowingly making a false statement in an application is falsification under section 2921.13 of the Revised Code, a misdemeanor of the first degree. In the case of a paper application form, the department shall provide the information by including on the form a statement printed in bold letters. 36535 36536 36537 36538 36539 36540

Sec. ~~173.771~~ 5169.071. The department of ~~aging~~ health care administration shall provide each applicant for the Ohio's best Rx program information about the medicaid program in accordance with rules adopted under section ~~173.83~~ 5169.13 of the Revised Code. The information shall include general eligibility requirements, application procedures, and benefits. The information shall also explain the ways in which the medicaid program's drug benefits are better than the Ohio's best Rx program. 36541 36542 36543 36544 36545 36546 36547 36548

Sec. ~~173.772~~ 5169.072. On receipt of applications, the department of ~~aging~~ health care administration shall make eligibility determinations for the Ohio's best Rx program in accordance with procedures established in rules adopted under section ~~173.83~~ 5169.13 of the Revised Code. 36549 36550 36551 36552 36553

An eligibility determination under this section may not be appealed under Chapter 119., section 5101.35, or any other provision of the Revised Code. 36554 36555 36556

Sec. ~~173.773~~ 5169.073. (A) The department of ~~aging~~ health care administration shall issue Ohio's best Rx program enrollment cards to or on behalf of individuals determined eligible to participate. One enrollment card may cover each member of a family determined eligible to participate. 36557 36558 36559 36560 36561

The department shall determine the information to be included 36562

on the card, including an identification number, and shall 36563
determine the card's size and format. If the department 36564
establishes an application method that permits individuals to 36565
apply through the internet, the department may issue the 36566
enrollment card by sending the applicant an electronic version of 36567
the card in a printable format. 36568

(B) Each time a drug is purchased under the program, the 36569
entity dispensing the drug shall confirm whether the individual 36570
for whom the drug is dispensed is enrolled in the program. If the 36571
drug is being purchased from a participating terminal distributor 36572
rather than the drug mail order system included in the program 36573
pursuant to section ~~173.78~~ 5169.08 of the Revised Code, and the 36574
individual's enrollment card is available for presentation at the 36575
time of the purchase, the purchaser shall present the card to the 36576
participating terminal distributor as confirmation of the 36577
individual's enrollment in the program. If the drug is being 36578
purchased through the drug mail order system and the individual's 36579
program identification number is available, the purchaser shall 36580
present the identification number as confirmation of enrollment. 36581
Otherwise, the terminal distributor or mail order system shall 36582
confirm the individual's enrollment through the department. The 36583
department shall establish the methods to be used in confirming 36584
enrollment through the department, including confirmation by 36585
telephone, through the internet, or by any other electronic means. 36586

(C) Purchasing a drug under the program by using an 36587
enrollment card or any other method shall serve as an attestation 36588
by the participant for whom the drug is dispensed that the 36589
participant meets the eligibility requirements specified in 36590
division (A)(3) of section ~~173.76~~ 5169.06 of the Revised Code 36591
regarding not having coverage for outpatient drugs. 36592

Sec. ~~173.78~~ 5169.08. (A) For purposes of making drugs 36593

included in the Ohio's best Rx program available to participants by mail, the department of ~~aging~~ health care administration shall include a drug mail order system within the program. Not more than one drug mail order system shall be included in the program. Subject to division (B) of this section, the program's drug mail order system shall be provided in accordance with rules adopted under section ~~173.83~~ 5169.13 of the Revised Code.

(B) Neither the department nor the drug mail order system shall promote the purchase of drugs through the system by using information collected under the program regarding the drugs purchased by participants from participating terminal distributors. This division does not preclude the use of the information for purposes of limiting the amount that a participant may be charged for a quantity of a drug purchased through the drug mail order system to an amount that is not more than the amount that would be charged if the same quantity of the drug were purchased from a participating terminal distributor.

Sec. ~~173.79~~ 5169.09. (A) For purposes of making drugs included in the Ohio's best Rx program available to participants from terminal distributors of dangerous drugs other than the drug mail order system included in the program pursuant to section ~~173.78~~ 5169.08 of the Revised Code, the department of ~~aging~~ health care administration shall enter into agreements under this section with terminal distributors of dangerous drugs. Any terminal distributor of dangerous drugs may enter into an agreement with the department to participate in the program pursuant to this section.

Before entering into an agreement with a terminal distributor, the department shall provide the terminal distributor with one of the following:

(1) A formula that allows the terminal distributor to

calculate for each drug included in the program the amount to be charged under division (A)(1) or (2) of section ~~173.75~~ 5169.05 of the Revised Code by participating terminal distributors.

(2) A statistically valid sampling of drug prices that includes the amount to be charged under division (A)(1) or (2) of section ~~173.75~~ 5169.05 of the Revised Code by participating terminal distributors for not fewer than two brand name drugs and two generic drugs from each category of drugs included in the program.

(3) The current amount to be charged under division (A)(1) or (2) of section ~~173.75~~ 5169.05 of the Revised Code by participating terminal distributors for each drug included in the program.

(B) An agreement entered into under this section shall do all of the following:

(1) Except as provided in division (B)(3) of this section, be in effect for not less than one year;

(2) Specify the dates that the agreement is to begin and end;

(3) Permit the terminal distributor to terminate the agreement before the date the agreement would otherwise end as specified pursuant to division (B)(2) of this section by providing the department notice of early termination at least thirty days before the effective date of the early termination;

(4) Require that the terminal distributor comply with section ~~173.75~~ 5169.05 of the Revised Code when charging for a drug purchased under the program;

(5) Permit the terminal distributor to add to the amount to be charged under division (A)(1) or (2) of section ~~173.75~~ 5169.05 of the Revised Code a professional fee in an amount not to exceed, except as provided in rules adopted under section ~~173.83~~ 5169.13 of the Revised Code, three dollars;

(6) Require the terminal distributor to disclose to each participant the amount the participant saves under the program as determined in accordance with section ~~173.752~~ 5169.052 of the Revised Code; 36655 36656 36657 36658

(7) Require the terminal distributor to submit a claim to the department under section ~~173.80~~ 5169.10 of the Revised Code for each sale of a drug to a participant; 36659 36660 36661

(8) Permit the terminal distributor to deliver drugs to Ohio's best Rx program participants by mail, but not by using a drug mail order system operated in the same manner as the system included in the program pursuant to section ~~173.78~~ 5169.08 of the Revised Code. 36662 36663 36664 36665 36666

Sec. ~~173.791~~ 5169.091. A terminal distributor of dangerous drugs shall not be prohibited from participating in any program or any network of health care providers on the basis that the terminal distributor has not entered into an agreement under section ~~173.79~~ 5169.09 of the Revised Code to participate in the Ohio's best Rx program. 36667 36668 36669 36670 36671 36672

Sec. ~~173.80~~ 5169.10. For each drug dispensed under the Ohio's best Rx program, a claim shall be submitted to the department of ~~aging~~ health care administration. The participating terminal distributor or the drug mail order system included in the program pursuant to section ~~173.78~~ 5169.08 of the Revised Code that dispensed the drug shall submit the claim not later than thirty days after the drug is dispensed. The claim shall be submitted in accordance with the electronic method provided for in rules adopted under section ~~173.83~~ 5169.13 of the Revised Code. 36673 36674 36675 36676 36677 36678 36679 36680 36681

The claim shall specify all of the following: 36682

(A) The prescription number of the participant's prescription under which the drug was dispensed to the participant; 36683 36684

(B) The name of, and national drug code number for, the drug dispensed to the participant; 36685 36686

(C) The number of units of the drug dispensed to the participant; 36687 36688

(D) The amount the participant was charged for the drug; 36689

(E) The date the drug was dispensed to the participant; 36690

(F) Any additional information required by rules adopted under section ~~173.83~~ <u>5169.13</u> of the Revised Code. 36691 36692

Sec. ~~173.801~~ <u>5169.101</u>. (A) In accordance with rules adopted under section ~~173.83~~ <u>5169.13</u> of the Revised Code and subject to section ~~173.803~~ <u>5169.103</u> of the Revised Code, the department of ~~aging~~ <u>health care administration</u> shall make payments under the Ohio's best Rx program for complete and timely claims submitted under section ~~173.80~~ <u>5169.10</u> of the Revised Code for drugs included in the program that are also included in a manufacturer agreement entered into under section ~~173.81~~ <u>5169.11</u> of the Revised Code. The payment for a complete and timely claim shall be made by a date that is not later than two weeks after the department receives the claim from the participating terminal distributor or the drug mail order system included in the program pursuant to section ~~173.78~~ <u>5169.08</u> of the Revised Code. 36693 36694 36695 36696 36697 36698 36699 36700 36701 36702 36703 36704 36705

(B) Subject to division (D) of this section, the amount to be paid for a claim for a drug dispensed under the program shall be determined as follows: 36706 36707 36708

(1) Compute the manufacturer payment amount that applies to the transaction, based on quantity of the drug dispensed and the drug's national drug code number, in accordance with the provisions of division (B) of section ~~173.812~~ <u>5169.112</u> of the Revised Code; 36709 36710 36711 36712 36713

(2) If rules adopted under section ~~173.83~~ <u>5169.13</u> of the 36714

Revised Code require that program participants be charged an administrative fee for each transaction in which a quantity of the drug was dispensed, subtract from the amount computed under division (B)(1) of this section the administrative fee amount specified in those rules. 36715 36716 36717 36718 36719

(C) The department may combine the claims submitted by a participating terminal distributor or the program's drug mail order system to make aggregate payments under this section to the distributor or system. 36720 36721 36722 36723

(D) If the total of the amounts computed under division (B) of this section for any period for which payments are due is a negative number, the participating terminal distributor or the program's drug mail order system that submitted the claims has been overpaid for the claims. When there is an overpayment, the department shall reduce future payments made under this section to the distributor or system or collect an amount from the distributor or system sufficient to reimburse the department for the overpayment. 36724 36725 36726 36727 36728 36729 36730 36731 36732

Sec. ~~173.802~~ 5169.102. Neither a participating terminal distributor nor the drug mail order system included in the Ohio's best Rx program pursuant to section ~~173.78~~ 5169.08 of the Revised Code may be charged by the department of ~~aging~~ health care administration for the submission of a claim under section ~~173.80~~ 5169.10 of the Revised Code or the processing of a claim under section ~~173.801~~ 5169.101 of the Revised Code. 36733 36734 36735 36736 36737 36738 36739

Sec. ~~173.803~~ 5169.103. The department of ~~aging~~ health care administration may not make a payment under section ~~173.801~~ 5169.101 of the Revised Code for a claim submitted under section ~~173.80~~ 5169.10 of the Revised Code if any of the following are the case: 36740 36741 36742 36743 36744

(A) The claim is submitted by either a terminal distributor 36745
of dangerous drugs that is not a participating terminal 36746
distributor or a drug mail order system that is not the system 36747
included in the Ohio's best Rx program pursuant to section ~~173.78~~ 36748
5169.08 of the Revised Code. 36749

(B) The claim is for a drug that is not included in the 36750
program. 36751

(C) The claim is for a drug included in the program but the 36752
drug is dispensed to an individual who is not covered by an Ohio's 36753
best Rx program enrollment card. 36754

(D) A person or government entity has paid the participating 36755
terminal distributor or the program's drug mail order system 36756
through any other prescription drug coverage program or 36757
prescription drug discount program for dispensing the drug, unless 36758
the payment is reimbursement for redeeming a coupon or is an 36759
amount directly paid by a drug manufacturer to the distributor or 36760
system for dispensing drugs to residents of a long-term care 36761
facility. 36762

Sec. ~~173.81~~ 5169.11. For purposes of participating in the 36763
Ohio's best Rx program, any drug manufacturer may enter into an 36764
agreement with the department of ~~aging~~ health care administration 36765
under which the manufacturer agrees to make payments to the 36766
department with respect to one or more of the manufacturer's drugs 36767
when the one or more drugs are dispensed under the program. The 36768
terms of the agreement shall comply with section ~~173.811~~ 5169.111 36769
of the Revised Code. 36770

Sec. ~~173.811~~ 5169.111. (A) A manufacturer agreement entered 36771
into under section ~~173.81~~ 5169.11 of the Revised Code by a drug 36772
manufacturer and the department of ~~aging~~ health care 36773
administration shall include terms that do all of the following: 36774

(1) Specify the time the agreement is to be in effect, which shall be not less than one year from the date the agreement is entered into; 36775 36776 36777

(2) Specify which of the manufacturer's drugs are included in the agreement; 36778 36779

(3) Permit the department to remove a drug from the agreement in the event of a dispute over the drug's utilization; 36780 36781

(4) Require that the manufacturer specify a per unit amount that will be paid to the department for each drug included in the agreement that is dispensed to an Ohio's best Rx program participant; 36782 36783 36784 36785

(5) Require that the per unit amount specified by the manufacturer be an amount that the manufacturer believes is greater than or comparable to the per unit amount generally payable by the manufacturer for the same drug when the drug is dispensed to an individual using the outpatient drug coverage included in a health benefit plan offered in this state or another state to public employees or retirees and the eligible dependents of those employees or retirees; 36786 36787 36788 36789 36790 36791 36792 36793

(6) Require the manufacturer to make payments in accordance with the amounts computed under division (A) of section ~~173.812~~ 5169.112 of the Revised Code; 36794 36795 36796

(7) Require that the manufacturer make the payments on a quarterly basis or in accordance with a schedule established by rules adopted under section ~~173.83~~ 5169.13 of the Revised Code. 36797 36798 36799

(B) For any drug included in a manufacturer agreement, the terms of the agreement may provide for the establishment of a process for referring Ohio's best Rx program applicants and participants to a patient assistance program operated or sponsored by the manufacturer. The referral process may be included only if the manufacturer agrees to refer to the Ohio's best Rx program 36800 36801 36802 36803 36804 36805

residents of this state who apply but are found to be ineligible for the patient assistance program. 36806 36807

Sec. ~~173.812~~ 5169.112. When a drug included in a manufacturer agreement entered into under section ~~173.81~~ 5169.11 of the Revised Code is dispensed under the Ohio's best Rx program, the manufacturer payment amount that applies to the transaction shall be established in accordance with the following: 36808 36809 36810 36811 36812

(A) For purposes of the amount to be paid by the manufacturer, the manufacturer payment amount shall be computed by multiplying the per unit amount specified for the drug in the manufacturer agreement by the number of units dispensed. 36813 36814 36815 36816

(B) For purposes of the amount that a participant is to be charged under section ~~173.75~~ 5169.05 of the Revised Code and the amount to be paid for claims under section ~~173.801~~ 5169.101 of the Revised Code, both of the following apply: 36817 36818 36819 36820

(1) If a program administration percentage is not determined by the department of ~~aging~~ health care administration in rules adopted under section ~~173.83~~ 5169.13 of the Revised Code, the manufacturer payment amount shall be the same as the manufacturer payment amount computed under division (A) of this section. 36821 36822 36823 36824 36825

(2) If a program administration percentage is determined by the department, the manufacturer payment amount shall be computed as follows: 36826 36827 36828

(a) Multiply the per unit amount specified for the drug in the agreement by the program administration percentage; 36829 36830

(b) Subtract the product determined under division (B)(2)(a) of this section from the per unit amount specified for the drug in the agreement; 36831 36832 36833

(c) Multiply the per unit amount resulting from the computation under division (B)(2)(b) of this section by the number 36834 36835

of units dispensed. 36836

Sec. ~~173.813~~ 5169.113. In its negotiations with a drug 36837
manufacturer proposing to enter into an agreement under section 36838
~~173.81~~ 5169.11 of the Revised Code, the department of ~~aging~~ health 36839
care administration shall use the best information on manufacturer 36840
payments that is available to the department, including 36841
information obtained from the verifications made under section 36842
~~173.814~~ 5169.114 of the Revised Code by the Ohio's best Rx 36843
program's consulting pharmacy benefit manager selected under 36844
section ~~173.731~~ 5169.031 of the Revised Code. The department shall 36845
use the information in an attempt to obtain manufacturer payments 36846
that maximize the benefits provided to Ohio's best Rx program 36847
participants. 36848

Sec. ~~173.814~~ 5169.114. Annually, the department of ~~aging~~ 36849
health care administration shall select a sample of not more than 36850
ten of the drugs that were included in the manufacturer agreements 36851
entered into under section ~~173.81~~ 5169.11 of the Revised Code in 36852
the immediately preceding year. The department shall submit to the 36853
program's consulting pharmacy benefit manager selected under 36854
section ~~173.731~~ 5169.031 of the Revised Code information that 36855
identifies the per unit amount of the manufacturer payments that 36856
applied to each of the drugs in the sample. 36857

The consulting pharmacy benefit manager shall review the 36858
submitted information. After the review, the consulting pharmacy 36859
benefit manager shall provide information to the department 36860
verifying whether any of the per unit payment amounts that applied 36861
to the selected drugs were more than two per cent lower than the 36862
per unit payment amounts negotiated by the consulting pharmacy 36863
benefit manager for the same drugs in connection with health 36864
benefit plans that generally do not use formularies to restrict 36865
the outpatient drug coverage included in the plans. The consulting 36866

pharmacy benefit manager shall specify which, if any, of the drugs in the sample were subject to the lower per unit payment amounts. The information provided to the department shall be certified by signature of an officer of the consulting pharmacy benefit manager.

Sec. ~~173.815~~ 5169.115. (A) The department of ~~aging~~ health care administration shall seek from the centers for medicare and medicaid services of the United States department of health and human services written confirmation that manufacturer payments made pursuant to an agreement entered into under section ~~173.81~~ 5169.11 of the Revised Code are exempt from the medicaid best price computation applicable under Title XIX of the "Social Security Act," 79 Stat. 286 (1965), 42 U.S.C. 1396r-8, as amended.

(B) Entering into a manufacturer agreement under section ~~173.81~~ 5169.11 of the Revised Code does not require a drug manufacturer to make a manufacturer payment that would establish the manufacturer's medicaid best price for a drug.

Sec. ~~173.82~~ 5169.12. A drug manufacturer that enters into an agreement under section ~~173.81~~ 5169.11 of the Revised Code may submit a request to the department of ~~aging~~ health care administration to audit claims submitted under section ~~173.80~~ 5169.10 of the Revised Code. On submission of a request that the department considers reasonable, the department shall permit the manufacturer to audit the claims.

Sec. ~~173.83~~ 5169.13. The department of ~~aging~~ health care administration shall adopt rules in accordance with Chapter 119. of the Revised Code to implement the Ohio's best Rx program. The rules shall provide for all of the following:

(A) Standards and procedures for establishing, pursuant to

section ~~173.74~~ 5169.04 of the Revised Code, the base price for 36897
each drug included in the program; 36898

(B) Determination of family income for the purpose of 36899
division (A)(2)(a) of section ~~173.76~~ 5169.06 of the Revised Code; 36900

(C) For the purpose of section ~~173.77~~ 5169.07 of the Revised 36901
Code, the application process for the program, including the 36902
information and documentation to be submitted with applications to 36903
verify eligibility and a process to be used in certifying that an 36904
applicant has attested to the accuracy of the submitted 36905
information and documentation; 36906

(D) The method of providing information about the medicaid 36907
program to applicants under section ~~173.771~~ 5169.071 of the 36908
Revised Code; 36909

(E) For the purpose of section ~~173.772~~ 5169.072 of the 36910
Revised Code, eligibility determination procedures; 36911

(F) Standards and procedures governing the drug mail order 36912
system included in the program pursuant to section ~~173.78~~ 5169.08 36913
of the Revised Code; 36914

(G) Subject to section ~~173.831~~ 5169.131 of the Revised Code, 36915
periodically increasing the maximum professional fee that 36916
participating terminal distributors may charge Ohio's best Rx 36917
program participants pursuant to an agreement entered into under 36918
section ~~173.79~~ 5169.09 of the Revised Code; 36919

(H) Subject to section ~~173.832~~ 5169.132 of the Revised Code, 36920
the amount of the administrative fee, if any, that Ohio's best Rx 36921
program participants are to be charged under the program; 36922

(I) The electronic method for submission of claims to the 36923
department under section ~~173.80~~ 5169.10 of the Revised Code; 36924

(J) Additional information to be included on claims submitted 36925
under section ~~173.80~~ 5169.10 of the Revised Code that the 36926

department determines is necessary for the department to be able 36927
to make payments under section ~~173.801~~ 5169.101 of the Revised 36928
Code; 36929

(K) The method for making payments under section ~~173.801~~ 36930
5169.101 of the Revised Code; 36931

(L) Subject to section ~~173.833~~ 5169.133 of the Revised Code, 36932
the percentage, if any, that is the program administration 36933
percentage; 36934

(M) If the department determines it is best that 36935
participating manufacturers make payments pursuant to manufacturer 36936
agreements entered into under section ~~173.81~~ 5169.11 of the 36937
Revised Code on a basis other than quarterly, a schedule for 36938
making the payments; 36939

(N) Procedures for making computations under sections ~~173.75~~ 36940
5169.05 and ~~173.812~~ 5169.112 of the Revised Code; 36941

(O) Standards and procedures for the use and preservation of 36942
records regarding the Ohio's best Rx program pursuant to section 36943
~~173.91~~ 5169.21 of the Revised Code; 36944

(P) The efficient administration of other provisions of 36945
sections ~~173.71~~ 5169.01 to ~~173.91~~ 5169.21 of the Revised Code for 36946
which the department determines rules are necessary. 36947

Sec. ~~173.831~~ 5169.131. As used in this section, "medicaid 36948
dispensing fee" means the dispensing fee established under section 36949
~~5111.071~~ 5163.251 of the Revised Code for the medicaid program. 36950

In adopting a rule under division (G) of section ~~173.83~~ 36951
5169.13 of the Revised Code increasing the maximum amount of the 36952
professional fee participating terminal distributors may charge 36953
Ohio's best Rx program participants pursuant to an agreement 36954
entered into under section ~~173.79~~ 5169.09 of the Revised Code, the 36955
department of ~~aging~~ health care administration shall review the 36956

amount of the professional fee once a year or, at the department's discretion, at more frequent intervals. The department shall not increase the professional fee to an amount exceeding the medicaid dispensing fee.

A participating terminal distributor may charge a maximum three dollar professional fee regardless of whether the medicaid dispensing fee for that drug is less than that amount. The department, however, may not adopt a rule increasing the maximum professional fee for that drug until the medicaid dispensing fee for that drug exceeds that amount.

Sec. ~~173.832~~ 5169.132. (A) Once a year or, at the discretion of the department of ~~aging~~ health care administration, at more frequent intervals, the department shall determine the amount, if any, that each Ohio's best Rx program participant will be charged as an administrative fee to be used in paying the administrative costs of the program. The fee, which shall not exceed one dollar per transaction, shall be specified in rules adopted under section ~~173.83~~ 5169.13 of the Revised Code. In adopting the rules, the department shall specify a fee that results in an amount that equals or is less than the amount needed to cover the administrative costs of the Ohio's best Rx program when added to the sum of the following:

(1) The amount resulting from the program administration percentage, if the department determines a program administration percentage in rules adopted under section ~~173.83~~ 5169.13 of the Revised Code;

(2) The investment earnings of the Ohio's best Rx program fund created by section ~~173.85~~ 5169.15 of the Revised Code;

(3) Any amounts accepted by the department as donations to the Ohio's best Rx program fund.

(B) Once a year or, at the discretion of the department, at more frequent intervals, the department shall report the methodology underlying the determination of the administrative fee to the Ohio's best Rx program council. 36987 36988 36989 36990

Sec. ~~173.833~~ 5169.133. (A) At least once a year or, at the discretion of the department of ~~aging~~ health care administration, at more frequent intervals, the department shall determine the percentage, if any, of each manufacturer payment made under an agreement entered into under section ~~173.81~~ 5169.11 of the Revised Code that will be retained by the department for use in paying the administrative costs of the Ohio's best Rx program. The percentage, which shall not exceed five per cent, shall be specified in rules adopted under section ~~173.83~~ 5169.13 of the Revised Code. In adopting the rules, the department shall specify a percentage that results in an amount that equals or is less than the amount needed to cover the administrative costs of the Ohio's best Rx program when added to the sum of the following: 36991 36992 36993 36994 36995 36996 36997 36998 36999 37000 37001 37002 37003

(1) The amount resulting from administrative fees, if the department determines an administrative fee in rules adopted under section ~~173.83~~ 5169.13 of the Revised Code; 37004 37005 37006

(2) The investment earnings of the Ohio's best Rx program fund created by section ~~173.85~~ 5169.15 of the Revised Code; 37007 37008

(3) Any amounts accepted by the department as donations to the Ohio's best Rx program fund. 37009 37010

(B) Once a year or, at the discretion of the department, at more frequent intervals, the department shall report the methodology underlying the determination of the program administration percentage to the Ohio's best Rx program council. 37011 37012 37013 37014

Sec. ~~173.84~~ 5169.14. Notwithstanding any conflicting provision of sections ~~173.71~~ 5169.01 to ~~173.91~~ 5169.21 of the 37015 37016

Revised Code, the department of ~~aging~~ <u>health care administration</u> may adopt rules in accordance with Chapter 119. of the Revised Code to make adjustments to the Ohio's best Rx program that the department considers appropriate to conform the program to, or coordinate it with, any federally funded prescription drug program created after October 1, 2003. 37017 37018 37019 37020 37021 37022

Sec. ~~173.85~~ <u>5169.15</u>. (A) The Ohio's best Rx program fund is hereby created in the state treasury. The fund shall consist of the following: 37023 37024 37025

(1) Manufacturer payments made by participating manufacturers pursuant to agreements entered into under section 173.81 of the Revised Code; 37026 37027 37028

(2) Administrative fees, if an administrative fee is determined by the department of ~~aging~~ <u>health care administration</u> in rules adopted under section ~~173.83~~ <u>5169.13</u> of the Revised Code; 37029 37030 37031 37032

(3) Any amounts donated to the fund and accepted by the department; 37033 37034

(4) The fund's investment earnings. 37035

(B) Money in the Ohio's best Rx program fund shall be used to make payments under section ~~173.801~~ <u>5169.101</u> of the Revised Code and to make transfers to the Ohio's best Rx administration fund in accordance with section ~~173.86~~ <u>5169.16</u> of the Revised Code. 37036 37037 37038 37039

Sec. ~~173.86~~ <u>5169.16</u>. (A) The Ohio's best Rx administration fund is hereby created in the state treasury. The director of budget and management shall transfer from the Ohio's best Rx program fund to the Ohio's best Rx administration fund amounts equal to the following: 37040 37041 37042 37043 37044

(1) Amounts resulting from application of the program 37045

administration percentage, if a program administration percentage 37046
is determined by the department of ~~aging~~ health care 37047
administration in rules adopted under section ~~173.83~~ 5169.13 of 37048
the Revised Code; 37049

(2) The amount of the administrative fees charged Ohio's best 37050
Rx participants, if an administrative fee is determined by the 37051
department of ~~aging~~ health care administration in rules adopted 37052
under section ~~173.83~~ 5169.13 of the Revised Code; 37053

(3) The amount of any donations credited to the Ohio's best 37054
Rx program fund; 37055

(4) The amount of investment earnings credited to the Ohio's 37056
best Rx program fund. 37057

The director of budget and management shall make the 37058
transfers in accordance with a schedule developed by the director 37059
and the department of ~~aging~~ health care administration. 37060

(B) The department of ~~aging~~ health care administration shall 37061
use money in the Ohio's best Rx administration fund to pay the 37062
administrative costs of the Ohio's best Rx program, including, but 37063
not limited to, costs associated with contracted services, staff, 37064
outreach activities, computers and network services, and the 37065
Ohio's best Rx program council. If the fund includes an amount 37066
that exceeds the amount necessary to pay the administrative costs 37067
of the program, the department may use the excess amount to pay 37068
the cost of subsidies provided to Ohio's best Rx program 37069
participants under any subsidy program established pursuant to 37070
section ~~173.861~~ 5169.161 of the Revised Code. 37071

37072

Sec. ~~173.861~~ 5169.161. The department of ~~aging~~ health care 37073
administration may establish a component of the Ohio's best Rx 37074
program under which subsidies are provided to participants to 37075

assist them with the cost of purchasing drugs under the program, 37076
including the cost of any professional fees charged for dispensing 37077
the drugs. The subsidies shall be provided only when the Ohio's 37078
best Rx administration fund created under section ~~173.86~~ <u>5169.16</u> 37079
of the Revised Code includes an amount that exceeds the amount 37080
necessary to pay the administrative costs of the program. 37081

Sec. ~~173.87~~ <u>5169.17</u>. There is hereby created the Ohio's best 37082
Rx program council. The council shall advise the department of 37083
~~aging~~ <u>health care administration</u> on the Ohio's best Rx program. 37084
With the approval of a majority of the council's appointed 37085
members, the council may initiate studies to determine whether 37086
there are more effective ways to administer the program and 37087
provide the department with suggestions for improvements. 37088

Sec. ~~173.871~~ <u>5169.171</u>. The Ohio's best Rx program council 37089
shall consist of the following members: 37090

(A) The president of the senate; 37091

(B) The speaker of the house of representatives; 37092

(C) The minority leader of the senate; 37093

(D) The minority leader of the house of representatives; 37094

(E) A representative of the Ohio chapter of the American 37095
federation of labor-congress of industrial organizations, 37096
appointed by the governor from a list of names submitted to the 37097
governor by that organization; 37098

(F) A representative of the Ohio chapter of the American 37099
association of retired persons, appointed by the governor from a 37100
list of names submitted to the governor by that organization; 37101

(G) A representative of a disability advocacy organization 37102
located in the state of Ohio, appointed by the governor from a 37103
list of names submitted to the governor by disability advocacy 37104

organizations located in the state of Ohio; 37105

(H) A representative of the Ohio chapter of the united way, appointed by the governor from a list of names submitted to the governor by that organization; 37106 37107 37108

(I) A representative of the Ohio alliance of retired Americans, appointed by the governor from a list of names submitted to the governor by that organization; 37109 37110 37111

(J) Three representatives of research-based drug manufacturers, appointed by the governor from a list of names submitted to the governor by the pharmaceutical research and manufacturers of America; 37112 37113 37114 37115

(K) A pharmacist licensed under Chapter 4729. of the Revised Code, appointed by the governor from a list of names submitted to the governor by the Ohio pharmacists association. 37116 37117 37118

Sec. ~~173.872~~ 5169.172. The governor shall make initial appointments to the Ohio's best Rx program council not later than thirty days after December 18, 2003. The members appointed by the governor shall serve at the pleasure of the governor. If an appointed member's seat becomes vacant, the governor shall fill the vacancy not later than thirty days after the vacancy occurs and in the manner provided for the initial appointment. 37119 37120 37121 37122 37123 37124 37125

Sec. ~~173.873~~ 5169.173. The president of the senate and speaker of the house of representatives shall serve as co-chairs of the Ohio's best Rx program council. 37126 37127 37128

The president of the senate, the minority leader of the senate, the speaker of the house of representatives, and the minority leader of the house of representatives may each appoint a member of the general assembly to attend any meeting of the Ohio's best Rx program council on behalf of the president of the senate, the minority leader of the senate, the speaker of the house of 37129 37130 37131 37132 37133 37134

representatives, or the minority leader of the house of 37135
representatives, respectively. 37136

Sec. ~~173.874~~ 5169.174. Members of the Ohio's best Rx program 37137
council shall serve without compensation and shall not be 37138
reimbursed for any expenses associated with their duties on the 37139
council. 37140

Sec. ~~173.875~~ 5169.175. Except for any part of records that 37141
contain a trade secret, the Ohio's best Rx program council's 37142
records are a public record for the purpose of section 149.43 of 37143
the Revised Code. 37144

Sec. ~~173.876~~ 5169.176. Sections 101.82 to 101.87 of the 37145
Revised Code do not apply to the Ohio's best Rx program council. 37146

Sec. ~~173.88~~ 5169.18. (A) The department of ~~aging~~ health care 37147
administration shall compile both of the following lists regarding 37148
the Ohio's best Rx program: 37149

(1) A list consisting of the name of each drug manufacturer 37150
that enters into a manufacturer agreement under section ~~173.791~~ 37151
5169.091 of the Revised Code and the names of the drugs included 37152
in each manufacturer agreement; 37153

(2) A list consisting of the name of each participating 37154
terminal distributor and the name of the drug mail order system 37155
included in the program pursuant to section ~~173.78~~ 5169.08 of the 37156
Revised Code. 37157

(B) As part of the list compiled under division (A)(1) of 37158
this section, the department may include aggregate information 37159
regarding the drugs selected under section ~~173.814~~ 5169.114 of the 37160
Revised Code that were verified under that section as having per 37161
unit manufacturer payment amounts that were not more than two per 37162

cent lower than the per unit payment amounts negotiated for the same drugs by the program's consulting pharmacy benefit manager selected under section ~~173.731~~ 5169.031 of the Revised Code. The information shall not identify a specific drug and shall be expressed only as a percentage of the sample of drugs selected under section ~~173.814~~ 5169.114 of the Revised Code.

(C) The lists compiled under this section are public records for the purpose of section 149.43 of the Revised Code. The department shall specifically make the lists available to physicians, participating terminal distributors, and other health professionals.

Sec. ~~173.89~~ 5169.19. Information transmitted by or to any of the following for any purpose related to the Ohio's best Rx program is confidential to the extent required by federal and state law:

(A) Drug manufacturers;

(B) Terminal distributors of dangerous drugs;

(C) The department of ~~aging~~ health care administration;

(D) The program's consulting pharmacy benefit manager selected under section ~~173.731~~ 5169.031 of the Revised Code;

(E) Ohio's best Rx program participants;

(F) Any other government entity or person.

Sec. ~~173.891~~ 5169.191. (A) Except as provided by section ~~173.892~~ 5169.192 of the Revised Code, all of the following are trade secrets, are not public records for the purposes of section 149.43 of the Revised Code, and shall not be used, released, published, or disclosed in a form that reveals a specific drug or the identity of a drug manufacturer:

(1) The amounts determined under section ~~173.801~~ 5169.101 of

the Revised Code for payment of claims submitted by participating terminal distributors and the drug mail order system included in the Ohio's best Rx program pursuant to section ~~173.78~~ 5169.08 of the Revised Code; 37192 37193 37194 37195

(2) Information disclosed in a manufacturer agreement entered into under section ~~173.81~~ 5169.11 of the Revised Code or in communications related to an agreement; 37196 37197 37198

(3) Drug pricing and drug manufacturer payment information verified under sections ~~173.742~~ 5169.042 and ~~173.814~~ 5169.114 of the Revised Code by the program's consulting pharmacy benefit manager selected under section ~~173.731~~ 5169.031 of the Revised Code; 37199 37200 37201 37202 37203

(4) Information contained in or pertaining to an audit provided for by the program's consulting pharmacy benefit manager under section ~~173.732~~ 5169.032 of the Revised Code; 37204 37205 37206

(5) The elements of the computations made pursuant to sections ~~173.75~~ 5169.05, ~~173.801~~ 5169.101, and ~~173.812~~ 5169.112 of the Revised Code and any results of those computations that reveal or could be used to reveal the manufacturer payment amounts used to make the computations. 37207 37208 37209 37210 37211

(B) No person or government entity shall use or reveal any information specified in division (A) of this section except as required for the implementation of sections ~~173.71~~ 5169.01 to ~~173.91~~ 5169.21 of the Revised Code. 37212 37213 37214 37215

Sec. ~~173.892~~ 5169.192. Sections ~~173.89~~ 5169.19 and ~~173.891~~ 5169.191 of the Revised Code shall not preclude the department of ~~aging~~ health care administration from disclosing information necessary for the implementation of sections ~~173.71~~ 5169.01 to ~~173.91~~ 5169.21 of the Revised Code, including the amount an Ohio's best Rx program participant is to be charged when the amount is 37216 37217 37218 37219 37220 37221

disclosed under section ~~173.751~~ 5169.051 of the Revised Code to participating terminal distributors or the drug mail order system included in the program pursuant to section ~~173.78~~ 5169.08 of the Revised Code. 37222 37223 37224 37225

Sec. ~~173.90~~ 5169.20. (A) As used in this section, "identifying information" means information that identifies or could be used to identify an Ohio's best Rx program applicant or participant. "Identifying information" does not include aggregate information about applicants and participants that does not identify and could not be used to identify an individual applicant or participant. 37226 37227 37228 37229 37230 37231 37232

(B) Except as provided in divisions (C), (D), and (E) of this section, no person or government entity shall sell, solicit, disclose, receive, or use identifying information or knowingly permit the use of identifying information. 37233 37234 37235 37236

(C)(1) The department of ~~aging~~ health care administration may solicit, disclose, receive, or use identifying information or knowingly permit the use of identifying information for a purpose directly connected to the administration of the Ohio's best Rx program, including disclosing and knowingly permitting the use of identifying information included in a claim that a participating manufacturer audits pursuant to section ~~173.82~~ 5169.12 of the Revised Code, contacting Ohio's best Rx program applicants or participants regarding participation in the program, and notifying applicants and participants regarding participating terminal distributors and the drug mail order system included in the program pursuant to section ~~173.78~~ 5169.08 of the Revised Code. 37237 37238 37239 37240 37241 37242 37243 37244 37245 37246 37247 37248

(2) The department may solicit, disclose, receive, or use identifying information or knowingly permit the use of identifying information to the extent required by federal law. 37249 37250 37251

(3) The department may disclose identifying information to 37252

the Ohio's best Rx program applicant or participant who is the subject of that information or to the parent, spouse, guardian, or custodian of that applicant or participant. 37253 37254 37255

(D)(1) A participating terminal distributor may solicit, disclose, receive, or use identifying information or knowingly permit the use of identifying information to the extent required or permitted by an agreement the distributor enters into under section ~~173.79~~ 5169.09 of the Revised Code. 37256 37257 37258 37259 37260

(2) Subject to division (B) of section ~~173.78~~ 5169.08 of the Revised Code, the drug mail order system included in the program pursuant to section ~~173.78~~ 5169.08 of the Revised Code may solicit, disclose, receive, or use identifying information or knowingly permit the use of identifying information to the extent required or permitted by the department. 37261 37262 37263 37264 37265 37266

(E) A participating manufacturer may, for the purpose of auditing a claim pursuant to section ~~173.82~~ 5169.12 of the Revised Code, solicit, receive, and use identifying information included in the claim. 37267 37268 37269 37270

Sec. ~~173.91~~ 5169.21. (A) Except as provided in division (B) of this section, the department of ~~aging~~ health care administration shall use and preserve records regarding the Ohio's best Rx program in accordance with rules adopted under section ~~173.83~~ 5169.13 of the Revised Code. The department shall use and preserve the records in accordance with those rules, regardless of whether the department generated the records or received them from another government entity or any person. 37271 37272 37273 37274 37275 37276 37277 37278

(B) All records received by the department under sections ~~173.742~~ 5169.042 and ~~173.814~~ 5169.114 of the Revised Code from the program's consulting pharmacy benefit manager selected under section ~~173.731~~ 5169.031 of the Revised Code shall be destroyed promptly after the department has completed the purpose for which 37279 37280 37281 37282 37283

the information contained in the records was obtained. 37284

Sec. 5169.99. Whoever violates division (B) of section 5169.20 of the Revised Code is guilty of a misdemeanor of the first degree. 37285 37286 37287

Sec. 5302.221. (A) As used in this section: 37288

"Estate" has the same meaning as in section ~~5111.11~~ 5162.40 of the Revised Code. 37289 37290

"Medicaid estate recovery program" means the program instituted under section ~~5111.11~~ 5162.40 of the Revised Code. 37291 37292

(B) The administrator of the medicaid estate recovery program shall prescribe a form on which a beneficiary of a transfer on death deed as provided in section 5302.22 of the Revised Code, who survives the deceased owner of the real property or an interest in the real property or that is in existence on the date of death of the deceased owner, or such a beneficiary's representative is to indicate both of the following: 37293 37294 37295 37296 37297 37298 37299

(1) Whether the deceased owner was either of the following: 37300

(a) A decedent subject to the medicaid estate recovery program; 37301 37302

(b) The spouse of a decedent subject to the medicaid estate recovery program. 37303 37304

(2) Whether the real property or interest in the real property was part of the estate of a decedent subject to the medicaid estate recovery program. 37305 37306 37307

(C) A county recorder shall obtain a properly completed form prescribed under division (B) of this section from the beneficiary of a transfer on death deed or the beneficiary's representative and send a copy of the form to the administrator of the medicaid estate recovery program before recording the transfer of the real 37308 37309 37310 37311 37312

property or interest in the real property under division (C) of section 5302.22 of the Revised Code.

Sec. 5309.082. (A) As used in this section:

"Estate" has the same meaning as in section ~~5111.11~~ 5162.40 of the Revised Code.

"Medicaid estate recovery program" means the program instituted under section ~~5111.11~~ 5162.40 of the Revised Code.

(B) The administrator of the medicaid estate recovery program shall prescribe a form on which a surviving tenant under a survivorship tenancy or such a surviving tenant's representative is to indicate both of the following:

(1) Whether the deceased survivorship tenant was either of the following:

(a) A decedent subject to the medicaid estate recovery program;

(b) The spouse of a decedent subject to the medicaid estate recovery program.

(2) Whether the registered land under a survivorship tenancy was part of the estate of a decedent subject to the medicaid estate recovery program.

(C) A county recorder shall obtain a properly completed form prescribed under division (B) of this section from the surviving tenant under a survivorship tenancy or the surviving tenant's representative and send a copy of the form to the administrator of the medicaid estate recovery program before registering the title in the surviving tenants under section 5309.081 of the Revised Code.

Sec. 5505.04. (A)(1) The general administration and management of the state highway patrol retirement system and the

making effective of this chapter are hereby vested in the state highway patrol retirement board. The board may sue and be sued, plead and be impleaded, contract and be contracted with, and do all things necessary to carry out this chapter. 37342 37343 37344 37345

The board shall consist of the following members: 37346

(a) The superintendent of the state highway patrol; 37347

(b) Two retirant members who reside in this state; 37348

(c) Five employee-members; 37349

(d) One member, known as the treasurer of state's investment designee, who shall be appointed by the treasurer of state for a term of four years and who shall have the following qualifications: 37350 37351 37352 37353

(i) The member is a resident of this state. 37354

(ii) Within the three years immediately preceding the appointment, the member has not been employed by the public employees retirement system, police and fire pension fund, state teachers retirement system, school employees retirement system, or state highway patrol retirement system or by any person, partnership, or corporation that has provided to one of those retirement systems services of a financial or investment nature, including the management, analysis, supervision, or investment of assets. 37355 37356 37357 37358 37359 37360 37361 37362 37363

(iii) The member has direct experience in the management, analysis, supervision, or investment of assets. 37364 37365

(iv) The member is not currently employed by the state or a political subdivision of the state. 37366 37367

(e) Two investment expert members, who shall be appointed to four-year terms. One investment expert member shall be appointed by the governor, and one investment expert member shall be jointly appointed by the speaker of the house of representatives and the 37368 37369 37370 37371

president of the senate. Each investment expert member shall have the following qualifications: 37372 37373

(i) Each investment expert member shall be a resident of this state. 37374 37375

(ii) Within the three years immediately preceding the appointment, each investment expert member shall not have been employed by the public employees retirement system, police and fire pension fund, state teachers retirement system, school employees retirement system, or state highway patrol retirement system or by any person, partnership, or corporation that has provided to one of those retirement systems services of a financial or investment nature, including the management, analysis, supervision, or investment of assets. 37376 37377 37378 37379 37380 37381 37382 37383 37384

(iii) Each investment expert member shall have direct experience in the management, analysis, supervision, or investment of assets. 37385 37386 37387

(2) The board shall annually elect a chairperson and vice-chairperson from among its members. The vice-chairperson shall act as chairperson in the absence of the chairperson. A majority of the members of the board shall constitute a quorum and any action taken shall be approved by a majority of the members of the board. The board shall meet not less than once each year, upon sufficient notice to the members. All meetings of the board shall be open to the public except executive sessions as set forth in division (G) of section 121.22 of the Revised Code, and any portions of any sessions discussing medical records or the degree of disability of a member excluded from public inspection by this section. 37388 37389 37390 37391 37392 37393 37394 37395 37396 37397 37398 37399

(3) Any investment expert member appointed to fill a vacancy occurring prior to the expiration of the term for which the member's predecessor was appointed holds office until the end of 37400 37401 37402

such term. The member continues in office subsequent to the expiration date of the member's term until the member's successor takes office, or until a period of sixty days has elapsed, whichever occurs first. 37403 37404 37405 37406

(B) The attorney general shall prescribe procedures for the adoption of rules authorized under this chapter, consistent with the provision of section 111.15 of the Revised Code under which all rules shall be filed in order to be effective. Such procedures shall establish methods by which notice of proposed rules are given to interested parties and rules adopted by the board published and otherwise made available. When it files a rule with the joint committee on agency rule review pursuant to section 111.15 of the Revised Code, the board shall submit to the Ohio retirement study council a copy of the full text of the rule, and if applicable, a copy of the rule summary and fiscal analysis required by division (B) of section 127.18 of the Revised Code. 37407 37408 37409 37410 37411 37412 37413 37414 37415 37416 37417 37418

(C)(1) As used in this division, "personal history record" means information maintained by the board on an individual who is a member, former member, retirant, or beneficiary that includes the address, telephone number, social security number, record of contributions, correspondence with the system, and other information the board determines to be confidential. 37419 37420 37421 37422 37423 37424

(2) The records of the board shall be open to public inspection, except for the following which shall be excluded: the member's, former member's, retirant's, or beneficiary's personal history record and the amount of a monthly allowance or benefit paid to a retirant, beneficiary, or survivor, except with the written authorization of the individual concerned. All medical reports and recommendations are privileged except that copies of such medical reports or recommendations shall be made available to the individual's personal physician, attorney, or authorized agent upon written release received from such individual or such 37425 37426 37427 37428 37429 37430 37431 37432 37433 37434

individual's agent, or when necessary for the proper administration of the fund to the board-assigned physician. 37435 37436

(D) Notwithstanding the exceptions to public inspection in division (C)(2) of this section, the board may furnish the following information: 37437 37438 37439

(1) If a member, former member, or retirant is subject to an order issued under section 2907.15 of the Revised Code or an order issued under division (A) or (B) of section 2929.192 of the Revised Code or is convicted of or pleads guilty to a violation of section 2921.41 of the Revised Code, on written request of a prosecutor as defined in section 2935.01 of the Revised Code, the board shall furnish to the prosecutor the information requested from the individual's personal history record. 37440 37441 37442 37443 37444 37445 37446 37447

(2) Pursuant to a court order issued under Chapters 3119., 3121., and 3123. of the Revised Code, the board shall furnish to a court or child support enforcement agency the information required under those chapters. 37448 37449 37450 37451

(3) At the written request of any nonprofit organization or association providing services to retirement system members, retirants, or beneficiaries, the board shall provide to the organization or association a list of the names and addresses of members, former members, retirants, or beneficiaries if the organization or association agrees to use such information solely in accordance with its stated purpose of providing services to such individuals and not for the benefit of other persons, organizations, or associations. The costs of compiling, copying, and mailing the list shall be paid by such entity. 37452 37453 37454 37455 37456 37457 37458 37459 37460 37461

(4) Within fourteen days after receiving ~~from the director of job and family services~~ a list of the names and social security numbers of recipients of public assistance pursuant to section 5101.181 of the Revised Code <u>or a list of the names and social</u> 37462 37463 37464 37465

security numbers of public medical assistance recipients pursuant to section 5160.43 of the Revised Code, the board shall inform the auditor of state of the name, current or most recent employer address, and social security number of each member whose name and social security number are the same as those of a person whose name or social security number was submitted by the director is included on the list. The board and its employees, except for purposes of furnishing the auditor of state with information required by this section, shall preserve the confidentiality of recipients of public assistance in compliance with division (A) of section 5101.181 of the Revised Code and preserve the confidentiality of public medical assistance program recipients in compliance with section 5160.43 of the Revised Code. 37466 37467 37468 37469 37470 37471 37472 37473 37474 37475 37476 37477 37478

(5) The system shall comply with orders issued under section 3105.87 of the Revised Code. 37479 37480

On the written request of an alternate payee, as defined in section 3105.80 of the Revised Code, the system shall furnish to the alternate payee information on the amount and status of any amounts payable to the alternate payee under an order issued under section 3105.171 or 3105.65 of the Revised Code. 37481 37482 37483 37484 37485

(6) At the request of any person, the board shall make available to the person copies of all documents, including resumes, in the board's possession regarding filling a vacancy of an employee member or retirant member of the board. The person who made the request shall pay the cost of compiling, copying, and mailing the documents. The information described in this division is a public record. 37486 37487 37488 37489 37490 37491 37492

(E) A statement that contains information obtained from the system's records that is certified and signed by an officer of the retirement system and to which the system's official seal is affixed, or copies of the system's records to which the signature and seal are attached, shall be received as true copies of the 37493 37494 37495 37496 37497

system's records in any court or before any officer of this state. 37498

Sec. 5725.18. (A) An annual franchise tax on the privilege of 37499
being an insurance company is hereby levied on each domestic 37500
insurance company. In the month of May, annually, the treasurer of 37501
state shall charge for collection from each domestic insurance 37502
company a franchise tax in the amount computed in accordance with 37503
the following, as applicable: 37504

(1) With respect to a domestic insurance company that is a 37505
health insuring corporation, one per cent of all premium rate 37506
payments received, exclusive of payments received under the 37507
medicare program ~~established under Title XVIII of the "Social~~ 37508
~~Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended,~~ 37509
or pursuant to the ~~medical assistance~~ medicaid program ~~established~~ 37510
~~under Chapter 5111. of the Revised Code~~, as reflected in its 37511
annual report for the preceding calendar year; 37512

(2) With respect to a domestic insurance company that is not 37513
a health insuring corporation, one and four-tenths per cent of the 37514
gross amount of premiums received from policies covering risks 37515
within this state, exclusive of premiums received under the 37516
medicare program ~~established under Title XVIII of the "Social~~ 37517
~~Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended,~~ 37518
or pursuant to the ~~medical assistance~~ medicaid program ~~established~~ 37519
~~under Chapter 5111. of the Revised Code~~, as reflected in its 37520
annual statement for the preceding calendar year, and, if the 37521
company operates a health insuring corporation as a line of 37522
business, one per cent of all premium rate payments received from 37523
that line of business, exclusive of payments received under the 37524
medicare program ~~established under Title XVIII of the "Social~~ 37525
~~Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended,~~ 37526
or pursuant to the ~~medical assistance~~ medicaid program ~~established~~ 37527
~~under Chapter 5111. of the Revised Code~~, as reflected in its 37528

annual statement for the preceding calendar year. 37529

(B) The gross amount of premium rate payments or premiums 37530
used to compute the applicable tax in accordance with division (A) 37531
of this section is subject to the deductions prescribed by section 37532
5729.03 of the Revised Code for foreign insurance companies. The 37533
objects of such tax are those declared in section 5725.24 of the 37534
Revised Code, to which only such tax shall be applied. 37535

(C) In no case shall such tax be less than two hundred fifty 37536
dollars. 37537

Sec. 5729.03. (A) If the superintendent of insurance finds 37538
the annual statement required by section 5729.02 of the Revised 37539
Code to be correct, the superintendent shall compute the following 37540
amount, as applicable, of the balance of such gross amount, after 37541
deducting such return premiums and considerations received for 37542
reinsurance, and charge such amount to such company as a tax upon 37543
the business done by it in this state for the period covered by 37544
such annual statement: 37545

(1) If the company is a health insuring corporation, one per 37546
cent of the balance of premium rate payments received, exclusive 37547
of payments received under the medicare program ~~established under~~ 37548
~~Title XVIII of the "Social Security Act," 49 Stat. 620 (1935), 42~~ 37549
~~U.S.C.A. 301, as amended,~~ or pursuant to the ~~medical assistance~~ 37550
medicaid program ~~established under Chapter 5111. of the Revised~~ 37551
~~Code~~, as reflected in its annual report; 37552

(2) If the company is not a health insuring corporation, one 37553
and four-tenths per cent of the balance of premiums received, 37554
exclusive of premiums received under the medicare program 37555
~~established under Title XVIII of the "Social Security Act," 49~~ 37556
~~Stat. 620 (1935), 42 U.S.C.A. 301, as amended,~~ or pursuant to the 37557
~~medical assistance~~ medicaid program ~~established under Chapter~~ 37558
~~5111. of the Revised Code~~, as reflected in its annual statement, 37559

and, if the company operates a health insuring corporation as a 37560
line of business, one per cent of the balance of premium rate 37561
payments received from that line of business, exclusive of 37562
payments received under the medicare program ~~established under~~ 37563
~~Title XVIII of the "Social Security Act," 49 Stat. 620 (1935), 42~~ 37564
~~U.S.C.A. 301, as amended,~~ or pursuant to the ~~medical assistance~~ 37565
<u>medicaid</u> program ~~established under Chapter 5111. of the Revised~~ 37566
~~Code~~, as reflected in its annual statement. 37567

(B) Any insurance policies that were not issued in violation 37568
of Title XXXIX of the Revised Code and that were issued prior to 37569
April 15, 1967, by a life insurance company organized and operated 37570
without profit to any private shareholder or individual, 37571
exclusively for the purpose of aiding educational or scientific 37572
institutions organized and operated without profit to any private 37573
shareholder or individual, are not subject to the tax imposed by 37574
this section. All taxes collected pursuant to this section shall 37575
be credited to the general revenue fund. 37576

(C) In no case shall the tax imposed under this section be 37577
less than two hundred fifty dollars. 37578

Sec. 5731.39. (A) No corporation organized or existing under 37579
the laws of this state shall transfer on its books or issue a new 37580
certificate for any share of its capital stock registered in the 37581
name of a decedent, or in trust for a decedent, or in the name of 37582
a decedent and another person or persons, without the written 37583
consent of the tax commissioner. 37584

(B) No safe deposit company, trust company, financial 37585
institution as defined in division (A) of section 5725.01 of the 37586
Revised Code or other corporation or person, having in possession, 37587
control, or custody a deposit standing in the name of a decedent, 37588
or in trust for a decedent, or in the name of a decedent and 37589
another person or persons, shall deliver or transfer an amount in 37590

excess of three-fourths of the total value of such deposit, including accrued interest and dividends, as of the date of decedent's death, without the written consent of the tax commissioner. The written consent of the tax commissioner need not be obtained prior to the delivery or transfer of amounts having a value of three-fourths or less of said total value. 37591 37592 37593 37594 37595 37596

(C) No life insurance company shall pay the proceeds of an annuity or matured endowment contract, or of a life insurance contract payable to the estate of a decedent, or of any other insurance contract taxable under Chapter 5731. of the Revised Code, without the written consent of the tax commissioner. Any life insurance company may pay the proceeds of any insurance contract not specified in this division (C) without the written consent of the tax commissioner. 37597 37598 37599 37600 37601 37602 37603 37604

(D) No trust company or other corporation or person shall pay the proceeds of any death benefit, retirement, pension or profit sharing plan in excess of two thousand dollars, without the written consent of the tax commissioner. Such trust company or other corporation or person, however, may pay the proceeds of any death benefit, retirement, pension, or profit-sharing plan which consists of insurance on the life of the decedent payable to a beneficiary other than the estate of the insured without the written consent of the tax commissioner. 37605 37606 37607 37608 37609 37610 37611 37612 37613

(E) No safe deposit company, trust company, financial institution as defined in division (A) of section 5725.01 of the Revised Code, or other corporation or person, having in possession, control, or custody securities, assets, or other property (including the shares of the capital stock of, or other interest in, such safe deposit company, trust company, financial institution as defined in division (A) of section 5725.01 of the Revised Code, or other corporation), standing in the name of a decedent, or in trust for a decedent, or in the name of a decedent 37614 37615 37616 37617 37618 37619 37620 37621 37622

and another person or persons, and the transfer of which is taxable under Chapter 5731. of the Revised Code, shall deliver or transfer any such securities, assets, or other property which have a value as of the date of decedent's death in excess of three-fourths of the total value thereof, without the written consent of the tax commissioner. The written consent of the tax commissioner need not be obtained prior to the delivery or transfer of any such securities, assets, or other property having a value of three-fourths or less of said total value. 37623 37624 37625 37626 37627 37628 37629 37630 37631

(F) No safe deposit company, financial institution as defined in division (A) of section 5725.01 of the Revised Code, or other corporation or person having possession or control of a safe deposit box or similar receptacle standing in the name of a decedent or in the name of the decedent and another person or persons, or to which the decedent had a right of access, except when such safe deposit box or other receptacle stands in the name of a corporation or partnership, or in the name of the decedent as guardian or executor, shall deliver any of the contents thereof unless the safe deposit box or similar receptacle has been opened and inventoried in the presence of the tax commissioner or the commissioner's agent, and a written consent to transfer issued; provided, however, that a safe deposit company, financial institution, or other corporation or person having possession or control of a safe deposit box may deliver wills, deeds to burial lots, and insurance policies to a representative of the decedent, but that a representative of the safe deposit company, financial institution, or other corporation or person must supervise the opening of the box and make a written record of the wills, deeds, and policies removed. Such written record shall be included in the tax commissioner's inventory records. 37632 37633 37634 37635 37636 37637 37638 37639 37640 37641 37642 37643 37644 37645 37646 37647 37648 37649 37650 37651 37652

(G) Notwithstanding any provision of this section: 37653

(1) The tax commissioner may authorize any delivery or 37654

transfer or waive any of the foregoing requirements under such terms and conditions as the commissioner may prescribe; 37655 37656

(2) An adult care facility, as defined in section 3722.01 of the Revised Code, or a home, as defined in section 3721.10 of the Revised Code, may transfer or use the money in a personal needs allowance account in accordance with section ~~5111.113~~ 5162.37 of the Revised Code without the written consent of the tax commissioner, and without the account having been opened and inventoried in the presence of the commissioner or the commissioner's agent. 37657 37658 37659 37660 37661 37662 37663 37664

Failure to comply with this section shall render such safe deposit company, trust company, life insurance company, financial institution as defined in division (A) of section 5725.01 of the Revised Code, or other corporation or person liable for the amount of the taxes and interest due under the provisions of Chapter 5731. of the Revised Code on the transfer of such stock, deposit, proceeds of an annuity or matured endowment contract or of a life insurance contract payable to the estate of a decedent, or other insurance contract taxable under Chapter 5731. of the Revised Code, proceeds of any death benefit, retirement, pension, or profit sharing plan in excess of two thousand dollars, or securities, assets, or other property of any resident decedent, and in addition thereto, to a penalty of not less than five hundred or more than five thousand dollars. 37665 37666 37667 37668 37669 37670 37671 37672 37673 37674 37675 37676 37677 37678

Sec. 5747.01. Except as otherwise expressly provided or clearly appearing from the context, any term used in this chapter that is not otherwise defined in this section has the same meaning as when used in a comparable context in the laws of the United States relating to federal income taxes or if not used in a comparable context in those laws, has the same meaning as in section 5733.40 of the Revised Code. Any reference in this chapter 37679 37680 37681 37682 37683 37684 37685

to the Internal Revenue Code includes other laws of the United States relating to federal income taxes. 37686 37687

As used in this chapter: 37688

(A) "Adjusted gross income" or "Ohio adjusted gross income" means federal adjusted gross income, as defined and used in the Internal Revenue Code, adjusted as provided in this section: 37689 37690 37691

(1) Add interest or dividends on obligations or securities of any state or of any political subdivision or authority of any state, other than this state and its subdivisions and authorities. 37692 37693 37694

(2) Add interest or dividends on obligations of any authority, commission, instrumentality, territory, or possession of the United States to the extent that the interest or dividends are exempt from federal income taxes but not from state income taxes. 37695 37696 37697 37698 37699

(3) Deduct interest or dividends on obligations of the United States and its territories and possessions or of any authority, commission, or instrumentality of the United States to the extent that the interest or dividends are included in federal adjusted gross income but exempt from state income taxes under the laws of the United States. 37700 37701 37702 37703 37704 37705

(4) Deduct disability and survivor's benefits to the extent included in federal adjusted gross income. 37706 37707

(5) Deduct benefits under Title II of the Social Security Act and tier 1 railroad retirement benefits to the extent included in federal adjusted gross income under section 86 of the Internal Revenue Code. 37708 37709 37710 37711

(6) In the case of a taxpayer who is a beneficiary of a trust that makes an accumulation distribution as defined in section 665 of the Internal Revenue Code, add, for the beneficiary's taxable years beginning before 2002, the portion, if any, of such 37712 37713 37714 37715

distribution that does not exceed the undistributed net income of the trust for the three taxable years preceding the taxable year in which the distribution is made to the extent that the portion was not included in the trust's taxable income for any of the trust's taxable years beginning in 2002 or thereafter. "Undistributed net income of a trust" means the taxable income of the trust increased by (a)(i) the additions to adjusted gross income required under division (A) of this section and (ii) the personal exemptions allowed to the trust pursuant to section 642(b) of the Internal Revenue Code, and decreased by (b)(i) the deductions to adjusted gross income required under division (A) of this section, (ii) the amount of federal income taxes attributable to such income, and (iii) the amount of taxable income that has been included in the adjusted gross income of a beneficiary by reason of a prior accumulation distribution. Any undistributed net income included in the adjusted gross income of a beneficiary shall reduce the undistributed net income of the trust commencing with the earliest years of the accumulation period. 37716 37717 37718 37719 37720 37721 37722 37723 37724 37725 37726 37727 37728 37729 37730 37731 37732 37733

(7) Deduct the amount of wages and salaries, if any, not otherwise allowable as a deduction but that would have been allowable as a deduction in computing federal adjusted gross income for the taxable year, had the targeted jobs credit allowed and determined under sections 38, 51, and 52 of the Internal Revenue Code not been in effect. 37734 37735 37736 37737 37738 37739

(8) Deduct any interest or interest equivalent on public obligations and purchase obligations to the extent that the interest or interest equivalent is included in federal adjusted gross income. 37740 37741 37742 37743

(9) Add any loss or deduct any gain resulting from the sale, exchange, or other disposition of public obligations to the extent that the loss has been deducted or the gain has been included in computing federal adjusted gross income. 37744 37745 37746 37747

(10) Deduct or add amounts, as provided under section 5747.70 of the Revised Code, related to contributions to variable college savings program accounts made or tuition units purchased pursuant to Chapter 3334. of the Revised Code. 37748 37749 37750 37751

(11)(a) Deduct, to the extent not otherwise allowable as a deduction or exclusion in computing federal or Ohio adjusted gross income for the taxable year, the amount the taxpayer paid during the taxable year for medical care insurance and qualified long-term care insurance for the taxpayer, the taxpayer's spouse, and dependents. No deduction for medical care insurance under division (A)(11) of this section shall be allowed either to any taxpayer who is eligible to participate in any subsidized health plan maintained by any employer of the taxpayer or of the taxpayer's spouse, or to any taxpayer who is entitled to, or on application would be entitled to, benefits under part A of ~~Title XVIII of~~ the ~~"Social Security Act," 49 Stat. 620 (1935), 42 U.S.C. 301, as amended~~ <u>medicare program</u>. For the purposes of division (A)(11)(a) of this section, "subsidized health plan" means a health plan for which the employer pays any portion of the plan's cost. The deduction allowed under division (A)(11)(a) of this section shall be the net of any related premium refunds, related premium reimbursements, or related insurance premium dividends received during the taxable year. 37752 37753 37754 37755 37756 37757 37758 37759 37760 37761 37762 37763 37764 37765 37766 37767 37768 37769 37770

(b) Deduct, to the extent not otherwise deducted or excluded in computing federal or Ohio adjusted gross income during the taxable year, the amount the taxpayer paid during the taxable year, not compensated for by any insurance or otherwise, for medical care of the taxpayer, the taxpayer's spouse, and dependents, to the extent the expenses exceed seven and one-half per cent of the taxpayer's federal adjusted gross income. 37771 37772 37773 37774 37775 37776 37777

(c) For purposes of division (A)(11) of this section, "medical care" has the meaning given in section 213 of the 37778 37779

Internal Revenue Code, subject to the special rules, limitations, and exclusions set forth therein, and "qualified long-term care" has the same meaning given in section 7702B(c) of the Internal Revenue Code. 37780 37781 37782 37783

(12)(a) Deduct any amount included in federal adjusted gross income solely because the amount represents a reimbursement or refund of expenses that in any year the taxpayer had deducted as an itemized deduction pursuant to section 63 of the Internal Revenue Code and applicable United States department of the treasury regulations. The deduction otherwise allowed under division (A)(12)(a) of this section shall be reduced to the extent the reimbursement is attributable to an amount the taxpayer deducted under this section in any taxable year. 37784 37785 37786 37787 37788 37789 37790 37791 37792

(b) Add any amount not otherwise included in Ohio adjusted gross income for any taxable year to the extent that the amount is attributable to the recovery during the taxable year of any amount deducted or excluded in computing federal or Ohio adjusted gross income in any taxable year. 37793 37794 37795 37796 37797

(13) Deduct any portion of the deduction described in section 1341(a)(2) of the Internal Revenue Code, for repaying previously reported income received under a claim of right, that meets both of the following requirements: 37798 37799 37800 37801

(a) It is allowable for repayment of an item that was included in the taxpayer's adjusted gross income for a prior taxable year and did not qualify for a credit under division (A) or (B) of section 5747.05 of the Revised Code for that year; 37802 37803 37804 37805

(b) It does not otherwise reduce the taxpayer's adjusted gross income for the current or any other taxable year. 37806 37807

(14) Deduct an amount equal to the deposits made to, and net investment earnings of, a medical savings account during the taxable year, in accordance with section 3924.66 of the Revised 37808 37809 37810

Code. The deduction allowed by division (A)(14) of this section does not apply to medical savings account deposits and earnings otherwise deducted or excluded for the current or any other taxable year from the taxpayer's federal adjusted gross income. 37811 37812 37813 37814

(15)(a) Add an amount equal to the funds withdrawn from a medical savings account during the taxable year, and the net investment earnings on those funds, when the funds withdrawn were used for any purpose other than to reimburse an account holder for, or to pay, eligible medical expenses, in accordance with section 3924.66 of the Revised Code; 37815 37816 37817 37818 37819 37820

(b) Add the amounts distributed from a medical savings account under division (A)(2) of section 3924.68 of the Revised Code during the taxable year. 37821 37822 37823

(16) Add any amount claimed as a credit under section 5747.059 of the Revised Code to the extent that such amount satisfies either of the following: 37824 37825 37826

(a) The amount was deducted or excluded from the computation of the taxpayer's federal adjusted gross income as required to be reported for the taxpayer's taxable year under the Internal Revenue Code; 37827 37828 37829 37830

(b) The amount resulted in a reduction of the taxpayer's federal adjusted gross income as required to be reported for any of the taxpayer's taxable years under the Internal Revenue Code. 37831 37832 37833

(17) Deduct the amount contributed by the taxpayer to an individual development account program established by a county department of job and family services pursuant to sections 329.11 to 329.14 of the Revised Code for the purpose of matching funds deposited by program participants. On request of the tax commissioner, the taxpayer shall provide any information that, in the tax commissioner's opinion, is necessary to establish the amount deducted under division (A)(17) of this section. 37834 37835 37836 37837 37838 37839 37840 37841

(18) Beginning in taxable year 2001 but not for any taxable year beginning after December 31, 2005, if the taxpayer is married and files a joint return and the combined federal adjusted gross income of the taxpayer and the taxpayer's spouse for the taxable year does not exceed one hundred thousand dollars, or if the taxpayer is single and has a federal adjusted gross income for the taxable year not exceeding fifty thousand dollars, deduct amounts paid during the taxable year for qualified tuition and fees paid to an eligible institution for the taxpayer, the taxpayer's spouse, or any dependent of the taxpayer, who is a resident of this state and is enrolled in or attending a program that culminates in a degree or diploma at an eligible institution. The deduction may be claimed only to the extent that qualified tuition and fees are not otherwise deducted or excluded for any taxable year from federal or Ohio adjusted gross income. The deduction may not be claimed for educational expenses for which the taxpayer claims a credit under section 5747.27 of the Revised Code. 37842 37843 37844 37845 37846 37847 37848 37849 37850 37851 37852 37853 37854 37855 37856 37857 37858

(19) Add any reimbursement received during the taxable year of any amount the taxpayer deducted under division (A)(18) of this section in any previous taxable year to the extent the amount is not otherwise included in Ohio adjusted gross income. 37859 37860 37861 37862

(20)(a)(i) Add five-sixths of the amount of depreciation expense allowed by subsection (k) of section 168 of the Internal Revenue Code, including the taxpayer's proportionate or distributive share of the amount of depreciation expense allowed by that subsection to a pass-through entity in which the taxpayer has a direct or indirect ownership interest. 37863 37864 37865 37866 37867 37868

(ii) Add five-sixths of the amount of qualifying section 179 depreciation expense, including a person's proportionate or distributive share of the amount of qualifying section 179 depreciation expense allowed to any pass-through entity in which the person has a direct or indirect ownership. For the purposes of 37869 37870 37871 37872 37873

this division, "qualifying section 179 depreciation expense" means the difference between (I) the amount of depreciation expense directly or indirectly allowed to the taxpayer under section 179 of the Internal Revenue Code, and (II) the amount of depreciation expense directly or indirectly allowed to the taxpayer under section 179 of the Internal Revenue Code as that section existed on December 31, 2002. 37874 37875 37876 37877 37878 37879 37880

The tax commissioner, under procedures established by the commissioner, may waive the add-backs related to a pass-through entity if the taxpayer owns, directly or indirectly, less than five per cent of the pass-through entity. 37881 37882 37883 37884

(b) Nothing in division (A)(20) of this section shall be construed to adjust or modify the adjusted basis of any asset. 37885 37886

(c) To the extent the add-back required under division (A)(20)(a) of this section is attributable to property generating nonbusiness income or loss allocated under section 5747.20 of the Revised Code, the add-back shall be sitused to the same location as the nonbusiness income or loss generated by the property for the purpose of determining the credit under division (A) of section 5747.05 of the Revised Code. Otherwise, the add-back shall be apportioned, subject to one or more of the four alternative methods of apportionment enumerated in section 5747.21 of the Revised Code. 37887 37888 37889 37890 37891 37892 37893 37894 37895 37896

(d) For the purposes of division (A) of this section, net operating loss carryback and carryforward shall not include five-sixths of the allowance of any net operating loss deduction carryback or carryforward to the taxable year to the extent such loss resulted from depreciation allowed by section 168(k) of the Internal Revenue Code and by the qualifying section 179 depreciation expense amount. 37897 37898 37899 37900 37901 37902 37903

(21)(a) If the taxpayer was required to add an amount under 37904

division (A)(20)(a) of this section for a taxable year, deduct one-fifth of the amount so added for each of the five succeeding taxable years. 37905 37906 37907

(b) If the amount deducted under division (A)(21)(a) of this section is attributable to an add-back allocated under division (A)(20)(c) of this section, the amount deducted shall be sitused to the same location. Otherwise, the add-back shall be apportioned using the apportionment factors for the taxable year in which the deduction is taken, subject to one or more of the four alternative methods of apportionment enumerated in section 5747.21 of the Revised Code. 37908 37909 37910 37911 37912 37913 37914 37915

(c) No deduction is available under division (A)(21)(a) of this section with regard to any depreciation allowed by section 168(k) of the Internal Revenue Code and by the qualifying section 179 depreciation expense amount to the extent that such depreciation resulted in or increased a federal net operating loss carryback or carryforward to a taxable year to which division (A)(20)(d) of this section does not apply. 37916 37917 37918 37919 37920 37921 37922

(22) Deduct, to the extent not otherwise deducted or excluded in computing federal or Ohio adjusted gross income for the taxable year, the amount the taxpayer received during the taxable year as reimbursement for life insurance premiums under section 5919.31 of the Revised Code. 37923 37924 37925 37926 37927

(23) Deduct, to the extent not otherwise deducted or excluded in computing federal or Ohio adjusted gross income for the taxable year, the amount the taxpayer received during the taxable year as a death benefit paid by the adjutant general under section 5919.33 of the Revised Code. 37928 37929 37930 37931 37932

(24) Deduct, to the extent included in federal adjusted gross income and not otherwise allowable as a deduction or exclusion in computing federal or Ohio adjusted gross income for the taxable 37933 37934 37935

year, military pay and allowances received by the taxpayer during the taxable year for active duty service in the United States army, air force, navy, marine corps, or coast guard or reserve components thereof or the national guard. The deduction may not be claimed for military pay and allowances received by the taxpayer while the taxpayer is stationed in this state. 37936 37937 37938 37939 37940 37941

(25) Deduct, to the extent not otherwise allowable as a deduction or exclusion in computing federal or Ohio adjusted gross income for the taxable year and not otherwise compensated for by any other source, the amount of qualified organ donation expenses incurred by the taxpayer during the taxable year, not to exceed ten thousand dollars. A taxpayer may deduct qualified organ donation expenses only once for all taxable years beginning with taxable years beginning in 2007. 37942 37943 37944 37945 37946 37947 37948 37949

For the purposes of division (A)(25) of this section: 37950

(a) "Human organ" means all or any portion of a human liver, pancreas, kidney, intestine, or lung, and any portion of human bone marrow. 37951 37952 37953

(b) "Qualified organ donation expenses" means travel expenses, lodging expenses, and wages and salary forgone by a taxpayer in connection with the taxpayer's donation, while living, of one or more of the taxpayer's human organs to another human being. 37954 37955 37956 37957 37958

(26) Deduct, to the extent not otherwise deducted or excluded in computing federal or Ohio adjusted gross income for the taxable year, amounts received by the taxpayer as retired military personnel pay for service in the United States army, navy, air force, coast guard, or marine corps or reserve components thereof, or the national guard, or received by the surviving spouse or former spouse of such a taxpayer under the survivor benefit plan on account of such a taxpayer's death. If the taxpayer receives 37959 37960 37961 37962 37963 37964 37965 37966

income on account of retirement paid under the federal civil service retirement system or federal employees retirement system, or under any successor retirement program enacted by the congress of the United States that is established and maintained for retired employees of the United States government, and such retirement income is based, in whole or in part, on credit for the taxpayer's military service, the deduction allowed under this division shall include only that portion of such retirement income that is attributable to the taxpayer's military service, to the extent that portion of such retirement income is otherwise included in federal adjusted gross income and is not otherwise deducted under this section. Any amount deducted under division (A)(26) of this section is not included in a taxpayer's adjusted gross income for the purposes of section 5747.055 of the Revised Code. No amount may be deducted under division (A)(26) of this section on the basis of which a credit was claimed under section 5747.055 of the Revised Code. 37967 37968 37969 37970 37971 37972 37973 37974 37975 37976 37977 37978 37979 37980 37981 37982 37983

(27) Deduct, to the extent not otherwise deducted or excluded in computing federal or Ohio adjusted gross income for the taxable year, the amount the taxpayer received during the taxable year from the military injury relief fund created in section 5101.98 of the Revised Code. 37984 37985 37986 37987 37988

(B) "Business income" means income, including gain or loss, arising from transactions, activities, and sources in the regular course of a trade or business and includes income, gain, or loss from real property, tangible property, and intangible property if the acquisition, rental, management, and disposition of the property constitute integral parts of the regular course of a trade or business operation. "Business income" includes income, including gain or loss, from a partial or complete liquidation of a business, including, but not limited to, gain or loss from the sale or other disposition of goodwill. 37989 37990 37991 37992 37993 37994 37995 37996 37997 37998

(C) "Nonbusiness income" means all income other than business income and may include, but is not limited to, compensation, rents and royalties from real or tangible personal property, capital gains, interest, dividends and distributions, patent or copyright royalties, or lottery winnings, prizes, and awards. 37999 38000 38001 38002 38003

(D) "Compensation" means any form of remuneration paid to an employee for personal services. 38004 38005

(E) "Fiduciary" means a guardian, trustee, executor, administrator, receiver, conservator, or any other person acting in any fiduciary capacity for any individual, trust, or estate. 38006 38007 38008

(F) "Fiscal year" means an accounting period of twelve months ending on the last day of any month other than December. 38009 38010

(G) "Individual" means any natural person. 38011

(H) "Internal Revenue Code" means the "Internal Revenue Code of 1986," 100 Stat. 2085, 26 U.S.C.A. 1, as amended. 38012 38013

(I) "Resident" means any of the following, provided that division (I)(3) of this section applies only to taxable years of a trust beginning in 2002 or thereafter: 38014 38015 38016

(1) An individual who is domiciled in this state, subject to section 5747.24 of the Revised Code; 38017 38018

(2) The estate of a decedent who at the time of death was domiciled in this state. The domicile tests of section 5747.24 of the Revised Code are not controlling for purposes of division (I)(2) of this section. 38019 38020 38021 38022

(3) A trust that, in whole or part, resides in this state. If only part of a trust resides in this state, the trust is a resident only with respect to that part. 38023 38024 38025

For the purposes of division (I)(3) of this section: 38026

(a) A trust resides in this state for the trust's current taxable year to the extent, as described in division (I)(3)(d) of 38027 38028

this section, that the trust consists directly or indirectly, in whole or in part, of assets, net of any related liabilities, that were transferred, or caused to be transferred, directly or indirectly, to the trust by any of the following: 38029 38030 38031 38032

(i) A person, a court, or a governmental entity or instrumentality on account of the death of a decedent, but only if the trust is described in division (I)(3)(e)(i) or (ii) of this section; 38033 38034 38035 38036

(ii) A person who was domiciled in this state for the purposes of this chapter when the person directly or indirectly transferred assets to an irrevocable trust, but only if at least one of the trust's qualifying beneficiaries is domiciled in this state for the purposes of this chapter during all or some portion of the trust's current taxable year; 38037 38038 38039 38040 38041 38042

(iii) A person who was domiciled in this state for the purposes of this chapter when the trust document or instrument or part of the trust document or instrument became irrevocable, but only if at least one of the trust's qualifying beneficiaries is a resident domiciled in this state for the purposes of this chapter during all or some portion of the trust's current taxable year. If a trust document or instrument became irrevocable upon the death of a person who at the time of death was domiciled in this state for purposes of this chapter, that person is a person described in division (I)(3)(a)(iii) of this section. 38043 38044 38045 38046 38047 38048 38049 38050 38051 38052

(b) A trust is irrevocable to the extent that the transferor is not considered to be the owner of the net assets of the trust under sections 671 to 678 of the Internal Revenue Code. 38053 38054 38055

(c) With respect to a trust other than a charitable lead trust, "qualifying beneficiary" has the same meaning as "potential current beneficiary" as defined in section 1361(e)(2) of the Internal Revenue Code, and with respect to a charitable lead trust 38056 38057 38058 38059

"qualifying beneficiary" is any current, future, or contingent beneficiary, but with respect to any trust "qualifying beneficiary" excludes a person or a governmental entity or instrumentality to any of which a contribution would qualify for the charitable deduction under section 170 of the Internal Revenue Code. 38060 38061 38062 38063 38064 38065

(d) For the purposes of division (I)(3)(a) of this section, the extent to which a trust consists directly or indirectly, in whole or in part, of assets, net of any related liabilities, that were transferred directly or indirectly, in whole or part, to the trust by any of the sources enumerated in that division shall be ascertained by multiplying the fair market value of the trust's assets, net of related liabilities, by the qualifying ratio, which shall be computed as follows: 38066 38067 38068 38069 38070 38071 38072 38073

(i) The first time the trust receives assets, the numerator of the qualifying ratio is the fair market value of those assets at that time, net of any related liabilities, from sources enumerated in division (I)(3)(a) of this section. The denominator of the qualifying ratio is the fair market value of all the trust's assets at that time, net of any related liabilities. 38074 38075 38076 38077 38078 38079

(ii) Each subsequent time the trust receives assets, a revised qualifying ratio shall be computed. The numerator of the revised qualifying ratio is the sum of (1) the fair market value of the trust's assets immediately prior to the subsequent transfer, net of any related liabilities, multiplied by the qualifying ratio last computed without regard to the subsequent transfer, and (2) the fair market value of the subsequently transferred assets at the time transferred, net of any related liabilities, from sources enumerated in division (I)(3)(a) of this section. The denominator of the revised qualifying ratio is the fair market value of all the trust's assets immediately after the subsequent transfer, net of any related liabilities. 38080 38081 38082 38083 38084 38085 38086 38087 38088 38089 38090 38091

(iii) Whether a transfer to the trust is by or from any of the sources enumerated in division (I)(3)(a) of this section shall be ascertained without regard to the domicile of the trust's beneficiaries. 38092 38093 38094 38095

(e) For the purposes of division (I)(3)(a)(i) of this section: 38096 38097

(i) A trust is described in division (I)(3)(e)(i) of this section if the trust is a testamentary trust and the testator of that testamentary trust was domiciled in this state at the time of the testator's death for purposes of the taxes levied under Chapter 5731. of the Revised Code. 38098 38099 38100 38101 38102

(ii) A trust is described in division (I)(3)(e)(ii) of this section if the transfer is a qualifying transfer described in any of divisions (I)(3)(f)(i) to (vi) of this section, the trust is an irrevocable inter vivos trust, and at least one of the trust's qualifying beneficiaries is domiciled in this state for purposes of this chapter during all or some portion of the trust's current taxable year. 38103 38104 38105 38106 38107 38108 38109

(f) For the purposes of division (I)(3)(e)(ii) of this section, a "qualifying transfer" is a transfer of assets, net of any related liabilities, directly or indirectly to a trust, if the transfer is described in any of the following: 38110 38111 38112 38113

(i) The transfer is made to a trust, created by the decedent before the decedent's death and while the decedent was domiciled in this state for the purposes of this chapter, and, prior to the death of the decedent, the trust became irrevocable while the decedent was domiciled in this state for the purposes of this chapter. 38114 38115 38116 38117 38118 38119

(ii) The transfer is made to a trust to which the decedent, prior to the decedent's death, had directly or indirectly transferred assets, net of any related liabilities, while the 38120 38121 38122

decedent was domiciled in this state for the purposes of this chapter, and prior to the death of the decedent the trust became irrevocable while the decedent was domiciled in this state for the purposes of this chapter. 38123 38124 38125 38126

(iii) The transfer is made on account of a contractual relationship existing directly or indirectly between the transferor and either the decedent or the estate of the decedent at any time prior to the date of the decedent's death, and the decedent was domiciled in this state at the time of death for purposes of the taxes levied under Chapter 5731. of the Revised Code. 38127 38128 38129 38130 38131 38132 38133

(iv) The transfer is made to a trust on account of a contractual relationship existing directly or indirectly between the transferor and another person who at the time of the decedent's death was domiciled in this state for purposes of this chapter. 38134 38135 38136 38137 38138

(v) The transfer is made to a trust on account of the will of a testator. 38139 38140

(vi) The transfer is made to a trust created by or caused to be created by a court, and the trust was directly or indirectly created in connection with or as a result of the death of an individual who, for purposes of the taxes levied under Chapter 5731. of the Revised Code, was domiciled in this state at the time of the individual's death. 38141 38142 38143 38144 38145 38146

(g) The tax commissioner may adopt rules to ascertain the part of a trust residing in this state. 38147 38148

(J) "Nonresident" means an individual or estate that is not a resident. An individual who is a resident for only part of a taxable year is a nonresident for the remainder of that taxable year. 38149 38150 38151 38152

(K) "Pass-through entity" has the same meaning as in section 38153

5733.04 of the Revised Code. 38154

(L) "Return" means the notifications and reports required to be filed pursuant to this chapter for the purpose of reporting the tax due and includes declarations of estimated tax when so required. 38155 38156 38157 38158

(M) "Taxable year" means the calendar year or the taxpayer's fiscal year ending during the calendar year, or fractional part thereof, upon which the adjusted gross income is calculated pursuant to this chapter. 38159 38160 38161 38162

(N) "Taxpayer" means any person subject to the tax imposed by section 5747.02 of the Revised Code or any pass-through entity that makes the election under division (D) of section 5747.08 of the Revised Code. 38163 38164 38165 38166

(O) "Dependents" means dependents as defined in the Internal Revenue Code and as claimed in the taxpayer's federal income tax return for the taxable year or which the taxpayer would have been permitted to claim had the taxpayer filed a federal income tax return. 38167 38168 38169 38170 38171

(P) "Principal county of employment" means, in the case of a nonresident, the county within the state in which a taxpayer performs services for an employer or, if those services are performed in more than one county, the county in which the major portion of the services are performed. 38172 38173 38174 38175 38176

(Q) As used in sections 5747.50 to 5747.55 of the Revised Code: 38177 38178

(1) "Subdivision" means any county, municipal corporation, park district, or township. 38179 38180

(2) "Essential local government purposes" includes all functions that any subdivision is required by general law to exercise, including like functions that are exercised under a 38181 38182 38183

charter adopted pursuant to the Ohio Constitution. 38184

(R) "Overpayment" means any amount already paid that exceeds the figure determined to be the correct amount of the tax. 38185 38186

(S) "Taxable income" or "Ohio taxable income" applies only to estates and trusts, and means federal taxable income, as defined and used in the Internal Revenue Code, adjusted as follows: 38187 38188 38189

(1) Add interest or dividends, net of ordinary, necessary, and reasonable expenses not deducted in computing federal taxable income, on obligations or securities of any state or of any political subdivision or authority of any state, other than this state and its subdivisions and authorities, but only to the extent that such net amount is not otherwise includible in Ohio taxable income and is described in either division (S)(1)(a) or (b) of this section: 38190 38191 38192 38193 38194 38195 38196 38197

(a) The net amount is not attributable to the S portion of an electing small business trust and has not been distributed to beneficiaries for the taxable year; 38198 38199 38200

(b) The net amount is attributable to the S portion of an electing small business trust for the taxable year. 38201 38202

(2) Add interest or dividends, net of ordinary, necessary, and reasonable expenses not deducted in computing federal taxable income, on obligations of any authority, commission, instrumentality, territory, or possession of the United States to the extent that the interest or dividends are exempt from federal income taxes but not from state income taxes, but only to the extent that such net amount is not otherwise includible in Ohio taxable income and is described in either division (S)(1)(a) or (b) of this section; 38203 38204 38205 38206 38207 38208 38209 38210 38211

(3) Add the amount of personal exemption allowed to the estate pursuant to section 642(b) of the Internal Revenue Code; 38212 38213

(4) Deduct interest or dividends, net of related expenses deducted in computing federal taxable income, on obligations of the United States and its territories and possessions or of any authority, commission, or instrumentality of the United States to the extent that the interest or dividends are exempt from state taxes under the laws of the United States, but only to the extent that such amount is included in federal taxable income and is described in either division (S)(1)(a) or (b) of this section; 38214 38215 38216 38217 38218 38219 38220 38221

(5) Deduct the amount of wages and salaries, if any, not otherwise allowable as a deduction but that would have been allowable as a deduction in computing federal taxable income for the taxable year, had the targeted jobs credit allowed under sections 38, 51, and 52 of the Internal Revenue Code not been in effect, but only to the extent such amount relates either to income included in federal taxable income for the taxable year or to income of the S portion of an electing small business trust for the taxable year; 38222 38223 38224 38225 38226 38227 38228 38229 38230

(6) Deduct any interest or interest equivalent, net of related expenses deducted in computing federal taxable income, on public obligations and purchase obligations, but only to the extent that such net amount relates either to income included in federal taxable income for the taxable year or to income of the S portion of an electing small business trust for the taxable year; 38231 38232 38233 38234 38235 38236

(7) Add any loss or deduct any gain resulting from sale, exchange, or other disposition of public obligations to the extent that such loss has been deducted or such gain has been included in computing either federal taxable income or income of the S portion of an electing small business trust for the taxable year; 38237 38238 38239 38240 38241

(8) Except in the case of the final return of an estate, add any amount deducted by the taxpayer on both its Ohio estate tax return pursuant to section 5731.14 of the Revised Code, and on its federal income tax return in determining federal taxable income; 38242 38243 38244 38245

(9)(a) Deduct any amount included in federal taxable income solely because the amount represents a reimbursement or refund of expenses that in a previous year the decedent had deducted as an itemized deduction pursuant to section 63 of the Internal Revenue Code and applicable treasury regulations. The deduction otherwise allowed under division (S)(9)(a) of this section shall be reduced to the extent the reimbursement is attributable to an amount the taxpayer or decedent deducted under this section in any taxable year. 38246 38247 38248 38249 38250 38251 38252 38253 38254

(b) Add any amount not otherwise included in Ohio taxable income for any taxable year to the extent that the amount is attributable to the recovery during the taxable year of any amount deducted or excluded in computing federal or Ohio taxable income in any taxable year, but only to the extent such amount has not been distributed to beneficiaries for the taxable year. 38255 38256 38257 38258 38259 38260

(10) Deduct any portion of the deduction described in section 1341(a)(2) of the Internal Revenue Code, for repaying previously reported income received under a claim of right, that meets both of the following requirements: 38261 38262 38263 38264

(a) It is allowable for repayment of an item that was included in the taxpayer's taxable income or the decedent's adjusted gross income for a prior taxable year and did not qualify for a credit under division (A) or (B) of section 5747.05 of the Revised Code for that year. 38265 38266 38267 38268 38269

(b) It does not otherwise reduce the taxpayer's taxable income or the decedent's adjusted gross income for the current or any other taxable year. 38270 38271 38272

(11) Add any amount claimed as a credit under section 5747.059 of the Revised Code to the extent that the amount satisfies either of the following: 38273 38274 38275

(a) The amount was deducted or excluded from the computation 38276

of the taxpayer's federal taxable income as required to be reported for the taxpayer's taxable year under the Internal Revenue Code; 38277 38278 38279

(b) The amount resulted in a reduction in the taxpayer's federal taxable income as required to be reported for any of the taxpayer's taxable years under the Internal Revenue Code. 38280 38281 38282

(12) Deduct any amount, net of related expenses deducted in computing federal taxable income, that a trust is required to report as farm income on its federal income tax return, but only if the assets of the trust include at least ten acres of land satisfying the definition of "land devoted exclusively to agricultural use" under section 5713.30 of the Revised Code, regardless of whether the land is valued for tax purposes as such land under sections 5713.30 to 5713.38 of the Revised Code. If the trust is a pass-through entity investor, section 5747.231 of the Revised Code applies in ascertaining if the trust is eligible to claim the deduction provided by division (S)(12) of this section in connection with the pass-through entity's farm income. 38283 38284 38285 38286 38287 38288 38289 38290 38291 38292 38293 38294

Except for farm income attributable to the S portion of an electing small business trust, the deduction provided by division (S)(12) of this section is allowed only to the extent that the trust has not distributed such farm income. Division (S)(12) of this section applies only to taxable years of a trust beginning in 2002 or thereafter. 38295 38296 38297 38298 38299 38300

(13) Add the net amount of income described in section 641(c) of the Internal Revenue Code to the extent that amount is not included in federal taxable income. 38301 38302 38303

(14) Add or deduct the amount the taxpayer would be required to add or deduct under division (A)(20) or (21) of this section if the taxpayer's Ohio taxable income were computed in the same manner as an individual's Ohio adjusted gross income is computed 38304 38305 38306 38307

under this section. In the case of a trust, division (S)(14) of this section applies only to any of the trust's taxable years beginning in 2002 or thereafter. 38308 38309 38310

(T) "School district income" and "school district income tax" have the same meanings as in section 5748.01 of the Revised Code. 38311 38312

(U) As used in divisions (A)(8), (A)(9), (S)(6), and (S)(7) of this section, "public obligations," "purchase obligations," and "interest or interest equivalent" have the same meanings as in section 5709.76 of the Revised Code. 38313 38314 38315 38316

(V) "Limited liability company" means any limited liability company formed under Chapter 1705. of the Revised Code or under the laws of any other state. 38317 38318 38319

(W) "Pass-through entity investor" means any person who, during any portion of a taxable year of a pass-through entity, is a partner, member, shareholder, or equity investor in that pass-through entity. 38320 38321 38322 38323

(X) "Banking day" has the same meaning as in section 1304.01 of the Revised Code. 38324 38325

(Y) "Month" means a calendar month. 38326

(Z) "Quarter" means the first three months, the second three months, the third three months, or the last three months of the taxpayer's taxable year. 38327 38328 38329

(AA)(1) "Eligible institution" means a state university or state institution of higher education as defined in section 3345.011 of the Revised Code, or a private, nonprofit college, university, or other post-secondary institution located in this state that possesses a certificate of authorization issued by the Ohio board of regents pursuant to Chapter 1713. of the Revised Code or a certificate of registration issued by the state board of career colleges and schools under Chapter 3332. of the Revised 38330 38331 38332 38333 38334 38335 38336 38337

Code. 38338

(2) "Qualified tuition and fees" means tuition and fees imposed by an eligible institution as a condition of enrollment or attendance, not exceeding two thousand five hundred dollars in each of the individual's first two years of post-secondary education. If the individual is a part-time student, "qualified tuition and fees" includes tuition and fees paid for the academic equivalent of the first two years of post-secondary education during a maximum of five taxable years, not exceeding a total of five thousand dollars. "Qualified tuition and fees" does not include: 38339 38340 38341 38342 38343 38344 38345 38346 38347 38348

(a) Expenses for any course or activity involving sports, games, or hobbies unless the course or activity is part of the individual's degree or diploma program; 38349 38350 38351

(b) The cost of books, room and board, student activity fees, athletic fees, insurance expenses, or other expenses unrelated to the individual's academic course of instruction; 38352 38353 38354

(c) Tuition, fees, or other expenses paid or reimbursed through an employer, scholarship, grant in aid, or other educational benefit program. 38355 38356 38357

(BB)(1) "Modified business income" means the business income included in a trust's Ohio taxable income after such taxable income is first reduced by the qualifying trust amount, if any. 38358 38359 38360

(2) "Qualifying trust amount" of a trust means capital gains and losses from the sale, exchange, or other disposition of equity or ownership interests in, or debt obligations of, a qualifying investee to the extent included in the trust's Ohio taxable income, but only if the following requirements are satisfied: 38361 38362 38363 38364 38365

(a) The book value of the qualifying investee's physical assets in this state and everywhere, as of the last day of the qualifying investee's fiscal or calendar year ending immediately 38366 38367 38368

prior to the date on which the trust recognizes the gain or loss, is available to the trust. 38369 38370

(b) The requirements of section 5747.011 of the Revised Code are satisfied for the trust's taxable year in which the trust recognizes the gain or loss. 38371 38372 38373

Any gain or loss that is not a qualifying trust amount is modified business income, qualifying investment income, or modified nonbusiness income, as the case may be. 38374 38375 38376

(3) "Modified nonbusiness income" means a trust's Ohio taxable income other than modified business income, other than the qualifying trust amount, and other than qualifying investment income, as defined in section 5747.012 of the Revised Code, to the extent such qualifying investment income is not otherwise part of modified business income. 38377 38378 38379 38380 38381 38382

(4) "Modified Ohio taxable income" applies only to trusts, and means the sum of the amounts described in divisions (BB)(4)(a) to (c) of this section: 38383 38384 38385

(a) The fraction, calculated under section 5747.013, and applying section 5747.231 of the Revised Code, multiplied by the sum of the following amounts: 38386 38387 38388

(i) The trust's modified business income; 38389

(ii) The trust's qualifying investment income, as defined in section 5747.012 of the Revised Code, but only to the extent the qualifying investment income does not otherwise constitute modified business income and does not otherwise constitute a qualifying trust amount. 38390 38391 38392 38393 38394

(b) The qualifying trust amount multiplied by a fraction, the numerator of which is the sum of the book value of the qualifying investee's physical assets in this state on the last day of the qualifying investee's fiscal or calendar year ending immediately 38395 38396 38397 38398

prior to the day on which the trust recognizes the qualifying trust amount, and the denominator of which is the sum of the book value of the qualifying investee's total physical assets everywhere on the last day of the qualifying investee's fiscal or calendar year ending immediately prior to the day on which the trust recognizes the qualifying trust amount. If, for a taxable year, the trust recognizes a qualifying trust amount with respect to more than one qualifying investee, the amount described in division (BB)(4)(b) of this section shall equal the sum of the products so computed for each such qualifying investee. 38399 38400 38401 38402 38403 38404 38405 38406 38407 38408

(c)(i) With respect to a trust or portion of a trust that is a resident as ascertained in accordance with division (I)(3)(d) of this section, its modified nonbusiness income. 38409 38410 38411

(ii) With respect to a trust or portion of a trust that is not a resident as ascertained in accordance with division (I)(3)(d) of this section, the amount of its modified nonbusiness income satisfying the descriptions in divisions (B)(2) to (5) of section 5747.20 of the Revised Code, except as otherwise provided in division (BB)(4)(c)(ii) of this section. With respect to a trust or portion of a trust that is not a resident as ascertained in accordance with division (I)(3)(d) of this section, the trust's portion of modified nonbusiness income recognized from the sale, exchange, or other disposition of a debt interest in or equity interest in a section 5747.212 entity, as defined in section 5747.212 of the Revised Code, without regard to division (A) of that section, shall not be allocated to this state in accordance with section 5747.20 of the Revised Code but shall be apportioned to this state in accordance with division (B) of section 5747.212 of the Revised Code without regard to division (A) of that section. 38412 38413 38414 38415 38416 38417 38418 38419 38420 38421 38422 38423 38424 38425 38426 38427 38428

If the allocation and apportionment of a trust's income under divisions (BB)(4)(a) and (c) of this section do not fairly 38429 38430

represent the modified Ohio taxable income of the trust in this state, the alternative methods described in division (C) of section 5747.21 of the Revised Code may be applied in the manner and to the same extent provided in that section. 38431 38432 38433 38434

(5)(a) Except as set forth in division (BB)(5)(b) of this section, "qualifying investee" means a person in which a trust has an equity or ownership interest, or a person or unit of government the debt obligations of either of which are owned by a trust. For the purposes of division (BB)(2)(a) of this section and for the purpose of computing the fraction described in division (BB)(4)(b) of this section, all of the following apply: 38435 38436 38437 38438 38439 38440 38441

(i) If the qualifying investee is a member of a qualifying controlled group on the last day of the qualifying investee's fiscal or calendar year ending immediately prior to the date on which the trust recognizes the gain or loss, then "qualifying investee" includes all persons in the qualifying controlled group on such last day. 38442 38443 38444 38445 38446 38447

(ii) If the qualifying investee, or if the qualifying investee and any members of the qualifying controlled group of which the qualifying investee is a member on the last day of the qualifying investee's fiscal or calendar year ending immediately prior to the date on which the trust recognizes the gain or loss, separately or cumulatively own, directly or indirectly, on the last day of the qualifying investee's fiscal or calendar year ending immediately prior to the date on which the trust recognizes the qualifying trust amount, more than fifty per cent of the equity of a pass-through entity, then the qualifying investee and the other members are deemed to own the proportionate share of the pass-through entity's physical assets which the pass-through entity directly or indirectly owns on the last day of the pass-through entity's calendar or fiscal year ending within or with the last day of the qualifying investee's fiscal or calendar 38448 38449 38450 38451 38452 38453 38454 38455 38456 38457 38458 38459 38460 38461 38462

year ending immediately prior to the date on which the trust recognizes the qualifying trust amount. 38463 38464

(iii) For the purposes of division (BB)(5)(a)(iii) of this section, "upper level pass-through entity" means a pass-through entity directly or indirectly owning any equity of another pass-through entity, and "lower level pass-through entity" means that other pass-through entity. 38465 38466 38467 38468 38469

An upper level pass-through entity, whether or not it is also a qualifying investee, is deemed to own, on the last day of the upper level pass-through entity's calendar or fiscal year, the proportionate share of the lower level pass-through entity's physical assets that the lower level pass-through entity directly or indirectly owns on the last day of the lower level pass-through entity's calendar or fiscal year ending within or with the last day of the upper level pass-through entity's fiscal or calendar year. If the upper level pass-through entity directly and indirectly owns less than fifty per cent of the equity of the lower level pass-through entity on each day of the upper level pass-through entity's calendar or fiscal year in which or with which ends the calendar or fiscal year of the lower level pass-through entity and if, based upon clear and convincing evidence, complete information about the location and cost of the physical assets of the lower pass-through entity is not available to the upper level pass-through entity, then solely for purposes of ascertaining if a gain or loss constitutes a qualifying trust amount, the upper level pass-through entity shall be deemed as owning no equity of the lower level pass-through entity for each day during the upper level pass-through entity's calendar or fiscal year in which or with which ends the lower level pass-through entity's calendar or fiscal year. Nothing in division (BB)(5)(a)(iii) of this section shall be construed to provide for any deduction or exclusion in computing any trust's Ohio taxable 38470 38471 38472 38473 38474 38475 38476 38477 38478 38479 38480 38481 38482 38483 38484 38485 38486 38487 38488 38489 38490 38491 38492 38493 38494

income. 38495

(b) With respect to a trust that is not a resident for the taxable year and with respect to a part of a trust that is not a resident for the taxable year, "qualifying investee" for that taxable year does not include a C corporation if both of the following apply: 38496 38497 38498 38499 38500

(i) During the taxable year the trust or part of the trust recognizes a gain or loss from the sale, exchange, or other disposition of equity or ownership interests in, or debt obligations of, the C corporation. 38501 38502 38503 38504

(ii) Such gain or loss constitutes nonbusiness income. 38505

(6) "Available" means information is such that a person is able to learn of the information by the due date plus extensions, if any, for filing the return for the taxable year in which the trust recognizes the gain or loss. 38506 38507 38508 38509

(CC) "Qualifying controlled group" has the same meaning as in section 5733.04 of the Revised Code. 38510 38511

(DD) "Related member" has the same meaning as in section 5733.042 of the Revised Code. 38512 38513

(EE)(1) For the purposes of division (EE) of this section: 38514

(a) "Qualifying person" means any person other than a qualifying corporation. 38515 38516

(b) "Qualifying corporation" means any person classified for federal income tax purposes as an association taxable as a corporation, except either of the following: 38517 38518 38519

(i) A corporation that has made an election under subchapter S, chapter one, subtitle A, of the Internal Revenue Code for its taxable year ending within, or on the last day of, the investor's taxable year; 38520 38521 38522 38523

(ii) A subsidiary that is wholly owned by any corporation 38524

that has made an election under subchapter S, chapter one, subtitle A of the Internal Revenue Code for its taxable year ending within, or on the last day of, the investor's taxable year. 38525 38526 38527

(2) For the purposes of this chapter, unless expressly stated otherwise, no qualifying person indirectly owns any asset directly or indirectly owned by any qualifying corporation. 38528 38529 38530

(FF) For purposes of this chapter and Chapter 5751. of the Revised Code: 38531 38532

(1) "Trust" does not include a qualified pre-income tax trust. 38533 38534

(2) A "qualified pre-income tax trust" is any pre-income tax trust that makes a qualifying pre-income tax trust election as described in division (FF)(3) of this section. 38535 38536 38537

(3) A "qualifying pre-income tax trust election" is an election by a pre-income tax trust to subject to the tax imposed by section 5751.02 of the Revised Code the pre-income tax trust and all pass-through entities of which the trust owns or controls, directly, indirectly, or constructively through related interests, five per cent or more of the ownership or equity interests. The trustee shall notify the tax commissioner in writing of the election on or before April 15, 2006. The election, if timely made, shall be effective on and after January 1, 2006, and shall apply for all tax periods and tax years until revoked by the trustee of the trust. 38538 38539 38540 38541 38542 38543 38544 38545 38546 38547 38548

(4) A "pre-income tax trust" is a trust that satisfies all of the following requirements: 38549 38550

(a) The document or instrument creating the trust was executed by the grantor before January 1, 1972; 38551 38552

(b) The trust became irrevocable upon the creation of the trust; and 38553 38554

(c) The grantor was domiciled in this state at the time the 38555
trust was created. 38556

Sec. 5747.122. (A) The tax commissioner, in accordance with 38557
section 5101.184 of the Revised Code, shall cooperate with the 38558
director of job and family services to collect overpayments of 38559
assistance under Chapter 5107.~~, 5111.,~~ or 5115., former Chapter 38560
5113., or section 5101.54 of the Revised Code from refunds of 38561
state income taxes for taxable year 1992 and thereafter that are 38562
payable to the recipients of such overpayments. The tax 38563
commissioner, in accordance with section 5160.45 of the Revised 38564
Code, shall cooperate with the director of health care 38565
administration to collect overpayments of assistance under the 38566
disability medical assistance program or medicaid program from 38567
refunds of state income taxes for taxable year 1992 and thereafter 38568
that are payable to disability medical assistance recipients or 38569
medicaid recipients. 38570

(B) At the request of the department of job and family 38571
services or department of health care administration in connection 38572
with the collection of an overpayment of assistance from a refund 38573
of state income taxes pursuant to this section and section 38574
5101.184 or 5160.45 of the Revised Code, the tax commissioner 38575
shall release to the department the home address and social 38576
security number of any recipient of assistance whose overpayment 38577
may be collected from a refund of state income taxes under those 38578
sections. 38579

(C) In the case of a joint income tax return for two people 38580
who were not married to each other at the time one of them 38581
received an overpayment of assistance, only the portion of a 38582
refund that is due to the recipient of the overpayment shall be 38583
available for collection of the overpayment under this section and 38584
section 5101.184 or 5160.45 of the Revised Code. The tax 38585

commissioner shall determine such portion. A recipient's spouse who objects to the portion as determined by the commissioner may file a complaint with the commissioner within twenty-one days after receiving notice of the collection, and the commissioner shall afford the spouse an opportunity to be heard on the complaint. The commissioner shall waive or extend the twenty-one-day period if the recipient's spouse establishes that such action is necessary to avoid unjust, unfair, or unreasonable results. After the hearing, the commissioner shall make a final determination of the portion of the refund available for collection of the overpayment. 38586 38587 38588 38589 38590 38591 38592 38593 38594 38595 38596

(D) The welfare overpayment intercept fund is hereby created in the state treasury. The tax commissioner shall deposit amounts collected from income tax refunds under this section to the credit of the welfare overpayment intercept fund. The director of job and family services and director of health care administration shall distribute money in the fund in accordance with appropriate federal or state laws and procedures regarding collection of welfare overpayments and disability medical assistance program and medicaid payments. 38597 38598 38599 38600 38601 38602 38603 38604 38605

Sec. 5747.18. The tax commissioner shall enforce and administer this chapter. In addition to any other powers conferred upon the commissioner by law, the commissioner may: 38606 38607 38608

(A) Prescribe all forms required to be filed pursuant to this chapter; 38609 38610

(B) Adopt such rules as the commissioner finds necessary to carry out this chapter; 38611 38612

(C) Appoint and employ such personnel as are necessary to carry out the duties imposed upon the commissioner by this chapter. 38613 38614 38615

Any information gained as the result of returns, investigations, hearings, or verifications required or authorized by this chapter is confidential, and no person shall disclose such information, except for official purposes, or as provided by section 3125.43, 4123.271, 4123.591, 4507.023, ~~or~~ 5101.182, or 5160.44, division (B) of section 5703.21 of the Revised Code, or in accordance with a proper judicial order. The tax commissioner may furnish the internal revenue service with copies of returns or reports filed and may furnish the officer of a municipal corporation charged with the duty of enforcing a tax subject to Chapter 718. of the Revised Code with the names, addresses, and identification numbers of taxpayers who may be subject to such tax. A municipal corporation shall use this information for tax collection purposes only. This section does not prohibit the publication of statistics in a form which does not disclose information with respect to individual taxpayers.

Sec. 5751.081. As used in this section, "debt to this state" means unpaid taxes due the state, unpaid workers' compensation premiums due under section 4123.35 of the Revised Code, unpaid unemployment compensation contributions due under section 4141.25 of the Revised Code, unpaid unemployment compensation payment in lieu of contribution under section 4141.241 of the Revised Code, unpaid fee payable to the state or to the clerk of courts pursuant to section 4505.06 of the Revised Code, incorrect ~~medical assistance~~ medicaid payments ~~under section 5111.02 of the Revised Code~~, or any unpaid charge, penalty, or interest arising from any of the foregoing.

If a taxpayer entitled to a refund under section 5751.08 of the Revised Code owes any debt to this state, the amount refundable may be applied in satisfaction of the debt. If the amount refundable is less than the amount of the debt, it may be applied in partial satisfaction of the debt. If the amount

refundable is greater than the amount of the debt, the amount remaining after satisfaction of the debt shall be refunded. This section applies only to debts that have become final. For the purposes of this section, a debt becomes final when, under the applicable law, any time provided for petition for reassessment, request for reconsideration, or other appeal of the legality or validity of the amount giving rise to the debt expires without an appeal having been filed in the manner provided by law. 38648 38649 38650 38651 38652 38653 38654 38655

Sec. 5815.28. (A) As used in this section: 38656

(1) "Ascertainable standard" includes a standard in a trust instrument requiring the trustee to provide for the care, comfort, maintenance, welfare, education, or general well-being of the beneficiary. 38657 38658 38659 38660

(2) "Disability" means any substantial, medically determinable impairment that can be expected to result in death or that has lasted or can be expected to last for a continuous period of at least twelve months, except that "disability" does not include an impairment that is the result of abuse of alcohol or drugs. 38661 38662 38663 38664 38665 38666

(3) "Political subdivision" and "state" have the same meanings as in section 2744.01 of the Revised Code. 38667 38668

(4) "Supplemental services" means services specified by rule of the department of mental health under section 5119.01 of the Revised Code or the department of mental retardation and developmental disabilities under section 5123.04 of the Revised Code that are provided to an individual with a disability in addition to services the individual is eligible to receive under programs authorized by federal or state law. 38669 38670 38671 38672 38673 38674 38675

(B) Any person may create a trust under this section to provide funding for supplemental services for the benefit of 38676 38677

another individual who meets either of the following conditions: 38678

(1) The individual has a physical or mental disability and is eligible to receive services through the department of mental retardation and developmental disabilities or a county board of mental retardation and developmental disabilities; 38679 38680 38681 38682

(2) The individual has a mental disability and is eligible to receive services through the department of mental health or a board of alcohol, drug addiction, and mental health services. 38683 38684 38685

The trust may confer discretion upon the trustee and may contain specific instructions or conditions governing the exercise of the discretion. 38686 38687 38688

(C) The general division of the court of common pleas and the probate court of the county in which the beneficiary of a trust authorized by division (B) of this section resides or is confined have concurrent original jurisdiction to hear and determine actions pertaining to the trust. In any action pertaining to the trust in a court of common pleas or probate court and in any appeal of the action, all of the following apply to the trial or appellate court: 38689 38690 38691 38692 38693 38694 38695 38696

(1) The court shall render determinations consistent with the testator's or other settlor's intent in creating the trust, as evidenced by the terms of the trust instrument. 38697 38698 38699

(2) The court may order the trustee to exercise discretion that the trust instrument confers upon the trustee only if the instrument contains specific instructions or conditions governing the exercise of that discretion and the trustee has failed to comply with the instructions or conditions. In issuing an order pursuant to this division, the court shall require the trustee to exercise the trustee's discretion only in accordance with the instructions or conditions. 38700 38701 38702 38703 38704 38705 38706 38707

(3) The court may order the trustee to maintain the trust and 38708

distribute assets in accordance with rules adopted by the director 38709
of mental health under section 5119.01 of the Revised Code or the 38710
director of mental retardation and developmental disabilities 38711
under section 5123.04 of the Revised Code if the trustee has 38712
failed to comply with such rules. 38713

(D) To the extent permitted by federal law and subject to the 38714
provisions of division (C)(2) of this section pertaining to the 38715
enforcement of specific instructions or conditions governing a 38716
trustee's discretion, a trust authorized by division (B) of this 38717
section that confers discretion upon the trustee shall not be 38718
considered an asset or resource of the beneficiary, the 38719
beneficiary's estate, the settlor, or the settlor's estate and 38720
shall be exempt from the claims of creditors, political 38721
subdivisions, the state, other governmental entities, and other 38722
claimants against the beneficiary, the beneficiary's estate, the 38723
settlor, or the settlor's estate, including claims based on 38724
provisions of ~~Chapters 5111.,~~ Chapter 5121.~~,~~ or 5123. of the 38725
Revised Code or the medicaid program and claims sought to be 38726
satisfied by way of a civil action, subrogation, execution, 38727
garnishment, attachment, judicial sale, or other legal process, if 38728
all of the following apply: 38729

(1) At the time the trust is created, the trust principal 38730
does not exceed the maximum amount determined under division (E) 38731
of this section; 38732

(2) The trust instrument contains a statement of the 38733
settlor's intent, or otherwise clearly evidences the settlor's 38734
intent, that the beneficiary does not have authority to compel the 38735
trustee under any circumstances to furnish the beneficiary with 38736
minimal or other maintenance or support, to make payments from the 38737
principal of the trust or from the income derived from the 38738
principal, or to convert any portion of the principal into cash, 38739
whether pursuant to an ascertainable standard specified in the 38740

instrument or otherwise; 38741

(3) The trust instrument provides that trust assets can be used only to provide supplemental services, as defined by rule of the director of mental health under section 5119.01 of the Revised Code or the director of mental retardation and developmental disabilities under section 5123.04 of the Revised Code, to the beneficiary; 38742 38743 38744 38745 38746 38747

(4) The trust is maintained and assets are distributed in accordance with rules adopted by the director of mental health under section 5119.01 of the Revised Code or the director of mental retardation and developmental disabilities under section 5123.04 of the Revised Code; 38748 38749 38750 38751 38752

(5) The trust instrument provides that on the death of the beneficiary, a portion of the remaining assets of the trust, which shall be not less than fifty per cent of such assets, will be deposited to the credit of the services fund for individuals with mental illness created by section 5119.17 of the Revised Code or the services fund for individuals with mental retardation and developmental disabilities created by section 5123.40 of the Revised Code. 38753 38754 38755 38756 38757 38758 38759 38760

(E) In 1994, the trust principal maximum amount for a trust created under this section shall be two hundred thousand dollars. The maximum amount for a trust created under this section prior to November 11, 1994, may be increased to two hundred thousand dollars. 38761 38762 38763 38764 38765

In 1995, the maximum amount for a trust created under this section shall be two hundred two thousand dollars. Each year thereafter, the maximum amount shall be the prior year's amount plus two thousand dollars. 38766 38767 38768 38769

(F) This section does not limit or otherwise affect the creation, validity, interpretation, or effect of any trust that is 38770 38771

not created under this section. 38772

(G) Once a trustee takes action on a trust created by a settlor under this section and disburses trust funds on behalf of the beneficiary of the trust, then the trust may not be terminated or otherwise revoked by a particular event or otherwise without payment into the services fund created pursuant to section 5119.17 or 5123.40 of the Revised Code of an amount that is equal to the disbursements made on behalf of the beneficiary for medical care by the state from the date the trust vests but that is not more than fifty per cent of the trust corpus. 38773 38774 38775 38776 38777 38778 38779 38780 38781

Sec. 5907.04. Subject to the following paragraph, all members of the armed forces, who served in the regular or volunteer forces of the United States or the Ohio national guard or members of the naval militia during the war with Spain, the Philippine insurrection, the China relief expedition, the Indian war, the Mexican expedition, World War I, World War II, or during the period beginning June 25, 1950 and ending July 19, 1953, known as the Korean conflict, or during the period beginning August 5, 1964, and ending July 1, 1973, known as the Vietnam conflict, or any person who is awarded either the armed forces expeditionary medal established by presidential executive order 10977 dated December 4, 1961, or the Vietnam service medal established by presidential executive order 11231 dated July 8, 1965, who have been honorably discharged or separated under honorable conditions therefrom, or any discharged members of the Polish and Czechoslovakian armed forces who served in armed conflict with an enemy of the United States in World War I or World War II who have been citizens of the United States for at least ten years, provided that the above-mentioned persons have been citizens of this state for five consecutive years or more at the date of making application for admission, are disabled by disease, wounds, or otherwise, and are by reason of such disability incapable of 38782 38783 38784 38785 38786 38787 38788 38789 38790 38791 38792 38793 38794 38795 38796 38797 38798 38799 38800 38801 38802 38803

earning their living, and all members of the Ohio national guard or naval militia who have lost an arm or leg, or their sight, or become permanently disabled from any cause, while in the line and discharge of duty, and are not able to support themselves, may be admitted to a veterans' home under such rules as the director of veterans services adopts. 38804 38805 38806 38807 38808 38809

A person who served in the armed forces of the United States as defined in division (E)(7) of section 5903.11 of the Revised Code is eligible for admission to a veterans' home under the preceding paragraph only if the person has the characteristics defined in division (B)(1) of section 5901.01 of the Revised Code. 38810 38811 38812 38813 38814

The superintendent of the Ohio veterans' home agency shall promptly and diligently pursue the establishment of the eligibility for ~~medical assistance under Chapter 5111. of~~ the ~~Revised Code~~ medicaid program of all persons admitted to a veterans' home and all residents of a home who appear to qualify and shall promptly and diligently pursue and maintain the certification of each home's compliance with federal laws and regulations governing participation in the ~~medical assistance~~ medicaid program to include as large as possible a part of the home's bed capacity. 38815 38816 38817 38818 38819 38820 38821 38822 38823 38824

Veterans' homes may reserve a bed during the temporary absence of a resident or patient from the home, including a nursing home within it, under conditions prescribed by the director, to include hospitalization for an acute condition, visits with relatives and friends, and participation in therapeutic programs outside the home. A home shall not reserve a bed for more than thirty days, except that absences for more than thirty days due to hospitalization may be authorized. 38825 38826 38827 38828 38829 38830 38831 38832

Section 2. That existing sections 9.231, 9.239, 9.24, 101.39, 101.391, 103.144, 109.572, 109.85, 117.10, 119.01, 121.02, 121.03, 38833 38834

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5751.081, 5815.28, and 5907.04 and section 5111.012 of the Revised 38926
Code are hereby repealed. 38927

Section 3. The organization of the Department of Health Care 38928
Administration as established by this act shall be in accordance 38929
with the business model, organization structure, cross-functional 38930
practices, information technology, state and local impact, fiscal 38931
and budget, transition, and long-term care recommendations as 38932

detailed in the Ohio Medicaid Administrative Study Council Final Report and Recommendations, as completed by the Ohio Medicaid Administrative Study Council in accordance with Am. Sub. H.B. 66 of the 126th General Assembly. 38933 38934 38935 38936

Section 4. On July 1, 2009, the Medicaid Program, Hospital Care Assurance Program, Children's Health Insurance Program, Children's Buy-In Program, and Disability Medical Assistance Program and all of the programs' functions, assets, and liabilities are transferred from the Department of Job and Family Services to the Department of Health Care Administration. The transferred programs are thereupon and thereafter successor to, assume the obligations of, and otherwise constitute the continuation of the programs as they were operated under Chapters 5101., 5111., 5112., and 5115. of the Revised Code immediately prior to July 1, 2009. 38937 38938 38939 38940 38941 38942 38943 38944 38945 38946 38947

Any business of the programs commenced but not completed before July 1, 2009, shall be completed by the Department of Health Care Administration under Chapters 5160., 5161., 5162., 5163., 5164., 5165., 5166., 5167., and 5168. of the Revised Code. The business shall be completed in the same manner, and with the same effect, as if completed by the Department of Job and Family Services under Chapters 5101., 5111., 5112., and 5115. of the Revised Code immediately prior to July 1, 2009. 38948 38949 38950 38951 38952 38953 38954 38955

No validation, cure, right, privilege, remedy, obligation, or liability pertaining to the programs is lost or impaired by reason of the programs' transfer from the Department of Job and Family Services to the Department of Health Care Administration. Each such validation, cure, right, privilege, remedy, obligation, or liability shall be administered by the Department of Health Care Administration pursuant to Chapters 5160., 5161., 5162., 5163., 5164., 5165., 5166., 5167., and 5168. of the Revised Code. 38956 38957 38958 38959 38960 38961 38962 38963

All rules, orders, and determinations pertaining to the programs as they were operated under Chapters 5101., 5111., 5112., and 5115. of the Revised Code immediately prior to July 1, 2009, continue in effect as rules, orders, and determinations of the programs under Chapters 5160., 5161., 5162., 5163., 5164., 5165., 5166., 5167., and 5168. of the Revised Code, until modified or rescinded by the Department of Health Care Administration. If necessary to ensure the integrity of the numbering of the Administrative Code, the Director of the Legislative Service Commission shall renumber the rules to reflect the transfer of the programs from the Department of Job and Family Services to the Department of Health Care Administration. 38964 38965 38966 38967 38968 38969 38970 38971 38972 38973 38974 38975

Subject to the lay-off provisions of sections 124.321 to 124.328 of the Revised Code, all of the programs' employees in the Department of Job and Family Services shall be transferred to the Department of Health Care Administration. The transferred employees shall retain their positions and all of the benefits accruing to those positions. 38976 38977 38978 38979 38980 38981

The Director of Budget and Management shall determine the amount of the unexpended balances in the appropriation accounts that pertain to the programs as they were operated under Chapters 5101., 5111., 5112., and 5115. of the Revised Code immediately prior to July 1, 2009, and shall recommend to the Controlling Board their transfer to the appropriation accounts that pertain to the Department of Health Care Administration. The Department of Job and Family Services shall provide full and timely information to the Controlling Board to facilitate this transfer. Any funds transferred under this section are hereby appropriated. 38982 38983 38984 38985 38986 38987 38988 38989 38990 38991

Section 5. On July 1, 2009, the Residential State Supplement Program and Ohio's Best Rx Program and all of the programs' functions, assets, and liabilities are transferred from the 38992 38993 38994

Department of Aging to the Department of Health Care Administration. The transferred programs are thereupon and thereafter successor to, assume the obligations of, and otherwise constitute the continuation of the programs as they were operated under Chapter 173. of the Revised Code immediately prior to July 1, 2009. 38995 38996 38997 38998 38999 39000

Any business of the program commenced but not completed before July 1, 2009, shall be completed by the Department of Health Care Administration under Chapters 5160. and 5169. of the Revised Code. The business shall be completed in the same manner, and with the same effect, as if completed by the Department of Aging under Chapter 173. of the Revised Code immediately prior to July 1, 2009. 39001 39002 39003 39004 39005 39006 39007

No validation, cure, right, privilege, remedy, obligation, or liability pertaining to the programs is lost or impaired by reason of the programs' transfer from the Department of Aging to the Department of Health Care Administration. Each such validation, cure, right, privilege, remedy, obligation, or liability shall be administered by the Department of Health Care Administration pursuant to Chapters 5160. and 5169. of the Revised Code. 39008 39009 39010 39011 39012 39013 39014

All rules, orders, and determinations pertaining to the programs as they were operated under Chapter 173. of the Revised Code immediately prior to July 1, 2009, continue in effect as rules, orders, and determinations of the programs under Chapters 5160. and 5169. of the Revised Code, until modified or rescinded by the Department of Health Care Administration. If necessary to ensure the integrity of the numbering of the Administrative Code, the Director of the Legislative Service Commission shall renumber the rules to reflect the transfer of the programs from the Department of Aging to the Department of Health Care Administration. 39015 39016 39017 39018 39019 39020 39021 39022 39023 39024 39025

Subject to the lay-off provisions of sections 124.321 to 39026

124.328 of the Revised Code, all of the programs' employees in the Department of Aging shall be transferred to the Department of Health Care Administration. The transferred employees shall retain their positions and all of the benefits accruing to those positions. 39027 39028 39029 39030 39031

The Director of Budget and Management shall determine the amount of the unexpended balances in the appropriation accounts that pertain to the programs as they were operated under Chapter 173. of the Revised Code immediately prior to July 1, 2009, and shall recommend to the Controlling Board their transfer to the appropriation accounts that pertain to the Department of Health Care Administration. The Department of Aging shall provide full and timely information to the Controlling Board to facilitate this transfer. Any funds transferred under this section are hereby appropriated. 39032 39033 39034 39035 39036 39037 39038 39039 39040 39041

Section 6. The amendments of sections 4723.063, 5112.01, 5112.03, 5112.04, 5112.05, 5112.06, 5112.07, 5112.08, 5112.09, 5112.10, 5112.11, 5112.18, 5112.19, 5112.21, and 5112.99 of the Revised Code are not intended to supersede the earlier repeals, with delayed effective dates, of those sections. 39042 39043 39044 39045 39046

Section 7. The sections of law amended, enacted, or repealed by this act, and the items of law of which such sections are composed, are not subject to the referendum. Therefore, under Ohio Constitution, Article II, Section 1d and section 1.471 of the Revised Code, the sections go into effect July 1, 2009. 39047 39048 39049 39050 39051

Section 8. The General Assembly, applying the principle stated in division (B) of section 1.52 of the Revised Code that amendments are to be harmonized if reasonably capable of simultaneous operation, finds that the following sections, presented in this act as composites of the sections as amended by 39052 39053 39054 39055 39056

the acts indicated, are the resulting versions of the sections in effect prior to the effective date of the sections as presented in this act: 39057 39058 39059

Section 109.572 of the Revised Code as amended by Sub. H.B. 195, Sub. H.B. 545, and Sub. S.B. 247, all of the 127th General Assembly. 39060 39061 39062

Section 1751.01 of the Revised Code as amended by both Am. Sub. H.B. 562 and Sub. S.B. 186 of the 127th General Assembly. 39063 39064