

As Introduced

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

S. B. No. 214

Senators Carey, Miller, D.

**Cosponsors: Senators Grendell, Schaffer, Seitz, Miller, R., Turner, Strahorn,
Morano, Cafaro**

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A B I L L

To amend sections 173.401, 3702.51, 3702.59, 5111.65, 1
5111.651, 5111.68, 5111.681, 5111.685, 5111.686, 2
5111.688, and 5111.894; to amend, for the purpose 3
of adopting a new section number as indicated in 4
parentheses, section 5111.688 (5111.689); and to 5
enact new section 5111.688 of the Revised Code; 6
and to amend Section 209.20 of Am. Sub. H.B. 1 of 7
the 128th General Assembly to revise the waiting 8
list provisions of the PASSPORT and Assisted 9
Living programs, to require the Director of Budget 10
and Management to make certain cash transfers and 11
expenditure authorizations regarding long-term 12
care budget services, to revise the law governing 13
the collection of long-term care facilities' 14
Medicaid debts, and to revise the law governing 15
the reasons for denying a Certificate of Need 16
application. 17

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

Section 1. That sections 173.401, 3702.51, 3702.59, 5111.65, 18
5111.651, 5111.68, 5111.681, 5111.685, 5111.686, 5111.688, and 19

5111.894 be amended; section 5111.688 (5111.689) be amended for 20
the purpose of adopting a new section number as indicated in 21
parentheses; and new section 5111.688 of the Revised Code be 22
enacted to read as follows: 23

Sec. 173.401. (A) As used in this section: 24

"Area agency on aging" has the same meaning as in section 25
173.14 of the Revised Code. 26

"Long-term care consultation program" means the program the 27
department of aging is required to develop under section 173.42 of 28
the Revised Code. 29

"Long-term care consultation program administrator" or 30
"administrator" means the department of aging or, if the 31
department contracts with an area agency on aging or other entity 32
to administer the long-term care consultation program for a 33
particular area, that agency or entity. 34

"Nursing facility" has the same meaning as in section 5111.20 35
of the Revised Code. 36

"PASSPORT waiver" means the federal medicaid waiver granted 37
by the United States secretary of health and human services that 38
authorizes the PASSPORT program. 39

(B) ~~The director of job and family services shall submit to 40
the United States secretary of health and human services an 41
amendment to the PASSPORT waiver that authorizes additional 42
enrollments in the PASSPORT program pursuant to this section. 43
Beginning with the month following the month in which the United 44
States secretary approves the amendment and each The department of 45
aging may establish one or more waiting lists for the PASSPORT 46
program. Only individuals eligible for the PASSPORT program may be 47
placed on a waiting list. 48~~

(C) The department shall establish a home first component of the PASSPORT program under which eligible individuals may be enrolled in the PASSPORT program in accordance with this section. An individual is eligible for the PASSPORT program's home first component if the individual is on a PASSPORT program waiting list and at least one of the following applies:

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

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

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

(4) Both of the following apply:

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

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

(D) Each month thereafter, each area agency on aging shall determine whether identify individuals who reside residing in the

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

(E) Each quarter, the department of aging shall certify to 105
the director of budget and management the estimated increase in 106
costs of the PASSPORT program resulting from enrollment of 107
individuals in the PASSPORT program pursuant to this section. 108

Sec. 3702.51. As used in sections 3702.51 to 3702.62 of the 109
Revised Code: 110

(A) "Applicant" means any person that submits an application	111
for a certificate of need and who is designated in the application	112
as the applicant.	113
(B) "Person" means any individual, corporation, business	114
trust, estate, firm, partnership, association, joint stock	115
company, insurance company, government unit, or other entity.	116
(C) "Certificate of need" means a written approval granted by	117
the director of health to an applicant to authorize conducting a	118
reviewable activity.	119
(D) "Health service area" means a geographic region	120
designated by the director of health under section 3702.58 of the	121
Revised Code.	122
(E) "Health service" means a clinically related service, such	123
as a diagnostic, treatment, rehabilitative, or preventive service.	124
(F) "Health service agency" means an agency designated to	125
serve a health service area in accordance with section 3702.58 of	126
the Revised Code.	127
(G) "Health care facility" means:	128
(1) A hospital registered under section 3701.07 of the	129
Revised Code;	130
(2) A nursing home licensed under section 3721.02 of the	131
Revised Code, or by a political subdivision certified under	132
section 3721.09 of the Revised Code;	133
(3) A county home or a county nursing home as defined in	134
section 5155.31 of the Revised Code that is certified under Title	135
XVIII or XIX of the "Social Security Act," 49 Stat. 620 (1935), 42	136
U.S.C.A. 301, as amended;	137
(4) A freestanding dialysis center;	138
(5) A freestanding inpatient rehabilitation facility;	139

- (6) An ambulatory surgical facility; 140
- (7) A freestanding cardiac catheterization facility; 141
- (8) A freestanding birthing center; 142
- (9) A freestanding or mobile diagnostic imaging center; 143
- (10) A freestanding radiation therapy center. 144

A health care facility does not include the offices of 145
private physicians and dentists whether for individual or group 146
practice, residential facilities licensed under section 5123.19 of 147
the Revised Code, or an institution for the sick that is operated 148
exclusively for patients who use spiritual means for healing and 149
for whom the acceptance of medical care is inconsistent with their 150
religious beliefs, accredited by a national accrediting 151
organization, exempt from federal income taxation under section 152
501 of the Internal Revenue Code of 1986, 100 Stat. 2085, 26 153
U.S.C.A. 1, as amended, and providing twenty-four hour nursing 154
care pursuant to the exemption in division (E) of section 4723.32 155
of the Revised Code from the licensing requirements of Chapter 156
4723. of the Revised Code. 157

(H) "Medical equipment" means a single unit of medical 158
equipment or a single system of components with related functions 159
that is used to provide health services. 160

(I) "Third-party payer" means a health insuring corporation 161
licensed under Chapter 1751. of the Revised Code, a health 162
maintenance organization as defined in division (K) of this 163
section, an insurance company that issues sickness and accident 164
insurance in conformity with Chapter 3923. of the Revised Code, a 165
state-financed health insurance program under Chapter 3701., 166
4123., or 5111. of the Revised Code, or any self-insurance plan. 167

(J) "Government unit" means the state and any county, 168
municipal corporation, township, or other political subdivision of 169

the state, or any department, division, board, or other agency of 170
the state or a political subdivision. 171

(K) "Health maintenance organization" means a public or 172
private organization organized under the law of any state that is 173
qualified under section 1310(d) of Title XIII of the "Public 174
Health Service Act," 87 Stat. 931 (1973), 42 U.S.C. 300e-9. 175

(L) "Existing health care facility" means either of the 176
following: 177

(1) A health care facility that is licensed or otherwise 178
authorized to operate in this state in accordance with applicable 179
law, including a county home or a county nursing home that is 180
certified as of February 1, 2008, under Title XVIII or Title XIX 181
of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C. 301, 182
as amended, is staffed and equipped to provide health care 183
services, and is actively providing health services; 184

(2) A health care facility that is licensed or otherwise 185
authorized to operate in this state in accordance with applicable 186
law, including a county home or a county nursing home that is 187
certified as of February 1, 2008, under Title XVIII or Title XIX 188
of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C. 301, 189
as amended, or that has beds registered under section 3701.07 of 190
the Revised Code as skilled nursing beds or long-term care beds 191
and has provided services for at least three hundred sixty-five 192
consecutive days within the twenty-four months immediately 193
preceding the date a certificate of need application is filed with 194
the director of health. 195

(M) "State" means the state of Ohio, including, but not 196
limited to, the general assembly, the supreme court, the offices 197
of all elected state officers, and all departments, boards, 198
offices, commissions, agencies, institutions, and other 199
instrumentalities of the state of Ohio. "State" does not include 200

political subdivisions.	201
(N) "Political subdivision" means a municipal corporation,	202
township, county, school district, and all other bodies corporate	203
and politic responsible for governmental activities only in	204
geographic areas smaller than that of the state to which the	205
sovereign immunity of the state attaches.	206
(O) "Affected person" means:	207
(1) An applicant for a certificate of need, including an	208
applicant whose application was reviewed comparatively with the	209
application in question;	210
(2) The person that requested the reviewability ruling in	211
question;	212
(3) Any person that resides or regularly uses health care	213
facilities within the geographic area served or to be served by	214
the health care services that would be provided under the	215
certificate of need or reviewability ruling in question;	216
(4) Any health care facility that is located in the health	217
service area where the health care services would be provided	218
under the certificate of need or reviewability ruling in question;	219
(5) Third-party payers that reimburse health care facilities	220
for services in the health service area where the health care	221
services would be provided under the certificate of need or	222
reviewability ruling in question;	223
(6) Any other person who testified at a public hearing held	224
under division (B) of section 3702.52 of the Revised Code or	225
submitted written comments in the course of review of the	226
certificate of need application in question.	227
(P) "Osteopathic hospital" means a hospital registered under	228
section 3701.07 of the Revised Code that advocates osteopathic	229
principles and the practice and perpetuation of osteopathic	230

medicine by doing any of the following:	231
(1) Maintaining a department or service of osteopathic	232
medicine or a committee on the utilization of osteopathic	233
principles and methods, under the supervision of an osteopathic	234
physician;	235
(2) Maintaining an active medical staff, the majority of	236
which is comprised of osteopathic physicians;	237
(3) Maintaining a medical staff executive committee that has	238
osteopathic physicians as a majority of its members.	239
(Q) "Ambulatory surgical facility" has the same meaning as in	240
section 3702.30 of the Revised Code.	241
(R) Except as provided in division (S) of this section,	242
"reviewable activity" means any of the following activities:	243
(1) The establishment, development, or construction of a new	244
long-term care facility;	245
(2) The replacement of an existing long-term care facility;	246
(3) The renovation of a long-term care facility that involves	247
a capital expenditure of two million dollars or more, not	248
including expenditures for equipment, staffing, or operational	249
costs;	250
(4) Either of the following changes in long-term care bed	251
capacity:	252
(a) An increase in bed capacity;	253
(b) A relocation of beds from one physical facility or site	254
to another, excluding the relocation of beds within a long-term	255
care facility or among buildings of a long-term care facility at	256
the same site.	257
(5) Any change in the health services, bed capacity, or site,	258
or any other failure to conduct the reviewable activity in	259

substantial accordance with the approved application for which a certificate of need concerning long-term care beds was granted, if the change is made within five years after the implementation of the reviewable activity for which the certificate was granted;

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

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

(1) Acquisition of computer hardware or software;

(2) Acquisition of a telephone system;

(3) Construction or acquisition of parking facilities;

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

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

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

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

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

(9) Construction, repair, or renovation of bathroom

facilities;	290
(10) Construction of laundry facilities, waste disposal facilities, dietary department projects, heating and air conditioning projects, administrative offices, and portions of medical office buildings used exclusively for physician services;	291 292 293 294
(11) Acquisition of medical equipment to conduct research required by the United States food and drug administration or clinical trials sponsored by the national institute of health. Use of medical equipment that was acquired without a certificate of need under division (S)(11) of this section and for which premarket approval has been granted by the United States food and drug administration to provide services for which patients or reimbursement entities will be charged shall be a reviewable activity.	295 296 297 298 299 300 301 302 303
(12) Removal of asbestos from a health care facility.	304
Only that portion of a project that meets the requirements of this division is not a reviewable activity.	305 306
(T) "Small rural hospital" means a hospital that is located within a rural area, has fewer than one hundred beds, and to which fewer than four thousand persons were admitted during the most recent calendar year.	307 308 309 310
(U) "Children's hospital" means any of the following:	311
(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;	312 313 314 315 316
(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	317 318 319

fifty registered pediatric special care and pediatric acute care 320
beds, and in which at least seventy-five per cent of annual 321
inpatient discharges for the preceding two calendar years were 322
individuals less than eighteen years of age; 323

(3) A distinct portion of a hospital, if the hospital is 324
registered under section 3701.07 of the Revised Code as a 325
children's hospital and the children's hospital meets all the 326
requirements of division (U)(1) of this section. 327

(V) "Long-term care facility" means any of the following: 328

(1) A nursing home licensed under section 3721.02 of the 329
Revised Code or by a political subdivision certified under section 330
3721.09 of the Revised Code; 331

(2) The portion of any facility, including a county home or 332
county nursing home, that is certified as a skilled nursing 333
facility or a nursing facility under Title XVIII or XIX of the 334
"Social Security Act"; 335

(3) The portion of any hospital that contains beds registered 336
under section 3701.07 of the Revised Code as skilled nursing beds 337
or long-term care beds. 338

(W) "Long-term care bed" means a bed in a long-term care 339
facility. 340

(X) "Freestanding birthing center" means any facility in 341
which deliveries routinely occur, regardless of whether the 342
facility is located on the campus of another health care facility, 343
and which is not licensed under Chapter 3711. of the Revised Code 344
as a level one, two, or three maternity unit or a limited 345
maternity unit. 346

(Y)(1) "Reviewability ruling" means a ruling issued by the 347
director of health under division (A) of section 3702.52 of the 348
Revised Code as to whether a particular proposed project is or is 349

not a reviewable activity. 350

(2) "Nonreviewability ruling" means a ruling issued under 351
that division that a particular proposed project is not a 352
reviewable activity. 353

(Z)(1) "Metropolitan statistical area" means an area of this 354
state designated a metropolitan statistical area or primary 355
metropolitan statistical area in United States office of 356
management and budget bulletin no. 93-17, June 30, 1993, and its 357
attachments. 358

(2) "Rural area" means any area of this state not located 359
within a metropolitan statistical area. 360

(AA) "County nursing home" has the same meaning as in section 361
5155.31 of the Revised Code. 362

(BB) "Principal participant" means both of the following: 363

(1) A person who has an ownership or controlling interest of 364
at least five per cent in an applicant, in a health care facility 365
that is the subject of an application for a certificate of need, 366
or in the owner or operator of the applicant or such a facility; 367

(2) An officer, director, trustee, or general partner of an 368
applicant, of a health care facility that is the subject of an 369
application for a certificate of need, or of the owner or operator 370
of the applicant or such a facility. 371

(CC) "Actual harm but not immediate jeopardy deficiency" 372
means a deficiency that, under 42 C.F.R. 488.404, either 373
constitutes a pattern of deficiencies resulting in actual harm 374
that is not immediate jeopardy or represents widespread 375
deficiencies resulting in actual harm that is not immediate 376
jeopardy. 377

(DD) "Immediate jeopardy deficiency" means a deficiency that, 378
under 42 C.F.R. 488.404, either constitutes a pattern of 379

deficiencies resulting in immediate jeopardy to resident health or 380
safety or represents widespread deficiencies resulting in 381
immediate jeopardy to resident health or safety. 382

Sec. 3702.59. (A) The director of health shall accept for 383
review certificate of need applications as provided in sections 384
3702.592, 3702.593, and 3702.594 of the Revised Code. 385

(B)(1) The director shall not approve an application for a 386
certificate of need for the addition of long-term care beds to an 387
existing health care facility or for the development of a new 388
health care facility if any of the following apply: 389

~~(1)(a)~~ (a) The existing health care facility in which the beds 390
are being placed has one or more waivers for life safety code 391
deficiencies, one or more state fire code violations, or one or 392
more state building code violations, and the project identified in 393
the application does not propose to correct all life safety code 394
deficiencies for which a waiver has been granted, all state fire 395
code violations, and all state building code violations at the 396
existing health care facility in which the beds are being placed; 397
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~~(2)(b)~~ (b) During the sixty-month period preceding the filing of 399
the application, a notice of proposed license revocation was 400
issued under section 3721.03 of the Revised Code for the existing 401
health care facility in which the beds are being placed or a 402
nursing home owned or operated by the applicant or ~~the corporation~~ 403
~~or other business that operates or seeks to operate the health~~ 404
~~care facility in which the beds are being placed~~ a principal 405
participant. 406

~~(3)(c)~~ (c) During the period that precedes the filing of the 407
application and is encompassed by the three most recent standard 408
surveys of the existing health care facility in which the beds are 409
being placed, ~~the~~ any of the following occurred: 410

~~(i) The facility was cited on three or more separate occasions for final, nonappealable actual harm but not immediate jeopardy deficiencies that, under 42 C.F.R. 488.404, either constitute a pattern of deficiencies resulting in actual harm that is not immediate jeopardy or are widespread deficiencies resulting in actual harm that is not immediate jeopardy.~~ 411-416

~~(4) During the period that precedes the filing of the application and is encompassed by the three most recent standard surveys of the existing health care facility in which the beds are being placed, the~~ (ii) The facility was cited on two or more separate occasions for final, nonappealable immediate jeopardy deficiencies that, under 42 C.F.R. 488.404, either constitute a pattern of deficiencies resulting in immediate jeopardy to resident health or safety or are widespread deficiencies resulting in immediate jeopardy to resident health or safety. 417-425

~~(5) During the period that precedes the filing of the application and is encompassed by the three most recent standard surveys of the existing health care facility in which the beds are being placed, more~~ (iii) The facility was cited on two separate occasions for final, nonappealable actual harm but not immediate jeopardy deficiencies and on one occasion for a final, nonappealable immediate jeopardy deficiency. 426-432

(d) More than two nursing homes owned or operated in this state by the applicant or the person who operates the facility in which the beds are being placed a principal participant or, if the applicant or person a principal participant owns or operates more than twenty nursing homes in this state, more than ten per cent of those nursing homes, were each cited on during the period that precedes the filing of the application for the certificate of need and is encompassed by the three most recent standard surveys of the nursing homes that were so cited in any of the following manners: 433-442

(i) On three or more separate occasions for final, 443
nonappealable actual harm but not immediate jeopardy deficiencies 444
~~that, under 42 C.F.R. 488.404, either constitute a pattern of~~ 445
~~deficiencies resulting in actual harm that is not immediate~~ 446
~~jeopardy or are widespread deficiencies resulting in actual harm~~ 447
~~that is not immediate jeopardy.~~ 448

~~(6) During the period that precedes the filing of the~~ 449
~~application and is encompassed by the three most recent standard~~ 450
~~surveys of the existing health care facility in which the beds are~~ 451
~~being placed, more than two nursing homes operated in this state~~ 452
~~by the applicant or the person who operates the facility in which~~ 453
~~the beds are being placed or, if the applicant or person operates~~ 454
~~more than twenty nursing homes in this state, more than ten per~~ 455
~~cent of those nursing homes, were each cited on;~~ 456

(ii) On two or more separate occasions for final, 457
nonappealable immediate jeopardy deficiencies ~~that, under 42~~ 458
~~C.F.R. 488.404, either constitute a pattern of deficiencies~~ 459
~~resulting in immediate jeopardy to resident health or safety or~~ 460
~~are widespread deficiencies resulting in immediate jeopardy to~~ 461
~~resident health or safety;~~ 462

(iii) On two separate occasions for final, nonappealable 463
actual harm but not immediate jeopardy deficiencies and on one 464
occasion for a final, nonappealable immediate jeopardy deficiency. 465

~~(7) During the sixty month period preceding the filing of the~~ 466
~~application, the applicant has violated this chapter on two or~~ 467
~~more separate occasions.~~ 468

(2) In applying divisions (B)(1)(a) to (6)(d) of this 469
section, the director shall not consider deficiencies or 470
violations cited before the ~~current operator~~ applicant or a 471
principal participant acquired or began to own or operate the 472
health care facility at which the deficiencies or violations were 473

cited. The director may disregard deficiencies and violations 474
cited after the health care facility was acquired or began to be 475
operated by the ~~current operator~~ applicant or a principal 476
participant if the deficiencies or violations were attributable to 477
circumstances that arose under the previous owner or operator and 478
the ~~current operator~~ applicant or principal participant has 479
implemented measures to alleviate the circumstances. In the case 480
of an application proposing development of a new health care 481
facility by relocation of beds, the director shall not consider 482
deficiencies or violations that were solely attributable to the 483
physical plant of the existing health care facility from which the 484
beds are being relocated. 485

(C) The director also shall accept for review any application 486
for the conversion of infirmary beds to long-term care beds if the 487
infirmary meets all of the following conditions: 488

(1) Is operated exclusively by a religious order; 489

(2) Provides care exclusively to members of religious orders 490
who take vows of celibacy and live by virtue of their vows within 491
the orders as if related; 492

(3) Was providing care exclusively to members of such a 493
religious order on January 1, 1994. 494

At no time shall individuals other than those described in 495
division (C)(2) of this section be admitted to a facility to use 496
beds for which a certificate of need is approved under this 497
division. 498

Sec. 5111.65. As used in sections 5111.65 to ~~5111.688~~ 499
5111.689 of the Revised Code: 500

(A) "Affiliated operator" means an operator affiliated with 501
either of the following: 502

(1) The exiting operator for whom the affiliated operator is 503

to assume liability for the entire amount of the exiting operator's debt under the medicaid program or the portion of the debt that represents the franchise permit fee the exiting operator owes; 504
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(2) The entering operator involved in the change of operator with the exiting operator specified in division (A)(1) of this section. 508
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(B) "Change of operator" means an entering operator becoming the operator of a nursing facility or intermediate care facility for the mentally retarded in the place of the exiting operator. 511
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(1) Actions that constitute a change of operator include the following: 514
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(a) A change in an exiting operator's form of legal organization, including the formation of a partnership or corporation from a sole proprietorship; 516
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(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; 519
520
521
522
523

(c) A lease of the facility to the entering operator or the exiting operator's termination of the exiting operator's lease; 524
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(d) If the exiting operator is a partnership, dissolution of the partnership; 526
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(e) If the exiting operator is a partnership, a change in composition of the partnership unless both of the following apply: 528
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(i) The change in composition does not cause the partnership's dissolution under state law. 530
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(ii) The partners agree that the change in composition does not constitute a change in operator. 532
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(f) If the operator is a corporation, dissolution of the corporation, a merger of the corporation into another corporation that is the survivor of the merger, or a consolidation of one or more other corporations to form a new corporation.

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

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

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

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

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

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

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

~~(E)~~(F) "Effective date of a voluntary withdrawal of

participation" means the day the nursing facility ceases to accept 564
new medicaid patients other than the individuals who reside in the 565
nursing facility on the day before the effective date of the 566
voluntary withdrawal of participation. 567

~~(F)~~(G) "Entering operator" means the person or government 568
entity that will become the operator of a nursing facility or 569
intermediate care facility for the mentally retarded when a change 570
of operator occurs. 571

~~(G)~~(H) "Exiting operator" means any of the following: 572

(1) An operator that will cease to be the operator of a 573
nursing facility or intermediate care facility for the mentally 574
retarded on the effective date of a change of operator; 575

(2) An operator that will cease to be the operator of a 576
nursing facility or intermediate care facility for the mentally 577
retarded on the effective date of a facility closure; 578

(3) An operator of an intermediate care facility for the 579
mentally retarded that is undergoing or has undergone a voluntary 580
termination; 581

(4) An operator of a nursing facility that is undergoing or 582
has undergone a voluntary withdrawal of participation. 583

~~(H)~~(I)(1) "Facility closure" means discontinuance of the use 584
of the building, or part of the building, that houses the facility 585
as a nursing facility or intermediate care facility for the 586
mentally retarded that results in the relocation of all of the 587
facility's residents. A facility closure occurs regardless of any 588
of the following: 589

(a) The operator completely or partially replacing the 590
facility by constructing a new facility or transferring the 591
facility's license to another facility; 592

(b) The facility's residents relocating to another of the 593

operator's facilities; 594

(c) Any action the department of health takes regarding the 595
facility's certification under Title XIX of the "Social Security 596
Act," 79 Stat. 286 (1965), 42 U.S.C. 1396, as amended, that may 597
result in the transfer of part of the facility's survey findings 598
to another of the operator's facilities; 599

(d) Any action the department of health takes regarding the 600
facility's license under Chapter 3721. of the Revised Code; 601

(e) Any action the department of mental retardation and 602
developmental disabilities takes regarding the facility's license 603
under section 5123.19 of the Revised Code. 604

(2) A facility closure does not occur if all of the 605
facility's residents are relocated due to an emergency evacuation 606
and one or more of the residents return to a medicaid-certified 607
bed in the facility not later than thirty days after the 608
evacuation occurs. 609

~~(I)~~(J) "Fiscal year," "franchise permit fee," "intermediate 610
care facility for the mentally retarded," "nursing facility," 611
"operator," "owner," and "provider agreement" have the same 612
meanings as in section 5111.20 of the Revised Code. 613

~~(J)~~(K) "Voluntary termination" means an operator's voluntary 614
election to terminate the participation of an intermediate care 615
facility for the mentally retarded in the medicaid program but to 616
continue to provide service of the type provided by a residential 617
facility as defined in section 5123.19 of the Revised Code. 618

~~(K)~~(L) "Voluntary withdrawal of participation" means an 619
operator's voluntary election to terminate the participation of a 620
nursing facility in the medicaid program but to continue to 621
provide service of the type provided by a nursing facility. 622

Sec. 5111.651. Sections 5111.65 to ~~5111.688~~ 5111.689 of the 623

Revised Code do not apply to a nursing facility or intermediate 624
care facility for the mentally retarded that undergoes a facility 625
closure, voluntary termination, voluntary withdrawal of 626
participation, or change of operator on or before September 30, 627
2005, if the exiting operator provided written notice of the 628
facility closure, voluntary termination, voluntary withdrawal of 629
participation, or change of operator to the department of job and 630
family services on or before June 30, 2005. 631

Sec. 5111.68. (A) On receipt of a written notice under 632
section 5111.66 of the Revised Code of a facility closure, 633
voluntary termination, or voluntary withdrawal of participation or 634
a written notice under section 5111.67 of the Revised Code of a 635
change of operator, the department of job and family services 636
shall ~~determine~~ estimate the amount of any overpayments made under 637
the medicaid program to the exiting operator, including 638
overpayments the exiting operator disputes, and other actual and 639
potential debts the exiting operator owes or may owe to the 640
department and United States centers for medicare and medicaid 641
services under the medicaid program, including a franchise permit 642
fee. ~~In determining~~ 643

(B) In estimating the exiting operator's other actual and 644
potential debts to the department and the United States centers 645
for medicare and medicaid services under the medicaid program, the 646
department shall ~~include~~ use a debt estimation methodology the 647
director of job and family services shall establish in rules 648
adopted under section 5111.689 of the Revised Code. The 649
methodology shall provide for estimating all of the following that 650
the department determines ~~is~~ are applicable: 651

(1) Refunds due the department under section 5111.27 of the 652
Revised Code; 653

(2) Interest owed to the department and United States centers 654

for medicare and medicaid services; 655

(3) Final civil monetary and other penalties for which all 656
right of appeal has been exhausted; 657

(4) Money owed the department and United States centers for 658
medicare and medicaid services from any outstanding final fiscal 659
audit, including a final fiscal audit for the last fiscal year or 660
portion thereof in which the exiting operator participated in the 661
medicaid program; 662

(5) Other amounts the department determines are applicable. 663

~~(B) If the department is unable to determine the amount of 664
the overpayments and other debts for any period before the 665
effective date of the entering operator's provider agreement or 666
the effective date of the facility closure, voluntary termination, 667
or voluntary withdrawal of participation, the department shall 668
make a reasonable estimate of the overpayments and other debts for 669
the period. The department shall make the estimate using 670
information available to the department, including prior 671
determinations of overpayments and other debts. 672~~

(C) The department shall provide the exiting operator written 673
notice of the department's estimate under division (A) of this 674
section not later than thirty days after the department receives 675
the notice under section 5111.66 of the Revised Code of the 676
facility closure, voluntary termination, or voluntary withdrawal 677
of participation or the notice under section 5111.67 of the 678
Revised Code of the change of operator. The department's written 679
notice shall include the basis for the estimate. 680

Sec. 5111.681. (A) Except as provided in division divisions 681
(B) and (C) of this section, the department of job and family 682
services ~~shall~~ may withhold ~~the greater of the following~~ from 683
payment due an exiting operator under the medicaid program; 684

~~(1) The the total amount of any overpayments made under the
medicaid program to the exiting operator, including overpayments
the exiting operator disputes, and other actual and potential
debts, including any unpaid penalties, specified in the notice
provided under division (C) of section 5111.68 of the Revised Code
that the exiting operator owes or may owe to the department and
United States centers for medicare and medicaid services under the
medicaid program.~~ 685
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~~(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.~~ 693
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~~(B) The In the case of a change of operator and subject to
division (D) of this section, the following shall apply regarding
a withholding under division (A) of this section if the exiting
operator or entering operator or an affiliated operator executes a
successor liability agreement meeting the requirements of division
(E) of this section:~~ 699
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~~(1) If the exiting operator, entering operator, or affiliated
operator assumes liability for the total, actual amount of debt
the exiting operator owes the department and the United States
centers for medicare and medicaid services under the medicaid
program as determined under section 5111.685 of the Revised Code,
the department may choose shall not to make the withholding under
division (A) of this section if an entering operator does both of
the following:~~ 705
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~~(1) Enters into a nontransferable, unconditional, written
agreement with the department to pay the department any debt the
exiting operator owes the department under the medicaid program.~~ 713
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~~(2) Provides the department a copy of the entering operator's balance sheet that assists the department in determining whether to make the withholding under division (A) of this section.~~

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

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

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

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

(D) For an exiting operator or affiliated operator to be 748
eligible to enter into a successor liability agreement under 749
division (B) or (C) of this section, both of the following must 750
apply: 751

(1) The exiting operator or affiliated operator must have one 752
or more valid provider agreements, other than the provider 753
agreement for the nursing facility or intermediate care facility 754
for the mentally retarded that is the subject of the voluntary 755
termination, voluntary withdrawal of participation, facility 756
closure, or change of operator; 757

(2) During the twelve-month period preceding the month in 758
which the department receives the notice of the voluntary 759
termination, voluntary withdrawal of participation, or facility 760
closure under section 5111.66 of the Revised Code or the notice of 761
the change of operator under section 5111.67 of the Revised Code, 762
the average monthly medicaid payment made to the exiting operator 763
or affiliated operator pursuant to the exiting operator's or 764
affiliated operator's one or more provider agreements, other than 765
the provider agreement for the nursing facility or intermediate 766
care facility for the mentally retarded that is the subject of the 767
voluntary termination, voluntary withdrawal of participation, 768
facility closure, or change of operator, must equal at least 769
ninety per cent of the sum of the following: 770

(a) The average monthly medicaid payment made to the exiting 771
operator pursuant to the exiting operator's provider agreement for 772
the nursing facility or intermediate care facility for the 773
mentally retarded that is the subject of the voluntary 774
termination, voluntary withdrawal of participation, facility 775
closure, or change of operator; 776

(b) Whichever of the following apply: 777

(i) If the exiting operator or affiliated operator has 778

assumed liability under one or more other successor liability agreements, the total amount for which the exiting operator or affiliated operator has assumed liability under the other successor liability agreements; 779
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(ii) If the exiting operator or affiliated operator has not assumed liability under any other successor liability agreements, zero. 783
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(E) A successor liability agreement executed under this section must comply with all of the following: 786
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(1) It must provide for the operator who executes the successor liability agreement to assume liability for either of the following as specified in the agreement: 788
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(a) The total, actual amount of debt the exiting operator owes the department and the United States centers for medicare and medicaid services under the medicaid program as determined under section 5111.685 of the Revised Code; 791
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(b) The portion of the amount specified in division (E)(1)(a) of this section that represents the franchise permit fee the exiting operator owes. 795
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(2) It may not require the operator who executes the successor liability agreement to furnish a surety bond. 798
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(3) It must provide that the department, after determining under section 5111.685 of the Revised Code the actual amount of debt the exiting operator owes the department and United States centers for medicare and medicaid services under the medicaid program, may deduct the lesser of the following from medicaid payments made to the operator who executes the successor liability agreement: 800
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(a) The total, actual amount of debt the exiting operator owes the department and the United States centers for medicare and 807
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medicaid services under the medicaid program as determined under 809
section 5111.685 of the Revised Code; 810

(b) The amount for which the operator who executes the 811
successor liability agreement assumes liability under the 812
agreement. 813

(4) It must provide that the deductions authorized by 814
division (E)(3) of this section are to be made for a number of 815
months, not to exceed six, agreed to by the operator who executes 816
the successor liability agreement and the department or, if the 817
operator who executes the successor liability agreement and 818
department cannot agree on a number of months that is less than 819
six, a greater number of months determined by the attorney general 820
pursuant to a claims collection process authorized by statute of 821
this state. 822

(5) It must provide that, if the attorney general determines 823
the number of months for which the deductions authorized by 824
division (E)(3) of this section are to be made, the operator who 825
executes the successor liability agreement shall pay, in addition 826
to the amount collected pursuant to the attorney general's claims 827
collection process, the part of the amount so collected that, if 828
not for division (G) of this section, would be required by section 829
109.081 of the Revised Code to be paid into the attorney general 830
claims fund. 831

(F) Execution of a successor liability agreement does not 832
waive an exiting operator's right to contest the amount specified 833
in the notice the department provides the exiting operator under 834
division (C) of section 5111.68 of the Revised Code. 835

(G) Notwithstanding section 109.081 of the Revised Code, the 836
entire amount that the attorney general, whether by employees or 837
agents of the attorney general or by special counsel appointed 838
pursuant to section 109.08 of the Revised Code, collects under a 839

successor liability agreement, other than the additional amount 840
the operator who executes the agreement is required by division 841
(E)(5) of this section to pay, shall be paid to the department of 842
job and family services for deposit into the appropriate fund. The 843
additional amount that the operator is required to pay shall be 844
paid into the state treasury to the credit of the attorney general 845
claims fund created under section 109.081 of the Revised Code. 846

Sec. 5111.685. The department of job and family services 847
shall determine the actual amount of debt an exiting operator owes 848
the department and the United States centers for medicare and 849
medicaid services under the medicaid program by completing all 850
final fiscal audits not already completed and performing all other 851
appropriate actions the department determines to be necessary. The 852
department shall issue a an initial debt summary report on this 853
matter not later than ~~ninety~~ sixty days after the date the exiting 854
operator files the properly completed cost report required by 855
section 5111.682 of the Revised Code with the department or, if 856
the department waives the cost report requirement for the exiting 857
operator, ~~ninety~~ sixty days after the date the department waives 858
the cost report requirement. ~~The report shall include the~~ 859
~~department's findings and the amount of debt the department~~ 860
~~determines the exiting operator owes the department and United~~ 861
~~States centers for medicare and medicaid services under the~~ 862
~~medicaid program. Only the parts of the report that are subject to~~ 863
~~an adjudication as specified in section 5111.30 of the Revised~~ 864
~~Code are subject to an adjudication conducted~~ The initial debt 865
summary report becomes the final debt summary report thirty-one 866
days after the department issues the initial debt summary report 867
unless the exiting operator, or an affiliated operator who 868
executes a successor liability agreement under section 5111.681 of 869
the Revised Code, requests a review before that date. 870

The exiting operator, and an affiliated operator who executes 872
a successor liability agreement under section 5111.681 of the 873
Revised Code, may request a review to contest any of the 874
department's findings included in the initial debt summary report. 875
The request for the review must be submitted to the department not 876
later than thirty days after the date the department issues the 877
initial debt summary report. The department shall conduct the 878
review on receipt of a timely request and issue a revised debt 879
summary report. If the department has withheld money from payment 880
due the exiting operator under division (A) of section 5111.681 of 881
the Revised Code, the department shall issue the revised debt 882
summary report not later than ninety days after the date the 883
department receives the timely request for the review unless the 884
department and exiting operator or affiliated operator agree to a 885
later date. The exiting operator or affiliated operator may submit 886
information to the department explaining what the operator 887
contests before and during the review, including documentation of 888
the amount of any debt the department owes the operator. The 889
exiting operator or affiliated operator may submit additional 890
information to the department not later than thirty days after the 891
department issues the revised debt summary report. The revised 892
debt summary report becomes the final debt summary report 893
thirty-one days after the department issues the revised debt 894
summary report unless the exiting operator or affiliated operator 895
timely submits additional information to the department. If the 896
exiting operator or affiliated operator timely submits additional 897
information to the department, the department shall consider the 898
additional information and issue a final debt summary report not 899
later than sixty days after the department issues the revised debt 900
summary report unless the department and exiting operator or 901
affiliated operator agree to a later date. 902

Each debt summary report the department issues under this 903
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section shall include the department's findings and the amount of 905
debt the department determines the exiting operator owes the 906
department and United States centers for medicare and medicaid 907
services under the medicaid program. The department shall explain 908
its findings and determination in each debt summary report. 909

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The exiting operator, and an affiliated operator who executes 911
a successor liability agreement under section 5111.681 of the 912
Revised Code, may request, in accordance with Chapter 119. of the 913
Revised Code, an adjudication regarding a finding in a final debt 914
summary report that pertains to an audit or alleged overpayment 915
made under the medicaid program to the exiting operator. The 916
adjudication shall be consolidated with any other uncompleted 917
adjudication that concerns a matter addressed in the final debt 918
summary report. 919

Sec. 5111.686. The department of job and family services 920
shall release the actual amount withheld under division (A) of 921
section 5111.681 of the Revised Code, less any amount the exiting 922
operator owes the department and United States centers for 923
medicare and medicaid services under the medicaid program, as 924
follows: 925

(A) ~~Ninety one days after the date the exiting operator files~~ 926
~~a properly completed cost report required by section 5111.682 of~~ 927
~~the Revised Code unless~~ Unless the department issues the initial 928
debt summary report required by section 5111.685 of the Revised 929
Code not later than ~~ninety~~ sixty days after the date the exiting 930
operator files the properly completed cost report required by 931
section 5111.682 of the Revised Code, sixty-one days after the 932
date the exiting operator files the properly completed cost 933
report; 934

(B) ~~Not later than thirty days after the exiting operator~~ 935

~~agrees to a final fiscal audit resulting from the report required~~ 936
~~by section 5111.685 of the Revised Code if~~ If the department 937
issues the initial debt summary report required by section 938
5111.685 of the Revised Code not later than ~~ninety~~ sixty days 939
after the date the exiting operator files a properly completed 940
cost report required by section 5111.682 of the Revised Code, not 941
later than the following: 942

(1) Thirty days after the deadline for requesting an 943
adjudication under section 5111.685 of the Revised Code regarding 944
the final debt summary report if the exiting operator, and an 945
affiliated operator who executes a successor liability agreement 946
under section 5111.681 of the Revised Code, fail to request the 947
adjudication on or before the deadline; 948

(2) Thirty days after the completion of an adjudication of 949
the final debt summary report if the exiting operator, or an 950
affiliated operator who executes a successor liability agreement 951
under section 5111.681 of the Revised Code, requests the 952
adjudication on or before the deadline for requesting the 953
adjudication. 954

~~(C) Ninety one days after the date the department waives the~~ 955
~~cost report requirement of section 5111.682 of the Revised Code~~ 956
~~unless~~ Unless the department issues the initial debt summary 957
report required by section 5111.685 of the Revised Code not later 958
than ~~ninety~~ sixty days after the date the department waives the 959
cost report requirement of section 5111.682 of the Revised Code, 960
sixty-one days after the date the department waives the cost 961
report requirement; 962

~~(D) Not later than thirty days after the exiting operator~~ 963
~~agrees to a final fiscal audit resulting from the report required~~ 964
~~by section 5111.685 of the Revised Code if~~ If the department 965
issues the initial debt summary report required by section 966
5111.685 of the Revised Code not later than ~~ninety~~ sixty days 967

after the date the department waives the cost report requirement 968
of section 5111.682 of the Revised Code, not later than the 969
following: 970

(1) Thirty days after the deadline for requesting an 971
adjudication under section 5111.685 of the Revised Code regarding 972
the final debt summary report if the exiting operator, and an 973
affiliated operator who executes a successor liability agreement 974
under section 5111.681 of the Revised Code, fail to request the 975
adjudication on or before the deadline; 976

(2) Thirty days after the completion of an adjudication of 977
the final debt summary report if the exiting operator, or an 978
affiliated operator who executes a successor liability agreement 979
under section 5111.681 of the Revised Code, requests the 980
adjudication on or before the deadline for requesting the 981
adjudication. 982

Sec. 5111.688. (A) All amounts withheld under section 983
5111.681 of the Revised Code from payment due an exiting operator 984
under the medicaid program shall be deposited into the medicaid 985
payment withholding fund created by the controlling board pursuant 986
to section 131.35 of the Revised Code. Money in the fund shall be 987
used as follows: 988

(1) To pay an exiting operator when a withholding is released 989
to the exiting operator under section 5111.686 or 5111.687 of the 990
Revised Code; 991

(2) To pay the department of job and family services and 992
United States centers for medicare and medicaid services the 993
amount an exiting operator owes the department and United States 994
centers under the medicaid program. 995

(B) Amounts paid from the medicaid payment withholding fund 996
pursuant to division (A)(2) of this section shall be deposited 997

into the appropriate department fund. 998

Sec. ~~5111.688~~ 5111.689. The director of job and family 999
services shall adopt rules under section 5111.02 of the Revised 1000
Code to implement sections 5111.65 to ~~5111.688~~ 5111.689 of the 1001
Revised Code, including rules applicable to an exiting operator 1002
that provides written notification under section 5111.66 of the 1003
Revised Code of a voluntary withdrawal of participation. Rules 1004
adopted under this section shall comply with section 1919(c)(2)(F) 1005
of the "Social Security Act," 79 Stat. 286 (1965), 42 U.S.C. 1006
1396r(c)(2)(F), regarding restrictions on transfers or discharges 1007
of nursing facility residents in the case of a voluntary 1008
withdrawal of participation. The rules may prescribe a medicaid 1009
reimbursement methodology and other procedures that are applicable 1010
after the effective date of a voluntary withdrawal of 1011
participation that differ from the reimbursement methodology and 1012
other procedures that would otherwise apply. 1013

Sec. 5111.894. (A) The state administrative agency may 1014
establish one or more waiting lists for the assisted living 1015
program. Only individuals eligible for the ~~medicaid~~ assisted 1016
living program may be placed on a waiting list. 1017

(B) The state administrative agency shall establish a home 1018
first component of the assisted living program under which 1019
eligible individuals may be enrolled in the assisted living 1020
program in accordance with this section. An individual is eligible 1021
for the assisted living program's home first component if the 1022
individual is on an assisted living program waiting list and at 1023
least one of the following applies: 1024

(1) The individual has been admitted to a nursing facility; 1025

(2) A physician has determined and documented in writing that 1026
the individual has a medical condition that, unless enrolled in 1027

home and community-based services such as the assisted living program, will require the individual to be admitted to a nursing facility within thirty days of the physician's determination; 1028
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(3) The individual has been hospitalized and a physician has determined and documented in writing that, unless the individual is enrolled in home and community-based services such as the assisted living program, the individual is to be transported directly from the hospital to a nursing facility admitted; 1031
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(4) Both of the following apply: 1036

(a) The individual is the subject of a report made under section 5101.61 of the Revised Code regarding abuse, neglect, or exploitation or such a report referred to a county department of job and family services under section 5126.31 of the Revised Code or has made a request to a county department for protective services as defined in section 5101.60 of the Revised Code; 1037
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(b) A county department of job and family services and an area agency on aging have jointly documented in writing that, unless the individual is enrolled in home and community-based services such as the assisted living program, the individual should be admitted to a nursing facility; 1043
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(5) The individual resided in a residential care facility for at least six months immediately before applying for the assisted living program and is at risk of imminent admission to a nursing facility because the costs of residing in the residential care facility have depleted the individual's resources such that the individual is unable to continue to afford the cost of residing in the residential care facility. 1048
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(C) Each month, each area agency on aging shall determine whether any individual who resides identify individuals residing in the area that the area agency on aging serves and is on a waiting list who are eligible for the home first component of the 1055
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assisted living program ~~has been admitted to a nursing facility.~~ 1059
~~If~~ When an area agency on aging ~~determines that~~ identifies such an 1060
individual ~~has been admitted to a nursing facility~~ and determines 1061
that there is a vacancy in a residential care facility 1062
participating in the assisted living program that is acceptable to 1063
the individual, the agency shall notify the long-term care 1064
consultation program administrator serving the area in which the 1065
individual resides ~~about the determination.~~ The administrator 1066
shall determine whether the assisted living program is appropriate 1067
for the individual and whether the individual would rather 1068
participate in the assisted living program than continue ~~residing~~ 1069
or begin to reside in ~~the~~ a nursing facility. If the administrator 1070
determines that the assisted living program is appropriate for the 1071
individual and the individual would rather participate in the 1072
assisted living program than continue ~~residing~~ or begin to reside 1073
in ~~the~~ a nursing facility, the administrator shall so notify the 1074
state administrative ~~agency.~~ 1075

~~On~~ an agency. On receipt of the notice from the administrator, 1077
the state administrative agency shall approve the individual's 1078
enrollment in the assisted living program regardless of any 1079
waiting list for the assisted living program, unless the 1080
enrollment would cause the assisted living program to exceed any 1081
limit on the number of individuals who may participate in the 1082
program as set by the United States secretary of health and human 1083
services when the medicaid waiver authorizing the program is 1084
approved. ~~Each~~ 1085

(D) Each quarter, the state administrative agency shall 1086
certify to the director of budget and management the estimated 1087
increase in costs of the assisted living program resulting from 1088
enrollment of individuals in the assisted living program pursuant 1089
to this section. 1090

Section 2. That existing sections 173.401, 3702.51, 3702.59, 1091
5111.65, 5111.651, 5111.68, 5111.681, 5111.685, 5111.686, 1092
5111.688, and 5111.894 of the Revised Code are hereby repealed. 1093

Section 3. That Section 209.20 of Am. Sub. H.B. 1 of the 1094
128th General Assembly be amended to read as follows: 1095

Sec. 209.20. LONG-TERM CARE 1096

Pursuant to an interagency agreement, the Department of Job 1097
and Family Services shall designate the Department of Aging to 1098
perform assessments under section 5111.204 of the Revised Code. 1099
The Department of Aging shall provide long-term care consultations 1100
under section 173.42 of the Revised Code to assist individuals in 1101
planning for their long-term health care needs. The foregoing 1102
appropriation items 490423, Long Term Care Budget - State, and 1103
490623, Long Term Care Budget, may be used to provide the 1104
preadmission screening and resident review (PASRR), which includes 1105
screening, assessments, and determinations made under sections 1106
5111.02, 5111.204, 5119.061, and 5123.021 of the Revised Code. 1107

The foregoing appropriation items 490423, Long Term Care 1108
Budget - State, and 490623, Long Term Care Budget, may be used to 1109
assess and provide long-term care consultations to clients 1110
regardless of Medicaid eligibility. 1111

The Director of Aging shall adopt rules under section 111.15 1112
of the Revised Code governing the nonwaiver funded PASSPORT 1113
program, including client eligibility. The foregoing appropriation 1114
item 490423, Long Term Care Budget - State, may be used by the 1115
Department of Aging to provide nonwaiver funded PASSPORT services 1116
to persons the Department has determined to be eligible to 1117
participate in the nonwaiver funded PASSPORT Program, including 1118
those persons not yet determined to be financially eligible to 1119
participate in the Medicaid waiver component of the PASSPORT 1120

Program by a county department of job and family services. 1121

The Department of Aging shall administer the Medicaid 1122
waiver-funded PASSPORT Home Care Program, the Choices Program, the 1123
Assisted Living Program, and the PACE Program as delegated by the 1124
Department of Job and Family Services in an interagency agreement. 1125
The foregoing appropriation item 490423, Long Term Care Budget - 1126
State, shall be used to provide the required state match for 1127
federal Medicaid funds supporting the Medicaid Waiver-funded 1128
PASSPORT Home Care Program, the Choices Program, the Assisted 1129
Living Program, and the PACE Program. The foregoing appropriation 1130
items 490423, Long Term Care Budget - State, and 490623, Long Term 1131
Care Budget, may also be used to support the Department of Aging's 1132
administrative costs associated with operating the PASSPORT, 1133
Choices, Assisted Living, and PACE programs. 1134

The foregoing appropriation item 490623, Long Term Care 1135
Budget, shall be used to provide the federal matching share for 1136
all program costs determined by the Department of Job and Family 1137
Services to be eligible for Medicaid reimbursement. 1138

HOME FIRST PROGRAM 1139

(A) As used in this section, "Long Term Care Budget Services" 1140
includes the following existing programs: PASSPORT, Assisted 1141
Living, Residential State Supplement, and PACE. 1142

(B) On ~~a quarterly basis, on~~ receipt of the certified 1143
expenditures related to sections 173.401, 173.351, and 5111.894 of 1144
the Revised Code during fiscal years 2010 and 2011, the Director 1145
of Budget and Management ~~may do all of the following for fiscal~~ 1146
~~years 2010 and 2011:~~ 1147

~~(1) Transfer shall transfer cash on a quarterly basis~~ from 1148
the Nursing Facility Stabilization Fund (Fund 5R20), used by the 1149
Department of Job and Family Services, to the PASSPORT/Residential 1150
State Supplement Fund (Fund 4J40), used by the Department of 1151

Aging. The 1152

~~The~~ transferred cash is hereby appropriated to appropriation 1153
item 490610, PASSPORT/Residential State Supplement. 1154

~~(2)~~ If receipts credited to the PASSPORT Fund (Fund 3C40) 1155
exceed the amounts appropriated from the fund, the Director of 1156
Aging ~~may~~ shall request the Director of Budget and Management to 1157
authorize expenditures from the fund in excess of the amounts 1158
appropriated. The Director of Budget and Management shall 1159
authorize the expenditures on receipt of the Director of Aging's 1160
request. Upon the ~~approval~~ authorization of the Director of Budget 1161
and Management, the additional amounts are hereby appropriated. 1162

~~(3)~~ If receipts credited to the Interagency Reimbursement 1163
Fund (Fund 3G50) exceed the amounts appropriated from the fund, 1164
the Director of Job and Family Services ~~may~~ shall request the 1165
Director of Budget and Management to authorize expenditures from 1166
the fund in excess of the amounts appropriated. The Director of 1167
Budget and Management shall authorize the expenditures on receipt 1168
of the Director of Job and Family Services' request. Upon the 1169
~~approval~~ authorization of the Director of Budget and Management, 1170
the additional amounts are hereby appropriated. 1171

(C) The individuals placed in Long Term Care Budget Services 1172
pursuant to this section shall be in addition to the individuals 1173
placed in Long Term Care Budget Services during fiscal years 2010 1174
and 2011 before any transfers to appropriation item 490423, Long 1175
Term Care Budget-State, are made under this section. 1176

ALLOCATION OF PACE SLOTS 1177

In order to effectively administer and manage growth within 1178
the PACE Program, the Director of Aging may, as the director deems 1179
appropriate and to the extent funding is available, expand the 1180
PACE Program to regions of Ohio beyond those currently served by 1181
the PACE Program. In implementing the expansion, the Director may 1182

not decrease the number of residents of Cuyahoga and Hamilton 1183
counties and parts of Butler, Clermont, and Warren counties who 1184
are participating in the PACE Program below the number of 1185
residents of those counties and parts of counties who were 1186
enrolled in the PACE Program on July 1, 2008. 1187

Section 4. That existing Section 209.20 of Am. Sub. H.B. 1 of 1188
the 128th General Assembly is hereby repealed. 1189