

**As Reported by the Senate Finance and Financial Institutions
Committee**

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

Sub. S. B. No. 214

Senators Carey, Miller, D.

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

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A B I L L

To amend sections 173.401, 173.501, 3702.51, 3702.59, 1
5111.65, 5111.651, 5111.68, 5111.681, 5111.685, 2
5111.686, 5111.688, 5111.874, 5111.875, and 3
5111.894; to amend, for the purpose of adopting a 4
new section number as indicated in parentheses, 5
section 5111.688 (5111.689); and to enact new 6
section 5111.688 and section 173.404 of the 7
Revised Code; and to amend Section 209.20 of Am. 8
Sub. H.B. 1 of the 128th General Assembly to 9
revise the waiting list provisions of the 10
PASSPORT, PACE, and Assisted Living programs, to 11
revise the law governing the collection of 12
long-term care facilities' Medicaid debts, to 13
authorize a Certificate of Need for the relocation 14
of long-term care beds from an existing hospital 15
to an existing nursing home in a contiguous county 16
if certain conditions are met, and to revise the 17
law governing the reasons for denying a 18
Certificate of Need application. 19

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

Section 1. That sections 173.401, 173.501, 3702.51, 3702.59, 20
5111.65, 5111.651, 5111.68, 5111.681, 5111.685, 5111.686, 21
5111.688, 5111.874, 5111.875, and 5111.894 be amended; section 22
5111.688 (5111.689) be amended for the purpose of adopting a new 23
section number as indicated in parentheses; and new section 24
5111.688 and section 173.404 of the Revised Code be enacted to 25
read as follows: 26

Sec. 173.401. (A) As used in this section: 27

"Area agency on aging" has the same meaning as in section 28
173.14 of the Revised Code. 29

"Long-term care consultation program" means the program the 30
department of aging is required to develop under section 173.42 of 31
the Revised Code. 32

"Long-term care consultation program administrator" or 33
"administrator" means the department of aging or, if the 34
department contracts with an area agency on aging or other entity 35
to administer the long-term care consultation program for a 36
particular area, that agency or entity. 37

"Nursing facility" has the same meaning as in section 5111.20 38
of the Revised Code. 39

"PASSPORT waiver" means the federal medicaid waiver granted 40
by the United States secretary of health and human services that 41
authorizes the PASSPORT program. 42

~~(B) The director of job and family services shall submit to 43
the United States secretary of health and human services an 44
amendment to the PASSPORT waiver that authorizes additional 45
enrollments in the PASSPORT program pursuant to this section. 46
Beginning with the month following the month in which the United 47
States secretary approves the amendment and each The department 48
shall establish a home first component of the PASSPORT program 49~~

under which eligible individuals may be enrolled in the PASSPORT program in accordance with this section. An individual is eligible for the PASSPORT program's home first component if all of the following apply: 50
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(1) The individual is eligible for the PASSPORT program. 54

(2) The individual is on the unified waiting list established under section 173.404 of the Revised Code. 55
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(3) At least one of the following applies: 57

(a) The individual has been admitted to a nursing facility. 58

(b) A physician has determined and documented in writing that the individual has a medical condition that, unless the individual is enrolled in home and community-based services such as the PASSPORT program, will require the individual to be admitted to a nursing facility within thirty days of the physician's determination. 59
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(c) The individual has been hospitalized and a physician has determined and documented in writing that, unless the individual is enrolled in home and community-based services such as the PASSPORT program, the individual is to be transported directly from the hospital to a nursing facility and admitted. 65
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(d) Both of the following apply: 70

(i) The individual is the subject of a report made under section 5101.61 of the Revised Code regarding abuse, neglect, or exploitation or such a report referred to a county department of job and family services under section 5126.31 of the Revised Code or has made a request to a county department for protective services as defined in section 5101.60 of the Revised Code. 71
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(ii) A county department of job and family services and an area agency on aging have jointly documented in writing that, unless the individual is enrolled in home and community-based 77
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services such as the PASSPORT program, the individual should be 80
admitted to a nursing facility. 81

(C) Each month thereafter, each area agency on aging shall 82
~~determine whether identify~~ individuals ~~who reside~~ residing in the 83
area that the area agency on aging serves and who are ~~on a waiting~~ 84
~~list~~ eligible for the home first component of the PASSPORT program 85
~~have been admitted to a nursing facility. If~~ When an area agency 86
on aging ~~determines that identifies~~ such an individual ~~has been~~ 87
~~admitted to a nursing facility~~, the agency shall notify the 88
long-term care consultation program administrator serving the area 89
in which the individual resides ~~about the determination~~. The 90
administrator shall determine whether the PASSPORT program is 91
appropriate for the individual and whether the individual would 92
rather participate in the PASSPORT program than continue ~~residing~~ 93
or begin to reside in ~~the~~ a nursing facility. If the administrator 94
determines that the PASSPORT program is appropriate for the 95
individual and the individual would rather participate in the 96
PASSPORT program than continue ~~residing~~ or begin to reside in ~~the~~ 97
a nursing facility, the administrator shall so notify the 98
department of aging. On receipt of the notice from the 99
administrator, the department ~~of aging~~ shall approve the 100
individual's enrollment in the PASSPORT program regardless of the 101
~~PASSPORT program's unified~~ waiting list and ~~even though the~~ 102
~~enrollment causes enrollment in the program to exceed the limit~~ 103
~~that would otherwise apply~~ established under section 173.404 of 104
the Revised Code, unless the enrollment would cause the PASSPORT 105
program to exceed any limit on the number of individuals who may 106
be enrolled in the program as set by the United States secretary 107
of health and human services in the PASSPORT waiver. 108

(D) Each quarter, the department of aging shall certify to 109
the director of budget and management the estimated increase in 110
costs of the PASSPORT program resulting from enrollment of 111

individuals in the PASSPORT program pursuant to this section. 112

Sec. 173.404. (A) As used in this section: 113

(1) "Department of aging-administered medicaid waiver component" means each of the following: 114
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(a) The PASSPORT program created under section 173.40 of the Revised Code; 116
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(b) The choices program created under section 173.403 of the Revised Code; 118
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(c) The assisted living program created under section 5111.89 of the Revised Code. 120
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(2) "PACE program" means the component of the medicaid program the department of aging administers pursuant to section 173.50 of the Revised Code. 122
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(B) The department of aging shall establish a unified waiting list for department of aging-administered medicaid waiver components and the PACE program. Only individuals eligible for a department of aging-administered medicaid waiver component or the PACE program may be placed on the unified waiting list. 125
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Sec. 173.501. (A) As used in this section: 130

"Nursing facility" has the same meaning as in section 5111.20 of the Revised Code. 131
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"PACE provider" has the same meaning as in 42 U.S.C. 133
1396u-4(a)(3). 134

(B) The department of aging shall establish a home first component of the PACE program under which eligible individuals may be enrolled in the PACE program in accordance with this section. An individual is eligible for the PACE program's home first component if all of the following apply: 135
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<u>(1) The individual is eligible for the PACE program.</u>	140
<u>(2) The individual is on the unified waiting list established under section 173.404 of the Revised Code.</u>	141 142
<u>(3) At least one of the following applies:</u>	143
<u>(a) The individual has been admitted to a nursing facility.</u>	144
<u>(b) A physician has determined and documented in writing that the individual has a medical condition that, unless the individual is enrolled in home and community-based services such as the PACE program, will require the individual to be admitted to a nursing facility within thirty days of the physician's determination.</u>	145 146 147 148 149
<u>(c) The individual has been hospitalized and a physician has determined and documented in writing that, unless the individual is enrolled in home and community-based services such as the PACE program, the individual is to be transported directly from the hospital to a nursing facility and admitted.</u>	150 151 152 153 154
<u>(d) Both of the following apply:</u>	155
<u>(i) The individual is the subject of a report made under section 5101.61 of the Revised Code regarding abuse, neglect, or exploitation or such a report referred to a county department of job and family services under section 5126.31 of the Revised Code or has made a request to a county department for protective services as defined in section 5101.60 of the Revised Code.</u>	156 157 158 159 160 161
<u>(ii) A county department of job and family services and an area agency on aging have jointly documented in writing that, unless the individual is enrolled in home and community-based services such as the PACE program, the individual should be admitted to a nursing facility.</u>	162 163 164 165 166
<u>(C) Each month, the department of aging shall determine whether identify individuals who are on a waiting list eligible for the home first component of the PACE program have been</u>	167 168 169

~~admitted to a nursing facility. If~~ When the department determines 170
~~that identifies~~ such an individual ~~has been admitted to a nursing~~ 171
~~facility,~~ the department shall notify the PACE provider serving 172
the area in which the individual resides ~~about the determination.~~ 173
The PACE provider shall determine whether the PACE program is 174
appropriate for the individual and whether the individual would 175
rather participate in the PACE program than continue ~~residing or~~ 176
begin to reside in ~~the~~ a nursing facility. If the PACE provider 177
determines that the PACE program is appropriate for the individual 178
and the individual would rather participate in the PACE program 179
than continue ~~residing or begin to reside~~ in ~~the~~ a nursing 180
facility, the PACE provider shall so notify the department of 181
aging. On receipt of the notice from the PACE provider, the 182
department of aging shall approve the individual's enrollment in 183
the PACE program in accordance with priorities established in 184
rules adopted under section 173.50 of the Revised Code. ~~Each~~ 185

(D) Each quarter, the department of aging shall certify to 186
the director of budget and management the estimated increase in 187
costs of the PACE program resulting from enrollment of individuals 188
in the PACE program pursuant to this section. 189

Sec. 3702.51. As used in sections 3702.51 to 3702.62 of the 190
Revised Code: 191

(A) "Applicant" means any person that submits an application 192
for a certificate of need and who is designated in the application 193
as the applicant. 194

(B) "Person" means any individual, corporation, business 195
trust, estate, firm, partnership, association, joint stock 196
company, insurance company, government unit, or other entity. 197

(C) "Certificate of need" means a written approval granted by 198
the director of health to an applicant to authorize conducting a 199
reviewable activity. 200

(D) "Health service area" means a geographic region 201
designated by the director of health under section 3702.58 of the 202
Revised Code. 203

(E) "Health service" means a clinically related service, such 204
as a diagnostic, treatment, rehabilitative, or preventive service. 205

(F) "Health service agency" means an agency designated to 206
serve a health service area in accordance with section 3702.58 of 207
the Revised Code. 208

(G) "Health care facility" means: 209

(1) A hospital registered under section 3701.07 of the 210
Revised Code; 211

(2) A nursing home licensed under section 3721.02 of the 212
Revised Code, or by a political subdivision certified under 213
section 3721.09 of the Revised Code; 214

(3) A county home or a county nursing home as defined in 215
section 5155.31 of the Revised Code that is certified under Title 216
XVIII or XIX of the "Social Security Act," 49 Stat. 620 (1935), 42 217
U.S.C.A. 301, as amended; 218

(4) A freestanding dialysis center; 219

(5) A freestanding inpatient rehabilitation facility; 220

(6) An ambulatory surgical facility; 221

(7) A freestanding cardiac catheterization facility; 222

(8) A freestanding birthing center; 223

(9) A freestanding or mobile diagnostic imaging center; 224

(10) A freestanding radiation therapy center. 225

A health care facility does not include the offices of 226
private physicians and dentists whether for individual or group 227
practice, residential facilities licensed under section 5123.19 of 228
the Revised Code, or an institution for the sick that is operated 229

exclusively for patients who use spiritual means for healing and 230
for whom the acceptance of medical care is inconsistent with their 231
religious beliefs, accredited by a national accrediting 232
organization, exempt from federal income taxation under section 233
501 of the Internal Revenue Code of 1986, 100 Stat. 2085, 26 234
U.S.C.A. 1, as amended, and providing twenty-four hour nursing 235
care pursuant to the exemption in division (E) of section 4723.32 236
of the Revised Code from the licensing requirements of Chapter 237
4723. of the Revised Code. 238

(H) "Medical equipment" means a single unit of medical 239
equipment or a single system of components with related functions 240
that is used to provide health services. 241

(I) "Third-party payer" means a health insuring corporation 242
licensed under Chapter 1751. of the Revised Code, a health 243
maintenance organization as defined in division (K) of this 244
section, an insurance company that issues sickness and accident 245
insurance in conformity with Chapter 3923. of the Revised Code, a 246
state-financed health insurance program under Chapter 3701., 247
4123., or 5111. of the Revised Code, or any self-insurance plan. 248

(J) "Government unit" means the state and any county, 249
municipal corporation, township, or other political subdivision of 250
the state, or any department, division, board, or other agency of 251
the state or a political subdivision. 252

(K) "Health maintenance organization" means a public or 253
private organization organized under the law of any state that is 254
qualified under section 1310(d) of Title XIII of the "Public 255
Health Service Act," 87 Stat. 931 (1973), 42 U.S.C. 300e-9. 256

(L) "Existing health care facility" means either of the 257
following: 258

(1) A health care facility that is licensed or otherwise 259
authorized to operate in this state in accordance with applicable 260

law, including a county home or a county nursing home that is 261
certified as of February 1, 2008, under Title XVIII or Title XIX 262
of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C. 301, 263
as amended, is staffed and equipped to provide health care 264
services, and is actively providing health services; 265

(2) A health care facility that is licensed or otherwise 266
authorized to operate in this state in accordance with applicable 267
law, including a county home or a county nursing home that is 268
certified as of February 1, 2008, under Title XVIII or Title XIX 269
of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C. 301, 270
as amended, or that has beds registered under section 3701.07 of 271
the Revised Code as skilled nursing beds or long-term care beds 272
and has provided services for at least three hundred sixty-five 273
consecutive days within the twenty-four months immediately 274
preceding the date a certificate of need application is filed with 275
the director of health. 276

(M) "State" means the state of Ohio, including, but not 277
limited to, the general assembly, the supreme court, the offices 278
of all elected state officers, and all departments, boards, 279
offices, commissions, agencies, institutions, and other 280
instrumentalities of the state of Ohio. "State" does not include 281
political subdivisions. 282

(N) "Political subdivision" means a municipal corporation, 283
township, county, school district, and all other bodies corporate 284
and politic responsible for governmental activities only in 285
geographic areas smaller than that of the state to which the 286
sovereign immunity of the state attaches. 287

(O) "Affected person" means: 288

(1) An applicant for a certificate of need, including an 289
applicant whose application was reviewed comparatively with the 290
application in question; 291

(2) The person that requested the reviewability ruling in question;	292 293
(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;	294 295 296 297
(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;	298 299 300
(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;	301 302 303 304
(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.	305 306 307 308
(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:	309 310 311 312
(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;	313 314 315 316
(2) Maintaining an active medical staff, the majority of which is comprised of osteopathic physicians;	317 318
(3) Maintaining a medical staff executive committee that has osteopathic physicians as a majority of its members.	319 320
(Q) "Ambulatory surgical facility" has the same meaning as in	321

section 3702.30 of the Revised Code.	322
(R) Except as provided in division (S) of this section,	323
"reviewable activity" means any of the following activities:	324
(1) The establishment, development, or construction of a new long-term care facility;	325 326
(2) The replacement of an existing long-term care facility;	327
(3) The renovation of a long-term care facility that involves a capital expenditure of two million dollars or more, not including expenditures for equipment, staffing, or operational costs;	328 329 330 331
(4) Either of the following changes in long-term care bed capacity:	332 333
(a) An increase in bed capacity;	334
(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.	335 336 337 338
(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;	339 340 341 342 343 344
(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.	345 346 347
(S) "Reviewable activity" does not include any of the following activities:	348 349
(1) Acquisition of computer hardware or software;	350

(2) Acquisition of a telephone system;	351
(3) Construction or acquisition of parking facilities;	352
(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;	353 354 355
(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;	356 357 358
(6) Correction of cited deficiencies identified by accreditation surveys of the joint commission on accreditation of healthcare organizations or of the American osteopathic association;	359 360 361 362
(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;	363 364 365
(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;	366 367 368 369
(9) Construction, repair, or renovation of bathroom facilities;	370 371
(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;	372 373 374 375
(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	376 377 378 379 380

premarket approval has been granted by the United States food and 381
drug administration to provide services for which patients or 382
reimbursement entities will be charged shall be a reviewable 383
activity. 384

(12) Removal of asbestos from a health care facility. 385

Only that portion of a project that meets the requirements of 386
this division is not a reviewable activity. 387

(T) "Small rural hospital" means a hospital that is located 388
within a rural area, has fewer than one hundred beds, and to which 389
fewer than four thousand persons were admitted during the most 390
recent calendar year. 391

(U) "Children's hospital" means any of the following: 392

(1) A hospital registered under section 3701.07 of the 393
Revised Code that provides general pediatric medical and surgical 394
care, and in which at least seventy-five per cent of annual 395
inpatient discharges for the preceding two calendar years were 396
individuals less than eighteen years of age; 397

(2) A distinct portion of a hospital registered under section 398
3701.07 of the Revised Code that provides general pediatric 399
medical and surgical care, has a total of at least one hundred 400
fifty registered pediatric special care and pediatric acute care 401
beds, and in which at least seventy-five per cent of annual 402
inpatient discharges for the preceding two calendar years were 403
individuals less than eighteen years of age; 404

(3) A distinct portion of a hospital, if the hospital is 405
registered under section 3701.07 of the Revised Code as a 406
children's hospital and the children's hospital meets all the 407
requirements of division (U)(1) of this section. 408

(V) "Long-term care facility" means any of the following: 409

(1) A nursing home licensed under section 3721.02 of the 410

Revised Code or by a political subdivision certified under section 411
3721.09 of the Revised Code; 412

(2) The portion of any facility, including a county home or 413
county nursing home, that is certified as a skilled nursing 414
facility or a nursing facility under Title XVIII or XIX of the 415
"Social Security Act"; 416

(3) The portion of any hospital that contains beds registered 417
under section 3701.07 of the Revised Code as skilled nursing beds 418
or long-term care beds. 419

(W) "Long-term care bed" means a bed in a long-term care 420
facility. 421

(X) "Freestanding birthing center" means any facility in 422
which deliveries routinely occur, regardless of whether the 423
facility is located on the campus of another health care facility, 424
and which is not licensed under Chapter 3711. of the Revised Code 425
as a level one, two, or three maternity unit or a limited 426
maternity unit. 427

(Y)(1) "Reviewability ruling" means a ruling issued by the 428
director of health under division (A) of section 3702.52 of the 429
Revised Code as to whether a particular proposed project is or is 430
not a reviewable activity. 431

(2) "Nonreviewability ruling" means a ruling issued under 432
that division that a particular proposed project is not a 433
reviewable activity. 434

(Z)(1) "Metropolitan statistical area" means an area of this 435
state designated a metropolitan statistical area or primary 436
metropolitan statistical area in United States office of 437
management and budget bulletin no. 93-17, June 30, 1993, and its 438
attachments. 439

(2) "Rural area" means any area of this state not located 440

within a metropolitan statistical area. 441

(AA) "County nursing home" has the same meaning as in section 442
5155.31 of the Revised Code. 443

(BB) "Principal participant" means both of the following: 444

(1) A person who has an ownership or controlling interest of 445
at least five per cent in an applicant, in a health care facility 446
that is the subject of an application for a certificate of need, 447
or in the owner or operator of the applicant or such a facility; 448

(2) An officer, director, trustee, or general partner of an 449
applicant, of a health care facility that is the subject of an 450
application for a certificate of need, or of the owner or operator 451
of the applicant or such a facility. 452

(CC) "Actual harm but not immediate jeopardy deficiency" 453
means a deficiency that, under 42 C.F.R. 488.404, either 454
constitutes a pattern of deficiencies resulting in actual harm 455
that is not immediate jeopardy or represents widespread 456
deficiencies resulting in actual harm that is not immediate 457
jeopardy. 458

(DD) "Immediate jeopardy deficiency" means a deficiency that, 459
under 42 C.F.R. 488.404, either constitutes a pattern of 460
deficiencies resulting in immediate jeopardy to resident health or 461
safety or represents widespread deficiencies resulting in 462
immediate jeopardy to resident health or safety. 463

Sec. 3702.59. (A) The director of health shall accept for 464
review certificate of need applications as provided in sections 465
3702.592, 3702.593, and 3702.594 of the Revised Code. 466

(B)(1) The director shall not approve an application for a 467
certificate of need for the addition of long-term care beds to an 468
existing health care facility or for the development of a new 469
health care facility if any of the following apply: 470

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

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

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

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

~~(4)~~ During the period that precedes the filing of the application and is encompassed by the three most recent standard surveys of the existing health care facility in which the beds are being placed, (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 503
resident health or safety or are widespread deficiencies resulting 504
in immediate jeopardy to resident health or safety. 505~~

~~(5) During the period that precedes the filing of the 506
application and is encompassed by the three most recent standard 507
surveys of the existing health care facility in which the beds are 508
being placed, more (iii) The facility was cited on two separate 509
occasions for final, nonappealable actual harm but not immediate 510
jeopardy deficiencies and on one occasion for a final, 511
nonappealable immediate jeopardy deficiency. 512~~

~~(d) More than two nursing homes owned or operated in this 513
state by the applicant or the person who operates the facility in 514
which the beds are being placed a principal participant or, if the 515
applicant or person a principal participant owns or operates more 516
than twenty nursing homes in this state, more than ten per cent of 517
those nursing homes, were each cited on during the period that 518
precedes the filing of the application for the certificate of need 519
and is encompassed by the three most recent standard surveys of 520
the nursing homes that were so cited in any of the following 521
manners: 522~~

~~(i) On three or more separate occasions for final, 523
nonappealable actual harm but not immediate jeopardy deficiencies 524
that, under 42 C.F.R. 488.404, either constitute a pattern of 525
deficiencies resulting in actual harm that is not immediate 526
jeopardy or are widespread deficiencies resulting in actual harm 527
that is not immediate jeopardy. 528~~

~~(6) During the period that precedes the filing of the 529
application and is encompassed by the three most recent standard 530
surveys of the existing health care facility in which the beds are 531
being placed, more than two nursing homes operated in this state 532
by the applicant or the person who operates the facility in which 533
the beds are being placed or, if the applicant or person operates 534~~

~~more than twenty nursing homes in this state, more than ten per cent of those nursing homes, were each cited on;~~ 535
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~~(ii) On two or more separate occasions for final, nonappealable immediate jeopardy deficiencies that, under 42 C.F.R. 488.404, either constitute a pattern of deficiencies resulting in immediate jeopardy to resident health or safety or are widespread deficiencies resulting in immediate jeopardy to resident health or safety;~~ 537
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~~(iii) On two separate occasions for final, nonappealable actual harm but not immediate jeopardy deficiencies and on one occasion for a final, nonappealable immediate jeopardy deficiency.~~ 543
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~~(7) During the sixty month period preceding the filing of the application, the applicant has violated this chapter on two or more separate occasions.~~ 546
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~~(2) In applying divisions (B)(1)(a) to (6)(d) of this section, the director shall not consider deficiencies or violations cited before the ~~current operator~~ applicant or a principal participant acquired or began to own or operate the health care facility at which the deficiencies or violations were cited. The director may disregard deficiencies and violations cited after the health care facility was acquired or began to be operated by the ~~current operator~~ applicant or a principal participant if the deficiencies or violations were attributable to circumstances that arose under the previous owner or operator and the ~~current operator~~ applicant or principal participant has implemented measures to alleviate the circumstances. In the case of an application proposing development of a new health care facility by relocation of beds, the director shall not consider deficiencies or violations that were solely attributable to the physical plant of the existing health care facility from which the beds are being relocated.~~ 549
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(C) The director also shall accept for review any application 566
for the conversion of infirmary beds to long-term care beds if the 567
infirmary meets all of the following conditions: 568

(1) Is operated exclusively by a religious order; 569

(2) Provides care exclusively to members of religious orders 570
who take vows of celibacy and live by virtue of their vows within 571
the orders as if related; 572

(3) Was providing care exclusively to members of such a 573
religious order on January 1, 1994. 574

At no time shall individuals other than those described in 575
division (C)(2) of this section be admitted to a facility to use 576
beds for which a certificate of need is approved under this 577
division. 578

Sec. 5111.65. As used in sections 5111.65 to ~~5111.688~~ 579
5111.689 of the Revised Code: 580

(A) "Affiliated operator" means an operator affiliated with 581
either of the following: 582

(1) The exiting operator for whom the affiliated operator is 583
to assume liability for the entire amount of the exiting 584
operator's debt under the medicaid program or the portion of the 585
debt that represents the franchise permit fee the exiting operator 586
owes; 587

(2) The entering operator involved in the change of operator 588
with the exiting operator specified in division (A)(1) of this 589
section. 590

(B) "Change of operator" means an entering operator becoming 591
the operator of a nursing facility or intermediate care facility 592
for the mentally retarded in the place of the exiting operator. 593

(1) Actions that constitute a change of operator include the 594

following:	595
(a) A change in an exiting operator's form of legal organization, including the formation of a partnership or corporation from a sole proprietorship;	596 597 598
(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;	599 600 601 602 603
(c) A lease of the facility to the entering operator or the exiting operator's termination of the exiting operator's lease;	604 605
(d) If the exiting operator is a partnership, dissolution of the partnership;	606 607
(e) If the exiting operator is a partnership, a change in composition of the partnership unless both of the following apply:	608 609
(i) The change in composition does not cause the partnership's dissolution under state law.	610 611
(ii) The partners agree that the change in composition does not constitute a change in operator.	612 613
(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.	614 615 616 617
(2) The following, alone, do not constitute a change of operator:	618 619
(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;	620 621 622 623
(b) A change of ownership, lease, or termination of a lease	624

of real property or personal property associated with a nursing 625
facility or intermediate care facility for the mentally retarded 626
if an entering operator does not become the operator in place of 627
an exiting operator; 628

(c) If the operator is a corporation, a change of one or more 629
members of the corporation's governing body or transfer of 630
ownership of one or more shares of the corporation's stock, if the 631
same corporation continues to be the operator. 632

~~(B)~~(C) "Effective date of a change of operator" means the day 633
the entering operator becomes the operator of the nursing facility 634
or intermediate care facility for the mentally retarded. 635

~~(C)~~(D) "Effective date of a facility closure" means the last 636
day that the last of the residents of the nursing facility or 637
intermediate care facility for the mentally retarded resides in 638
the facility. 639

~~(D)~~(E) "Effective date of a voluntary termination" means the 640
day the intermediate care facility for the mentally retarded 641
ceases to accept medicaid patients. 642

~~(E)~~(F) "Effective date of a voluntary withdrawal of 643
participation" means the day the nursing facility ceases to accept 644
new medicaid patients other than the individuals who reside in the 645
nursing facility on the day before the effective date of the 646
voluntary withdrawal of participation. 647

~~(F)~~(G) "Entering operator" means the person or government 648
entity that will become the operator of a nursing facility or 649
intermediate care facility for the mentally retarded when a change 650
of operator occurs. 651

~~(G)~~(H) "Exiting operator" means any of the following: 652

(1) An operator that will cease to be the operator of a 653
nursing facility or intermediate care facility for the mentally 654

retarded on the effective date of a change of operator; 655

(2) An operator that will cease to be the operator of a 656
nursing facility or intermediate care facility for the mentally 657
retarded on the effective date of a facility closure; 658

(3) An operator of an intermediate care facility for the 659
mentally retarded that is undergoing or has undergone a voluntary 660
termination; 661

(4) An operator of a nursing facility that is undergoing or 662
has undergone a voluntary withdrawal of participation. 663

~~(H)~~(I)(1) "Facility closure" means discontinuance of the use 664
of the building, or part of the building, that houses the facility 665
as a nursing facility or intermediate care facility for the 666
mentally retarded that results in the relocation of all of the 667
facility's residents. A facility closure occurs regardless of any 668
of the following: 669

(a) The operator completely or partially replacing the 670
facility by constructing a new facility or transferring the 671
facility's license to another facility; 672

(b) The facility's residents relocating to another of the 673
operator's facilities; 674

(c) Any action the department of health takes regarding the 675
facility's certification under Title XIX of the "Social Security 676
Act," 79 Stat. 286 (1965), 42 U.S.C. 1396, as amended, that may 677
result in the transfer of part of the facility's survey findings 678
to another of the operator's facilities; 679

(d) Any action the department of health takes regarding the 680
facility's license under Chapter 3721. of the Revised Code; 681

(e) Any action the department of developmental disabilities 682
takes regarding the facility's license under section 5123.19 of 683
the Revised Code. 684

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

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

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

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

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

Sec. 5111.68. (A) On receipt of a written notice under
section 5111.66 of the Revised Code of a facility closure,
voluntary termination, or voluntary withdrawal of participation or

a written notice under section 5111.67 of the Revised Code of a 715
change of operator, the department of job and family services 716
shall ~~determine~~ estimate the amount of any overpayments made under 717
the medicaid program to the exiting operator, including 718
overpayments the exiting operator disputes, and other actual and 719
potential debts the exiting operator owes or may owe to the 720
department and United States centers for medicare and medicaid 721
services under the medicaid program, including a franchise permit
fee. ~~In determining~~ 723

(B) In estimating the exiting operator's other actual and 724
potential debts to the department and the United States centers
for medicare and medicaid services under the medicaid program, the 725
department shall ~~include~~ use a debt estimation methodology the
director of job and family services shall establish in rules
adopted under section 5111.689 of the Revised Code. The
methodology shall provide for estimating all of the following that 730
the department determines ~~is~~ are applicable: 731

(1) Refunds due the department under section 5111.27 of the 732
Revised Code; 733

(2) Interest owed to the department and United States centers 734
for medicare and medicaid services; 735

(3) Final civil monetary and other penalties for which all 736
right of appeal has been exhausted; 737

(4) Money owed the department and United States centers for 738
medicare and medicaid services from any outstanding final fiscal 739
audit, including a final fiscal audit for the last fiscal year or 740
portion thereof in which the exiting operator participated in the 741
medicaid program; 742

(5) Other amounts the department determines are applicable. 743

~~(B) If the department is unable to determine the amount of~~ 744

~~the overpayments and other debts for any period before the~~ 745
~~effective date of the entering operator's provider agreement or~~ 746
~~the effective date of the facility closure, voluntary termination,~~ 747
~~or voluntary withdrawal of participation, the department shall~~ 748
~~make a reasonable estimate of the overpayments and other debts for~~ 749
~~the period. The department shall make the estimate using~~ 750
~~information available to the department, including prior~~ 751
~~determinations of overpayments and other debts.~~ 752

(C) The department shall provide the exiting operator written 753
notice of the department's estimate under division (A) of this 754
section not later than thirty days after the department receives 755
the notice under section 5111.66 of the Revised Code of the 756
facility closure, voluntary termination, or voluntary withdrawal 757
of participation or the notice under section 5111.67 of the 758
Revised Code of the change of operator. The department's written 759
notice shall include the basis for the estimate. 760

Sec. 5111.681. (A) Except as provided in ~~division~~ divisions 761
(B) and (C) of this section, the department of job and family 762
services ~~shall~~ may withhold ~~the greater of the following~~ from 763
payment due an exiting operator under the medicaid program~~+~~ 764

~~(1) The~~ the total amount ~~of any overpayments made under the~~ 765
~~medicaid program to the exiting operator, including overpayments~~ 766
~~the exiting operator disputes, and other actual and potential~~ 767
~~debts, including any unpaid penalties, specified in the notice~~ 768
provided under division (C) of section 5111.68 of the Revised Code 769
that the exiting operator owes or may owe to the department and 770
United States centers for medicare and medicaid services under the 771
medicaid program~~+~~ 772

~~(2) An amount equal to the average amount of monthly payments~~ 773
~~to the exiting operator under the medicaid program for the~~ 774
~~twelve month period immediately preceding the month that includes~~ 775

~~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.~~ 776
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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: 779
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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: 785
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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;~~ 793
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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.~~ 796
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(2) If the exiting operator, entering operator, or affiliated operator assumes liability for only the portion of the amount specified in division (B)(1) of this section that represents the franchise permit fee the exiting operator owes, the department shall withhold not more than the difference between the total amount specified in the notice provided under division (C) of section 5111.68 of the Revised Code and the amount for which the exiting operator, entering operator, or affiliated operator 799
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assumes liability. 807

(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: 808
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(1) If the exiting operator or affiliated operator assumes liability for the total, actual amount of debt the exiting operator owes the department and the United States centers for medicare and medicaid services under the medicaid program as determined under section 5111.685 of the Revised Code, the department shall not make the withholding. 815
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(2) If the exiting operator or affiliated operator assumes liability for only the portion of the amount specified in division (C)(1) of this section that represents the franchise permit fee the exiting operator owes, the department shall withhold not more than the difference between the total amount specified in the notice provided under division (C) of section 5111.68 of the Revised Code and the amount for which the exiting operator or affiliated operator assumes liability. 821
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(D) For an exiting operator or affiliated operator to be eligible to enter into a successor liability agreement under division (B) or (C) of this section, both of the following must apply: 829
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(1) The exiting operator or affiliated operator must have one or more valid provider agreements, other than the provider agreement for the nursing facility or intermediate care facility for the mentally retarded that is the subject of the voluntary termination, voluntary withdrawal of participation, facility 833
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closure, or change of operator; 838

(2) During the twelve-month period preceding the month in 839
which the department receives the notice of the voluntary 840
termination, voluntary withdrawal of participation, or facility 841
closure under section 5111.66 of the Revised Code or the notice of 842
the change of operator under section 5111.67 of the Revised Code, 843
the average monthly medicaid payment made to the exiting operator 844
or affiliated operator pursuant to the exiting operator's or 845
affiliated operator's one or more provider agreements, other than 846
the provider agreement for the nursing facility or intermediate 847
care facility for the mentally retarded that is the subject of the 848
voluntary termination, voluntary withdrawal of participation, 849
facility closure, or change of operator, must equal at least 850
ninety per cent of the sum of the following: 851

(a) The average monthly medicaid payment made to the exiting 852
operator pursuant to the exiting operator's provider agreement for 853
the nursing facility or intermediate care facility for the 854
mentally retarded that is the subject of the voluntary 855
termination, voluntary withdrawal of participation, facility 856
closure, or change of operator; 857

(b) Whichever of the following apply: 858

(i) If the exiting operator or affiliated operator has 859
assumed liability under one or more other successor liability 860
agreements, the total amount for which the exiting operator or 861
affiliated operator has assumed liability under the other 862
successor liability agreements; 863

(ii) If the exiting operator or affiliated operator has not 864
assumed liability under any other successor liability agreements, 865
zero. 866

(E) A successor liability agreement executed under this 867
section must comply with all of the following: 868

(1) It must provide for the operator who executes the 869
successor liability agreement to assume liability for either of 870
the following as specified in the agreement: 871

(a) The total, actual amount of debt the exiting operator 872
owes the department and the United States centers for medicare and 873
medicaid services under the medicaid program as determined under 874
section 5111.685 of the Revised Code; 875

(b) The portion of the amount specified in division (E)(1)(a) 876
of this section that represents the franchise permit fee the 877
exiting operator owes. 878

(2) It may not require the operator who executes the 879
successor liability agreement to furnish a surety bond. 880

(3) It must provide that the department, after determining 881
under section 5111.685 of the Revised Code the actual amount of 882
debt the exiting operator owes the department and United States 883
centers for medicare and medicaid services under the medicaid 884
program, may deduct the lesser of the following from medicaid 885
payments made to the operator who executes the successor liability 886
agreement: 887

(a) The total, actual amount of debt the exiting operator 888
owes the department and the United States centers for medicare and 889
medicaid services under the medicaid program as determined under 890
section 5111.685 of the Revised Code; 891

(b) The amount for which the operator who executes the 892
successor liability agreement assumes liability under the 893
agreement. 894

(4) It must provide that the deductions authorized by 895
division (E)(3) of this section are to be made for a number of 896
months, not to exceed six, agreed to by the operator who executes 897
the successor liability agreement and the department or, if the 898
operator who executes the successor liability agreement and 899

department cannot agree on a number of months that is less than 900
six, a greater number of months determined by the attorney general 901
pursuant to a claims collection process authorized by statute of 902
this state. 903

(5) It must provide that, if the attorney general determines 904
the number of months for which the deductions authorized by 905
division (E)(3) of this section are to be made, the operator who 906
executes the successor liability agreement shall pay, in addition 907
to the amount collected pursuant to the attorney general's claims 908
collection process, the part of the amount so collected that, if 909
not for division (G) of this section, would be required by section 910
109.081 of the Revised Code to be paid into the attorney general 911
claims fund. 912

(F) Execution of a successor liability agreement does not 913
waive an exiting operator's right to contest the amount specified 914
in the notice the department provides the exiting operator under 915
division (C) of section 5111.68 of the Revised Code. 916

(G) Notwithstanding section 109.081 of the Revised Code, the 917
entire amount that the attorney general, whether by employees or 918
agents of the attorney general or by special counsel appointed 919
pursuant to section 109.08 of the Revised Code, collects under a 920
successor liability agreement, other than the additional amount 921
the operator who executes the agreement is required by division 922
(E)(5) of this section to pay, shall be paid to the department of 923
job and family services for deposit into the appropriate fund. The 924
additional amount that the operator is required to pay shall be 925
paid into the state treasury to the credit of the attorney general 926
claims fund created under section 109.081 of the Revised Code. 927

Sec. 5111.685. The department of job and family services 928
shall determine the actual amount of debt an exiting operator owes 929
the department and the United States centers for medicare and 930

medicaid services under the medicaid program by completing all 931
final fiscal audits not already completed and performing all other 932
appropriate actions the department determines to be necessary. The 933
department shall issue ~~a~~ an initial debt summary report on this 934
matter not later than ~~ninety~~ sixty days after the date the exiting 935
operator files the properly completed cost report required by 936
section 5111.682 of the Revised Code with the department or, if 937
the department waives the cost report requirement for the exiting 938
operator, ~~ninety~~ sixty days after the date the department waives 939
the cost report requirement. ~~The report shall include the~~ 940
~~department's findings and the amount of debt the department~~ 941
~~determines the exiting operator owes the department and United~~ 942
~~States centers for medicare and medicaid services under the~~ 943
~~medicaid program. Only the parts of the report that are subject to~~ 944
~~an adjudication as specified in section 5111.30 of the Revised~~ 945
~~Code are subject to an adjudication conducted~~ The initial debt 946
summary report becomes the final debt summary report thirty-one 947
days after the department issues the initial debt summary report 948
unless the exiting operator, or an affiliated operator who 949
executes a successor liability agreement under section 5111.681 of 950
the Revised Code, requests a review before that date. 951

The exiting operator, and an affiliated operator who executes 952
a successor liability agreement under section 5111.681 of the 953
Revised Code, may request a review to contest any of the 954
department's findings included in the initial debt summary report. 955
The request for the review must be submitted to the department not 956
later than thirty days after the date the department issues the 957
initial debt summary report. The department shall conduct the 958
review on receipt of a timely request and issue a revised debt 959
summary report. If the department has withheld money from payment 960
due the exiting operator under division (A) of section 5111.681 of 961
the Revised Code, the department shall issue the revised debt 962
summary report not later than ninety days after the date the 963

department receives the timely request for the review unless the 964
department and exiting operator or affiliated operator agree to a 965
later date. The exiting operator or affiliated operator may submit 966
information to the department explaining what the operator 967
contests before and during the review, including documentation of 968
the amount of any debt the department owes the operator. The 969
exiting operator or affiliated operator may submit additional 970
information to the department not later than thirty days after the 971
department issues the revised debt summary report. The revised 972
debt summary report becomes the final debt summary report 973
thirty-one days after the department issues the revised debt 974
summary report unless the exiting operator or affiliated operator 975
timely submits additional information to the department. If the 976
exiting operator or affiliated operator timely submits additional 977
information to the department, the department shall consider the 978
additional information and issue a final debt summary report not 979
later than sixty days after the department issues the revised debt 980
summary report unless the department and exiting operator or 981
affiliated operator agree to a later date. 982

Each debt summary report the department issues under this 983
section shall include the department's findings and the amount of 984
debt the department determines the exiting operator owes the 985
department and United States centers for medicare and medicaid 986
services under the medicaid program. The department shall explain 987
its findings and determination in each debt summary report. 988

The exiting operator, and an affiliated operator who executes 989
a successor liability agreement under section 5111.681 of the 990
Revised Code, may request, in accordance with Chapter 119. of the 991
Revised Code, an adjudication regarding a finding in a final debt 992
summary report that pertains to an audit or alleged overpayment 993
made under the medicaid program to the exiting operator. The 994
adjudication shall be consolidated with any other uncompleted 995

adjudication that concerns a matter addressed in the final debt 996
summary report. 997

Sec. 5111.686. The department of job and family services 998
shall release the actual amount withheld under division (A) of 999
section 5111.681 of the Revised Code, less any amount the exiting 1000
operator owes the department and United States centers for 1001
medicare and medicaid services under the medicaid program, as 1002
follows: 1003

(A) ~~Ninety one days after the date the exiting operator files~~ 1004
~~a properly completed cost report required by section 5111.682 of~~ 1005
~~the Revised Code unless~~ Unless the department issues the initial 1006
debt summary report required by section 5111.685 of the Revised 1007
Code not later than ~~ninety~~ sixty days after the date the exiting 1008
operator files the properly completed cost report required by 1009
section 5111.682 of the Revised Code, sixty-one days after the 1010
date the exiting operator files the properly completed cost 1011
report; 1012

(B) ~~Not later than thirty days after the exiting operator~~ 1013
~~agrees to a final fiscal audit resulting from the report required~~ 1014
~~by section 5111.685 of the Revised Code if~~ If the department 1015
issues the initial debt summary report required by section 1016
5111.685 of the Revised Code not later than ~~ninety~~ sixty days 1017
after the date the exiting operator files a properly completed 1018
cost report required by section 5111.682 of the Revised Code, not 1019
later than the following: 1020

(1) Thirty days after the deadline for requesting an 1021
adjudication under section 5111.685 of the Revised Code regarding 1022
the final debt summary report if the exiting operator, and an 1023
affiliated operator who executes a successor liability agreement 1024
under section 5111.681 of the Revised Code, fail to request the 1025
adjudication on or before the deadline; 1026

(2) Thirty days after the completion of an adjudication of 1027
the final debt summary report if the exiting operator, or an 1028
affiliated operator who executes a successor liability agreement 1029
under section 5111.681 of the Revised Code, requests the 1030
adjudication on or before the deadline for requesting the 1031
adjudication. 1032

~~(C) Ninety one days after the date the department waives the~~ 1033
~~cost report requirement of section 5111.682 of the Revised Code~~ 1034
~~unless~~ Unless the department issues the initial debt summary 1035
report required by section 5111.685 of the Revised Code not later 1036
than ~~ninety~~ sixty days after the date the department waives the 1037
cost report requirement of section 5111.682 of the Revised Code, 1038
sixty-one days after the date the department waives the cost 1039
report requirement; 1040

~~(D) Not later than thirty days after the exiting operator~~ 1041
~~agrees to a final fiscal audit resulting from the report required~~ 1042
~~by section 5111.685 of the Revised Code if~~ If the department 1043
issues the initial debt summary report required by section 1044
5111.685 of the Revised Code not later than ~~ninety~~ sixty days 1045
after the date the department waives the cost report requirement 1046
of section 5111.682 of the Revised Code, not later than the 1047
following: 1048

(1) Thirty days after the deadline for requesting an 1049
adjudication under section 5111.685 of the Revised Code regarding 1050
the final debt summary report if the exiting operator, and an 1051
affiliated operator who executes a successor liability agreement 1052
under section 5111.681 of the Revised Code, fail to request the 1053
adjudication on or before the deadline; 1054

(2) Thirty days after the completion of an adjudication of 1055
the final debt summary report if the exiting operator, or an 1056
affiliated operator who executes a successor liability agreement 1057
under section 5111.681 of the Revised Code, requests the 1058

adjudication on or before the deadline for requesting the 1059
adjudication. 1060

Sec. 5111.688. (A) All amounts withheld under section 1061
5111.681 of the Revised Code from payment due an exiting operator 1062
under the medicaid program shall be deposited into the medicaid 1063
payment withholding fund created by the controlling board pursuant 1064
to section 131.35 of the Revised Code. Money in the fund shall be 1065
used as follows: 1066

(1) To pay an exiting operator when a withholding is released 1067
to the exiting operator under section 5111.686 or 5111.687 of the 1068
Revised Code; 1069

(2) To pay the department of job and family services and 1070
United States centers for medicare and medicaid services the 1071
amount an exiting operator owes the department and United States 1072
centers under the medicaid program. 1073

(B) Amounts paid from the medicaid payment withholding fund 1074
pursuant to division (A)(2) of this section shall be deposited 1075
into the appropriate department fund. 1076

Sec. ~~5111.688~~ 5111.689. The director of job and family 1077
services shall adopt rules under section 5111.02 of the Revised 1078
Code to implement sections 5111.65 to ~~5111.688~~ 5111.689 of the 1079
Revised Code, including rules applicable to an exiting operator 1080
that provides written notification under section 5111.66 of the 1081
Revised Code of a voluntary withdrawal of participation. Rules 1082
adopted under this section shall comply with section 1919(c)(2)(F) 1083
of the "Social Security Act," 79 Stat. 286 (1965), 42 U.S.C. 1084
1396r(c)(2)(F), regarding restrictions on transfers or discharges 1085
of nursing facility residents in the case of a voluntary 1086
withdrawal of participation. The rules may prescribe a medicaid 1087
reimbursement methodology and other procedures that are applicable 1088

after the effective date of a voluntary withdrawal of 1089
participation that differ from the reimbursement methodology and 1090
other procedures that would otherwise apply. 1091

Sec. 5111.874. (A) As used in sections 5111.874 to 5111.8710 1092
of the Revised Code: 1093

"Home and community-based services" has the same meaning as 1094
in section 5123.01 of the Revised Code. 1095

"ICF/MR services" means intermediate care facility for the 1096
mentally retarded services covered by the medicaid program that an 1097
intermediate care facility for the mentally retarded provides to a 1098
resident of the facility who is a medicaid recipient eligible for 1099
medicaid-covered intermediate care facility for the mentally 1100
retarded services. 1101

"Intermediate care facility for the mentally retarded" means 1102
an intermediate care facility for the mentally retarded that is 1103
certified as in compliance with applicable standards for the 1104
medicaid program by the director of health in accordance with 1105
Title XIX of the "Social Security Act," 79 Stat. 286 (1965), 42 1106
U.S.C. 1396, as amended, and licensed as a residential facility 1107
under section 5123.19 of the Revised Code. 1108

"Residential facility" has the same meaning as in section 1109
5123.19 of the Revised Code. 1110

(B) For the purpose of increasing the number of slots 1111
available for home and community-based services and subject to 1112
sections 5111.877 and 5111.878 of the Revised Code, the operator 1113
of an intermediate care facility for the mentally retarded may 1114
convert all of the beds in the facility from providing ICF/MR 1115
services to providing home and community-based services if all of 1116
the following requirements are met: 1117

(1) The operator provides the directors of health, job and 1118

family services, and developmental disabilities at least ninety 1119
days' notice of the operator's intent to relinquish the facility's 1120
certification as an intermediate care facility for the mentally 1121
retarded and to begin providing home and community-based services. 1122

(2) The operator complies with the requirements of sections 1123
5111.65 to ~~5111.688~~ 5111.689 of the Revised Code regarding a 1124
voluntary termination as defined in section 5111.65 of the Revised 1125
Code if those requirements are applicable. 1126

(3) The operator notifies each of the facility's residents 1127
that the facility is to cease providing ICF/MR services and inform 1128
each resident that the resident may do either of the following: 1129

(a) Continue to receive ICF/MR services by transferring to 1130
another facility that is an intermediate care facility for the 1131
mentally retarded willing and able to accept the resident if the 1132
resident continues to qualify for ICF/MR services; 1133

(b) Begin to receive home and community-based services 1134
instead of ICF/MR services from any provider of home and 1135
community-based services that is willing and able to provide the 1136
services to the resident if the resident is eligible for the 1137
services and a slot for the services is available to the resident. 1138

(4) The operator meets the requirements for providing home 1139
and community-based services, including the following: 1140

(a) Such requirements applicable to a residential facility if 1141
the operator maintains the facility's license as a residential 1142
facility; 1143

(b) Such requirements applicable to a facility that is not 1144
licensed as a residential facility if the operator surrenders the 1145
facility's residential facility license under section 5123.19 of 1146
the Revised Code. 1147

(5) The director of developmental disabilities approves the 1148

conversion. 1149

(C) The notice to the director of developmental disabilities 1150
under division (B)(1) of this section shall specify whether the 1151
operator wishes to surrender the facility's license as a 1152
residential facility under section 5123.19 of the Revised Code. 1153

(D) If the director of developmental disabilities approves a 1154
conversion under division (B) of this section, the director of 1155
health shall terminate the certification of the intermediate care 1156
facility for the mentally retarded to be converted. The director 1157
of health shall notify the director of job and family services of 1158
the termination. On receipt of the director of health's notice, 1159
the director of job and family services shall terminate the 1160
operator's medicaid provider agreement that authorizes the 1161
operator to provide ICF/MR services at the facility. The operator 1162
is not entitled to notice or a hearing under Chapter 119. of the 1163
Revised Code before the director of job and family services 1164
terminates the medicaid provider agreement. 1165

Sec. 5111.875. (A) For the purpose of increasing the number 1166
of slots available for home and community-based services and 1167
subject to sections 5111.877 and 5111.878 of the Revised Code, a 1168
person who acquires, through a request for proposals issued by the 1169
director of developmental disabilities, a residential facility 1170
that is an intermediate care facility for the mentally retarded 1171
and for which the license as a residential facility was previously 1172
surrendered or revoked may convert some or all of the facility's 1173
beds from providing ICF/MR services to providing home and 1174
community-based services if all of the following requirements are 1175
met: 1176

(1) The person provides the directors of health, job and 1177
family services, and developmental disabilities at least ninety 1178
days' notice of the person's intent to make the conversion. 1179

(2) The person complies with the requirements of sections 1180
5111.65 to ~~5111.688~~ 5111.689 of the Revised Code regarding a 1181
voluntary termination as defined in section 5111.65 of the Revised 1182
Code if those requirements are applicable. 1183

(3) If the person intends to convert all of the facility's 1184
beds, the person notifies each of the facility's residents that 1185
the facility is to cease providing ICF/MR services and informs 1186
each resident that the resident may do either of the following: 1187

(a) Continue to receive ICF/MR services by transferring to 1188
another facility that is an intermediate care facility for the 1189
mentally retarded willing and able to accept the resident if the 1190
resident continues to qualify for ICF/MR services; 1191

(b) Begin to receive home and community-based services 1192
instead of ICF/MR services from any provider of home and 1193
community-based services that is willing and able to provide the 1194
services to the resident if the resident is eligible for the 1195
services and a slot for the services is available to the resident. 1196

(4) If the person intends to convert some but not all of the 1197
facility's beds, the person notifies each of the facility's 1198
residents that the facility is to convert some of its beds from 1199
providing ICF/MR services to providing home and community-based 1200
services and inform each resident that the resident may do either 1201
of the following: 1202

(a) Continue to receive ICF/MR services from any provider of 1203
ICF/MR services that is willing and able to provide the services 1204
to the resident if the resident continues to qualify for ICF/MR 1205
services; 1206

(b) Begin to receive home and community-based services 1207
instead of ICF/MR services from any provider of home and 1208
community-based services that is willing and able to provide the 1209
services to the resident if the resident is eligible for the 1210

services and a slot for the services is available to the resident. 1211

(5) The person meets the requirements for providing home and 1212
community-based services at a residential facility. 1213

(B) The notice provided to the directors under division 1214
(A)(1) of this section shall specify whether some or all of the 1215
facility's beds are to be converted. If some but not all of the 1216
beds are to be converted, the notice shall specify how many of the 1217
facility's beds are to be converted and how many of the beds are 1218
to continue to provide ICF/MR services. 1219

(C) On receipt of a notice under division (A)(1) of this 1220
section, the director of health shall do the following: 1221

(1) Terminate the certification of the intermediate care 1222
facility for the mentally retarded if the notice specifies that 1223
all of the facility's beds are to be converted; 1224

(2) Reduce the facility's certified capacity by the number of 1225
beds being converted if the notice specifies that some but not all 1226
of the beds are to be converted. 1227

(D) The director of health shall notify the director of job 1228
and family services of the termination or reduction under division 1229
(C) of this section. On receipt of the director of health's 1230
notice, the director of job and family services shall do the 1231
following: 1232

(1) Terminate the person's medicaid provider agreement that 1233
authorizes the person to provide ICF/MR services at the facility 1234
if the facility's certification was terminated; 1235

(2) Amend the person's medicaid provider agreement to reflect 1236
the facility's reduced certified capacity if the facility's 1237
certified capacity is reduced. 1238

The person is not entitled to notice or a hearing under 1239
Chapter 119. of the Revised Code before the director of job and 1240

family services terminates or amends the medicaid provider 1241
agreement. 1242

~~Sec. 5111.894. The state administrative agency may establish 1243
one or more waiting lists for the assisted living program. Only 1244
individuals eligible for the medicaid program may be placed on a 1245
waiting list. (A) The state administrative agency shall establish 1246
a home first component of the assisted living program under which 1247
eligible individuals may be enrolled in the assisted living 1248
program in accordance with this section. An individual is eligible 1249
for the assisted living program's home first component if all of 1250
the following apply: 1251~~

~~(1) The individual is eligible for the assisted living 1252
program. 1253~~

~~(2) The individual is on the unified waiting list established 1254
under section 173.404 of the Revised Code. 1255~~

~~(3) At least one of the following applies: 1256~~

~~(a) The individual has been admitted to a nursing facility. 1257~~

~~(b) A physician has determined and documented in writing that 1258
the individual has a medical condition that, unless the individual 1259
is enrolled in home and community-based services such as the 1260
assisted living program, will require the individual to be 1261
admitted to a nursing facility within thirty days of the 1262
physician's determination. 1263~~

~~(c) The individual has been hospitalized and a physician has 1264
determined and documented in writing that, unless the individual 1265
is enrolled in home and community-based services such as the 1266
assisted living program, the individual is to be transported 1267
directly from the hospital to a nursing facility admitted. 1268~~

~~(d) Both of the following apply: 1269~~

~~(i) The individual is the subject of a report made under 1270~~

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. 1271
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(ii) A county department of job and family services and an area agency on aging have jointly documented in writing that, unless the individual is enrolled in home and community-based services such as the assisted living program, the individual should be admitted to a nursing facility. 1276
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(e) The individual resided in a residential care facility for at least six months immediately before applying for the assisted living program and is at risk of imminent admission to a nursing facility because the costs of residing in the residential care facility have depleted the individual's resources such that the individual is unable to continue to afford the cost of residing in the residential care facility. 1281
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(B) Each month, each area agency on aging shall ~~determine whether any individual who resides~~ identify individuals residing in the area that the area agency on aging serves ~~and is on a waiting list~~ who are eligible for the home first component of the assisted living program ~~has been admitted to a nursing facility.~~ 1288
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~~If~~ When an area agency on aging ~~determines that~~ identifies such an individual ~~has been admitted to a nursing facility~~ and determines that there is a vacancy in a residential care facility 1293
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participating in the assisted living program that is acceptable to the individual, the agency shall notify the long-term care 1296
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consultation program administrator serving the area in which the individual resides ~~about the determination.~~ The administrator 1298
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shall determine whether the assisted living program is appropriate for the individual and whether the individual would rather 1300
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participate in the assisted living program than continue ~~residing~~ 1302

or begin to reside in ~~the~~ a nursing facility. If the administrator 1303
determines that the assisted living program is appropriate for the 1304
individual and the individual would rather participate in the 1305
assisted living program than continue ~~residing~~ or begin to reside 1306
in ~~the~~ a nursing facility, the administrator shall so notify the 1307
state administrative ~~agency~~. 1308

~~On~~ agency. On receipt of the notice from the administrator, 1309
the state administrative agency shall approve the individual's 1310
enrollment in the assisted living program regardless of ~~any~~ the 1311
unified waiting list ~~for the assisted living program~~ established 1312
under section 173.404 of the Revised Code, unless the enrollment 1313
would cause the assisted living program to exceed any limit on the 1314
number of individuals who may participate in the program as set by 1315
the United States secretary of health and human services when the 1316
medicaid waiver authorizing the program is approved. ~~Each~~ 1317

(C) Each quarter, the state administrative agency shall 1318
certify to the director of budget and management the estimated 1319
increase in costs of the assisted living program resulting from 1320
enrollment of individuals in the assisted living program pursuant 1321
to this section. 1322

Section 2. That existing sections 173.401, 173.501, 3702.51, 1323
3702.59, 5111.65, 5111.651, 5111.68, 5111.681, 5111.685, 5111.686, 1324
5111.688, 5111.874, 5111.875, and 5111.894 of the Revised Code are 1325
hereby repealed. 1326

Section 3. That Section 209.20 of Am. Sub. H.B. 1 of the 1327
128th General Assembly be amended to read as follows: 1328

Sec. 209.20. LONG-TERM CARE 1329

Pursuant to an interagency agreement, the Department of Job 1330
and Family Services shall designate the Department of Aging to 1331

perform assessments under section 5111.204 of the Revised Code. 1332

The Department of Aging shall provide long-term care consultations 1333
under section 173.42 of the Revised Code to assist individuals in 1334
planning for their long-term health care needs. The foregoing 1335
appropriation items 490423, Long Term Care Budget - State, and 1336
490623, Long Term Care Budget, may be used to provide the 1337
preadmission screening and resident review (PASRR), which includes 1338
screening, assessments, and determinations made under sections 1339
5111.02, 5111.204, 5119.061, and 5123.021 of the Revised Code. 1340

The foregoing appropriation items 490423, Long Term Care 1341
Budget - State, and 490623, Long Term Care Budget, may be used to 1342
assess and provide long-term care consultations to clients 1343
regardless of Medicaid eligibility. 1344

The Director of Aging shall adopt rules under section 111.15 1345
of the Revised Code governing the nonwaiver funded PASSPORT 1346
program, including client eligibility. The foregoing appropriation 1347
item 490423, Long Term Care Budget - State, may be used by the 1348
Department of Aging to provide nonwaiver funded PASSPORT services 1349
to persons the Department has determined to be eligible to 1350
participate in the nonwaiver funded PASSPORT Program, including 1351
those persons not yet determined to be financially eligible to 1352
participate in the Medicaid waiver component of the PASSPORT 1353
Program by a county department of job and family services. 1354

The Department of Aging shall administer the Medicaid 1355
waiver-funded PASSPORT Home Care Program, the Choices Program, the 1356
Assisted Living Program, and the PACE Program as delegated by the 1357
Department of Job and Family Services in an interagency agreement. 1358
The foregoing appropriation item 490423, Long Term Care Budget - 1359
State, shall be used to provide the required state match for 1360
federal Medicaid funds supporting the Medicaid Waiver-funded 1361
PASSPORT Home Care Program, the Choices Program, the Assisted 1362
Living Program, and the PACE Program. The foregoing appropriation 1363

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

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

HOME FIRST PROGRAM

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

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

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

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

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

appropriated. 1395

(3) ~~If receipts credited to~~ Authorize expenditures from the 1396
Interagency Reimbursement Fund (Fund 3G50) for amounts that exceed 1397
the amounts appropriated from receipts credited to the fund, ~~the~~ 1398
~~Director of Job and Family Services may request the Director of~~ 1399
~~Budget and Management to authorize expenditures from the fund in~~ 1400
~~excess of the amounts appropriated. Upon the approval of the~~ 1401
~~Director of Budget and Management, the~~ Any additional authorized 1402
amounts are hereby appropriated. 1403

(C) Not later than thirty days after the Director of Budget 1404
and Management receives certification of expenditures specified in 1405
division (B) of this section, the Executive Director of Executive 1406
Medicaid Management Administration shall submit a report to the 1407
General Assembly in accordance with section 101.68 of the Revised 1408
Code and to the chairs and ranking minority members of the 1409
committees of the House of Representatives and Senate to which the 1410
biennial budget bill is referred. The report shall describe and 1411
document the criteria and data the Department of Aging, Department 1412
of Job and Family Services, and Office of Budget and Management 1413
use to justify a transfer of funds under division (B) of this 1414
section, including spending and utilization trends for PASSPORT, 1415
PACE, assisted living, and nursing facility services. In addition 1416
to providing the information for the transfer of funds, the report 1417
shall include the following: 1418

(1) In the case of reports for transfers that occur during 1420
fiscal year 2010, the descriptions and documents of the criteria 1421
and data used to justify other such transfers that previously 1422
occurred during that fiscal year; 1423

(2) In the case of reports for transfers that occur during 1424
fiscal year 2011, the descriptions and documents of the criteria 1425

and data used to justify other such transfers that previously 1426
occurred during that fiscal year and fiscal year 2010. 1427

The Directors of Aging, Job and Family Services, and Budget 1428
and Management shall provide the Executive Director of the 1429
Executive Medicaid Management Administration with all information 1430
the Executive Director needs to prepare the reports required by 1431
this division. 1432

(D) The individuals placed in Long Term Care Budget Services 1433
pursuant to this section shall be in addition to the individuals 1434
placed in Long Term Care Budget Services during fiscal years 2010 1435
and 2011 before any transfers to appropriation item 490423, Long 1436
Term Care Budget-State, are made under this section. 1437

ALLOCATION OF PACE SLOTS 1438

In order to effectively administer and manage growth within 1439
the PACE Program, the Director of Aging may, as the director deems 1440
appropriate and to the extent funding is available, expand the 1441
PACE Program to regions of Ohio beyond those currently served by 1442
the PACE Program. In implementing the expansion, the Director may 1443
not decrease the number of residents of Cuyahoga and Hamilton 1444
counties and parts of Butler, Clermont, and Warren counties who 1445
are participating in the PACE Program below the number of 1446
residents of those counties and parts of counties who were 1447
enrolled in the PACE Program on July 1, 2008. 1448

Section 4. That existing Section 209.20 of Am. Sub. H.B. 1 of 1449
the 128th General Assembly is hereby repealed. 1450

Section 5. During fiscal years 2012 and 2013, on receipt of 1451
certified expenditures related to sections 173.401, 173.351, 1452
173.501, and 5111.894 of the Revised Code, the Director of Budget 1453
and Management shall transfer cash from the Nursing Facility 1454
Stabilization Fund (Fund 5R20), used by the Department of Job and 1455

Family Services, to the PASSPORT/Residential State Supplement Fund 1456
(Fund 4J40), used by the Department of Aging. 1457

If receipts credited to the PASSPORT Fund (Fund 3C40) exceed 1458
the amounts appropriated from the fund in fiscal years 2012 and 1459
2013, the Director of Aging shall request the Director of Budget 1460
and Management to authorize expenditures from the fund in excess 1461
of the amounts appropriated. 1462

If receipts credited to the Interagency Reimbursement Fund 1463
(Fund 3G50) exceed the amounts appropriated from the fund in 1464
fiscal years 2012 and 2013, the Director of Job and Family 1465
Services shall request the Director of Budget and Management to 1466
authorize expenditures from the fund in excess of the amounts 1467
appropriated. 1468

Section 6. Until December 31, 2010, the Director of Health 1469
shall accept, for review under section 3702.52 of the Revised 1470
Code, certificate of need applications for an increase in beds in 1471
an existing nursing home if all of the following conditions are 1472
met: 1473

(A) The proposed increase is attributable solely to a 1474
relocation of beds registered under section 3701.07 of the Revised 1475
Code as long-term care beds from an existing hospital located in a 1476
county with a population of at least forty thousand persons and 1477
not more than forty-five thousand persons to an existing nursing 1478
home located in a county that has a population of at least one 1479
million persons and not more than one million one hundred thousand 1480
persons and is contiguous to the county from which the beds are to 1481
be relocated. 1482

(B) Not more than fifteen beds are proposed for relocation. 1483

(C) After the proposed relocation, there will be existing 1484
long-term care beds, as defined in section 3702.51 of the Revised 1485

Code, remaining in the county from which the beds are relocated.	1486
(D) The beds are proposed to be licensed as nursing home beds	1487
under Chapter 3721. of the Revised Code.	1488