Ohio Legislative Service Commission

Bill Analysis

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Sub. S.B. 214

128th General Assembly
(As Reported by S. Finance and Financial Institutions)

Sens. Carey and D. Miller, Grendell, Schaffer, Seitz, R. Miller, Turner, Strahorn, Morano, Cafaro, Gillmor, Sawyer, Kearney

BILL SUMMARY

HOME FIRST

- Permits individuals to qualify for enrollment in the PASSPORT, Assisted Living, and PACE programs through the Home First process without first having to be admitted to a nursing facility.

- Requires the Ohio Department of Aging (ODA) to establish a unified waiting list for the PASSPORT, Assisted Living, PACE, and Choices programs and restricts placement on the waiting list to individuals eligible for any of those programs.

- Eliminates a requirement for ODA to approve an individual's enrollment in the PASSPORT program through the Home First process even though the individual's enrollment causes the program's enrollment to exceed the limit that would otherwise apply and instead provides that an individual is not to be enrolled in the program through the Home First process if enrollment would cause the program to exceed any limit on the number of individuals who may be enrolled in the program as set in the federal waiver authorizing the program.

- Revises the law governing cash transfers and expenditure authorizations regarding Home First for fiscal years 2010 and 2011.

- Requires the Executive Director of the Executive Medicaid Management Administration to prepare reports regarding the fiscal years 2010 and 2011 cash transfers.

- Requires the Director of Budget and Management, during fiscal years 2012 and 2013, to make a cash transfer in support of Home First.

- Requires the ODA Director and Director of Job and Family Services, during fiscal years 2012 and 2013, to request expenditure authorizations in support of Home First.

COLLECTION OF LONG-TERM CARE FACILITIES' MEDICAID DEBTS

- Revises the law governing the collection of a nursing facility or ICF/MR's Medicaid debt when the nursing facility or ICF/MR undergoes a change of operator, closes, or ceases to participate in the Medicaid program.

- Clarifies that the Ohio Department of Job and Family Services (ODJFS) is to initially estimate, rather than determine, the amount of a facility's Medicaid debt.

- Provides that the amount of estimated debt is to include any franchise permit fee a facility owes or may owe under the Medicaid program.

- Establishes a deadline for ODJFS to provide a facility written notice of the facility's estimated Medicaid debt.

- Permits rather than requires ODJFS to withhold a specified amount from payment due the operator of a facility under the Medicaid program, changes the amount to be withheld, and creates new circumstances under which the withholding is not to occur or is to be reduced.

- Revises the procedures ODJFS is to follow when determining a facility's actual Medicaid debt, including reducing the number of days ODJFS has to issue a report specifying the amount of actual debt.

- Revises the deadlines for ODJFS to release the amount of Medicaid payments it withholds from an operator.

CERTIFICATE OF NEED

- Requires the Director of Health to accept, until December 31, 2010, certificate of need applications for an increase of up to 15 beds in an existing nursing home located in a county with a population of 1 million to 1.1 million if the increase is attributable solely to a relocation of long-term care beds from an existing hospital located in a contiguous county with a population of 40,000 to 45,000 and certain other requirements are met.

- Revises circumstances under which the Director of Health is to deny a certificate of need for the addition of long-term care beds to an existing health care facility or for the development of a new health care facility.

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CONTENT AND OPERATION

HOME FIRST

Background

Ohio's Medicaid program includes components under which eligible individuals receive home and community-based services in lieu of nursing facility services. The components are authorized by federal waivers granted by the United States Department of Health and Human Services. One of these components is the PASSPORT program, which serves eligible Medicaid recipients aged 60 or older. Another of the components is the Assisted Living program, which permits eligible Medicaid recipients to reside in a residential care facility (i.e., assisted living facility) rather than continue or begin to reside in a nursing facility. The Ohio Department of Aging (ODA) administers both components pursuant to an interagency agreement with the Ohio Department of Job and Family Services (ODJFS).

Ohio's Medicaid program also includes a component known as the Program of All-inclusive Care for the Elderly (PACE). Persons enrolled in PACE receive medical services covered by PACE through a comprehensive, multidisciplinary health and social services delivery system that integrates acute and long-term services pursuant to federal regulations. To be eligible for PACE, a Medicaid recipient must be (1) at least 55 years old, (2) require the level of care required by the state's Medicaid program for coverage of nursing facility services, (3) reside in an area of the state in which PACE is available, and (4) meet other eligibility requirements. PACE is available in two areas of the state. The first area is comprised of Cuyahoga County. The second area is comprised of Hamilton County and parts of Warren, Butler, and Clermont counties. ODA is responsible for the day-to-day administration of PACE pursuant to an agreement with ODJFS.

Current law establishes a process under which an individual on a waiting list for the PASSPORT, Assisted Living, or PACE program may be enrolled in the program for which the individual qualifies following admission to a nursing facility. This process is popularly, but not statutorily, known as Home First. The bill revises the law governing Home First for the PASSPORT, Assisted Living, and PACE programs, including by expressly using the phrase "Home First" in statute and permitting individuals to qualify for enrollment in the programs through Home First without first having to be admitted to a nursing facility.[1] The bill also requires ODA to establish a unified waiting list for components of the Medicaid program that ODA administers. Only individuals who are on the unified waiting list and meet other requirements are to be enrolled in the PASSPORT, Assisted Living, or PACE program through the Home First process.

Unified waiting list

(R.C. 173.404)

ODA is required by the bill to establish a unified waiting list for the following components of the Medicaid program that ODA administers:

(1) The PASSPORT program;

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[1] The bill introduces the phrase "Home First" in statute by requiring ODA to establish a Home First component for the PASSPORT, Assisted Living, and PACE programs under which eligible individuals may be enrolled in one of the programs in accordance with the statute governing the Home First process. (Technically, the bill requires the "state administrative agency" to establish the Home First component for the Assisted Living program. This is because under continuing law, ODA's authority to administer the Assisted Living program is contingent on the Director of Budget and Management approval of the interagency agreement between ODA and ODJFS regarding the program's administration. Had the Director rejected the interagency agreement, ODJFS would administer the Assisted Living program directly and therefore be the state administrative agency for the program.)

(2) The Assisted Living program;

(3) The PACE program;

(4) The Choices program.[2]

Only individuals eligible for any of those Medicaid components may be placed on the unified waiting list.

PASSPORT

(R.C. 173.401)

The ODJFS Director is required by current law to submit to the United States Secretary of Health and Human Services an amendment to the federal waiver authorizing the PASSPORT program for the purpose of obtaining authorization for additional enrollments in the PASSPORT program pursuant to the Home First process. Beginning with the month following the month in which the waiver amendment is approved and each month thereafter, each area agency on aging is required to determine whether individuals who reside in the area that the agency serves and are on a waiting list for the PASSPORT program have been admitted to a nursing facility. If an area agency on aging determines that such an individual has been admitted to a nursing facility, the agency is required to notify the local administrator of the Long-Term Care Consultation Program serving the area in which the individual resides about the determination. The local administrator must determine whether the PASSPORT program is appropriate for the individual and whether the individual would rather participate in the PASSPORT program than continue residing in the nursing facility. The local administrator is required to notify ODA if the determination is affirmative. ODA, on receipt of the local administrator's notice, must approve the individual's enrollment in the PASSPORT program regardless of the program's waiting list and even though the individual's enrollment causes the program's enrollment to exceed the limit that would otherwise apply.

The bill does not limit Home First to individuals on a waiting list for the PASSPORT program who have been admitted to a nursing facility. Under the bill, an individual qualifies for Home First under the PASSPORT program if the individual is

[2] The Choices program provides consumer-driven home and community-based services to participants of the PASSPORT program. An individual enrolled in the Choices program may choose an agency or non-agency professional caregiver or individual provider such as a friend, neighbor, or relative (other than a spouse, parent, step-parent, or legal guardian) to provide home and community-based services to the individual. (Ohio Department of Aging. *Choices Home Care Waiver*, available at <http://aging.ohio.gov/services/choices/>.)

eligible for the PASSPORT program, is on ODA's unified waiting list, and any of the following apply:

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

(2) A physician determines and documents 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 30 days of the physician's determination;

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

(4) The individual is the subject of a report regarding abuse, neglect, or exploitation of an adult (over age 60) or the individual has made a request to a county department of job and family services for adult protective services and a county department and area agency on aging jointly document in writing that, unless the individual is enrolled in home and community-based services such as the PASSPORT program, the individual should be admitted to a nursing facility.

The bill eliminates the requirement for the ODJFS Director to submit an amendment to the federal PASSPORT waiver to authorize additional enrollments in the PASSPORT program pursuant to the Home First process. The bill also eliminates the requirement for ODA to approve an individual's enrollment in the PASSPORT program through the Home First process even though the individual's enrollment causes the program's enrollment to exceed the limit that would otherwise apply. Instead, ODA is to approve an individual's enrollment through the Home First process unless the enrollment would cause the PASSPORT program to exceed any limit on the number of individuals who may be enrolled in the program as set by the United States Secretary of Health and Human Services in the federal waiver authorizing the PASSPORT program.

Assisted Living

(R.C. 5111.894)

Current law expressly authorizes ODA, as the state agency that administers the Assisted Living program, to establish one or more waiting lists for the program and restricts the waiting list to individuals eligible for the Medicaid program. The bill eliminates ODA's authority to establish waiting lists specific to the Assisted Living program and instead applies ODA's unified waiting list to the Home First process for the Assisted Living program.

As it does with the PASSPORT program, the bill expands eligibility for the Assisted Living program's Home First component so that an individual on a waiting list does not have to be admitted to a nursing facility to be enrolled in the Assisted Living program through the Home First process. The bill establishes the same new pathways under which individuals eligible for the Assisted Living and on ODA's unified waiting list may be enrolled in the Assisted Living program through the Home First component that the bill establishes for the PASSPORT program, but with one additional new pathway. The additional new pathway is available to an individual who has 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.

The Assisted Living program's Home First process is similar to the Home First process for the PASSPORT program. A difference, though, is that the Assisted Living program's Home First process conditions ODA's enrollment of an individual in the Assisted Living program on the enrollment not causing the program's enrollment to exceed any limit on the number of individuals who may participate in the program as set by the United States Secretary of Health and Human Services when the federal waiver authorizing the program was approved.[3] As discussed above, the bill establishes the same type of condition for the PASSPORT program's Home First process.

PACE

(R.C. 173.501)

The bill revises the Home First process for the PACE program in a manner similar to the bill's changes to the PASSPORT and Assisted Living programs' Home First processes. Eligibility for the PACE program's Home First process is no longer limited to individuals on a waiting list for the PACE program who are admitted to a nursing facility. Instead, the bill establishes the same new pathways under which individuals eligible for the PACE program and on ODA's unified waiting list may be

[3] Another difference is that an area agency on aging, as part of the Assisted Living program's Home First process, is required by continuing law to determine whether there is a vacancy in a residential care facility participating in the program that is acceptable to the individual seeking enrollment in the program.

enrolled in the PACE program through the Home First process that the bill establishes for the PASSPORT program.[4]

The PACE program's Home First process is similar to the Home First process for the PASSPORT and Assisted Living programs. There are differences, though. Under the Home First process for the PACE program, ODA, rather than an area agency on aging, is to identify individuals eligible for the program's Home First process. Another difference is that a PACE provider, rather than a long-term care consultation program administrator, is to determine whether the program is appropriate for an individual and whether the individual would rather participate in the program than reside in a nursing facility. Enrollment in the PACE program through the Home First process is to be done in accordance with priorities established in ODA rules.

Cash transfers and spending authorizations

(Sections 3, 4, and 5)

Fiscal years 2010 and 2011

Current law permits the Director of the Office of Budget and Management (OBM) to transfer cash on a quarterly basis during fiscal years 2010 and 2011 from the Nursing Facility Stabilization Fund[5] to the PASSPORT/Residential State Supplement Fund[6] on receipt of certified expenditures related to state law governing Home First for the PASSPORT and Assisted Living programs and for the Residential State Supplement program.[7] The bill provides for the OBM Director to consult with the ODA Director and ODJFS Director regarding the cash transfers and removes the provision providing for the transfers to be done on a quarterly basis. Also, the bill authorizes such cash transfers on receipt of certified expenditures related to state law governing Home First for the PACE program.

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[4] The additional pathway that the bill establishes for the Assisted Living program is not also established for the PACE program.

[5] Continuing law requires that money in the Nursing Facility Stabilization Fund be used to make Medicaid payments to nursing facilities (R.C. 3721.561, not in the bill).

[6] The PASSPORT/Residential State Supplement Fund is known in the Revised Code as the Home and Community-Based Services for the Aged Fund. Continuing law requires that money in the fund be used to fund the Medicaid program, including the PASSPORT program, and the Residential State Supplement program. (R.C. 3721.56, not in the bill.)

[7] There is a Home First process for the Residential State Supplement program that is similar to the Home First process for the PASSPORT and Assisted Living programs (R.C. 173.351, not in the bill). The bill does not change the law governing the Home First process for the Residential State Supplement program.

The ODA Director is permitted by current law to request that the OBM Director authorize expenditures from the PASSPORT Fund[8] in excess of the amount appropriated if receipts credited to the fund exceed the amounts appropriated from the fund. The ODJFS Director is permitted by current law to request that the OBM Director authorize expenditures from the Interagency Reimbursement Fund[9] in excess of the amounts appropriated if receipts credited to the fund exceed the amounts appropriated from it. The OBM Director is permitted to make the expenditure authorizations on a quarterly basis in fiscal years 2010 and 2011 on receipt of certified expenditures related to state law governing Home First for the PASSPORT, Assisted Living, and Residential State Supplement programs. The bill permits the OBM Director to authorize the expenditures without needing to first receive a request from the ODA Director or ODJFS Director. The OBM Director, though, is to consult with the ODA Director and ODJFS Director with regard to the authorizations. The bill provides that the authorizations may also be made on receipt of certified expenditures related to state law governing Home First for the PACE program. The authorizations do not have to be done on a quarterly basis.

The Executive Director of the Executive Medicaid Management Administration (EMMA) is required by the bill to prepare reports regarding the cash transfers in fiscal years 2010 and 2011 discussed above. A report is to be made not later than 30 days after the OBM Director receives certification of expenditures related to the Home First process for the PASSPORT, Assisted Living, PACE, and Residential State Supplement programs. The following information is to be included in a report:

(1) A description and documentation of the criteria and data that ODA, ODJFS, and OBM use to justify a cash transfer, including spending and utilization trends for the PASSPORT, Assisted Living, and PACE programs and nursing facility services;

(2) The descriptions and documents of the criteria and data used to justify such transfers that previously occurred during fiscal years 2010 and 2011.

The bill requires the ODA Director, ODJFS Director, and OBM Director to provide the EMMA Executive Director with all information needed to prepare the reports. Each report is to be submitted to the General Assembly, specifically including

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[8] Part of the money raised from pari-mutuel wagering is required to be deposited into the PASSPORT Fund and money in the fund is to be used for the PASSPORT program (R.C. 3769.08 and 3769.26, not in the bill).

[9] The Interagency Reimbursement Fund, originally established by Am. Sub. H.B. 111 of the 118th General Assembly, is used to hold federal funds, including federal Medicaid funds, that ODJFS is to use to pay other agencies that incur costs eligible for the federal reimbursement.

the chairs and ranking minority members of the committees of the House of Representatives and Senate to which the biennial budget bill is referred.[10]

Fiscal years 2012 and 2013

The bill requires the OBM Director, during fiscal years 2012 and 2013 and on receipt of certified expenditures related to Home First for the PASSPORT, Assisted Living, PACE, and Residential State Supplement programs, to transfer cash from the Nursing Facility Stabilization Fund to the PASSPORT/Residential State Supplement Fund. The ODA Director is required, if receipts credited to the PASSPORT Fund exceed the amounts appropriated from the fund in fiscal years 2012 and 2013, to request that the OBM Director authorize expenditures from the fund in excess of the amounts appropriated. The ODJFS Director is required, if receipts credited to the Interagency Reimbursement Fund exceed the amounts appropriated from the fund in fiscal years 2012 and 2013, to request that the OBM Director authorize expenditures from the fund in excess of the amounts appropriated.

COLLECTION OF LONG-TERM CARE FACILITIES' MEDICAID DEBTS

Background

Current law establishes requirements for a nursing facility or intermediate care facility for the mentally retarded (ICF/MR) that undergoes a change of operator,[11] facility closure,[12] voluntary termination,[13] or voluntary withdrawal of participation.[14] The requirements concern the state collecting debts a nursing facility or ICF/MR owes under the Medicaid program.

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[10] In submitting the report to the General Assembly, the EMMA Executive Director is to provide it to the Senate President, Senate Minority Leader, Speaker of the House of Representatives, House Minority Leader, and the Director of the Legislative Service Commission (R.C. 101.68(B)).

[11] A change of operator occurs when an entering (i.e., new) operator becomes the operator of a nursing facility or ICF/MR in the place of an exiting (i.e., former) operator (R.C. 5111.65(A)).

[12] A facility closure occurs when a building, or part of a building, that houses a nursing facility or ICF/MR ceases to be used as a nursing facility or ICF/MR and all of the facility's residents are relocated (R.C. 5111.65(H)).

[13] A voluntary termination occurs when an operator voluntarily elects to terminate the participation of an ICF/MR in the Medicaid program but the facility continues to provide service of the type provided by a residential facility for persons with mental retardation or a developmental disability (R.C. 5111.65(J)).

[14] A voluntary withdrawal of participation occurs when an operator voluntarily elects to terminate a nursing facility's participation in the Medicaid program but the nursing facility continues to provide service of the type provided by a nursing facility (R.C. 5111.65(K)).

Estimate of Medicaid debt

(R.C. 5111.68 (primary) and 5111.65)

Current law requires an operator to notify the Ohio Department of Job and Family Services (ODJFS) of an impending change of operator, facility closure, voluntary termination, or voluntary withdrawal of participation.[15] On receipt of the notice, ODJFS must determine the amount of any overpayments made under the Medicaid program to the operator, including overpayments the operator disputes, and other actual and potential debts the operator owes or may owe under the Medicaid program.[16] The bill clarifies that ODJFS is to estimate, rather than determine, this amount and provides that the amount of the estimated debt includes any franchise permit fee[17] the operator owes or may owe under the Medicaid program. ODJFS is required by the bill to use a debt estimation methodology in estimating the operator's actual and potential Medicaid debts. The debt estimation methodology is to be established in rules. The bill eliminates a requirement that ODJFS, if it is unable to determine the amount of Medicaid debts for any period of time before the effective date of the new provider's Medicaid provider agreement in the case of a change of operator or the effective date of a facility closure, voluntary termination, or voluntary withdrawal of participation, make a reasonable estimate of the Medicaid debts for the period using information available to ODJFS, including prior determinations of Medicaid debts.

ODJFS is required by the bill to provide the operator written notice of ODJFS's estimate of the operator's Medicaid debt not later than 30 days after ODJFS receives the notice of the change of operator, facility closure, voluntary termination, or voluntary withdrawal of participation. The notice must include the basis for the estimate.

Withholding

(R.C. 5111.681 (primary) and 5111.65)

Current law requires, with a certain exception, that ODJFS withhold a specified amount from payment due the operator under the Medicaid program. The bill permits rather than requires ODJFS to make the withholding, changes the amount to be withheld, eliminates the existing exception to the withholding requirement, and creates new circumstances under which the withholding is not to occur or is to be reduced.

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[15] R.C. 5111.66 and 5111.67 (not in the bill).

[16] R.C. 5111.68.

[17] The franchise permit fee is a per-bed fee that is assessed on each long-term care bed in a nursing facility, ICF/MR, or hospital. Funds generated from the fee mostly contribute to the operation of the Medicaid program, including Medicaid-funded home and community-based services.

Under current law, ODJFS must withhold the greater of (1) the total amount of any overpayments made under the Medicaid program to the operator, including overpayments the operator disputes, and other actual and potential debts, including unpaid penalties, the operator owes or may owe under the Medicaid program and (2) an amount equal to the average amount of monthly payments to the operator under the Medicaid program for the 12-month period immediately preceding the month that includes the last day the operator's Medicaid provider agreement is in effect or, in the case of a voluntary withdrawal of participation, the effective date of the voluntary withdrawal of participation. The bill provides instead for the withholding to equal the total amount of the operator's Medicaid debt as specified in the notice the bill requires ODJFS to provide the operator.

Current law permits ODJFS to choose not to make the withholding in the case of a change of operator if the new operator (1) enters into a nontransferable, unconditional, written agreement with ODJFS to pay ODJFS the former operator's Medicaid debt and (2) provides ODJFS a copy of the new operator's balance sheet that assists ODJFS in determining whether to make the withholding. The bill eliminates this provision and establishes circumstances applicable to a change of operator under which the withholding is not to occur or is to be reduced and circumstances applicable to a facility closure, voluntary termination, or voluntary withdrawal of participation under which the withholding is not to occur or is to be reduced.

Some of the circumstances under which a withholding is not to occur or is to be reduced involve an affiliated operator. "Affiliated operator" is defined by the bill as a nursing facility or ICF/MR operator affiliated with either the former operator for whom the affiliated operator is to assume liability for all or part of the former operator's Medicaid debt or the new operator involved in a change of operator with the former operator.

In the case of a change of operator, ODJFS is not to make the withholding if the former operator, the new operator, or an affiliated operator executes a successor liability agreement meeting requirements the bill establishes and the liability agreement provides for the former, new, or affiliated operator to assume liability for the total, actual amount of the former operator's Medicaid debt as determined by ODJFS. ODJFS is to reduce the amount of the withholding if the former, new, or affiliated operator executes such a successor liability agreement to assume liability for the portion of the former operator's Medicaid debt that represents the franchise permit fee the former operator owes. The amount of the reduction is to at least equal the former operator's franchise permit fee debt.

In the case of a facility closure, voluntary termination, or voluntary withdrawal of participation, ODJFS is not to make the withholding if the former operator or an

affiliated operator executes a successor liability agreement meeting requirements the bill establishes and the successor liability agreement provides for the former operator or affiliated operator to assume liability for the total, actual amount of the former operator's Medicaid debt. ODJFS is to reduce the amount of the withholding if the former operator or affiliated operator executes such a successor liability agreement to assume liability for the portion of the former operator's Medicaid debt that represents the franchise permit fee the former operator owes. The amount of the reduction is to at least equal the former operator's franchise permit fee debt.

The bill establishes two conditions that must be met for a former operator or affiliated operator to be able to execute a successor liability agreement. First, the former operator or affiliated operator must have one or more valid Medicaid provider agreements, other than the Medicaid provider agreement for the nursing facility or ICF/MR that is the subject of the change of operator, facility closure, voluntary termination, or voluntary withdrawal of participation. Second, during the 12-month period preceding the month in which ODJFS receives notice of the change of operator, facility closure, voluntary termination, or voluntary withdrawal of participation, the average monthly Medicaid payment made to the former operator or affiliated operator pursuant to the former operator's or affiliated operator's one or more Medicaid provider agreements (other than the Medicaid provider agreement for the nursing facility or ICF/MR that is the subject of the change of operator, facility closure, voluntary termination, or voluntary withdrawal of participation) must equal at least 90% of the sum of the following:

(1) The average monthly Medicaid payment made to the former operator pursuant to the former operator's Medicaid provider agreement for the nursing facility or ICF/MR that is the subject of the change of operator, facility closure, voluntary termination, or voluntary withdrawal of participation;

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

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

The bill establishes a number of requirements that a successor liability agreement must meet. Specifically, the requirements a successor liability agreement must meet are as follows:

(1) It must provide for the operator who executes the successor liability agreement to assume liability for either the total, actual amount of the former operator's Medicaid debt or the portion of that amount that represents the franchise permit fee the former operator owes.

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

(3) It must provide that ODJFS, after determining the actual amount of the former operator's Medicaid debt, may deduct, from Medicaid payments made to the operator who executes the successor liability agreement, the lesser of the total, actual amount of the former operator's Medicaid debt or the amount for which the operator who executes the successor liability agreement assumes liability under the agreement.

(4) It must provide that the deductions from Medicaid payments made to the operator who executes the successor liability agreement are to be made for a number of months, not to exceed six, agreed to by that operator and ODJFS or, if that operator and ODJFS cannot agree on a number of months that is less than six, a greater number of months determined by the Attorney General pursuant to a claims collection process authorized by state law.

(5) It must provide that, if the Attorney General determines the number of months for which the deductions are to be made, the operator who executes the successor liability agreement must pay, in addition to the amount collected pursuant to the Attorney General's claims collection process, the part of the amount so collected that, if not for the bill, would be required to be paid into the Attorney General Claims Fund.

The fifth requirement for successor liability agreements concerns a provision of current law that requires that up to 11% of all amounts collected by the Attorney General on claims due the state be deposited into the Attorney General Claims Fund. The bill requires that the entire amount that the Attorney General collects under a successor liability agreement, excluding the additional amount collected pursuant to the fifth requirement for successor liability agreements, be paid to ODJFS for deposit into the appropriate fund (rather than have up to 11% of that amount be deposited into the Attorney General Claims Fund). The additional amount collected pursuant to the fifth requirement for successor liability agreements is to be deposited into the Attorney General Claims Fund.

The bill provides that execution of a successor liability agreement does not waive a former operator's right to contest the ODJFS estimate of the operator's Medicaid debt.

Determination of actual Medicaid debt

(R.C. 5111.685)

Current law requires ODJFS to determine the actual amount of an operator's Medicaid debt by completing all final fiscal audits not already completed and performing all other appropriate actions ODJFS determines to be necessary. ODJFS must issue a debt summary report not later than 90 days after the operator files a properly completed cost report with ODJFS or, if ODJFS waives the requirement for the operator to file a cost report, 90 days after the date ODJFS waives the cost report requirement. The bill provides for this report to be issued as an initial debt summary report and reduces the number of days ODJFS has to issue it to 60 days following the date the operator files a properly completed cost report or ODJFS waives the cost report requirement.

Under the bill, an initial debt summary report becomes the final debt summary report 31 days after ODJFS issues the initial debt summary report unless the operator, or an affiliated operator who executes a successor liability agreement, requests a review before that date. A review may be requested to contest any of ODJFS's findings included in the initial debt summary report. The request for a review must be submitted to ODJFS not later than 30 days after ODJFS issues the initial debt summary report. ODJFS is required to conduct the review on receipt of a timely request and issue a revised debt summary report. If ODJFS has withheld money from payment due the operator, ODJFS is required to issue the revised debt summary report not later than 90 days after the date ODJFS receives the request for the review unless ODJFS and the operator or affiliated operator agree to a later date. The operator and affiliated operator are permitted to submit information to ODJFS explaining what the operator or affiliated operator contests before and during the review. This may include documentation of the amount of any debt ODJFS owes the operator or affiliated operator. The operator and affiliated operator are also permitted to submit additional information to ODJFS not later than 30 days after ODJFS issues the revised debt summary report. The revised debt summary report becomes the final debt summary report 31 days after ODJFS issues the revised debt summary report unless the operator or affiliated operator timely submits additional information to ODJFS. If additional information is timely submitted, ODJFS is required to consider the additional information and issue a final debt summary report not later than 60 days after ODJFS issues the revised debt summary report unless ODJFS and the operator or affiliated operator agree to a later date.

Current law requires the report that the bill names the initial debt summary report to include ODJFS's findings and the amount of the operator's Medicaid debt. The bill retains this requirement for each initial debt summary report and requires that each

revised and final debt summary report include the information. The bill also requires that ODJFS explain its findings and determination in each debt summary report.

Current law provides that only the parts of a debt summary report that are subject to an adjudication under another provision of state Medicaid law are subject to an adjudication under the Administrative Procedure Act (R.C. Chapter 119.).[18] The bill provides instead that the operator, and an affiliated operator who executes a successor liability agreement, may request an adjudication regarding a finding in a final debt summary report that pertains to an audit or alleged overpayment made under the Medicaid program to the operator. The request is to be made in accordance with the Administrative Procedure Act. The adjudication must be consolidated with any other uncompleted adjudication that concerns a matter addressed in the final debt summary report.

Release of withholding

(R.C. 5111.686)

Current law requires ODJFS to release the amounts ODJFS withholds from an operator, less any amount the operator owes under the Medicaid program, according to the following deadlines:

(1) If ODJFS fails to issue a debt summary report within the required time, 91 days after the date the operator files a properly completed cost report or the date ODJFS waives the cost report requirement;

(2) If ODJFS issues the debt summary report within the required time, not later than 30 days after the operator agrees to a final fiscal audit resulting from the debt summary report.

The bill revises the deadlines for ODJFS to release the amount of the withholding that is to be released. The following are the bill's deadlines:

(1) If ODJFS fails to issue the initial debt summary report within the required time, 61 days after the date the operator files the properly completed cost report or ODJFS waives the cost report requirement;

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[18] Current law may contain an incorrect citation regarding which parts of a debt summary report are subject to an adjudication. Presumably what is meant are the parts of a debt summary report that pertain to (1) an audit disallowance that ODJFS makes as the result of an audit of a Medicaid cost report, (2) an adverse finding that results from an exception review of resident assessment information conducted after the effective date of a nursing facility or ICF/MR's Medicaid rate that is based on the assessment information, (3) a Medicaid payment deemed an overpayment, or (4) an ODJFS-imposed penalty.

(2) If ODJFS issues the initial debt summary report within the required time, not later than the following:

(a) Thirty days after the deadline for requesting an adjudication regarding the final debt summary report if the operator and an affiliated operator who executes a successor liability agreement fail to request the adjudication on or before the deadline;

(b) Thirty days after the completion of an adjudication of the final debt summary report if the operator or an affiliated operator who executes a successor liability agreement requests the adjudication on or before the deadline.

Medicaid Payment Withholding Fund

(R.C. 5111.688 (primary), 5111.651, 5111.689, 5111.874, and 5111.875)

The bill requires that all amounts withheld from an operator be deposited into the existing Medicaid Payment Withholding Fund. Money in the fund is to be used to pay an operator when a withholding is released and to pay ODJFS and the federal government the amount an operator owes under the Medicaid program. Amounts paid to ODJFS or the federal government from the fund are to be deposited into the appropriate ODJFS fund.

CERTIFICATE OF NEED

Background

Continuing law prohibits anyone from carrying out a "reviewable activity" for which a certificate of need (CON) is required until the Director of Health has granted the CON.[19] In general, reviewable activities include constructing, replacing, and renovating long-term care facilities. Long-term care facilities are nursing homes, skilled nursing facilities, nursing facilities, and the portions of hospitals that contain beds registered with the Department of Health as skilled nursing beds or long-term care beds.[20]

Certificate of need to relocate beds between contiguous counties

(Section 6)

The bill requires the Director of Health to accept for review, until December 31, 2010, CON applications for an increase of up to 15 beds in an existing nursing home

[19] R.C. 3702.53.

[20] R.C. 3702.51.

located in a county that has a population of at least 1 million and not more than 1.1 million persons. The beds being added to the nursing facility must be long-term care beds being moved from an existing hospital located in a county that has a population of at least 40,000 but not more than 45,000 persons and is contiguous to the county in which the nursing facility is located. The beds being relocated must be proposed for nursing home licensure and the county from which the beds are relocated must continue to have existing nursing home, county home, or hospital long-term care beds after the relocation.

Reasons for denying a certificate of need

(R.C. 3721.59 (primary) and 3702.51)

Current law specifies circumstances under which the Director of Health is to deny a CON for the addition of long-term care beds to an existing health care facility or for the development of a new health care facility. For example, the Director is to deny a CON if 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 CON application does not propose to correct all of the deficiencies and violations. The bill does not change this provision, but it revises the other circumstances for denying such a CON that are specified in current law.

Some of the revisions concern a principal participant, which the bill defines as (1) a person who has an ownership or controlling interest of at least 5% in the entity that applies for the CON, in a health care facility that is the subject of a CON application, or of the owner or operator of the applicant or such a facility and (2) an officer, director, trustee, or general partner of an applicant, of a health care facility that is the subject of a CON application, or of the owner or operator of the applicant or such a facility. Other revisions concern deficiencies that constitute actual harm but not immediate jeopardy and deficiencies that constitute immediate jeopardy. The bill defines "actual harm but not immediate jeopardy deficiency" as a deficiency that, under federal regulations, either constitutes a pattern of deficiencies resulting in actual harm that is not immediate jeopardy or represents widespread deficiencies resulting in actual harm that is not immediate jeopardy. "Immediate jeopardy deficiency" is defined as a deficiency that, under federal regulations, either constitutes a pattern of deficiencies resulting in immediate jeopardy to resident health or safety or represents widespread deficiencies resulting in immediate jeopardy to resident health or safety.

Under current law, the Director is to deny a CON if, during the 60-month period preceding the filing of the application, a notice of proposed license revocation was issued 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. With regard to a corporation or other business that operates or seeks to operate the health care facility in which the beds are being placed, the bill provides instead that a CON is to be denied if, during the 60-month period, a notice of proposed license revocation was issued for a nursing home owned or operated by a principal participant.

The Director is required by continuing law[21] to deny a CON if, 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, any of the following occurred:

(1) The facility was cited on three or more separate occasions for final, nonappealable actual harm but not immediate jeopardy deficiencies.

(2) The facility was cited on two or more separate occasions for final, nonappealable immediate jeopardy deficiencies.

The bill requires the Director to also deny a CON if, during that period, the facility was cited on two separate occasions for final, nonappealable actual harm but not immediate jeopardy deficiencies and on one occasion for a final, nonappealable immediate jeopardy deficiency.

Current law requires the Director to deny a CON if more than two nursing homes operated in Ohio by the applicant or the person who operates the facility in which the beds are being placed or, if the applicant or person operates more than 20 nursing homes in Ohio, more than 10% of those nursing homes, were each cited during the period that precedes the filing of the CON application and is encompassed by the three most recent standard surveys of the nursing homes that were so cited in either of the following manners:

(1) On three or more separate occasions for final, nonappealable actual harm but not immediate jeopardy deficiencies;

(2) On two or more separate occasions for final, nonappealable immediate jeopardy deficiencies.

Under the bill, the CON is to be denied under these circumstances also if the applicant or a principal participant, rather than the person who operates the facility in which the beds are being placed, owns or operates, rather than just operates, the

[21] The bill makes nonsubstantive, stylistic changes to these provisions.

nursing homes so cited and if the nursing homes were cited on two separate occasions for final, nonappealable actual harm but not immediate jeopardy deficiencies and on one occasion for a final, nonappealable immediate jeopardy deficiency.

Current law prohibits the Director, when applying the reasons discussed above for which a CON must be denied, from considering deficiencies cited before the current operator began to operate the health care facility at which the deficiencies were cited. The Director is permitted to disregard deficiencies cited after the health care facility was acquired by the current operator if the deficiencies were attributable to circumstances that arose under the previous operator and the current operator has implemented measures to alleviate the circumstances. In the case of a CON application proposing the development of a new health care facility by relocation of beds, the Director is prohibited from considering deficiencies that were solely attributable to the physical plant of the existing health care facility from which the beds are being relocated. The bill modifies these provisions to include references to violations along with deficiencies to reflect the fact that certain of the circumstances for denying the CON concern violations. The bill also replaces references to current operators with references to applicants and principal participants to reflect the fact that, under the bill, certain of the circumstances for denying a CON concern applicants and principal participants. The bill further modifies this provision by prohibiting the Director from considering deficiencies or violations cited before the 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 bill eliminates a requirement that a CON be denied if, during the 60-month period preceding the filing of the application, the applicant has violated the law governing CON on two or more separate occasions.

HISTORY

ACTION	DATE
Introduced	11-24-09
Reported, S. Finance & Financial Institutions	02-10-10

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