Appendix 3

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licensee of a center or type A home, the conviction shall constitute grounds for denial~~,~~ or revocation~~, or refusal to renew~~ of an application for licensure pursuant to section 5104.04 of the Revised Code. If the offender is a person eighteen years of age or older residing in a center or type A home or is an employee of a center or a type A home and if the licensee had knowledge of, and acquiesced in, the commission of the offense, the conviction shall constitute grounds for denial~~,~~ or revocation~~, or refusal to renew~~ of an application for licensure pursuant to section 5104.04 of the Revised Code.

(C) Whoever violates division (C) of section 5104.09 of the Revised Code is guilty of a misdemeanor of the third degree.

Sec. 5111.011. (A) The director of job and family services shall adopt rules establishing eligibility requirements for the medicaid program. The rules shall be adopted pursuant to section 111.15 of the Revised Code and shall be consistent with federal and state law. The rules shall include rules that do all of the following:

(1) Establish standards consistent with federal law for allocating income and resources as income and resources of the spouse, children, parents, or stepparents of a recipient of or applicant for medicaid;

(2) Define the term "resources" as used in division (A)(1) of this section;

(3) Specify the number of months that is to be used for the purpose of the term "look-back date" used in section 5111.0116 of the Revised Code;

(4) Establish processes to be used to determine both of the following:

(a) The date an institutionalized individual's ineligibility for services under section 5111.0116 of the Revised Code is to begin;

(b) The number of months an institutionalized individual's ineligibility for such services is to continue.

(5) ~~Establish exceptions to~~ For the purpose of division (C) of section 5111.0116 of the Revised Code, establish procedures for granting waivers of all or a portion of the period of ineligibility that an institutionalized individual would otherwise be subject to under that section ~~5111.0116 of the Revised Code~~ and additional reasons for which such waivers may be granted;

(6) Define the term "other medicaid-funded long-term care services" as used in sections 5111.0117 and 5111.0118 of the Revised Code;

(7) For the purpose of division (C)(2)(c) of section 5111.0117 of the Revised Code, establish the process to determine whether the child of an aged, blind, or disabled individual is financially dependent on the individual for housing.

(B) Notwithstanding any provision of state law, including statutes,

administrative rules, common law, and court rules, regarding real or personal property or domestic relations, the standards established under rules adopted under division (A)(1) of this section shall be used to determine eligibility for medicaid.

Sec. 5111.012. ~~The~~ (A) Except as provided in division (B) of this section, the county department of job and family services of each county shall establish the eligibility for medical assistance of persons living in the county, and shall notify the department of job and family services in the manner prescribed by the department. The county shall be reimbursed for administrative expenditures in accordance with sections 5101.16, 5101.161, and 5701.01 of the Revised Code. Expenditures for medical assistance shall be made from funds appropriated to the department of job and family services for public assistance subsidies. The program shall conform to the requirements of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended.

(B) If the department of job and family services elects to enter into agreements with county departments of job and family services pursuant to division (B) of section 5101.47 of the Revised Code, a county department of job and family services shall establish eligibility for medical assistance only if authorized to do so under such an agreement.

Sec. 5111.013. (A) The provision of medical assistance to pregnant women and young children who are eligible for medical assistance under division (A)(3) of section 5111.01 of the Revised Code, but who are not otherwise eligible for medical assistance under that section, shall be known as the healthy start program.

(B) The department of job and family services shall do all of the following with regard to the application procedures for the healthy start program:

(1) Establish a short application form for the program that requires the applicant to provide no more information than is necessary for making determinations of eligibility for the healthy start program, except that the form may require applicants to provide their social security numbers. The form shall include a statement, which must be signed by the applicant, indicating that she does not choose at the time of making application for the program to apply for assistance provided under any other program administered by the department and that she understands that she is permitted at any other time to apply at the county department of job and family services of the county in which she resides for any other assistance administered by the department.

(2) To the extent permitted by federal law, do one or both of the

following:

(a) Distribute the application form for the program to each public or private entity that serves as a women, infants, and children clinic or as a child and family health clinic and to each administrative body for such clinics and train employees of each such agency or entity to provide applicants assistance in completing the form;

(b) In cooperation with the department of health, develop arrangements under which employees of county departments of job and family services are stationed at public or private agencies or entities selected by the department of job and family services that serve as women, infants, and children clinics; child and family health clinics; or administrative bodies for such clinics for the purpose both of assisting applicants for the program in completing the application form and of making determinations at that location of eligibility for the program.

(3) Establish performance standards by which a county department of job and family services' level of enrollment of persons potentially eligible for the program can be measured, and establish acceptable levels of enrollment for each county department.

(4) Direct any county department of job and family services whose rate of enrollment of potentially eligible enrollees in the program is below acceptable levels established under division (B)(3) of this section to implement corrective action. Corrective action may include but is not limited to any one or more of the following to the extent permitted by federal law:

(a) Establishing formal referral and outreach methods with local health departments and local entities receiving funding through the bureau of maternal and child health;

(b) Designating a specialized intake unit within the county department for healthy start applicants;

(c) Establishing abbreviated timeliness requirements to shorten the time between receipt of an application and the scheduling of an initial application interview;

(d) Establishing a system for telephone scheduling of intake interviews for applicants;

(e) Establishing procedures to minimize the time an applicant must spend in completing the application and eligibility determination process, including permitting applicants to complete the process at times other than the regular business hours of the county department and at locations other than the offices of the county department.

(C) To the extent permitted by federal law, local funds, whether from

public or private sources, expended by a county department for administration of the healthy start program shall be considered to have been expended by the state for the purpose of determining the extent to which the state has complied with any federal requirement that the state provide funds to match federal funds for medical assistance, except that this division shall not affect the amount of funds the county is entitled to receive under section 5101.16, 5101.161, or 5111.012 of the Revised Code.

(D) ~~The director of job and family services shall do one or both of the following:~~

~~(1) To the extent that federal funds are provided for such assistance, adopt a plan for granting presumptive eligibility for pregnant women applying for healthy start;~~

~~(2) To the extent permitted by federal medicaid regulations, adopt a plan for making same-day determinations of eligibility for pregnant women applying for healthy start.~~

~~(E)~~ A county department of job and family services that maintains offices at more than one location shall accept applications for the healthy start program at all of those locations.

~~(F)~~(E) The director of job and family services shall adopt rules in accordance with section 111.15 of the Revised Code as necessary to implement this section.

Sec. 5111.0112. (A) The director of job and family services shall institute a cost-sharing program under the medicaid program. In instituting the cost-sharing program, the director shall comply with federal law. ~~In the case of an individual participating in the children's buy-in program established under sections 5101.5211 to 5101.5216 of the Revised Code, the cost-sharing program shall be consistent with sections 5101.5213 and 5101.5214 of the Revised Code if the children's buy-in program is a component of the medicaid program.~~ The cost-sharing program shall establish a copayment requirement for at least dental services, vision services, nonemergency emergency department services, and prescription drugs, other than generic drugs. The cost-sharing program shall establish requirements regarding premiums, enrollment fees, deductions, and similar charges. The director shall adopt rules under section 5111.02 of the Revised Code governing the cost-sharing program.

(B) The cost-sharing program shall, to the extent permitted by federal law, provide for all of the following with regard to any providers participating in the medicaid program:

(1) No provider shall refuse to provide a service to a medicaid recipient who is unable to pay a required copayment for the service.

(2) Division (B)(1) of this section shall not be considered to do either of the following with regard to a medicaid recipient who is unable to pay a required copayment:

(a) Relieve the medicaid recipient from the obligation to pay a copayment;

(b) Prohibit the provider from attempting to collect an unpaid copayment.

(3) Except as provided in division (C) of this section, no provider shall waive a medicaid recipient's obligation to pay the provider a copayment.

(4) No provider or drug manufacturer, including the manufacturer's representative, employee, independent contractor, or agent, shall pay any copayment on behalf of a medicaid recipient.

(5) If it is the routine business practice of the provider to refuse service to any individual who owes an outstanding debt to the provider, the provider may consider an unpaid copayment imposed by the cost-sharing program as an outstanding debt and may refuse service to a medicaid recipient who owes the provider an outstanding debt. If the provider intends to refuse service to a medicaid recipient who owes the provider an outstanding debt, the provider shall notify the individual of the provider's intent to refuse services.

(C) In the case of a provider that is a hospital, the cost-sharing program shall permit the hospital to take action to collect a copayment by providing, at the time services are rendered to a medicaid recipient, notice that a copayment may be owed. If the hospital provides the notice and chooses not to take any further action to pursue collection of the copayment, the prohibition against waiving copayments specified in division (B)(3) of this section does not apply.

(D) The department of job and family services may work with a state agency that is administering, pursuant to a contract entered into under section 5111.91 of the Revised Code, one or more components of the medicaid program or one or more aspects of a component as necessary for the state agency to apply the cost-sharing program to the components or aspects of the medicaid program that the state agency administers.

Sec. 5111.0116. (A) As used in this section:

(1) "Assets" include all of an individual's income and resources and those of the individual's spouse, including any income or resources the individual or spouse is entitled to but does not receive because of action by any of the following:

(a) The individual or spouse;

(b) A person or government entity, including a court or administrative

agency, with legal authority to act in place of or on behalf of the individual or spouse;

(c) A person or government entity, including a court or administrative agency, acting at the direction or on the request of the individual or spouse.

(2) "Home and community-based services" means home and community-based services furnished under a medicaid waiver granted by the United States secretary of health and human services under 42 U.S.C. 1396n(c) or (d).

(3) "Institutionalized individual" means a resident of a nursing facility, an inpatient in a medical institution for whom a payment is made based on a level of care provided in a nursing facility, or an individual described in 42 U.S.C. 1396a(a)(10)(A)(ii)(VI).

(4) "Look-back date" means the date that is a number of months specified in rules adopted under section 5111.011 of the Revised Code immediately before either of the following:

(a) The date an individual becomes an institutionalized individual if the individual is eligible for medicaid on that date;

(b) The date an individual applies for medicaid while an institutionalized individual.

(5) "Nursing facility" has the same meaning as in section 5111.20 of the Revised Code.

(6) "Nursing facility equivalent services" means services that are covered by the medicaid program, equivalent to nursing facility services, provided by an institution that provides the same level of care as a nursing facility, and provided to an inpatient of the institution who is a medicaid recipient eligible for medicaid-covered nursing facility equivalent services.

(7) "Nursing facility services" means nursing facility services covered by the medicaid program that a nursing facility provides to a resident of the nursing facility who is a medicaid recipient eligible for medicaid-covered nursing facility services.

(8) "Undue hardship" means being deprived of either of the following:

(a) Medical care such that an individual's health or life is endangered;

(b) Food, clothing, shelter, or other necessities of life.

(B) Except as provided in division (C) of this section and rules adopted under section 5111.011 of the Revised Code, an institutionalized individual is ineligible for nursing facility services, nursing facility equivalent services, and home and community-based services if the individual or individual's spouse disposes of assets for less than fair market value on or after the look-back date. The institutionalized individual's ineligibility shall begin on a date determined in accordance with rules adopted under section 5111.011

of the Revised Code and shall continue for a number of months determined in accordance with such rules.

(C) An institutionalized individual may be granted a waiver of all or a portion of the period of ineligibility to which the individual would otherwise be subjected under division (B) of this section if the ineligibility would cause an undue hardship for the individual. An institutionalized individual shall be granted a waiver of all or a portion of the period of ineligibility if the administrator of the nursing facility in which the individual resides has notified the individual of a proposed transfer or discharge under section 3721.16 of the Revised Code due to failure to pay for the care the nursing facility has provided to the individual, the individual or the individual's sponsor requests a hearing on the proposed transfer or discharge in accordance with section 3721.161 of the Revised Code, and the transfer or discharge is upheld by a final determination that is not subject to further appeal. Waivers shall be granted in accordance with rules adopted under section 5111.011 of the Revised Code.

(D) To secure compliance with this section, the director of job and family services may require an individual, as a condition of initial or continued eligibility for medicaid, to provide documentation of the individual's assets up to five years before the date the individual becomes an institutionalized individual if the individual is eligible for medicaid on that date or the date the individual applies for medicaid while an institutionalized individual. Documentation may include tax returns, records from financial institutions, and real property records.

Sec. 5111.0122. As used in this section, "maintenance of effort requirement" means the requirement established by section 1902(gg) of the "Social Security Act," 124 Stat. 275 (2010), 42 U.S.C. 1396a(gg), as amended, regarding medicaid eligibility standards, methodologies, and procedures.

Except to the extent, if any, otherwise authorized by the United States secretary of health and human services, the department of job and family services shall comply with the maintenance of effort requirement while the requirement is in effect.

Sec. 5111.0123. (A) Subject to division (B) of this section, the director of job and family services shall adopt rules under sections 5111.011 and 5111.85 of the Revised Code to reduce the complexity of the eligibility determination processes for the medicaid program caused by the different income and resource standards for the numerous medicaid eligibility categories.

(B) In implementing division (A) of this section, both of the following

apply:

(1) Before implementing a revision to an eligibility determination process, the director shall obtain, to the extent necessary, the approval of the United States secretary of health and human services in the form of a federal medicaid waiver, medicaid state plan amendment, or demonstration grant.

(2) The director shall comply with section 5111.0122 of the Revised Code.

Sec. 5111.0124. (A) As used in this section:

"Children's hospital" has the same meaning as in section 2151.86 of the Revised Code.

"Federally-qualified health center" has the same meaning as in 42 U.S.C. 1396d(l)(2)(B).

"Federally qualified health center look-alike" has the same meaning as in section 3701.047 of the Revised Code.

"Presumptive eligibility for pregnant women option" means the option available under 42 U.S.C. 1396r-1 to make ambulatory prenatal care available to pregnant women under the medicaid program during presumptive eligibility periods.

"Qualified provider" has the same meaning as in 42 U.S.C. 1396r-1(b)(2).

(B) The director of job and family services shall submit a medicaid state plan amendment to the United States secretary of health and human services to implement the presumptive eligibility for pregnant women option. The director shall include in the medicaid state plan amendment a request to authorize children's hospitals, federally qualified health centers, and federally qualified health center look-alikes, if they are eligible to be qualified providers under 42 U.S.C. 1396r-1(b)(2) and request to serve as qualified providers, to serve as qualified providers for purposes of the presumptive eligibility for pregnant women option. The director may include in the medicaid state plan amendment a request to authorize other types of providers that are eligible to be qualified providers under 42 U.S.C. 1396r-1(b)(2) and request to serve as qualified providers to serve as qualified providers for purposes of the presumptive eligibility for pregnant women option. The director shall begin to implement the medicaid state plan amendment on the later of April 1, 2012, or a date that is not later than ninety days after the effective date of the approval of the amendment.

The director shall adopt rules under section 5111.011 of the Revised Code as necessary to implement this section.

Sec. 5111.0125. (A) As used in this section:

"Children's hospital" has the same meaning as in section 2151.86 of the

Revised Code.

"Federally-qualified health center" has the same meaning as in 42 U.S.C. 1396d(l)(2)(B).

"Federally qualified health center look-alike" has the same meaning as in section 3701.047 of the Revised Code.

"Presumptive eligibility for children option" means the option available under 42 U.S.C. 1396r-1a to make medical assistance with respect to health care items and services available to children under the medicaid program during presumptive eligibility periods.

"Qualified entity" has the same meaning as in 42 U.S.C. 1396r-1a(b)(3).

(B) The director of job and family services shall retain the presumptive eligibility for children option that was included in the state medicaid plan on the effective date of this section. The director shall submit a medicaid state plan amendment to the United States secretary of health and human services to authorize children's hospitals, federally qualified health centers, and federally qualified health center look-alikes, if they are eligible to be qualified entities under 42 U.S.C. 1396r-1a(b)(3) and request to serve as qualified entities, to serve as qualified entities for purposes of the presumptive eligibility for children option. The director may include in the medicaid state plan amendment a request to authorize other types of entities that are eligible to be qualified entities under 42 U.S.C. 1396r-1a(b)(3) and request to serve as qualified entities to serve as qualified entities for purposes of the presumptive eligibility for children option. The director shall begin to implement the medicaid state plan amendment on the later of April 1, 2012, or a date that is not later than ninety days after the effective date of the approval of the amendment.

The director shall adopt rules under section 5111.011 of the Revised Code as necessary to implement this section.

Sec. 5111.021. Under the medicaid program:

(A) Except as otherwise ~~permitted~~ required by federal statute or regulation ~~and at the department's discretion~~, ~~reimbursement by~~ the department of job and family services ~~to~~ shall not reimburse a medical provider for any medical ~~service~~ assistance rendered under the program ~~shall not exceed~~ an amount that exceeds the following:

(1) If the provider is a hospital, nursing facility, or intermediate care facility for the mentally retarded, the limits established under Subpart C of 42 C.F.R. Part 447;

(2) If the provider is other than a provider described in division (A)(1) of this section, the authorized reimbursement ~~level~~ limits for the same service under the medicare program established under Title XVIII of the

"Social Security Act," 79 Stat. 286 (1965), 42 U.S.C. 1395, as amended.

(B) Reimbursement for freestanding medical laboratory charges shall not exceed the customary and usual fee for laboratory profiles.

(C) The department may deduct from payments for services rendered by a medicaid provider under the medicaid program any amounts the provider owes the state as the result of incorrect medicaid payments the department has made to the provider.

(D) The department may conduct final fiscal audits in accordance with the applicable requirements set forth in federal laws and regulations and determine any amounts the provider may owe the state. When conducting final fiscal audits, the department shall consider generally accepted auditing standards, which include the use of statistical sampling.

(E) The number of days of inpatient hospital care for which reimbursement is made on behalf of a medicaid recipient to a hospital that is not paid under a diagnostic-related-group prospective payment system shall not exceed thirty days during a period beginning on the day of the recipient's admission to the hospital and ending sixty days after the termination of that hospital stay, except that the department may make exceptions to this limitation. The limitation does not apply to children participating in the program for medically handicapped children established under section 3701.023 of the Revised Code.

(F) The division of any reimbursement between a collaborating physician or podiatrist and a clinical nurse specialist, certified nurse-midwife, or certified nurse practitioner for services performed by the nurse shall be determined and agreed on by the nurse and collaborating physician or podiatrist. In no case shall reimbursement exceed the payment that the physician or podiatrist would have received had the physician or podiatrist provided the entire service.

Sec. 5111.023. (A) As used in this section:

(1) "Community mental health agency or facility" means a community mental health agency or facility that has ~~a quality assurance program accredited by the joint commission on accreditation of healthcare organizations or is~~ its community mental health services certified by the department of mental health under section 5119.611 of the Revised Code or by the department of job and family services.

(2) "Mental health professional" means a person qualified to work with mentally ill persons under the standards established by the director of mental health pursuant to section 5119.611 of the Revised Code.

(B) The state medicaid plan ~~shall~~ may include provision of the following mental health services when provided by community mental

health agencies or facilities:

(1) Outpatient mental health services, including, but not limited to, preventive, diagnostic, therapeutic, rehabilitative, and palliative interventions rendered to individuals in an individual or group setting by a mental health professional in accordance with a plan of treatment appropriately established, monitored, and reviewed;

(2) Partial-hospitalization mental health services rendered by persons directly supervised by a mental health professional;

(3) Unscheduled, emergency mental health services of a kind ordinarily provided to persons in crisis when rendered by persons supervised by a mental health professional;

(4) Subject to receipt of federal approval, assertive community treatment and intensive home-based mental health services.

(C) ~~The comprehensive annual plan shall certify the availability of sufficient unencumbered community mental health state subsidy and local funds to match federal medicaid reimbursement funds earned by community mental health facilities.~~

~~(D)~~ The department of job and family services shall enter into a separate contract with the department of mental health under section 5111.91 of the Revised Code with regard to the component of the medicaid program provided for by this section.

~~(E) Not later than July 21, 2006, the department of job and family services shall request federal approval to provide assertive community treatment and intensive home-based mental health services under medicaid pursuant to this section.~~

~~(F) On receipt of federal approval sought under division (E) of this section, the director of job and family services shall adopt rules in accordance with Chapter 119. of the Revised Code for assertive community treatment and intensive home-based mental health services provided under medicaid pursuant to this section. The director shall consult with the department of mental health in adopting the rules.~~

Sec. 5111.025. (A) In rules adopted under section 5111.02 of the Revised Code, the director of job and family services shall modify the manner or establish a new manner in which the following are paid under medicaid:

(1) Community mental health agencies or facilities for providing community mental health services included in the state medicaid plan pursuant to section 5111.023 of the Revised Code;

(2) Providers of alcohol and drug addiction services for providing alcohol and drug addiction services included in the medicaid program

pursuant to rules adopted under section 5111.02 of the Revised Code.

(B) The director's authority to modify the manner, or to establish a new manner, for medicaid to pay for the services specified in division (A) of this section is not limited by any rules adopted under section 5111.02 or 5119.61 of the Revised Code that are in effect on June 26, 2003, and govern the way medicaid pays for those services. This is the case regardless of what state agency adopted the rules.

Sec. 5111.0212. As necessary to comply with section 1902(a)(13)(A) of the "Social Security Act," 111 Stat. 507 (1997), 42 U.S.C. 1396a(a)(13)(A), as amended, and any other federal law that requires public notice of proposed changes to reimbursement rates for medical assistance provided under the medicaid program, the director of job and family services shall give public notice in the register of Ohio of any change to a method or standard used to determine the medicaid reimbursement rate for medical assistance.

Sec. 5111.0213. (A) As used in this section:

(1) "Aide services" means all of the following:

(a) Home health aide services available under the home health services benefit pursuant to 42 C.F.R. 440.70(b)(2);

(b) Home care attendant services available under a home and community-based services medicaid waiver component;

(c) Personal care aide services available under a home and community-based services medicaid waiver component.

(2) "Home and community-based services medicaid waiver component" has the same meaning as in section 5111.85 of the Revised Code.

(3) "Independent provider" means an individual who personally provides aide services or nursing services and is not employed by, under contract with, or affiliated with another entity that provides those services.

(4) "Nursing services" means all of the following:

(a) Nursing services available under the home health services benefit pursuant to 42 C.F.R. 440.70(b)(1);

(b) Private duty nursing services as defined in 42 C.F.R. 440.80;

(c) Nursing services available under a home and community-based services medicaid waiver component.

(B) The department of job and family services shall do both of the following:

(1) Effective October 1, 2011, reduce the medicaid program's first-hour-unit price for aide services to ninety-seven per cent of the price paid on June 30, 2011, and for nursing services to ninety-five per cent of the price paid on June 30, 2011;

(2) Effective October 1, 2011, pay for a service that is an aide service or a nursing service provided by an independent provider eighty per cent of the price it pays for the same service provided by a provider that is not an independent provider;

(3) Not sooner than July 1, 2012, adjust the medicaid reimbursement rates for aide services and nursing services in a manner that reflects, at a minimum, labor market data, education and licensure status, home health agency and independent provider status, and length of service visit.

(C) The department shall strive to have the adjustment made under division (B)(3) of this section go into effect on July 1, 2012. The reductions made under divisions (B)(1) and (2) of this section shall remain in effect until the adjustment made under division (B)(3) of this section goes into effect.

(D) The director of job and family services shall adopt rules under sections 5111.02 and 5111.85 of the Revised Code as necessary to implement this section.

Sec. 5111.0214. The department of job and family services shall not knowingly make a medicaid payment for a provider-preventable condition for which federal financial participation is prohibited by regulations adopted under section 2702 of the "Patient Protection and Affordable Care Act," 124 Stat. 318 (2010), 42 U.S.C. 1396b-1. The director of job and family services shall adopt rules under section 5111.02 of the Revised Code as necessary to implement this section.

Sec. 5111.0215. (A) The department of job and family services may establish a program under which it provides incentive payments, as authorized by the "Health Information Technology for Economic and Clinical Health Act," 123 Stat. 489 (2009), 42 U.S.C. 1396b(a)(3)(F) and 1396b(t), as amended, to encourage the adoption and use of electronic health record technology by medicaid providers who are identified under that federal law as eligible professionals.

(B) After the department has made a determination regarding the amount of a medicaid provider's electronic health record incentive payment or the denial of an incentive payment, the department shall notify the provider. The provider may request that the department reconsider its determination.

A request for reconsideration shall be submitted in writing to the department not later than fifteen days after the provider receives notification of the determination. The request shall be accompanied by written materials setting forth the basis for, and supporting, the reconsideration request.

On receipt of a timely request, the department shall reconsider the

determination. On the basis of the written materials accompanying the request, the department may uphold, reverse, or modify its original determination. The department shall mail to the provider by certified mail a written notice of the reconsideration decision.

In accordance with Chapter 2505. of the Revised Code, the medicaid provider may appeal the reconsideration decision by filing a notice of appeal with the court of common pleas of Franklin county. The notice shall identify the decision being appealed and the specific grounds for the appeal. The notice of appeal shall be filed not later than fifteen days after the department mails its notice of the reconsideration decision. A copy of the notice of appeal shall be filed with the department not later than three days after the notice is filed with the court.

(C) The director of job and family services may adopt rules in accordance with Chapter 119. of the Revised Code as necessary to implement this section.

Sec. 5111.031. (A) As used in this section:

(1) "Independent provider" has the same meaning as in section 5111.034 of the Revised Code.

(2) "Intermediate care facility for the mentally retarded" and "nursing facility" have the same meanings as in section 5111.20 of the Revised Code.

(3) "Noninstitutional medicaid provider" means any person or entity with a medicaid provider agreement other than a hospital, nursing facility, or intermediate care facility for the mentally retarded.

(4) "Owner" means any person having at least five per cent ownership in a noninstitutional medicaid provider.

(B) Notwithstanding any provision of this chapter to the contrary, the department of job and family services shall take action under this section against a noninstitutional medicaid provider or its owner, officer, authorized agent, associate, manager, or employee.

(C) Except as provided in division (D) of this section and in rules adopted by the department under division (H) of this section, on receiving notice and a copy of an indictment that is issued on or after ~~the effective date of this section~~ September 29, 2007, and charges a noninstitutional medicaid provider or its owner, officer, authorized agent, associate, manager, or employee with committing an offense specified in division (E) of this section, the department shall suspend the provider agreement held by the noninstitutional medicaid provider. Subject to division (D) of this section, the department shall also terminate medicaid reimbursement to the provider for services rendered.

The suspension shall continue in effect until the proceedings in the

criminal case are completed through ~~conviction,~~ dismissal of the indictment~~,~~ or through conviction, entry of a guilty plea, or finding of not guilty. If the department commences a process to terminate the suspended provider agreement, the suspension shall also continue in effect until the termination process is concluded. ~~Pursuant~~

Pursuant to section 5111.06 of the Revised Code, the department is not required to take action under this division by issuing an order pursuant to an adjudication conducted in accordance with Chapter 119. of the Revised Code.

When subject to a suspension under this division, a provider, owner, officer, authorized agent, associate, manager, or employee shall not own or provide services to any other medicaid provider or risk contractor or arrange for, render, or order services for medicaid recipients during the period of suspension. During the period of suspension, the provider, owner, officer, authorized agent, associate, manager, or employee shall not receive reimbursement in the form of direct payments from the department or indirect payments of medicaid funds in the form of salary, shared fees, contracts, kickbacks, or rebates from or through any participating provider or risk contractor.

(D)(1) The department shall not suspend a provider agreement or terminate medicaid reimbursement under division (C) of this section if the provider or owner can demonstrate through the submission of written evidence that the provider or owner did not directly or indirectly sanction the action of its authorized agent, associate, manager, or employee that resulted in the indictment.

(2) The termination of medicaid reimbursement applies only to payments for medicaid services rendered subsequent to the date on which the notice required under division (F) of this section is sent. Claims for reimbursement for medicaid services rendered by the provider prior to the issuance of the notice may be subject to prepayment review procedures whereby the department reviews claims to determine whether they are supported by sufficient documentation, are in compliance with state and federal statutes and rules, and are otherwise complete.

(E)(1) In the case of a noninstitutional medicaid provider that is not an independent provider, the suspension of a provider agreement under division (C) of this section applies when an indictment charges a person with committing an act that would be a felony or misdemeanor under the laws of this state and the act relates to or results from either of the following:

(a) Furnishing or billing for medical care, services, or supplies under the medicaid program;

(b) Participating in the performance of management or administrative services relating to furnishing medical care, services, or supplies under the medicaid program.

(2) In the case of a noninstitutional medicaid provider that is an independent provider, the suspension of a provider agreement under division (C) of this section applies when an indictment charges a person with committing an act that would constitute one of the offenses specified in division (D) of section 5111.034 of the Revised Code.

(F) Not later than five days after suspending a provider agreement under division (C) of this section, the department shall send notice of the suspension to the affected provider or owner. In providing the notice, the department shall do all of the following:

(1) Describe the indictment that was the cause of the suspension, without necessarily disclosing specific information concerning any ongoing civil or criminal investigation;

(2) State that the suspension will continue in effect until the proceedings in the criminal case are completed through ~~conviction,~~ dismissal of the indictment~~,~~ or through conviction, entry of a guilty plea, or finding of not guilty and, if the department commences a process to terminate the suspended provider agreement, until the termination process is concluded;

(3) Inform the provider or owner of the opportunity to submit to the department, not later than thirty days after receiving the notice, a request for a reconsideration pursuant to division (G) of this section.

(G)(1) ~~A~~ Pursuant to the procedure specified in division (G)(2) of this section, a noninstitutional medicaid provider or owner subject to a suspension under this section may request a reconsideration. The request shall be made not later than thirty days after receipt of the notice provided under division (F) of this section. The reconsideration is not subject to an adjudication hearing pursuant to Chapter 119. of the Revised Code.

(2) In requesting a reconsideration, the provider or owner shall submit written information and documents to the department. The information and documents may pertain to any of the following issues:

(a) Whether the determination to suspend the provider agreement was based on a mistake of fact, other than the validity of the indictment;

(b) Whether any offense charged in the indictment resulted from an offense specified in division (E) of this section;

(c) Whether the provider or owner can demonstrate that the provider or owner did not directly or indirectly sanction the action of its authorized agent, associate, manager, or employee that resulted in the indictment.

(3) The department shall review the information and documents

submitted in a request for reconsideration. After the review, the suspension may be affirmed, reversed, or modified, in whole or in part. The department shall notify the affected provider or owner of the results of the review. The review and notification of its results shall be completed not later than forty-five days after receiving the information and documents submitted in a request for reconsideration.

(H) The department may adopt rules in accordance with Chapter 119. of the Revised Code to implement this section. The rules may specify circumstances under which the department would not suspend a provider agreement pursuant to this section.

Sec. 5111.035. (A) As used in this section:

(1) "Creditable allegation of fraud" has the same meaning as in 42 C.F.R. 455.2, except that for purposes of this section any reference in that regulation to the "state" or the "state medicaid agency" means the department of job and family services.

(2) "Provider" has the same meaning as in section 5111.032 of the Revised Code.

(3) "Owner" has the same meaning as in section 5111.031 of the Revised Code.

(B)(1) Except as provided in division (C) of this section and in rules adopted by the department of job and family services under division (J) of this section, on determining there is a creditable allegation of fraud for which an investigation is pending under the medicaid program against a provider, the department shall suspend the provider agreement held by the provider. Subject to division (C) of this section, the department shall also terminate medicaid reimbursement to the provider for services rendered.

(2)(a) The suspension shall continue in effect until either of the following is the case:

(i) The department or a prosecuting authority determines that there is insufficient evidence of fraud by the provider;

(ii) The proceedings in any related criminal case are completed through dismissal of the indictment or through conviction, entry of a guilty plea, or finding of not guilty.

(b) If the department commences a process to terminate the suspended provider agreement, the suspension shall also continue in effect until the termination process is concluded.

(3) Pursuant to section 5111.06 of the Revised Code, the department is not required to take action under division (B)(1) of this section by issuing an order pursuant to an adjudication in accordance with Chapter 119. of the Revised Code.

(4) When subject to a suspension under this section, a provider, owner, officer, authorized agent, associate, manager, or employee shall not own or provide services to any other medicaid provider or risk contractor or arrange for, render, or order services to any other medicaid provider or risk contractor or arrange for, render, or order services for medicaid recipients during the period of suspension. During the period of suspension, the provider, owner, officer, authorized agent, associate, manager, or employee shall not receive reimbursement in the form of direct payments from the department or indirect payments of medicaid funds in the form of salary, shared fees, contracts, kickbacks, or rebates from or through any participating provider or risk contractor.

(C) The department shall not suspend a provider agreement or terminate medicaid reimbursement under division (B) of this section if the provider or owner can demonstrate through the submission of written evidence that the provider or owner did not directly or indirectly sanction the action of its authorized agent, associate, manager, or employee that resulted in the creditable allegation of fraud.

(D) The termination of medicaid reimbursement under division (B) of this section applies only to payments for medicaid services rendered subsequent to the date on which the notice required by division (E) of this section is sent. Claims for reimbursement of medicaid services rendered by the provider prior to the issuance of the notice may be subject to prepayment review procedures whereby the department reviews claims to determine whether they are supported by sufficient documentation, are in compliance with state and federal statutes and rules, and are otherwise complete.

(E) After suspending a provider agreement under division (B) of this section, the department shall, as specified in 42 C.F.R. 455.23(b), send notice of the suspension to the affected provider or owner in accordance with the following timeframes:

(1) Not later than five days after the suspension, unless a law enforcement agency makes a written request to temporarily delay the notice;

(2) If a law enforcement agency makes a written request to temporarily delay the notice, not later than thirty days after the suspension occurs subject to the conditions specified in division (F) of this section.

(F) A written request for a temporary delay described in division (E)(2) of this section may be renewed in writing by a law enforcement agency not more than two times except that under no circumstances shall the notice be issued more than ninety days after the suspension occurs.

(G) The notice required by division (E) of this section shall do all of the following:

(1) State that payments are being suspended in accordance with this section and 42 C.F.R. 455.23;

(2) Set forth the general allegations related to the nature of the conduct leading to the suspension, except that it is not necessary to disclose any specific information concerning an ongoing investigation;

(3) State that the suspension continues to be in effect until either of the following is the case:

(a) The department or a prosecuting authority determines that there is insufficient evidence of fraud by the provider;

(b) The proceedings in any related criminal case are completed through dismissal of the indictment or through conviction, entry of a guilty plea, or finding of not guilty and, if the department commences a process to terminate the suspended provider agreement, until the termination process is concluded.

(4) Specify, if applicable, the type or types of medicaid claims or business units of the provider that are affected by the suspension;

(5) Inform the provider or owner of the opportunity to submit to the department, not later than thirty days after receiving the notice, a request for reconsideration of the suspension in accordance with division (H) of this section.

(H)(1) Pursuant to the procedure specified in division (H)(2) of this section, a provider or owner subject to a suspension under this section may request a reconsideration of the suspension. The request shall be made not later than thirty days after receipt of a notice required by division (E) of this section. The reconsideration is not subject to an adjudication hearing pursuant to Chapter 119. of the Revised Code.

(2) In requesting a reconsideration, the provider or owner shall submit written information and documents to the department. The information and documents may pertain to any of the following issues:

(a) Whether the determination to suspend the provider agreement was based on a mistake of fact, other than the validity of an indictment in a related criminal case.

(b) If there has been an indictment in a related criminal case, whether any offense charged in the indictment resulted from an offense specified in division (E) of section 5111.031 of the Revised Code.

(c) Whether the provider or owner can demonstrate that the provider or owner did not directly or indirectly sanction the action of its authorized agent, associate, manager, or employee that resulted in the suspension under this section or an indictment in a related criminal case.

(I) The department shall review the information and documents

submitted in a request made under division (H) of this section for reconsideration of a suspension. After the review, the suspension may be affirmed, reversed, or modified, in whole or in part. The department shall notify the affected provider or owner of the results of the review. The review and notification of its results shall be completed not later than forty-five days after receiving the information and documents submitted in a request for reconsideration.

(J) The department may adopt rules in accordance with Chapter 119. of the Revised Code to implement this section. The rules may specify circumstances under which the department would not suspend a provider agreement pursuant to this section.

Sec. 5111.051. The director of job and family services may submit a medicaid state plan amendment or request for a federal waiver to the United States secretary of health and human services as necessary to implement, at the director's discretion, a system under which payments for medical assistance provided under the medicaid program are made to an organization on behalf of the providers of the medical assistance. The system may not provide for an organization to receive an amount that exceeds, in aggregate, the amount the department would have paid directly to the providers if not for this section.

Sec. 5111.052. (A) As used in this section, "electronic claims submission process" means any of the following:

(1) Electronic interchange of data;

(2) Direct entry of data through an internet-based mechanism implemented by the department of job and family services;

(3) Any other process for the electronic submission of claims that is specified in rules adopted under this section.

(B) Not later than January 1, 2013, and except as provided in division (C) of this section, each provider of services to medicaid recipients shall do both of the following:

(1) Use only an electronic claims submission process to submit to the department of job and family services claims for medicaid reimbursement for services provided to medicaid recipients;

(2) Arrange to receive medicaid reimbursement from the department by means of electronic funds transfer.

(C) Division (B) of this section does not apply to any of the following:

(1) A nursing facility, as defined in section 5111.20 of the Revised Code;

(2) An intermediate care facility for the mentally retarded, as defined in section 5111.20 of the Revised Code;

(3) A medicaid managed care organization under contract with the department pursuant to section 5111.17 of the Revised Code;

(4) Any other provider or type of provider designated in rules adopted under this section.

(D) The department shall not process a medicaid claim submitted on or after January 1, 2013, unless the claim is submitted through an electronic claims submission process in accordance with this section.

(E) The director of job and family services may adopt rules in accordance with Chapter 119. of the Revised Code as the director considers necessary to implement this section.

Sec. 5111.053. (A) As used in this section, "group practice" has the same meaning as in section 4731.65 of the Revised Code.

(B) The department of job and family services shall establish a process by which a physician assistant may enter into a medicaid provider agreement.

(C)(1) Subject to division (C)(2) of this section, a claim for reimbursement for a service provided by a physician assistant to a medicaid recipient may be submitted by the physician assistant who provided the service or the physician, group practice, clinic, or other health care facility that employs the physician assistant.

(2) A claim for reimbursement may be submitted by the physician assistant who provided the service only if the physician assistant has a valid provider agreement. When submitting the claim, the physician assistant shall use only the medicaid provider number the department has assigned to the physician assistant.

(D) The director of job and family services may adopt rules under section 5111.02 of the Revised Code to implement this section.

Sec. 5111.054. (A) As used in this section:

(1) "Federal financial participation" means the federal government's share of expenditures made by an entity in implementing the medicaid program.

(2) "OCHSPS" means the private, not-for-profit corporation known as the Ohio children's hospital solutions for patient safety, which was formed for the purpose of improving pediatric patient care in this state, which performs functions that are included within the functions of a peer review committee as defined in section 2305.25 of the Revised Code, and which consists of all of the following members: Akron children's hospital, Cincinnati children's hospital medical center, Cleveland clinic children's hospital, Dayton children's medical center, mercy children's hospital, nationwide children's hospital, rainbow babies & children's hospital, and

Toledo children's hospital.

(B) If, as authorized by section 5101.10 of the Revised Code, the department of job and family services chooses to contract with a person to perform either or both of the following services, it may contract with any qualified person, including OCHSPS, to perform the service or services on the department's behalf:

(1) Review and analyze claims for medical assistance made under this chapter to children in accordance with all state and federal laws governing the confidentiality of patient-identifying information;

(2) Perform quality assurance and quality review functions, other than those described in division (B)(1) of this section, related to medical assistance made under this chapter to children.

The functions specified in division (B)(2) of this section may include those recommended by the best evidence for advancing child health in Ohio now (BEACON) council.

(C) If the department enters into a contract with OCHSPS for OCHSPS to perform either or both of the services described in division (B) of this section, OCHSPS shall, only for purposes of section 5101.11 of the Revised Code, be considered a public entity and the department shall seek federal financial participation for costs incurred by OCHSPS in performing the service or services.

Sec. 5111.06. (A)(1) As used in this section and in sections 5111.061 and ~~5111.062~~ 5111.063 of the Revised Code:

(a) "Provider" means any person, institution, or entity that furnishes medicaid services under a provider agreement with the department of job and family services pursuant to Title XIX of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended.

(b) "Party" has the same meaning as in division (G) of section 119.01 of the Revised Code.

(c) "Adjudication" has the same meaning as in division (D) of section 119.01 of the Revised Code.

(2) This section does not apply to any action taken by the department of job and family services under sections 5111.16 to 5111.177 or sections 5111.35 to 5111.62 of the Revised Code.

(B) Except as provided in division (D) of this section and section 5111.914 of the Revised Code, the department shall do either of the following by issuing an order pursuant to an adjudication conducted in accordance with Chapter 119. of the Revised Code:

(1) Enter into or refuse to enter into a provider agreement with a provider, or suspend, terminate, renew, or refuse to renew an existing

provider agreement with a provider;

(2) Take any action based upon a final fiscal audit of a provider.

(C) Any party who is adversely affected by the issuance of an adjudication order under division (B) of this section may appeal to the court of common pleas of Franklin county in accordance with section 119.12 of the Revised Code.

(D) The department is not required to comply with division (B)(1) of this section whenever any of the following occur:

(1) The terms of a provider agreement require the provider to hold a license, permit, or certificate or maintain a certification issued by an official, board, commission, department, division, bureau, or other agency of state or federal government other than the department of job and family services, and the license, permit, certificate, or certification has been denied, revoked, not renewed, suspended, or otherwise limited.

(2) The terms of a provider agreement require the provider to hold a license, permit, or certificate or maintain certification issued by an official, board, commission, department, division, bureau, or other agency of state or federal government other than the department of job and family services, and the provider has not obtained the license, permit, certificate, or certification.

(3) The provider agreement is denied, terminated, or not renewed due to the termination, refusal to renew, or denial of a license, permit, certificate, or certification by an official, board, commission, department, division, bureau, or other agency of this state other than the department of job and family services, notwithstanding the fact that the provider may hold a license, permit, certificate, or certification from an official, board, commission, department, division, bureau, or other agency of another state.

(4) The provider agreement is denied, terminated, or not renewed pursuant to division (C) or (F) of section 5111.03 of the Revised Code.

(5) The provider agreement is denied, terminated, or not renewed due to the provider's termination, suspension, or exclusion from the medicare program established under Title XVIII of the "Social Security Act~~,~~" or from another state's medicaid program and, in either case, the termination, suspension, or exclusion is binding on the provider's participation in the medicaid program in this state.

(6) The provider agreement is denied, terminated, or not renewed due to the provider's pleading guilty to or being convicted of a criminal activity materially related to either the medicare or medicaid program.

(7) The provider agreement is denied, terminated, or suspended as a result of action by the United States department of health and human

services and that action is binding on the provider's participation in the medicaid program.

(8) ~~The~~ Pursuant to either section 5111.031 or 5111.035 of the Revised Code, the provider agreement is suspended ~~pursuant to section 5111.031 of the Revised Code~~ and payments to the provider are suspended pending indictment of the provider.

(9) The provider agreement is denied, terminated, or not renewed because the provider or its owner, officer, authorized agent, associate, manager, or employee has been convicted of one of the offenses that caused the provider agreement to be suspended pursuant to section 5111.031 of the Revised Code.

(10) The provider agreement is converted under section 5111.028 of the Revised Code from a provider agreement that is not time-limited to a provider agreement that is time-limited.

(11) The provider agreement is terminated or an application for re-enrollment is denied because the provider has failed to apply for re-enrollment within the time or in the manner specified for re-enrollment pursuant to section 5111.028 of the Revised Code.

(12) The provider agreement is suspended or terminated, or an application for enrollment or re-enrollment is denied, for any reason authorized or required by one or more of the following: 42 C.F.R. 455.106, 455.23, 455.416, 455.434, or 455.450.

(13) The provider agreement is terminated or not renewed because the provider has not billed or otherwise submitted a medicaid claim to the department for two years or longer.

~~(13)~~(14) The provider agreement is denied, terminated, or not renewed because the provider fails to provide to the department the national provider identifier assigned the provider by the national provider system pursuant to 45 C.F.R. 162.408.

In the case of a provider described in division (D)~~(12)~~(13) or ~~(13)~~(14) of this section, the department may take its proposed action against a provider agreement by sending a notice explaining the proposed action to the provider. The notice shall be sent to the provider's address on record with the department. The notice may be sent by regular mail.

(E) The department may withhold payments for services rendered by a medicaid provider under the medicaid program during the pendency of proceedings initiated under division (B)(1) of this section. If the proceedings are initiated under division (B)(2) of this section, the department may withhold payments only to the extent that they equal amounts determined in a final fiscal audit as being due the state. This division does not apply if the

department fails to comply with section 119.07 of the Revised Code, requests a continuance of the hearing, or does not issue a decision within thirty days after the hearing is completed. This division does not apply to nursing facilities and intermediate care facilities for the mentally retarded as defined in section 5111.20 of the Revised Code.

Sec. 5111.061. (A) ~~The~~ (1) Except as provided in division (A)(2) of this section, the department of job and family services may recover a medicaid payment or portion of a payment made to a provider to which the provider is not entitled if the department notifies the provider of the overpayment during the five-year period immediately following the end of the state fiscal year in which the overpayment was made.

(2) In the case of a hospital provider, if the department determines as a result of a medicare or medicaid cost report settlement that the provider received an amount under the medicaid program to which the provider is not entitled, the department may recover the overpayment if the department notifies the provider of the overpayment during the later of the following:

(a) The five-year period immediately following the end of the state fiscal year in which the overpayment was made;

(b) The one-year period immediately following the date the department receives from the United States centers for medicare and medicaid services a completed, audited, medicare cost report for the provider that applies to the state fiscal year in which the overpayment was made.

(B) Among the overpayments that may be recovered under this section are the following:

(1) Payment for a service, or a day of service, not rendered;

(2) Payment for a day of service at a full per diem rate that should have been paid at a percentage of the full per diem rate;

(3) Payment for a service, or day of service, that was paid by, or partially paid by, a ~~third-party~~ third party, as defined in section 5101.571 of the Revised Code, and the ~~third-party's~~ third party's payment or partial payment was not offset against the amount paid by the medicaid program to reduce or eliminate the amount that was paid by the medicaid program;

(4) Payment when a medicaid recipient's responsibility for payment was understated and resulted in an overpayment to the provider.

(C) The department may recover an overpayment under this section prior to or after any of the following:

(1) Adjudication of a final fiscal audit that section 5111.06 of the Revised Code requires to be conducted in accordance with Chapter 119. of the Revised Code;

(2) Adjudication of a finding under any other provision of this chapter

or the rules adopted under it;

(3) Expiration of the time to issue a final fiscal audit that section 5111.06 of the Revised Code requires to be conducted in accordance with Chapter 119. of the Revised Code;

(4) Expiration of the time to issue a finding under any other provision of this chapter or the rules adopted under it.

(D)(1) Subject to division (D)(2) of this section, the recovery of an overpayment under this section does not preclude the department from subsequently doing the following:

(a) Issuing a final fiscal audit in accordance with Chapter 119. of the Revised Code, as required under section 5111.06 of the Revised Code;

(b) Issuing a finding under any other provision of this chapter or the rules adopted under it.

(2) A final fiscal audit or finding issued subsequent to the recovery of an overpayment under this section shall be reduced by the amount of the prior recovery, as appropriate.

(E) Nothing in this section limits the department's authority to recover overpayments pursuant to any other provision of the Revised Code.

Sec. 5111.063. For the purpose of raising funds necessary to pay the expenses of implementing the provider screening requirements of subpart E of 42 C.F.R. Part 455, the department of job and family services shall charge an application fee to a provider seeking to enter into or renew a medicaid provider agreement, unless the provider is exempt from paying the application fee under 42 C.F.R. 455.460(a). The application fees shall be deposited into the health care services administration fund created under section 5111.94 of the Revised Code.

The director of job and family services shall adopt rules in accordance with Chapter 119. of the Revised Code as necessary to implement this section, including a rule establishing the amount of the application fee that is charged under this section. The amount of the application fee shall not be set at an amount that is more than necessary to pay for the expenses of implementing the provider screening requirements.

Sec. 5111.086. As used in this section, "federal upper reimbursement limit" means the limit established pursuant to section 1927(e) of the "Social Security Act," 104 Stat. 1388-151 (1990), 42 U.S.C. 1396r-8(e), as amended.

The medicaid payment for a drug that is subject to a federal upper reimbursement limit shall not exceed, in the aggregate, the federal upper reimbursement limit for the drug. The director of job and family services shall adopt rules under section 5111.02 of the Revised Code as necessary to

implement this section.

Sec. 5111.113. (A) As used in this section:

(1) "Adult care facility" has the same meaning as in section ~~3722.01~~ 5119.70 of the Revised Code.

(2) "Commissioner" means a person appointed by a probate court under division (B) of section 2113.03 of the Revised Code to act as a commissioner.

(3) "Home" has the same meaning as in section 3721.10 of the Revised Code.

(4) "Personal needs allowance account" means an account or petty cash fund that holds the money of a resident of an adult care facility or home and that the facility or home manages for the resident.

(B) Except as provided in divisions (C) and (D) of this section, the owner or operator of an adult care facility or home shall transfer to the department of job and family services the money in the personal needs allowance account of a resident of the facility or home who was a recipient of the medical assistance program no earlier than sixty days but not later than ninety days after the resident dies. The adult care facility or home shall transfer the money even though the owner or operator of the facility or home has not been issued letters testamentary or letters of administration concerning the resident's estate.

(C) If funeral or burial expenses for a resident of an adult care facility or home who has died have not been paid and the only resource the resident had that could be used to pay for the expenses is the money in the resident's personal needs allowance account, or all other resources of the resident are inadequate to pay the full cost of the expenses, the money in the resident's personal needs allowance account shall be used to pay for the expenses rather than being transferred to the department of job and family services pursuant to division (B) of this section.

(D) If, not later than sixty days after a resident of an adult care facility or home dies, letters testamentary or letters of administration are issued, or an application for release from administration is filed under section 2113.03 of the Revised Code, concerning the resident's estate, the owner or operator of the facility or home shall transfer the money in the resident's personal needs allowance account to the administrator, executor, commissioner, or person who filed the application for release from administration.

(E) The transfer or use of money in a resident's personal needs allowance account in accordance with division (B), (C), or (D) of this section discharges and releases the adult care facility or home, and the owner or operator of the facility or home, from any claim for the money

from any source.

(F) If, sixty-one or more days after a resident of an adult care facility or home dies, letters testamentary or letters of administration are issued, or an application for release from administration under section 2113.03 of the Revised Code is filed, concerning the resident's estate, the department of job and family services shall transfer the funds to the administrator, executor, commissioner, or person who filed the application, unless the department is entitled to recover the money under the medicaid estate recovery program instituted under section 5111.11 of the Revised Code.

Sec. 5111.13. (A) As used in this section, "cost-effective" and "group health plan" have the same meanings as in section 1906 of the "Social Security Act," ~~49~~ 104 Stat. ~~620 (1935)~~ 1388-161 (1990), 42 U.S.C.~~A.~~ 1396e, as amended, and any regulations adopted under that section.

(B) The department of job and family services~~, pursuant to guidelines issued by~~ may submit a medicaid state plan amendment to the United States secretary of health and human services~~, shall identify cases in which enrollment of an individual otherwise eligible for medical assistance under this chapter in a group health plan in which the individual is eligible to enroll and payment of the individual's premiums, deductibles, coinsurance, and other cost-sharing expenses is cost effective.~~

~~The department shall require, as a condition of eligibility for medical assistance, individuals identified under this division, or in the case of a child, the child's parent, to apply for enrollment in the group health plan, except that the failure of a parent to enroll self or the parent's child in a group health plan does not affect the child's eligibility under the medical assistance program.~~

~~The department shall pay enrollee premiums and deductibles, coinsurance, and other cost-sharing obligations for services and items otherwise covered under the medical assistance program. The department shall treat coverage under the group health plan in the same manner as any other third-party liability under the program. If not all members of a family are eligible for medical assistance and enrollment of the eligible members in a group health plan is not possible without also enrolling the members who are ineligible for medical assistance, the department shall pay the premiums for the ineligible members if the payments are cost effective. The department shall not pay deductibles, coinsurance, or other cost-sharing obligations of enrolled members who are not eligible for medical assistance.~~

~~The department may make payments under this section to employers, insurers, or other entities. The department may make the payments without entering into a contract with employers, insurers, or other entities.~~

~~(C) To the extent permitted by federal law and regulations, the department of job and family services shall coordinate the medical assistance program with group health plans in such a manner that the medical assistance program serves as a supplement to the group health plans. In its coordination efforts, the department shall consider cost-effectiveness and quality of care. The department may enter into agreements with group health plans as necessary to implement this division~~ for the purpose of implementing a program pursuant to section 1906 of the "Social Security Act," 104 Stat. 1388-161 (1990), 42 U.S.C. 1396e, as amended, for the enrollment of medicaid-eligible individuals in group health plans when the department determines that enrollment is cost-effective.

~~(D)~~(C) The director of job and family services ~~shall~~ may adopt rules in accordance with Chapter 119. of the Revised Code as necessary to implement this section.

Sec. 5111.14. The director of job and family services may submit to the United States secretary of health and human services an amendment to the medicaid state plan in order to implement within the medicaid program a system under which medicaid recipients with chronic conditions are provided with coordinated care through health homes, as authorized by section 1945 of the "Social Security Act," 124 Stat. 319 (2010), 42 U.S.C. 1396w-4.

The director may adopt rules under section 5111.02 of the Revised Code to implement this section.

Sec. ~~5111.14~~ 5111.141. The department of job and family services may require county departments of job and family services to provide case management of nonemergency transportation services provided under the medical assistance program. County departments shall provide the case management if required by the department in accordance with rules adopted by the director of job and family services.

The department shall determine, for the purposes of claiming federal reimbursement under the medical assistance program, whether it will claim expenditures for nonemergency transportation services as administrative or program expenditures.

Sec. 5111.151. (A)(1) This section applies only to either of the following:

(a) Initial eligibility determinations for ~~all cases involving medicaid provided pursuant to this chapter, qualified medicare beneficiaries, specified low-income medicare beneficiaries, qualifying individuals-1, qualifying individuals-2, and medical assistance for covered families and children~~ the medicaid program made by the department of job and family services

pursuant to section 5101.47 of the Revised Code or by a county department of job and family services pursuant to section 5111.012 of the Revised Code;

(b) An appeal from a determination described in division (A)(1)(a) of this section pursuant to section 5101.35 of the Revised Code.

(2)(a) Except as provided in division (A)(2)(b) of this section, this section shall not be used by a court to determine the effect of a trust on an individual's initial eligibility for the medicaid program.

(b) The prohibition in division (A)(2)(a) of this section does not apply to an appeal described in division (A)(1)(b) of this section.

(B) As used in this section:

(1) "Trust" means any arrangement in which a grantor transfers real or personal property to a trust with the intention that it be held, managed, or administered by at least one trustee for the benefit of the grantor or beneficiaries. "Trust" includes any legal instrument or device similar to a trust.

(2) "Legal instrument or device similar to a trust" includes, but is not limited to, escrow accounts, investment accounts, partnerships, contracts, and other similar arrangements that are not called trusts under state law but are similar to a trust and to which all of the following apply:

(a) The property in the trust is held, managed, retained, or administered by a trustee.

(b) The trustee has an equitable, legal, or fiduciary duty to hold, manage, retain, or administer the property for the benefit of the beneficiary.

(c) The trustee holds identifiable property for the beneficiary.

(3) "Grantor" is a person who creates a trust, including all of the following:

(a) An individual;

(b) An individual's spouse;

(c) A person, including a court or administrative body, with legal authority to act in place of or on behalf of an individual or an individual's spouse;

(d) A person, including a court or administrative body, that acts at the direction or on request of an individual or the individual's spouse.

(4) "Beneficiary" is a person or persons, including a grantor, who benefits in some way from a trust.

(5) "Trustee" is a person who manages a trust's principal and income for the benefit of the beneficiaries.

(6) "Person" has the same meaning as in section 1.59 of the Revised Code and includes an individual, corporation, business trust, estate, trust,

partnership, and association.

(7) "Applicant" is an individual who applies for medicaid or the individual's spouse.

(8) "Recipient" is an individual who receives medicaid or the individual's spouse.

(9) "Revocable trust" is a trust that can be revoked by the grantor or the beneficiary, including all of the following, even if the terms of the trust state that it is irrevocable:

(a) A trust that provides that the trust can be terminated only by a court;

(b) A trust that terminates on the happening of an event, but only if the event occurs at the direction or control of the grantor, beneficiary, or trustee.

(10) "Irrevocable trust" is a trust that cannot be revoked by the grantor or terminated by a court and that terminates only on the occurrence of an event outside of the control or direction of the beneficiary or grantor.

(11) "Payment" is any disbursal from the principal or income of the trust, including actual cash, noncash or property disbursements, or the right to use and occupy real property.

(12) "Payments to or for the benefit of the applicant or recipient" is a payment to any person resulting in a direct or indirect benefit to the applicant or recipient.

(13) "Testamentary trust" is a trust that is established by a will and does not take effect until after the death of the person who created the trust.

(C)(1) If an applicant or recipient is a beneficiary of a trust, the county department of job and family services shall determine what type of trust it is and shall treat the trust in accordance with the appropriate provisions of this section and rules adopted by the department of job and family services governing trusts. The county department of job and family services may determine that the trust or portion of the trust ~~is one of the following~~:

~~(1) A countable~~ (a) Is a resource available to the applicant or recipient;

~~(2) Countable~~ (b) Contains income available to the applicant or recipient;

~~(3) A countable resource and countable income~~ (c) Constitutes both items described in divisions (C)(1)(a) and (b) of this section;

~~(4) Not a countable resource or countable income~~ (d) Is neither an item described in division (C)(1)(a) nor (C)(1)(b) of this section.

(2) Except as provided in division (F) of this section, a trust or portion of a trust that is a resource available to the applicant or recipient or contains income available to the applicant or recipient shall be counted for purposes of determining medicaid eligibility.

(D)(1) A trust or legal instrument or device similar to a trust shall be

considered a medicaid qualifying trust if all of the following apply:

(a) The trust was established on or prior to August 10, 1993.

(b) The trust was not established by a will.

(c) The trust was established by an applicant or recipient.

(d) The applicant or recipient is or may become the beneficiary of all or part of the trust.

(e) Payment from the trust is determined by one or more trustees who are permitted to exercise any discretion with respect to the distribution to the applicant or recipient.

(2) If a trust meets the requirement of division (D)(1) of this section, the amount of the trust that is considered by the county department of job and family services ~~as an available~~ to be a resource available to the applicant or recipient shall be the maximum amount of payments permitted under the terms of the trust to be distributed to the applicant or recipient, assuming the full exercise of discretion by the trustee or trustees. The maximum amount shall include only amounts that are permitted to be distributed but are not distributed from either the income or principal of the trust.

(3) Amounts that are actually distributed from a medicaid qualifying trust to a beneficiary for any purpose shall be treated in accordance with rules adopted by the department of job and family services governing income.

(4) Availability of a medicaid qualifying trust shall be considered without regard to any of the following:

(a) Whether or not the trust is irrevocable or was established for purposes other than to enable a grantor to qualify for medicaid, medical assistance for covered families and children, or as a qualified medicare beneficiary, specified low-income medicare beneficiary, qualifying individual-1, or qualifying individual-2;

(b) Whether or not the trustee actually exercises discretion.

(5) If any real or personal property is transferred to a medicaid qualifying trust that is not distributable to the applicant or recipient, the transfer shall be considered an improper disposition of assets and shall be subject to section 5111.0116 of the Revised Code and rules to implement that section adopted under section 5111.011 of the Revised Code.

(6) The baseline date for the look-back period for disposition of assets involving a medicaid qualifying trust shall be the date on which the applicant or recipient is both institutionalized and first applies for medicaid.

(E)(1) A trust or legal instrument or device similar to a trust shall be considered a self-settled trust if all of the following apply:

(a) The trust was established on or after August 11, 1993.

(b) The trust was not established by a will.

(c) The trust was established by an applicant or recipient, spouse of an applicant or recipient, or a person, including a court or administrative body, with legal authority to act in place of or on behalf of an applicant, recipient, or spouse, or acting at the direction or on request of an applicant, recipient, or spouse.

(2) A trust that meets the requirements of division (E)(1) of this section and is a revocable trust shall be treated by the county department of job and family services as follows:

(a) The corpus of the trust shall be considered a resource available to the applicant or recipient.

(b) Payments from the trust to or for the benefit of the applicant or recipient shall be considered unearned income of the applicant or recipient.

(c) Any other payments from the trust shall be considered an improper disposition of assets and shall be subject to section 5111.0116 of the Revised Code and rules to implement that section adopted under section 5111.011 of the Revised Code.

(3) A trust that meets the requirements of division (E)(1) of this section and is an irrevocable trust shall be treated by the county department of job and family services as follows:

(a) If there are any circumstances under which payment from the trust could be made to or for the benefit of the applicant or recipient, including a payment that can be made only in the future, the portion from which payments could be made shall be considered a resource available to the applicant or recipient. The county department of job and family services shall not take into account when payments can be made.

(b) Any payment that is actually made to or for the benefit of the applicant or recipient from either the corpus or income shall be considered unearned income.

(c) If a payment is made to someone other than to the applicant or recipient and the payment is not for the benefit of the applicant or recipient, the payment shall be considered an improper disposition of assets and shall be subject to section 5111.0116 of the Revised Code and rules to implement that section adopted under section 5111.011 of the Revised Code.

(d) The date of the disposition shall be the later of the date of establishment of the trust or the date of the occurrence of the event.

(e) When determining the value of the disposed asset under this provision, the value of the trust shall be its value on the date payment to the applicant or recipient was foreclosed.

(f) Any income earned or other resources added subsequent to the

foreclosure date shall be added to the total value of the trust.

(g) Any payments to or for the benefit of the applicant or recipient after the foreclosure date but prior to the application date shall be subtracted from the total value. Any other payments shall not be subtracted from the value.

(h) Any addition of assets after the foreclosure date shall be considered a separate disposition.

(4) If a trust is funded with assets of another person or persons in addition to assets of the applicant or recipient, the applicable provisions of this section and rules adopted by the department of job and family services governing trusts shall apply only to the portion of the trust attributable to the applicant or recipient.

(5) The availability of a self-settled trust shall be considered without regard to any of the following:

(a) The purpose for which the trust is established;

(b) Whether the trustees have exercised or may exercise discretion under the trust;

(c) Any restrictions on when or whether distributions may be made from the trust;

(d) Any restrictions on the use of distributions from the trust.

(6) The baseline date for the look-back period for dispositions of assets involving a self-settled trust shall be the date on which the applicant or recipient is both institutionalized and first applies for medicaid.

(F) The principal or income from any of the following shall ~~be exempt from being counted as~~ not be a resource ~~by a county department of job and family services~~ available to the applicant or recipient:

(1)(a) A special needs trust that meets all of the following requirements:

(i) The trust contains assets of an applicant or recipient under sixty-five years of age and may contain the assets of other individuals.

(ii) The applicant or recipient is disabled as defined in rules adopted by the department of job and family services.

(iii) The trust is established for the benefit of the applicant or recipient by a parent, grandparent, legal guardian, or a court.

(iv) The trust requires that on the death of the applicant or recipient the state will receive all amounts remaining in the trust up to an amount equal to the total amount of medicaid paid on behalf of the applicant or recipient.

(b) If a special needs trust meets the requirements of division (F)(1)(a) of this section and has been established for a disabled applicant or recipient under sixty-five years of age, the exemption for the trust granted pursuant to division (F) of this section shall continue after the disabled applicant or recipient becomes sixty-five years of age if the applicant or recipient

continues to be disabled as defined in rules adopted by the department of job and family services. Except for income earned by the trust, the grantor shall not add to or otherwise augment the trust after the applicant or recipient attains sixty-five years of age. An addition or augmentation of the trust by the applicant or recipient with the applicant's own assets after the applicant or recipient attains sixty-five years of age shall be treated as an improper disposition of assets.

(c) Cash distributions to the applicant or recipient shall be counted as unearned income. All other distributions from the trust shall be treated as provided in rules adopted by the department of job and family services governing in-kind income.

(d) Transfers of assets to a special needs trust shall not be treated as an improper transfer of resources. ~~Assets~~ An Asset held prior to the transfer to the trust shall be considered as ~~countable assets or countable~~ a resource available to the applicant or recipient, income available to the applicant or recipient, or ~~countable assets~~ both a resource and income available to the individual.

(2)(a) A qualifying income trust that meets all of the following requirements:

(i) The trust is composed only of pension, social security, and other income to the applicant or recipient, including accumulated interest in the trust.

(ii) The income is received by the individual and the right to receive the income is not assigned or transferred to the trust.

(iii) The trust requires that on the death of the applicant or recipient the state will receive all amounts remaining in the trust up to an amount equal to the total amount of medicaid paid on behalf of the applicant or recipient.

(b) No resources shall be used to establish or augment the trust.

(c) If an applicant or recipient has irrevocably transferred or assigned the applicant's or recipient's right to receive income to the trust, the trust shall not be considered a qualifying income trust by the county department of job and family services.

(d) Income placed in a qualifying income trust shall not be counted in determining an applicant's or recipient's eligibility for medicaid. The recipient of the funds may place any income directly into a qualifying income trust without those funds adversely affecting the applicant's or recipient's eligibility for medicaid. Income generated by the trust that remains in the trust shall not be considered as income to the applicant or recipient.

(e) All income placed in a qualifying income trust shall be combined

with any ~~countable~~ income available to the individual that is not placed in the trust to arrive at a base income figure to be used for spend down calculations.

(f) The base income figure shall be used for post-eligibility deductions, including personal needs allowance, monthly income allowance, family allowance, and medical expenses not subject to third party payment. Any income remaining shall be used toward payment of patient liability. Payments made from a qualifying income trust shall not be combined with the base income figure for post-eligibility calculations.

(g) The base income figure shall be used when determining the spend down budget for the applicant or recipient. Any income remaining after allowable deductions are permitted as provided under rules adopted by the department of job and family services shall be considered the applicant's or recipient's spend down liability.

(3)(a) A pooled trust that meets all of the following requirements:

(i) The trust contains the assets of the applicant or recipient of any age who is disabled as defined in rules adopted by the department of job and family services.

(ii) The trust is established and managed by a nonprofit association.

(iii) A separate account is maintained for each beneficiary of the trust but, for purposes of investment and management of funds, the trust pools the funds in these accounts.

(iv) Accounts in the trust are established by the applicant or recipient, the applicant's or recipient's parent, grandparent, or legal guardian, or a court solely for the benefit of individuals who are disabled.

(v) The trust requires that, to the extent that any amounts remaining in the beneficiary's account on the death of the beneficiary are not retained by the trust, the trust pay to the state the amounts remaining in the trust up to an amount equal to the total amount of medicaid paid on behalf of the beneficiary.

(b) Cash distributions to the applicant or recipient shall be counted as unearned income. All other distributions from the trust shall be treated as provided in rules adopted by the department of job and family services governing in-kind income.

(c) Transfers of assets to a pooled trust shall not be treated as an improper disposition of assets. ~~Assets~~ An asset held prior to the transfer to the trust shall be considered as ~~countable assets, countable~~ a resource available to the applicant or recipient, income available to the applicant or recipient, or ~~countable assets~~ both a resource and income available to the applicant or recipient.

(4) A supplemental services trust that meets the requirements of section 5815.28 of the Revised Code and to which all of the following apply:

(a) A person may establish a supplemental services trust pursuant to section 5815.28 of the Revised Code only for another person who is eligible to receive services through one of the following agencies:

(i) The department of developmental disabilities;

(ii) A county board of developmental disabilities;

(iii) The department of mental health;

(iv) A board of alcohol, drug addiction, and mental health services.

(b) A county department of job and family services shall not determine eligibility for another agency's program. An applicant or recipient shall do one of the following:

(i) Provide documentation from one of the agencies listed in division (F)(4)(a) of this section that establishes that the applicant or recipient was determined to be eligible for services from the agency at the time of the creation of the trust;

(ii) Provide an order from a court of competent jurisdiction that states that the applicant or recipient was eligible for services from one of the agencies listed in division (F)(4)(a) of this section at the time of the creation of the trust.

(c) At the time the trust is created, the trust principal does not exceed the maximum amount permitted. The maximum amount permitted in calendar year 2006 is two hundred twenty-two thousand dollars. Each year thereafter, the maximum amount permitted is the prior year's amount plus two thousand dollars.

(d) A county department of job and family services shall review the trust to determine whether it complies with the provisions of section 5815.28 of the Revised Code.

(e) Payments from supplemental services trusts shall be exempt as long as the payments are for supplemental services as defined in rules adopted by the department of job and family services. All supplemental services shall be purchased by the trustee and shall not be purchased through direct cash payments to the beneficiary.

(f) If a trust is represented as a supplemental services trust and a county department of job and family services determines that the trust does not meet the requirements provided in division (F)(4) of this section and section 5815.28 of the Revised Code, the county department of job and family services shall not consider it an exempt trust.

(G)(1) A trust or legal instrument or device similar to a trust shall be considered a trust established by an individual for the benefit of the

applicant or recipient if all of the following apply:

(a) The trust is created by a person other than the applicant or recipient.

(b) The trust names the applicant or recipient as a beneficiary.

(c) The trust is funded with assets or property in which the applicant or recipient has never held an ownership interest prior to the establishment of the trust.

(2) Any portion of a trust that meets the requirements of division (G)(1) of this section shall be ~~an available~~ a resource available to the applicant or recipient only if the trust permits the trustee to expend principal, corpus, or assets of the trust for the applicant's or recipient's medical care, care, comfort, maintenance, health, welfare, general well being, or any combination of these purposes.

(3) A trust that meets the requirements of division (G)(1) of this section shall be considered ~~an available~~ a resource available to the applicant or recipient even if the trust contains any of the following types of provisions:

(a) A provision that prohibits the trustee from making payments that would supplant or replace medicaid or other public assistance;

(b) A provision that prohibits the trustee from making payments that would impact or have an effect on the applicant's or recipient's right, ability, or opportunity to receive medicaid or other public assistance;

(c) A provision that attempts to prevent the trust or its corpus or principal from being ~~counted as an available~~ a resource available to the applicant or recipient.

(4) A trust that meets the requirements of division (G)(1) of this section shall not be counted as ~~an available~~ a resource available to the applicant or recipient if at least one of the following circumstances applies:

(a) If a trust contains a clear statement requiring the trustee to preserve a portion of the trust for another beneficiary or remainderman, that portion of the trust shall not be counted as ~~an available~~ a resource available to the applicant or recipient. Terms of a trust that grant discretion to preserve a portion of the trust shall not qualify as a clear statement requiring the trustee to preserve a portion of the trust.

(b) If a trust contains a clear statement requiring the trustee to use a portion of the trust for a purpose other than medical care, care, comfort, maintenance, welfare, or general well being of the applicant or recipient, that portion of the trust shall not be counted as ~~an available~~ a resource available to the applicant or recipient. Terms of a trust that grant discretion to limit the use of a portion of the trust shall not qualify as a clear statement requiring the trustee to use a portion of the trust for a particular purpose.

(c) If a trust contains a clear statement limiting the trustee to making

fixed periodic payments, the trust shall not be counted as ~~an available~~ a resource available to the applicant or recipient and payments shall be treated in accordance with rules adopted by the department of job and family services governing income. Terms of a trust that grant discretion to limit payments shall not qualify as a clear statement requiring the trustee to make fixed periodic payments.

(d) If a trust contains a clear statement that requires the trustee to terminate the trust if it is counted as ~~an available~~ a resource available to the applicant or recipient, the trust shall not be counted as ~~an available resource~~ such. Terms of a trust that grant discretion to terminate the trust do not qualify as a clear statement requiring the trustee to terminate the trust.

(e) If a person obtains a judgment from a court of competent jurisdiction that expressly prevents the trustee from using part or all of the trust for the medical care, care, comfort, maintenance, welfare, or general well being of the applicant or recipient, the trust or that portion of the trust subject to the court order shall not be counted as a resource available to the applicant or recipient.

(f) If a trust is specifically exempt from being counted as ~~an available~~ a resource available to the applicant or recipient by a provision of the Revised Code, rules, or federal law, the trust shall not be counted as ~~a resource~~ such.

(g) If an applicant or recipient presents a final judgment from a court demonstrating that the applicant or recipient was unsuccessful in a civil action against the trustee to compel payments from the trust, the trust shall not be counted as ~~an available~~ a resource available to the applicant or recipient.

(h) If an applicant or recipient presents a final judgment from a court demonstrating that in a civil action against the trustee the applicant or recipient was only able to compel limited or periodic payments, the trust shall not be counted as ~~an available~~ a resource available to the applicant or recipient and payments shall be treated in accordance with rules adopted by the department of job and family services governing income.

(i) If an applicant or recipient provides written documentation showing that the cost of a civil action brought to compel payments from the trust would be cost prohibitive, the trust shall not be counted as ~~an available~~ a resource available to the applicant or recipient.

(5) Any actual payments to the applicant or recipient from a trust that meet the requirements of division (G)(1) of this section, including trusts that are not counted as ~~an available~~ a resource available to the applicant or recipient, shall be treated as provided in rules adopted by the department of job and family services governing income. Payments to any person other

than the applicant or recipient shall not be considered income to the applicant or recipient. Payments from the trust to a person other than the applicant or recipient shall not be considered an improper disposition of assets.

Sec. 5111.16. (A) As part of the medicaid program, the department of job and family services shall establish a care management system. The department shall submit, if necessary, applications to the United States department of health and human services for waivers of federal medicaid requirements that would otherwise be violated in the implementation of the system.

(B) The department shall implement the care management system in some or all counties and shall designate the medicaid recipients who are required or permitted to participate in the system. In the department's implementation of the system and designation of participants, all of the following apply:

(1) In the case of individuals who receive medicaid on the basis of being included in the category identified by the department as covered families and children, the department shall implement the care management system in all counties. All individuals included in the category shall be designated for participation, except for individuals included in one or more of the medicaid recipient groups specified in 42 C.F.R. 438.50(d). The department shall ensure that all participants are enrolled in health insuring corporations under contract with the department pursuant to section 5111.17 of the Revised Code.

(2) In the case of individuals who receive medicaid on the basis of being aged, blind, or disabled, as specified in division (A)(2) of section 5111.01 of the Revised Code, the department shall implement the care management system in all counties. ~~All~~ Except as provided in division (C) of this section, all individuals included in the category shall be designated for participation~~, except for the individuals specified in divisions (B)(2)(a) to (e) of this section~~. The department shall ensure that all participants are enrolled in health insuring corporations under contract with the department pursuant to section 5111.17 of the Revised Code.

~~In~~ (3) Alcohol, drug addiction, and mental health services covered by medicaid shall not be included in any component of the care management system when the nonfederal share of the cost of those services is provided by a board of alcohol, drug addiction, and mental health services or a state agency other than the department of job and family services, but the recipients of those services may otherwise be designated for participation in the system.

(C)(1) In designating participants who receive medicaid on the basis of being aged, blind, or disabled, the department shall not include any of the following, except as provided under division (C)(2) of this section:

(a) Individuals who are under twenty-one years of age;

(b) Individuals who are institutionalized;

(c) Individuals who become eligible for medicaid by spending down their income or resources to a level that meets the medicaid program's financial eligibility requirements;

(d) Individuals who are dually eligible under the medicaid program and the medicare program established under Title XVIII of the "Social Security Act," 79 Stat. 286 (1965), 42 U.S.C. 1395, as amended;

(e) Individuals to the extent that they are receiving medicaid services through a medicaid waiver component, as defined in section 5111.85 of the Revised Code.

~~(3) Alcohol, drug addiction, and mental health services covered by medicaid shall not be included in any component of the care management system when the nonfederal share of the cost of those services is provided by a board of alcohol, drug addiction, and mental health services or a state agency other than the department of job and family services, but the recipients of those services may otherwise be designated for participation in the system.~~

~~(C)~~(2) If any necessary waiver of federal medicaid requirements is granted, the department may designate any of the following individuals who receive medicaid on the basis of being aged, blind, or disabled as individuals who are permitted or required to participate in the care management system:

(a) Individuals who are under twenty-one years of age;

(b) Individuals who reside in a nursing facility, as defined in section 5111.20 of the Revised Code;

(c) Individuals who, as an alternative to receiving nursing facility services, are participating in a home and community-based services medicaid waiver component, as defined in section 5111.85 of the Revised Code;

(d) Individuals who are dually eligible under the medicaid program and the medicare program.

(D) Subject to division (B) of this section, the department may do both of the following under the care management system:

(1) Require or permit participants in the system to obtain health care services from providers designated by the department;

(2) Require or permit participants in the system to obtain health care services through managed care organizations under contract with the

department pursuant to section 5111.17 of the Revised Code.

~~(D)~~(E)(1) The department shall prepare an annual report on the care management system. The report shall address the department's ability to implement the system, including all of the following components:

(a) The required designation of participants included in the category identified by the department as covered families and children;

(b) The required designation of participants included in the aged, blind, or disabled category of medicaid recipients;

(c) The use of any programs for enhanced care management.

(2) The department shall submit each annual report to the general assembly. The first report shall be submitted not later than October 1, 2007.

~~(E)~~(F) The director of job and family services may adopt rules in accordance with Chapter 119. of the Revised Code to implement this section.

Sec. 5111.161. (A) As used in this section:

(1) "Children's care network" means any of the following:

(a) A children's hospital;

(b) A group of children's hospitals;

(c) A group of pediatric physicians;

(2) "Children's hospital" has the same meaning as in section 2151.86 of the Revised Code.

(B) If the department of job and family services includes in the care management system, pursuant to section 5111.16 of the Revised Code, individuals under twenty-one years of age included in the category of individuals who receive medicaid on the basis of being aged, blind, or disabled, as specified in division (A)(2) of section 5111.01 of the Revised Code, the department shall develop a system to recognize entities as pediatric accountable care organizations. The purpose of the recognition system shall be to meet the complex medical and behavioral needs of disabled children through new approaches to care coordination. The department shall implement the recognition system not later than July 1, 2012.

An entity recognized by the department as a pediatric accountable care organization may develop innovative partnerships between relevant groups and may contract directly or subcontract with the state to provide services to the medicaid recipients under twenty-one years of age described in this division who are permitted or required to participate in the care management system.

(C)(1) To be recognized by the department as a pediatric accountable care organization, an entity shall meet the standards established in rules

adopted under this section. Unless required by sections 2706 and 3022 of the "Patient Protection and Affordable Care Act," 124 Stat. 325 (2010) and Title XVIII of the "Social Security Act," 124 Stat. 395 (2010), 42 U.S.C. 1395jjj, the regulations adopted pursuant to those sections, and the laws of this state, the department shall not require that an entity be a health insuring corporation as a condition of receiving the department's recognition.

(2) Any of the following entities may receive the department's recognition, if the standards for recognition have been met:

(a) A children's care network;

(b) A children's care network that may include one or more other entities, including, but not limited to, health insuring corporations or other managed care organizations;

(c) Any other entity the department determines is qualified.

(D) The department shall consult with all of the following in adopting rules under division (E) of this section necessary for an entity to be recognized by the department as a pediatric accountable care organization:

(1) The superintendent of insurance;

(2) Children's hospitals;

(3) Managed care organizations under contract pursuant to section 5111.17 of the Revised Code;

(4) Any other relevant entities, as determined necessary by the department, with interests in pediatric accountable care organizations.

(E) The department shall adopt rules in accordance with Chapter 119. of the Revised Code as necessary to implement this section. In adopting the rules, the department shall do all of the following:

(1) Establish application procedures to be followed by an entity seeking recognition as a pediatric accountable care organization;

(2) Ensure that the standards for recognition as a pediatric accountable care organization are the same as and do not conflict with those specified in sections 2706 and 3022 of the "Patient Protection and Affordable Care Act," 124 Stat. 325 (2010) and Title XVIII of the "Social Security Act," 124 Stat. 395 (2010), 42 U.S.C. 1395jjj or the regulations adopted pursuant to those sections;

(3) Establish requirements regarding the access to pediatric specialty care provided through or by a pediatric accountable care organization;

(4) Establish accountability and financial requirements for an entity recognized as a pediatric accountable care organization;

(5) Establish quality improvement initiatives consistent with any state medicaid quality plan established by the department;

(6) Establish transparency and consumer protection requirements for an

entity recognized as a pediatric accountable care organization;

(7) Establish a process for sharing data.

(F) This section does not limit the authority of the department of insurance to regulate the business of insurance in this state.

Sec. 5111.17. (A) The department of job and family services may enter into contracts with managed care organizations, including health insuring corporations, under which the organizations are authorized to provide, or arrange for the provision of, health care services to medical assistance recipients who are required or permitted to obtain health care services through managed care organizations as part of the care management system established under section 5111.16 of the Revised Code.

(B) The department or its actuary shall base the hospital inpatient capital payment portion of the payment made to managed care organizations on data for services provided to all recipients enrolled in managed care organizations with which the department contracts, as reported by hospitals on relevant cost reports submitted pursuant to rules adopted under this section.

(C) The director of job and family services may adopt rules in accordance with Chapter 119. of the Revised Code to implement this section.

~~(C)~~(D) The department of job and family services shall allow a managed care ~~plans~~ organization to use providers to render care upon completion of the managed care ~~plan's~~ organization's credentialing process.

Sec. 5111.172. (A) When contracting under section 5111.17 of the Revised Code with a managed care organization that is a health insuring corporation, the department of job and family services ~~may~~ shall require the health insuring corporation to provide coverage of prescription drugs for medicaid recipients enrolled in the health insuring corporation. In providing the required coverage, the health insuring corporation may, subject to the department's approval and the limitations specified in division (B) of this section, use strategies for the management of drug utilization.

(B) The department shall not permit a health insuring corporation to impose a prior authorization requirement in the case of a drug to which all of the following apply:

(1) The drug is an antidepressant or antipsychotic.

(2) The drug is administered or dispensed in a standard tablet or capsule form, except that in the case of an antipsychotic, the drug also may be administered or dispensed in a long-acting injectable form.

(3) The drug is prescribed by either of the following:

(a) A physician whom the health insuring corporation, pursuant to

division (C) of section 5111.17 of the Revised Code, has credentialed to provide care as a psychiatrist;

(b) A psychiatrist practicing at a community mental health agency certified by the department of mental health under section 5119.611 of the Revised Code.

(4) The drug is prescribed for a use that is indicated on the drug's labeling, as approved by the federal food and drug administration.

(C) As used in this division, "controlled substance" has the same meaning as in section 3719.01 of the Revised Code.

~~If~~ The department shall permit a health insuring corporation ~~is required under this section to provide coverage of prescription drugs, the department shall permit the health insuring corporation~~ to develop and implement a pharmacy utilization management program under which prior authorization through the program is established as a condition of obtaining a controlled substance pursuant to a prescription. The program may include processes for requiring medicaid recipients at high risk for fraud or abuse involving controlled substances to have their prescriptions for controlled substances filled by a pharmacy, medical provider, or health care facility designated by the program.

Sec. 5111.1711. (A)(1) The department of job and family services shall establish a managed care performance payment program. Under the program, the department may provide payments to managed care organizations under contract with the department pursuant to section 5111.17 of the Revised Code that meet performance standards established by the department.

(2) In establishing performance standards, the department may consult any of the following:

(a) Any quality measurements developed under the pediatric quality measures program established pursuant to 42 U.S.C. 1320b-9a;

(b) Any core set of adult health quality measures for medicaid eligible adults used for purposes of 42 U.S.C. 1320b-9b and any adult health quality used for purposes of the medicaid quality measurement program when the program is established under 42 U.S.C. 1320b-9b;

(c) The most recent healthcare effectiveness data and information set and quality measurement tool established by the national committee for quality assurance.

(3) The standards that must be met to receive the payments may be specified in the contract the department enters into with a managed care organization.

(4) If a managed care organization meets the performance standards

established by the department, the department shall make one or more performance payments to the organization. The amount of each performance payment, the number of payments, and the schedule for making the payments shall be established by the department. The payments shall be discontinued if the department determines that the organization no longer meets the performance standards. The department shall not make or discontinue payments based on any performance standard that has been in effect as part of the organization's contract for less than six months.

(B) For purposes of the program, the department shall establish an amount that is to be withheld each time a premium payment is made to a managed care organization. The amount shall be established as a percentage of each premium payment. The percentage shall be the same for all managed care organizations under contract with the department. The sum of all withholdings under this division shall not exceed one per cent of the total of all premium payments made to all managed care organizations under contract with the department.

Each managed care organization shall agree to the withholding as a condition of receiving or maintaining its medicaid provider agreement with the department.

When the amount is established and each time the amount is modified thereafter, the department shall certify the amount to the director of budget and management and begin withholding the amount from each premium the department pays to a managed care organization.

(C) There is hereby created in the state treasury the managed care performance payment fund. The fund shall consist of amounts transferred to it by the director of budget and management for the purpose of the program. All investment earnings of the fund shall be credited to the fund. Amounts in the fund shall be used solely to make performance payments to managed care organizations in accordance with this section.

(D) The department may adopt rules as necessary to implement this section. The rules shall be adopted in accordance with Chapter 119. of the Revised Code.

Sec. 5111.20. As used in sections 5111.20 to ~~5111.34~~ 5111.331 of the Revised Code:

(A) "Allowable costs" are those costs determined by the department of job and family services to be reasonable and do not include fines paid under sections 5111.35 to 5111.61 and section 5111.99 of the Revised Code.

(B) "Ancillary and support costs" means all reasonable costs incurred by a nursing facility other than direct care costs or capital costs. "Ancillary and support costs" includes, but is not limited to, costs of activities, social

services, pharmacy consultants, habilitation supervisors, qualified mental retardation professionals, program directors, medical and habilitation records, program supplies, incontinence supplies, food, enterals, dietary supplies and personnel, laundry, housekeeping, security, administration, medical equipment, utilities, liability insurance, bookkeeping, purchasing department, human resources, communications, travel, dues, license fees, subscriptions, home office costs not otherwise allocated, legal services, accounting services, minor equipment, wheelchairs, resident transportation, maintenance and repairs, help-wanted advertising, informational advertising, start-up costs, organizational expenses, other interest, property insurance, employee training and staff development, employee benefits, payroll taxes, and workers' compensation premiums or costs for self-insurance claims and related costs as specified in rules adopted by the director of job and family services under section 5111.02 of the Revised Code, for personnel listed in this division. "Ancillary and support costs" also means the cost of equipment, including vehicles, acquired by operating lease executed before December 1, 1992, if the costs are reported as administrative and general costs on the facility's cost report for the cost reporting period ending December 31, 1992.

(C) "Capital costs" means costs of ownership and, in the case of an intermediate care facility for the mentally retarded, costs of nonextensive renovation.

(1) "Cost of ownership" means the actual expense incurred for all of the following:

(a) Depreciation and interest on any capital assets that cost five hundred dollars or more per item, including the following:

(i) Buildings;

(ii) Building improvements that are not approved as nonextensive renovations under section 5111.251 of the Revised Code;

(iii) Except as provided in division (B) of this section, equipment;

(iv) In the case of an intermediate care facility for the mentally retarded, extensive renovations;

(v) Transportation equipment.

(b) Amortization and interest on land improvements and leasehold improvements;

(c) Amortization of financing costs;

(d) Except as provided in division (K) of this section, lease and rent of land, building, and equipment.

The costs of capital assets of less than five hundred dollars per item may be considered capital costs in accordance with a provider's practice.

(2) "Costs of nonextensive renovation" means the actual expense incurred by an intermediate care facility for the mentally retarded for depreciation or amortization and interest on renovations that are not extensive renovations.

(D) "Capital lease" and "operating lease" shall be construed in accordance with generally accepted accounting principles.

(E) "Case-mix score" means the measure determined under section 5111.232 of the Revised Code of the relative direct-care resources needed to provide care and habilitation to a resident of a nursing facility or intermediate care facility for the mentally retarded.

(F)(1) "Date of licensure," for a facility originally licensed as a nursing home under Chapter 3721. of the Revised Code, means the date specific beds were originally licensed as nursing home beds under that chapter, regardless of whether they were subsequently licensed as residential facility beds under section 5123.19 of the Revised Code. For a facility originally licensed as a residential facility under section 5123.19 of the Revised Code, "date of licensure" means the date specific beds were originally licensed as residential facility beds under that section.

If nursing home beds licensed under Chapter 3721. of the Revised Code or residential facility beds licensed under section 5123.19 of the Revised Code were not required by law to be licensed when they were originally used to provide nursing home or residential facility services, "date of licensure" means the date the beds first were used to provide nursing home or residential facility services, regardless of the date the present provider obtained licensure.

If a facility adds nursing home beds or residential facility beds or extensively renovates all or part of the facility after its original date of licensure, it will have a different date of licensure for the additional beds or extensively renovated portion of the facility, unless the beds are added in a space that was constructed at the same time as the previously licensed beds but was not licensed under Chapter 3721. or section 5123.19 of the Revised Code at that time.

(2) The definition of "date of licensure" in this section applies in determinations of the medicaid reimbursement rate for a nursing facility or intermediate care facility for the mentally retarded but does not apply in determinations of the franchise permit fee for a nursing facility or intermediate care facility for the mentally retarded.

(G) "Desk-reviewed" means that costs as reported on a cost report submitted under section 5111.26 of the Revised Code have been subjected to a desk review under division (A) of section 5111.27 of the Revised Code

and preliminarily determined to be allowable costs.

(H) "Direct care costs" means all of the following:

(1)(a) Costs for registered nurses, licensed practical nurses, and nurse aides employed by the facility;

(b) Costs for direct care staff, administrative nursing staff, medical directors, respiratory therapists, and except as provided in division (H)(2) of this section, other persons holding degrees qualifying them to provide therapy;

(c) Costs of purchased nursing services;

(d) Costs of quality assurance;

(e) Costs of training and staff development, employee benefits, payroll taxes, and workers' compensation premiums or costs for self-insurance claims and related costs as specified in rules adopted by the director of job and family services in accordance with Chapter 119. of the Revised Code, for personnel listed in divisions (H)(1)(a), (b), and (d) of this section;

(f) Costs of consulting and management fees related to direct care;

(g) Allocated direct care home office costs.

(2) In addition to the costs specified in division (H)(1) of this section, for nursing facilities only, direct care costs include costs of habilitation staff (other than habilitation supervisors), medical supplies, oxygen, over-the-counter pharmacy products, behavioral and mental health services, physical therapists, physical therapy assistants, occupational therapists, occupational therapy assistants, speech therapists, audiologists, habilitation supplies, and universal precautions supplies.

(3) In addition to the costs specified in division (H)(1) of this section, for intermediate care facilities for the mentally retarded only, direct care costs include both of the following:

(a) Costs for physical therapists and physical therapy assistants, occupational therapists and occupational therapy assistants, speech therapists, audiologists, habilitation staff (including habilitation supervisors), qualified mental retardation professionals, program directors, social services staff, activities staff, off-site day programming, psychologists and psychology assistants, and social workers and counselors;

(b) Costs of training and staff development, employee benefits, payroll taxes, and workers' compensation premiums or costs for self-insurance claims and related costs as specified in rules adopted under section 5111.02 of the Revised Code, for personnel listed in division (H)(3)(a) of this section.

(4) Costs of other direct-care resources that are specified as direct care costs in rules adopted under section 5111.02 of the Revised Code.

(I) "Fiscal year" means the fiscal year of this state, as specified in section 9.34 of the Revised Code.

(J) "Franchise permit fee" means the following:

(1) In the context of nursing facilities, the fee imposed by sections 3721.50 to 3721.58 of the Revised Code;

(2) In the context of intermediate care facilities for the mentally retarded, the fee imposed by sections 5112.30 to 5112.39 of the Revised Code.

(K) "Indirect care costs" means all reasonable costs incurred by an intermediate care facility for the mentally retarded other than direct care costs, other protected costs, or capital costs. "Indirect care costs" includes but is not limited to costs of habilitation supplies, pharmacy consultants, medical and habilitation records, program supplies, incontinence supplies, food, enterals, dietary supplies and personnel, laundry, housekeeping, security, administration, liability insurance, bookkeeping, purchasing department, human resources, communications, travel, dues, license fees, subscriptions, home office costs not otherwise allocated, legal services, accounting services, minor equipment, maintenance and repairs, help-wanted advertising, informational advertising, start-up costs, organizational expenses, other interest, property insurance, employee training and staff development, employee benefits, payroll taxes, and workers' compensation premiums or costs for self-insurance claims and related costs as specified in rules adopted under section 5111.02 of the Revised Code, for personnel listed in this division. Notwithstanding division (C)(1) of this section, "indirect care costs" also means the cost of equipment, including vehicles, acquired by operating lease executed before December 1, 1992, if the costs are reported as administrative and general costs on the facility's cost report for the cost reporting period ending December 31, 1992.

(L) "Inpatient days" means all days during which a resident, regardless of payment source, occupies a bed in a nursing facility or intermediate care facility for the mentally retarded that is included in the facility's certified capacity under Title XIX. Therapeutic or hospital leave days for which payment is made under section 5111.33 or 5111.331 of the Revised Code are considered inpatient days proportionate to the percentage of the facility's per resident per day rate paid for those days.

(M) "Intermediate care facility for the mentally retarded" means an intermediate care facility for the mentally retarded certified as in compliance with applicable standards for the medicaid program by the director of health in accordance with Title XIX.

(N) "Maintenance and repair expenses" means, except as provided in

division (BB)(2) of this section, expenditures that are necessary and proper to maintain an asset in a normally efficient working condition and that do not extend the useful life of the asset two years or more. "Maintenance and repair expenses" includes but is not limited to the cost of ordinary repairs such as painting and wallpapering.

(O) "Medicaid days" means all days during which a resident who is a ~~Medicaid~~ medicaid recipient eligible for nursing facility services occupies a bed in a nursing facility that is included in the nursing facility's certified capacity under Title XIX. Therapeutic or hospital leave days for which payment is made under section 5111.33 or 5111.331 of the Revised Code are considered ~~Medicaid~~ medicaid days proportionate to the percentage of the nursing facility's per resident per day rate paid for those days.

(P) "Nursing facility" means a facility, or a distinct part of a facility, that is certified as a nursing facility by the director of health in accordance with Title XIX and is not an intermediate care facility for the mentally retarded. "Nursing facility" includes a facility, or a distinct part of a facility, that is certified as a nursing facility by the director of health in accordance with Title XIX and is certified as a skilled nursing facility by the director in accordance with Title XVIII.

(Q) "Operator" means the person or government entity responsible for the daily operating and management decisions for a nursing facility or intermediate care facility for the mentally retarded.

(R) "Other protected costs" means costs incurred by an intermediate care facility for the mentally retarded for medical supplies; real estate, franchise, and property taxes; natural gas, fuel oil, water, electricity, sewage, and refuse and hazardous medical waste collection; allocated other protected home office costs; and any additional costs defined as other protected costs in rules adopted under section 5111.02 of the Revised Code.

(S)(1) "Owner" means any person or government entity that has at least five per cent ownership or interest, either directly, indirectly, or in any combination, in any of the following regarding a nursing facility or intermediate care facility for the mentally retarded:

(a) The land on which the facility is located;

(b) The structure in which the facility is located;

(c) Any mortgage, contract for deed, or other obligation secured in whole or in part by the land or structure on or in which the facility is located;

(d) Any lease or sublease of the land or structure on or in which the facility is located.

(2) "Owner" does not mean a holder of a debenture or bond related to

the nursing facility or intermediate care facility for the mentally retarded and purchased at public issue or a regulated lender that has made a loan related to the facility unless the holder or lender operates the facility directly or through a subsidiary.

(T) "Patient" includes "resident."

(U) Except as provided in divisions (U)(1) and (2) of this section, "per diem" means a nursing facility's or intermediate care facility for the mentally retarded's actual, allowable costs in a given cost center in a cost reporting period, divided by the facility's inpatient days for that cost reporting period.

(1) When calculating indirect care costs for the purpose of establishing rates under section 5111.241 of the Revised Code, "per diem" means an intermediate care facility for the mentally retarded's actual, allowable indirect care costs in a cost reporting period divided by the greater of the facility's inpatient days for that period or the number of inpatient days the facility would have had during that period if its occupancy rate had been eighty-five per cent.

(2) When calculating capital costs for the purpose of establishing rates under section 5111.251 of the Revised Code, "per diem" means a facility's actual, allowable capital costs in a cost reporting period divided by the greater of the facility's inpatient days for that period or the number of inpatient days the facility would have had during that period if its occupancy rate had been ninety-five per cent.

(V) "Provider" means an operator with a provider agreement.

(W) "Provider agreement" means a contract between the department of job and family services and the operator of a nursing facility or intermediate care facility for the mentally retarded for the provision of nursing facility services or intermediate care facility services for the mentally retarded under the medicaid program.

(X) "Purchased nursing services" means services that are provided in a nursing facility by registered nurses, licensed practical nurses, or nurse aides who are not employees of the facility.

(Y) "Reasonable" means that a cost is an actual cost that is appropriate and helpful to develop and maintain the operation of patient care facilities and activities, including normal standby costs, and that does not exceed what a prudent buyer pays for a given item or services. Reasonable costs may vary from provider to provider and from time to time for the same provider.

(Z) "Related party" means an individual or organization that, to a significant extent, has common ownership with, is associated or affiliated

with, has control of, or is controlled by, the provider.

(1) An individual who is a relative of an owner is a related party.

(2) Common ownership exists when an individual or individuals possess significant ownership or equity in both the provider and the other organization. Significant ownership or equity exists when an individual or individuals possess five per cent ownership or equity in both the provider and a supplier. Significant ownership or equity is presumed to exist when an individual or individuals possess ten per cent ownership or equity in both the provider and another organization from which the provider purchases or leases real property.

(3) Control exists when an individual or organization has the power, directly or indirectly, to significantly influence or direct the actions or policies of an organization.

(4) An individual or organization that supplies goods or services to a provider shall not be considered a related party if all of the following conditions are met:

(a) The supplier is a separate bona fide organization.

(b) A substantial part of the supplier's business activity of the type carried on with the provider is transacted with others than the provider and there is an open, competitive market for the types of goods or services the supplier furnishes.

(c) The types of goods or services are commonly obtained by other nursing facilities or intermediate care facilities for the mentally retarded from outside organizations and are not a basic element of patient care ordinarily furnished directly to patients by the facilities.

(d) The charge to the provider is in line with the charge for the goods or services in the open market and no more than the charge made under comparable circumstances to others by the supplier.

(AA) "Relative of owner" means an individual who is related to an owner of a nursing facility or intermediate care facility for the mentally retarded by one of the following relationships:

(1) Spouse;

(2) Natural parent, child, or sibling;

(3) Adopted parent, child, or sibling;

(4) Stepparent, stepchild, stepbrother, or stepsister;

(5) Father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, or sister-in-law;

(6) Grandparent or grandchild;

(7) Foster caregiver, foster child, foster brother, or foster sister.

(BB) "Renovation" and "extensive renovation" mean:

(1) Any betterment, improvement, or restoration of an intermediate care facility for the mentally retarded started before July 1, 1993, that meets the definition of a renovation or extensive renovation established in rules adopted by the director of job and family services in effect on December 22, 1992.

(2) In the case of betterments, improvements, and restorations of intermediate care facilities for the mentally retarded started on or after July 1, 1993:

(a) "Renovation" means the betterment, improvement, or restoration of an intermediate care facility for the mentally retarded beyond its current functional capacity through a structural change that costs at least five hundred dollars per bed. A renovation may include betterment, improvement, restoration, or replacement of assets that are affixed to the building and have a useful life of at least five years. A renovation may include costs that otherwise would be considered maintenance and repair expenses if they are an integral part of the structural change that makes up the renovation project. "Renovation" does not mean construction of additional space for beds that will be added to a facility's licensed or certified capacity.

(b) "Extensive renovation" means a renovation that costs more than sixty-five per cent and no more than eighty-five per cent of the cost of constructing a new bed and that extends the useful life of the assets for at least ten years.

For the purposes of division (BB)(2) of this section, the cost of constructing a new bed shall be considered to be forty thousand dollars, adjusted for the estimated rate of inflation from January 1, 1993, to the end of the calendar year during which the renovation is completed, using the consumer price index for shelter costs for all urban consumers for the north central region, as published by the United States bureau of labor statistics.

The department of job and family services may treat a renovation that costs more than eighty-five per cent of the cost of constructing new beds as an extensive renovation if the department determines that the renovation is more prudent than construction of new beds.

(CC) "Title XIX" means Title XIX of the "Social Security Act," 79 Stat. 286 (1965), 42 U.S.C. 1396, as amended.

(DD) "Title XVIII" means Title XVIII of the "Social Security Act," 79 Stat. 286 (1965), 42 U.S.C. 1395, as amended.

Sec. 5111.21. (A) In order to be eligible for medicaid payments, the operator of a nursing facility or intermediate care facility for the mentally retarded shall do all of the following:

(1) Enter into a provider agreement with the department as provided in section 5111.22, 5111.671, or 5111.672 of the Revised Code;

(2) Apply for and maintain a valid license to operate if so required by law;

(3) Subject to division (B) of this section, comply with all applicable state and federal laws and rules.

(B) A state rule that requires the operator of an intermediate care facility for the mentally retarded to have received approval of a plan for the proposed facility pursuant to section 5123.042 of the Revised Code as a condition of the operator being eligible for medicaid payments for the facility does not apply if, under former section 5123.193 of the Revised Code as enacted by Am. Sub. H.B. 1 of the 128th general assembly or section 5123.197 of the Revised Code, a residential facility license was obtained or modified for the facility without obtaining approval of such a plan.

(C)(1) Except as provided in division (C)(2) of this section, the operator of a nursing facility that elects to obtain and maintain eligibility for payments under the medicaid program shall qualify all of the facility's medicaid-certified beds in the medicare program established by Title XVIII. The director of job and family services may adopt rules under section 5111.02 of the Revised Code to establish the time frame in which a nursing facility must comply with this requirement.

(2) The department of veterans services is not required to qualify all of the medicaid-certified beds in a nursing facility the agency maintains and operates under section 5907.01 of the Revised Code in the medicare program.

Sec. 5111.211. (A) Except as provided in ~~division~~ divisions (C) and (D) of this section, the department of developmental disabilities is responsible for the nonfederal share of claims submitted for services that are covered by the medicaid program and provided to an eligible medicaid recipient by an intermediate care facility for the mentally retarded if all of the following are the case:

(1) The services are provided on or after July 1, 2003;

(2) The facility receives initial certification by the director of health as an intermediate care facility for the mentally retarded on or after June 1, 2003;

(3) The facility, or a portion of the facility, is licensed by the director of developmental disabilities as a residential facility under section 5123.19 of the Revised Code;

(4) There is a valid provider agreement for the facility.

(B) Each month, the department of job and family services shall invoice the department of developmental disabilities by interagency transfer voucher for the claims for which the department of developmental disabilities is responsible pursuant to this section.

(C) Division (A) of this section does not apply to claims submitted for an intermediate care facility for the mentally retarded if, under former section 5123.193 of the Revised Code as enacted by Am. Sub. H.B. 1 of the 128th general assembly or section 5123.197 of the Revised Code, a residential facility license was obtained or modified for the facility without obtaining approval of a plan for the proposed residential facility pursuant to section 5123.042 of the Revised Code.

(D) Beginning on the date the department of developmental disabilities assumes, under section 5111.226 of the Revised Code, the powers and duties of the department of job and family services regarding the medicaid program's coverage of services provided by intermediate care facilities for the mentally retarded, this section shall apply only to the extent, if any, provided in the contract required by that section.

Sec. 5111.212. As used in this section, "effective date of an involuntary termination" and "involuntary termination" have the same meanings as in section 5111.65 of the Revised Code.

Medicaid payments may be made for nursing facility services and intermediate care facility for the mentally retarded services provided not later than thirty days after the effective date of an involuntary termination of the facility that provides the services if the services are provided to a medicaid recipient who is eligible for the services and resided in the facility before the effective date of the involuntary termination.

Sec. 5111.22. A provider agreement between the department of job and family services and the provider of a nursing facility or intermediate care facility for the mentally retarded shall contain the following provisions:

(A) The department agrees to make payments to the provider, as provided in sections 5111.20 to ~~5111.33~~ 5111.331 of the Revised Code, for medicaid-covered services the facility provides to a resident of the facility who is a medicaid recipient. No payment shall be made for the day a medicaid recipient is discharged from the facility.

(B) The provider agrees to:

(1) Maintain eligibility as provided in section 5111.21 of the Revised Code;

(2) Keep records relating to a cost reporting period for the greater of seven years after the cost report is filed or, if the department issues an audit report in accordance with division (B) of section 5111.27 of the Revised

Code, six years after all appeal rights relating to the audit report are exhausted;

(3) File reports as required by the department;

(4) Open all records relating to the costs of its services for inspection and audit by the department;

(5) Open its premises for inspection by the department, the department of health, and any other state or local authority having authority to inspect;

(6) Supply to the department such information as it requires concerning the facility's services to residents who are or are eligible to be medicaid recipients;

(7) Comply with section 5111.31 of the Revised Code.

The provider agreement may contain other provisions that are consistent with law and considered necessary by the department.

A provider agreement shall be effective for no longer than twelve months, except that if federal statute or regulations authorize a longer term, it may be effective for a longer term so authorized. A provider agreement may be renewed only if the facility is certified by the department of health for participation in the medicaid program.

The department of job and family services, in accordance with rules adopted under section 5111.02 of the Revised Code, may elect not to enter into, not to renew, or to terminate a provider agreement when the department determines that such an agreement would not be in the best interests of medicaid recipients or of the state.

Sec. 5111.221. The department of job and family services shall make its best efforts each year to calculate rates under sections 5111.20 to ~~5111.33~~ 5111.331 of the Revised Code in time to use them to make the payments due to providers by the fifteenth day of August. If the department is unable to calculate the rates so that they can be paid by that date, the department shall pay each provider the rate calculated for the provider's nursing facilities and intermediate care facilities for the mentally retarded under those sections at the end of the previous fiscal year. If the department also is unable to calculate the rates to make the payments due by the fifteenth day of September and the fifteenth day of October, the department shall pay the previous fiscal year's rate to make those payments. The department may increase by five per cent the previous fiscal year's rate paid for any facility pursuant to this section at the request of the provider. The department shall use rates calculated for the current fiscal year to make the payments due by the fifteenth day of November.

If the rate paid to a provider for a facility pursuant to this section is lower than the rate calculated for the facility for the current fiscal year, the

department shall pay the provider the difference between the two rates for the number of days for which the provider was paid for the facility pursuant to this section. If the rate paid for a facility pursuant to this section is higher than the rate calculated for it for the current fiscal year, the provider shall refund to the department the difference between the two rates for the number of days for which the provider was paid for the facility pursuant to this section.

Sec. 5111.222. (A) Except as otherwise provided by sections 5111.20 to ~~5111.33~~ 5111.331 of the Revised Code and by division (B) of this section, the payments that the department of job and family services shall agree to make to the provider of a nursing facility pursuant to a provider agreement shall equal the sum of all of the following:

(1) The rate for direct care costs determined for the nursing facility under section 5111.231 of the Revised Code;

(2) The rate for ancillary and support costs determined for the nursing facility's ancillary and support cost peer group under section 5111.24 of the Revised Code;

(3) The rate for tax costs determined for the nursing facility under section 5111.242 of the Revised Code;

(4) ~~The rate for franchise permit fees determined for the nursing facility under section 5111.243 of the Revised Code;~~

~~(5)~~ The quality incentive payment paid to the nursing facility under section 5111.244 of the Revised Code;

~~(6)~~(5) The ~~median~~ rate for capital costs determined for the ~~nursing facilities in the~~ nursing facility's capital costs peer group ~~as determined~~ under section 5111.25 of the Revised Code.

(B) The department shall adjust the rates otherwise determined under ~~divisions~~ division (A)~~(1), (2), (3), and (6)~~ of this section as directed by the general assembly through the enactment of law governing medicaid payments to providers of nursing facilities, including any law that ~~does either of the following:~~

~~(1) Establishes~~ establishes factors by which the rates are to be adjusted~~;~~

~~(2) Establishes a methodology for phasing in the rates determined for fiscal year 2006 under uncodified law the general assembly enacts to rates determined for subsequent fiscal years under sections 5111.20 to 5111.33 of the Revised Code~~.

Sec. 5111.224. (A) Except as otherwise provided by sections 5111.20 to 5111.331 of the Revised Code and by division (B) of this section, the payments that the department of job and family services shall agree to make to the provider of an intermediate care facility for the mentally retarded

pursuant to a provider agreement shall equal the sum of all of the following:

(1) The rate for direct care costs determined for the facility under section 5111.23 of the Revised Code;

(2) The rate for other protected costs determined for the facility under section 5111.235 of the Revised Code;

(3) The rate for indirect care costs determined for the facility under section 5111.241 of the Revised Code;

(4) The rate for capital costs determined for the facility under section 5111.251 of the Revised Code.

(B) The department shall adjust the total rate otherwise determined under division (A) of this section as directed by the general assembly through the enactment of law governing medicaid payments to providers of intermediate care facilities for the mentally retarded.

Sec. 5111.225. (A) As used in this section:

"Dual eligible individual" has the same meaning as in section 1915(h)(2)(B) of the "Social Security Act," 124 Stat. 315 (2010), 42 U.S.C. 1396n(h)(2)(B).

"Medicaid maximum allowable amount" means one hundred per cent of a nursing facility's per diem rate for a medicaid day.

(B) The department of job and family services shall pay the provider of a nursing facility the lesser of the following for nursing facility services the nursing facility provides on or after January 1, 2012, to a dual eligible individual who is eligible for nursing facility services under the medicaid program and post-hospital extended care services under Part A of Title XVIII:

(1) The coinsurance amount for the services as provided under Part A of Title XVIII;

(2) The medicaid maximum allowable amount for the services, less the amount paid under Part A of Title XVIII for the services.

Sec. 5111.226. Subject, if needed, to the approval of the United States secretary of health and human services, the department of job and family services shall enter into a contract with the department of developmental disabilities under section 5111.91 of the Revised Code that provides for the department of developmental disabilities to assume the powers and duties of the department of job and family services with regard to the medicaid program's coverage of services provided by intermediate care facilities for the mentally retarded. The contract shall include a schedule for the assumption of the powers and duties. Except as otherwise authorized by the United States secretary of health and human services, no provision of the contract may violate a federal law or regulation governing the medicaid

program. Once the contract goes into effect, all references to the department of job and family services, and all references to the director of job and family services, with regard to intermediate care facilities for the mentally retarded that are in law enacted by the general assembly shall be deemed to be references to the department of developmental disabilities and director of developmental disabilities, respectively, to the extent necessary to implement the terms of the contract.

Sec. 5111.23. (A) The department of job and family services shall pay a provider for each of the provider's eligible intermediate care facilities for the mentally retarded a per resident per day rate for direct care costs established prospectively for each facility. The department shall establish each facility's rate for direct care costs quarterly.

(B) Each facility's rate for direct care costs shall be based on the facility's cost per case-mix unit, subject to the maximum costs per case-mix unit established under division (B)(2) of this section, from the calendar year preceding the fiscal year in which the rate is paid. To determine the rate, the department shall do all of the following:

(1) Determine each facility's cost per case-mix unit for the calendar year preceding the fiscal year in which the rate will be paid by dividing the facility's desk-reviewed, actual, allowable, per diem direct care costs for that year by its average case-mix score determined under section 5111.232 of the Revised Code for the same calendar year.

(2)(a) Set the maximum cost per case-mix unit for each peer group of intermediate care facilities for the mentally retarded with more than eight beds specified in rules adopted under division ~~(E)~~(F) of this section at a percentage above the cost per case-mix unit of the facility in the group that has the group's median medicaid inpatient day for the calendar year preceding the fiscal year in which the rate will be paid, as calculated under division (B)(1) of this section, that is no less than the percentage calculated under division ~~(D)~~(E)(2) of this section.

(b) Set the maximum cost per case-mix unit for each peer group of intermediate care facilities for the mentally retarded with eight or fewer beds specified in rules adopted under division ~~(E)~~(F) of this section at a percentage above the cost per case-mix unit of the facility in the group that has the group's median medicaid inpatient day for the calendar year preceding the fiscal year in which the rate will be paid, as calculated under division (B)(1) of this section, that is no less than the percentage calculated under division ~~(D)~~(E)(3) of this section.

(c) In calculating the maximum cost per case-mix unit under divisions (B)(2)(a) ~~to~~ and (b) of this section for each peer group, the department shall

exclude from its calculations the cost per case-mix unit of any facility in the group that participated in the medicaid program under the same operator for less than twelve months during the calendar year preceding the fiscal year in which the rate will be paid.

(3) Estimate the rate of inflation for the eighteen-month period beginning on the first day of July of the calendar year preceding the fiscal year in which the rate will be paid and ending on the thirty-first day of December of the fiscal year in which the rate will be paid, using the ~~employment cost~~ index ~~for total compensation, health services component, published by the United States bureau of labor statistics~~ specified in division (C) of this section. If the estimated inflation rate for the eighteen-month period is different from the actual inflation rate for that period, as measured using the same index, the difference shall be added to or subtracted from the inflation rate estimated under division (B)(3) of this section for the following fiscal year.

(4) The department shall not recalculate a maximum cost per case-mix unit under division (B)(2) of this section or a percentage under division ~~(D)~~(E) of this section based on additional information that it receives after the maximum costs per case-mix unit or percentages are set. The department shall recalculate a maximum cost per case-mix units or percentage only if it made an error in computing the maximum cost per case-mix unit or percentage based on information available at the time of the original calculation.

(C) The department shall use the following index for the purpose of division (B)(3) of this section:

(1) The employment cost index for total compensation, health services component, published by the United States bureau of labor statistics;

(2) If the United States bureau of labor statistics ceases to publish the index specified in division (C)(1) of this section, the index that is subsequently published by the bureau and covers nursing facilities' staff costs.

(D) Each facility's rate for direct care costs shall be determined as follows for each calendar quarter within a fiscal year:

(1) Multiply the lesser of the following by the facility's average case-mix score determined under section 5111.232 of the Revised Code for the calendar quarter that preceded the immediately preceding calendar quarter:

(a) The facility's cost per case-mix unit for the calendar year preceding the fiscal year in which the rate will be paid, as determined under division (B)(1) of this section;

(b) The maximum cost per case-mix unit established for the fiscal year in which the rate will be paid for the facility's peer group under division (B)(2) of this section;

(2) Adjust the product determined under division ~~(C)~~(D)(1) of this section by the inflation rate estimated under division (B)(3) of this section.

~~(D)~~(E)(1) The department shall calculate the percentage above the median cost per case-mix unit determined under division (B)(1) of this section for the facility that has the median medicaid inpatient day for calendar year 1992 for all intermediate care facilities for the mentally retarded with more than eight beds that would result in payment of all desk-reviewed, actual, allowable direct care costs for eighty and one-half per cent of the medicaid inpatient days for such facilities for calendar year 1992.

(2) The department shall calculate the percentage above the median cost per case-mix unit determined under division (B)(1) of this section for the facility that has the median medicaid inpatient day for calendar year 1992 for all intermediate care facilities for the mentally retarded with eight or fewer beds that would result in payment of all desk-reviewed, actual, allowable direct care costs for eighty and one-half per cent of the medicaid inpatient days for such facilities for calendar year 1992.

~~(E)~~(F) The director of job and family services shall adopt rules under section 5111.02 of the Revised Code that specify peer groups of intermediate care facilities for the mentally retarded with more than eight beds and intermediate care facilities for the mentally retarded with eight or fewer beds, based on findings of significant per diem direct care cost differences due to geography and facility bed-size. The rules also may specify peer groups based on findings of significant per diem direct care cost differences due to other factors which may include case-mix.

~~(F)~~(G) The department, in accordance with division (D) of section 5111.232 of the Revised Code and rules adopted under division ~~(E)~~(F) of that section, may assign case-mix scores or costs per case-mix unit if a provider fails to submit assessment data necessary to calculate an intermediate care facility for the mentally retarded's case-mix score in accordance with that section.

Sec. 5111.231. (A) As used in this section~~, "applicable~~:

(1) "Applicable calendar year" means the following:

~~(1)~~(a) For the purpose of the department of job and family services' initial determination under division (D) of this section of each peer group's cost per case-mix unit, calendar year 2003;

~~(2)~~(b) For the purpose of the department's ~~subsequent determinations~~

~~under division (D) of this section of each peer group's cost per case-mix unit~~ rebasings, the calendar year the department selects.

(2) "Rebasing" means a redetermination under division (D) of this section of each peer groups' cost per case-mix unit using information from cost reports for an applicable calendar year that is later than the applicable calendar year used for the previous determination of such costs.

(B) The department of job and family services shall pay a provider for each of the provider's eligible nursing facilities a per resident per day rate for direct care costs determined semiannually by multiplying the cost per case-mix unit determined under division (D) of this section for the facility's peer group by the facility's semiannual case-mix score determined under section 5111.232 of the Revised Code.

(C) For the purpose of determining nursing facilities' rate for direct care costs, the department shall establish three peer groups.

Each nursing facility located in any of the following counties shall be placed in peer group one: Brown, Butler, Clermont, Clinton, Hamilton, and Warren.

Each nursing facility located in any of the following counties shall be placed in peer group two: Ashtabula, Champaign, Clark, Cuyahoga, Darke, Delaware, Fairfield, Fayette, Franklin, Fulton, Geauga, Greene, Hancock, Knox, Lake, Licking, Lorain, Lucas, Madison, Marion, Medina, Miami, Montgomery, Morrow, Ottawa, Pickaway, Portage, Preble, Ross, Sandusky, Seneca, Summit, Union, and Wood.

Each nursing facility located in any of the following counties shall be placed in peer group three: Adams, Allen, Ashland, Athens, Auglaize, Belmont, Carroll, Columbiana, Coshocton, Crawford, Defiance, Erie, Gallia, Guernsey, Hardin, Harrison, Henry, Highland, Hocking, Holmes, Huron, Jackson, Jefferson, Lawrence, Logan, Mahoning, Meigs, Mercer, Monroe, Morgan, Muskingum, Noble, Paulding, Perry, Pike, Putnam, Richland, Scioto, Shelby, Stark, Trumbull, Tuscarawas, Van Wert, Vinton, Washington, Wayne, Williams, and Wyandot.

(D)(1) ~~At least once every ten years, the~~ The department shall determine a cost per case-mix unit for each peer group established under division (C) of this section. ~~A~~ The department is not required to conduct a rebasing more than once every ten years. Except as necessary to implement the amendments made by this act to this section, the cost per case-mix unit determined under this division for a peer group shall be used for subsequent years until the department ~~redetermines it~~ conducts a rebasing. To determine a peer group's cost per case-mix unit, the department shall do all of the following:

(a) Determine the cost per case-mix unit for each nursing facility in the peer group for the applicable calendar year by dividing each facility's desk-reviewed, actual, allowable, per diem direct care costs for the applicable calendar year by the facility's annual average case-mix score determined under section 5111.232 of the Revised Code for the applicable calendar year~~.~~;

(b) Subject to division (D)(2) of this section, identify which nursing facility in the peer group is at the twenty-fifth percentile of the cost per case-mix units determined under division (D)(1)(a) of this section~~.~~;

(c) Calculate the amount that is ~~seven~~ two per cent above the cost per case-mix unit determined under division (D)(1)(a) of this section for the nursing facility identified under division (D)(1)(b) of this section~~.~~;

(d) ~~Multiply the amount calculated under division (D)(1)(c) of this section by~~ Using the index specified in division (D)(3) of this section, multiply the rate of inflation for the eighteen-month period beginning on the first day of July of the applicable calendar year and ending the last day of December of the calendar year immediately following the applicable calendar year ~~using the following:~~

~~(i) In the case of the initial calculation made under division (D)(1)(d) of this section, the employment cost index for total compensation, health services component, published by the United States bureau of labor statistics, as the index existed on July 1, 2005;~~

~~(ii) In the case of subsequent calculations made under division (D)(1)(d) of this section and except as provided in division (D)(1)(d)(iii) of this section, the employment cost index for total compensation, nursing and residential care facilities occupational group, published by the United States bureau of labor statistics;~~

~~(iii) If the United States bureau of labor statistics ceases to publish the index specified in division (D)(1)(d)(ii) of this section, the index the bureau subsequently publishes that covers nursing facilities' staff costs~~ by the amount calculated under division (D)(1)(c) of this section;

(e) Until the first rebasing occurs, add one dollar and eighty-eight cents to the amount calculated under division (D)(1)(d) of this section.

(2) In making the identification under division (D)(1)(b) of this section, the department shall exclude both of the following:

(a) Nursing facilities that participated in the medicaid program under the same provider for less than twelve months in the applicable calendar year;

(b) Nursing facilities whose cost per case-mix unit is more than one standard deviation from the mean cost per case-mix unit for all nursing facilities in the nursing facility's peer group for the applicable calendar year.

(3) The following index shall be used for the purpose of the calculation made under division (D)(1)(d) of this section:

(a) Until the first rebasing occurs, the employment cost index for total compensation, health services component, published by the United States bureau of labor statistics, as the index existed on July 1, 2005;

(b) Effective with the first rebasing and except as provided in division (D)(3)(c) of this section, the employment cost index for total compensation, nursing and residential care facilities occupational group, published by the United States bureau of labor statistics;

(c) If the United States bureau of labor statistics ceases to publish the index specified in division (D)(3)(b) of this section, the index the bureau subsequently publishes that covers nursing facilities' staff costs.

(4) The department shall not redetermine a peer group's cost per case-mix unit under this division based on additional information that it receives after the peer group's per case-mix unit is determined. The department shall redetermine a peer group's cost per case-mix unit only if it made an error in determining the peer group's cost per case-mix unit based on information available to the department at the time of the original determination.

Sec. 5111.232. (A)(1) The department of job and family services shall determine semiannual and annual average case-mix scores for nursing facilities by using all of the following:

(a) Data from a resident assessment instrument specified in rules adopted under section 5111.02 of the Revised Code pursuant to section 1919(e)(5) of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 1396r(e)(5), as amended, for the following residents:

(i) When determining semiannual case-mix scores for fiscal year 2012, each resident who is a medicaid recipient;

(ii) When determining semiannual case-mix scores for fiscal year 2013 and thereafter, each resident who is a medicaid recipient and not placed in either of the two lowest resource utilization groups, excluding any resource utilization group that is a default group used for residents with incomplete assessment data;

(iii) When determining annual average case-mix scores, each resident regardless of payment source.

(b) Except as provided in rules authorized by divisions (A)(2)(a) and (b) of this section, the case-mix values established by the United States department of health and human services;

(c) Except as modified in rules authorized by division (A)(2)(c) of this section, the grouper methodology used on June 30, 1999, by the United

States department of health and human services for prospective payment of skilled nursing facilities under the medicare program established by Title XVIII.

(2) The director of job and family services may adopt rules under section 5111.02 of the Revised Code that do any of the following:

(a) Adjust the case-mix values specified in division (A)(1)(b) of this section to reflect changes in relative wage differentials that are specific to this state;

(b) Express all of those case-mix values in numeric terms that are different from the terms specified by the United States department of health and human services but that do not alter the relationship of the case-mix values to one another;

(c) Modify the grouper methodology specified in division (A)(1)(c) of this section as follows:

(i) Establish a different hierarchy for assigning residents to case-mix categories under the methodology;

(ii) Prohibit the use of the index maximizer element of the methodology;

(iii) Incorporate changes to the methodology the United States department of health and human services makes after June 30, 1999;

(iv) Make other changes the department determines are necessary.

(B) The department shall determine case-mix scores for intermediate care facilities for the mentally retarded using data for each resident, regardless of payment source, from a resident assessment instrument and grouper methodology prescribed in rules adopted under section 5111.02 of the Revised Code and expressed in case-mix values established by the department in those rules.

(C) Each calendar quarter, each provider shall compile complete assessment data, from the resident assessment instrument specified in rules authorized by division (A) or (B) of this section, for each resident of each of the provider's facilities, regardless of payment source, who was in the facility or on hospital or therapeutic leave from the facility on the last day of the quarter. Providers of a nursing facility shall submit the data to the department of health and, if required by rules, the department of job and family services. Providers of an intermediate care facility for the mentally retarded shall submit the data to the department of job and family services. The data shall be submitted not later than fifteen days after the end of the calendar quarter for which the data is compiled.

Except as provided in division (D) of this section, the department, every six months and after the end of each calendar year, shall calculate a semiannual and annual average case-mix score for each nursing facility

using the facility's quarterly case-mix scores for that six-month period or calendar year. Also except as provided in division (D) of this section, the department, after the end of each calendar year, shall calculate an annual average case-mix score for each intermediate care facility for the mentally retarded using the facility's quarterly case-mix scores for that calendar year. The department shall make the calculations pursuant to procedures specified in rules adopted under section 5111.02 of the Revised Code.

(D)(1) If a provider does not timely submit information for a calendar quarter necessary to calculate a facility's case-mix score, or submits incomplete or inaccurate information for a calendar quarter, the department may assign the facility a quarterly average case-mix score that is five per cent less than the facility's quarterly average case-mix score for the preceding calendar quarter. If the facility was subject to an exception review under division (C) of section 5111.27 of the Revised Code for the preceding calendar quarter, the department may assign a quarterly average case-mix score that is five per cent less than the score determined by the exception review. If the facility was assigned a quarterly average case-mix score for the preceding quarter, the department may assign a quarterly average case-mix score that is five per cent less than that score assigned for the preceding quarter.

The department may use a quarterly average case-mix score assigned under division (D)(1) of this section, instead of a quarterly average case-mix score calculated based on the provider's submitted information, to calculate the facility's rate for direct care costs being established under section 5111.23 or 5111.231 of the Revised Code for one or more months, as specified in rules authorized by division (E) of this section, of the quarter for which the rate established under section 5111.23 or 5111.231 of the Revised Code will be paid.

Before taking action under division (D)(1) of this section, the department shall permit the provider a reasonable period of time, specified in rules authorized by division (E) of this section, to correct the information. In the case of an intermediate care facility for the mentally retarded, the department shall not assign a quarterly average case-mix score due to late submission of corrections to assessment information unless the provider fails to submit corrected information prior to the eighty-first day after the end of the calendar quarter to which the information pertains. In the case of a nursing facility, the department shall not assign a quarterly average case-mix score due to late submission of corrections to assessment information unless the provider fails to submit corrected information prior to the earlier of the forty-sixth day after the end of the calendar quarter to

which the information pertains or the deadline for submission of such corrections established by regulations adopted by the United States department of health and human services under Titles XVIII and XIX.

(2) If a provider is paid a rate for a facility calculated using a quarterly average case-mix score assigned under division (D)(1) of this section for more than six months in a calendar year, the department may assign the facility a cost per case-mix unit that is five per cent less than the facility's actual or assigned cost per case-mix unit for the preceding calendar year. The department may use the assigned cost per case-mix unit, instead of calculating the facility's actual cost per case-mix unit in accordance with section 5111.23 or 5111.231 of the Revised Code, to establish the facility's rate for direct care costs for the following fiscal year.

(3) The department shall take action under division (D)(1) or (2) of this section only in accordance with rules authorized by division (E) of this section. The department shall not take an action that affects rates for prior payment periods except in accordance with sections 5111.27 and 5111.28 of the Revised Code.

(E) The director shall adopt rules under section 5111.02 of the Revised Code that do all of the following:

(1) Specify whether providers of a nursing facility must submit the assessment data to the department of job and family services;

(2) Specify the medium or media through which the completed assessment data shall be submitted;

(3) Establish procedures under which the assessment data shall be reviewed for accuracy and providers shall be notified of any data that requires correction;

(4) Establish procedures for providers to correct assessment data and specify a reasonable period of time by which providers shall submit the corrections. The procedures may limit the content of corrections by providers of nursing facilities in the manner required by regulations adopted by the United States department of health and human services under Titles XVIII and XIX.

(5) Specify when and how the department will assign case-mix scores or costs per case-mix unit under division (D) of this section if information necessary to calculate the facility's case-mix score is not provided or corrected in accordance with the procedures established by the rules. Notwithstanding any other provision of sections 5111.20 to ~~5111.33~~ 5111.331 of the Revised Code, the rules also may provide for the following:

(a) Exclusion of case-mix scores assigned under division (D) of this section from calculation of an intermediate care facility for the mentally

retarded's annual average case-mix score and the maximum cost per case-mix unit for the facility's peer group;

(b) Exclusion of case-mix scores assigned under division (D) of this section from calculation of a nursing facility's semiannual or annual average case-mix score and the cost per case-mix unit for the facility's peer group.

Sec. 5111.235. (A) The department of job and family services shall pay a provider for each of the provider's eligible intermediate care facilities for the mentally retarded a per resident per day rate for other protected costs established prospectively each fiscal year for each facility. The rate for each facility shall be the facility's desk-reviewed, actual, allowable, per diem other protected costs from the calendar year preceding the fiscal year in which the rate will be paid, all adjusted for the estimated inflation rate for the eighteen-month period beginning on the first day of July of the calendar year preceding the fiscal year in which the rate will be paid and ending on the thirty-first day of December of that fiscal year. The department shall estimate inflation using the ~~consumer price~~ index ~~for all urban consumers for nonprescription drugs and medical supplies, as published by the United States bureau of labor statistics~~ specified in division (B) of this section. If the estimated inflation rate for the eighteen-month period is different from the actual inflation rate for that period, the difference shall be added to or subtracted from the inflation rate estimated for the following year.

(B) The department shall use the following index for the purpose of division (A) of this section:

(1) The consumer price index for all urban consumers for nonprescription drugs and medical supplies, as published by the United States bureau of labor statistics;

(2) If the United States bureau of labor statistics ceases to publish the index specified in division (B)(1) of this section, the index that is subsequently published by the bureau and covers nonprescription drugs and medical supplies.

Sec. 5111.24. (A) As used in this section~~, "applicable~~:

(1) "Applicable calendar year" means the following:

~~(1)~~(a) For the purpose of the department of job and family services' initial determination under division (D) of this section of each peer group's rate for ancillary and support costs, calendar year 2003;

~~(2)~~(b) For the purpose of the department's ~~subsequent determinations under division (D) of this section of each peer group's rate for ancillary and support costs~~ rebasings, the calendar year the department selects.

(2) "Rebasing" means a redetermination under division (D) of this section of each peer groups' rate for ancillary and support costs using

information from cost reports for an applicable calendar year that is later than the applicable calendar year used for the previous determination of such rates.

(B) The department of job and family services shall pay a provider for each of the provider's eligible nursing facilities a per resident per day rate for ancillary and support costs determined for the nursing facility's peer group under division (D) of this section.

(C) For the purpose of determining nursing facilities' rate for ancillary and support costs, the department shall establish six peer groups.

Each nursing facility located in any of the following counties shall be placed in peer group one or two: Brown, Butler, Clermont, Clinton, Hamilton, and Warren. Each nursing facility located in any of those counties that has fewer than one hundred beds shall be placed in peer group one. Each nursing facility located in any of those counties that has one hundred or more beds shall be placed in peer group two.

Each nursing facility located in any of the following counties shall be placed in peer group three or four: Ashtabula, Champaign, Clark, Cuyahoga, Darke, Delaware, Fairfield, Fayette, Franklin, Fulton, Geauga, Greene, Hancock, Knox, Lake, Licking, Lorain, Lucas, Madison, Marion, Medina, Miami, Montgomery, Morrow, Ottawa, Pickaway, Portage, Preble, Ross, Sandusky, Seneca, Summit, Union, and Wood. Each nursing facility located in any of those counties that has fewer than one hundred beds shall be placed in peer group three. Each nursing facility located in any of those counties that has one hundred or more beds shall be placed in peer group four.

Each nursing facility located in any of the following counties shall be placed in peer group five or six: Adams, Allen, Ashland, Athens, Auglaize, Belmont, Carroll, Columbiana, Coshocton, Crawford, Defiance, Erie, Gallia, Guernsey, Hardin, Harrison, Henry, Highland, Hocking, Holmes, Huron, Jackson, Jefferson, Lawrence, Logan, Mahoning, Meigs, Mercer, Monroe, Morgan, Muskingum, Noble, Paulding, Perry, Pike, Putnam, Richland, Scioto, Shelby, Stark, Trumbull, Tuscarawas, Van Wert, Vinton, Washington, Wayne, Williams, and Wyandot. Each nursing facility located in any of those counties that has fewer than one hundred beds shall be placed in peer group five. Each nursing facility located in any of those counties that has one hundred or more beds shall be placed in peer group six.

(D)(1) ~~At least once every ten years, the~~ The department shall determine the rate for ancillary and support costs for each peer group established under division (C) of this section. The department is not required to conduct a

rebasing more than once every ten years. Except as necessary to implement the amendments made by this act to this section, the rate for ancillary and support costs determined under this division for a peer group shall be used for subsequent years until the department ~~redetermines it~~ conducts a rebasing. To determine a peer group's rate for ancillary and support costs, the department shall do all of the following:

(a) ~~Determine~~ Subject to division (D)(2) of this section, determine the rate for ancillary and support costs for each nursing facility in the peer group for the applicable calendar year by using the greater of the nursing facility's actual inpatient days for the applicable calendar year or the inpatient days the nursing facility would have had for the applicable calendar year if its occupancy rate had been ninety per cent~~. For the purpose of determining a nursing facility's occupancy rate under division (D)(1)(a) of this section, the department shall include any beds that the nursing facility removes from its medicaid-certified capacity unless the nursing facility also removes the beds from its licensed bed capacity.~~;

(b) Subject to division (D)~~(2)~~(3) of this section, identify which nursing facility in the peer group is at the twenty-fifth percentile of the rate for ancillary and support costs for the applicable calendar year determined under division (D)(1)(a) of this section~~.~~;

(c) ~~Calculate the amount that is three per cent above the rate for ancillary and support costs determined under division (D)(1)(a) of this section for the nursing facility identified under division (D)(1)(b) of this section.~~

~~(d)~~ Multiply the ~~amount calculated~~ rate for ancillary and support costs determined under division (D)(1)~~(c)~~(a) of this section for the nursing facility identified under division (D)(1)(b) of this section by the rate of inflation for the eighteen-month period beginning on the first day of July of the applicable calendar year and ending the last day of December of the calendar year immediately following the applicable calendar year using the following:

(i) ~~In the case of the initial calculation made under division (D)(1)(d) of this section~~ Until the first rebasing occurs, the consumer price index for all items for all urban consumers for the north central region, published by the United States bureau of labor statistics, as that index existed on July 1, 2005;

(ii) ~~In the case of subsequent calculations made under division (D)(1)(d) of this section~~ Effective with the first rebasing and except as provided in division (D)(1)~~(d)~~(c)(iii) of this section, the consumer price index for all items for all urban consumers for the midwest region, published by the United States bureau of labor statistics;

(iii) If the United States bureau of labor statistics ceases to publish the index specified in division (D)(1)~~(d)~~(c)(ii) of this section, the index the bureau subsequently publishes that covers urban consumers' prices for items for the region that includes this state.

(2) For the purpose of determining a nursing facility's occupancy rate under division (D)(1)(a) of this section, the department shall include any beds that the nursing facility removes from its medicaid-certified capacity unless the nursing facility also removes the beds from its licensed bed capacity.

(3) In making the identification under division (D)(1)(b) of this section, the department shall exclude both of the following:

(a) Nursing facilities that participated in the medicaid program under the same provider for less than twelve months in the applicable calendar year;

(b) Nursing facilities whose ancillary and support costs are more than one standard deviation from the mean desk-reviewed, actual, allowable, per diem ancillary and support cost for all nursing facilities in the nursing facility's peer group for the applicable calendar year.

~~(3)~~(4) The department shall not redetermine a peer group's rate for ancillary and support costs under this division based on additional information that it receives after the rate is determined. The department shall redetermine a peer group's rate for ancillary and support costs only if ~~it~~ the department made an error in determining the rate based on information available to the department at the time of the original determination.

Sec. 5111.241. (A) The department of job and family services shall pay a provider for each of the provider's eligible intermediate care facilities for the mentally retarded a per resident per day rate for indirect care costs established prospectively each fiscal year for each facility. The rate for each intermediate care facility for the mentally retarded shall be the sum of the following, but shall not exceed the maximum rate established for the facility's peer group under division (B) of this section:

(1) The facility's desk-reviewed, actual, allowable, per diem indirect care costs from the calendar year preceding the fiscal year in which the rate will be paid, adjusted for the inflation rate estimated under division (C)(1) of this section;

(2) An efficiency incentive in the following amount:

(a) For fiscal years ending in even-numbered calendar years:

(i) In the case of intermediate care facilities for the mentally retarded with more than eight beds, seven and one-tenth per cent of the maximum rate established for the facility's peer group under division (B) of this section;

(ii) In the case of intermediate care facilities for the mentally retarded with eight or fewer beds, seven per cent of the maximum rate established for the facility's peer group under division (B) of this section;

(b) For fiscal years ending in odd-numbered calendar years, the amount calculated for the preceding fiscal year under division (A)(2)(a) of this section.

(B)(1) The maximum rate for indirect care costs for each peer group of intermediate care facilities for the mentally retarded with more than eight beds specified in rules adopted under division (D) of this section shall be determined as follows:

(a) For fiscal years ending in even-numbered calendar years, the maximum rate for each peer group shall be the rate that is no less than twelve and four-tenths per cent above the median desk-reviewed, actual, allowable, per diem indirect care cost for all intermediate care facilities for the mentally retarded with more than eight beds in the group, excluding facilities in the group whose indirect care costs for that period are more than three standard deviations from the mean desk-reviewed, actual, allowable, per diem indirect care cost for all intermediate care facilities for the mentally retarded with more than eight beds, for the calendar year preceding the fiscal year in which the rate will be paid, adjusted by the inflation rate estimated under division (C)(1) of this section.

(b) For fiscal years ending in odd-numbered calendar years, the maximum rate for each peer group is the group's maximum rate for the previous fiscal year, adjusted for the inflation rate estimated under division (C)(2) of this section.

(2) The maximum rate for indirect care costs for each peer group of intermediate care facilities for the mentally retarded with eight or fewer beds specified in rules adopted under division (D) of this section shall be determined as follows:

(a) For fiscal years ending in even-numbered calendar years, the maximum rate for each peer group shall be the rate that is no less than ten and three-tenths per cent above the median desk-reviewed, actual, allowable, per diem indirect care cost for all intermediate care facilities for the mentally retarded with eight or fewer beds in the group, excluding facilities in the group whose indirect care costs are more than three standard deviations from the mean desk-reviewed, actual, allowable, per diem indirect care cost for all intermediate care facilities for the mentally retarded with eight or fewer beds, for the calendar year preceding the fiscal year in which the rate will be paid, adjusted by the inflation rate estimated under division (C)(1) of this section.

(b) For fiscal years that end in odd-numbered calendar years, the maximum rate for each peer group is the group's maximum rate for the previous fiscal year, adjusted for the inflation rate estimated under division (C)(2) of this section.

(3) The department shall not recalculate a maximum rate for indirect care costs under division (B)(1) or (2) of this section based on additional information that it receives after the maximum rate is set. The department shall recalculate the maximum rate for indirect care costs only if it made an error in computing the maximum rate based on the information available at the time of the original calculation.

(C)(1) When adjusting rates for inflation under divisions (A)(1), (B)(1)(a), and (B)(2)(a) of this section, the department shall estimate the rate of inflation for the eighteen-month period beginning on the first day of July of the calendar year preceding the fiscal year in which the rate will be paid and ending on the thirty-first day of December of the fiscal year in which the rate will be paid~~, using the~~. To estimate the rate of inflation, the department shall use the following:

(a) The consumer price index for all items for all urban consumers for the north central region, published by the United States bureau of labor statistics;

(b) If the United States bureau of labor statistics ceases to publish the index specified in division (C)(1)(a) of this section, a comparable index that the bureau publishes and the department determines is appropriate.

(2) When adjusting rates for inflation under divisions (B)(1)(b) and (B)(2)(b) of this section, the department shall estimate the rate of inflation for the twelve-month period beginning on the first day of January of the fiscal year preceding the fiscal year in which the rate will be paid and ending on the thirty-first day of December of the fiscal year in which the rate will be paid~~, using the~~. To estimate the rate of inflation, the department shall use the following:

(a) The consumer price index for all items for all urban consumers for the north central region, published by the United States bureau of labor statistics;

(b) If the United States bureau of labor statistics ceases to publish the index specified in division (C)(2)(a) of this section, a comparable index that the bureau publishes and the department determines is appropriate.

(3) If an inflation rate estimated under division (C)(1) or (2) of this section is different from the actual inflation rate for the relevant time period, as measured using the same index, the difference shall be added to or subtracted from the inflation rate estimated pursuant to this division for the

following fiscal year.

(D) The director of job and family services shall adopt rules under section 5111.02 of the Revised Code that specify peer groups of intermediate care facilities for the mentally retarded with more than eight beds, and peer groups of intermediate care facilities for the mentally retarded with eight or fewer beds, based on findings of significant per diem indirect care cost differences due to geography and facility bed-size. The rules also may specify peer groups based on findings of significant per diem indirect care cost differences due to other factors, including case-mix.

Sec. 5111.244. (A) As used in this section, "deficiency" and "standard survey" have the same meanings as in section 5111.35 of the Revised Code.

(B) ~~Each fiscal year, the~~ The department of job and family services shall pay the provider of each nursing facility a quality incentive payment. The amount of a quality incentive payment paid to a provider ~~for a fiscal year~~ shall be based on the number of points the provider's nursing facility is awarded ~~under division (C) of this section~~ for ~~that fiscal year~~ meeting accountability measures. The amount of a quality incentive payment paid to a provider of a nursing facility that is awarded no points may be zero. ~~The mean payment for fiscal year 2007, weighted by medicaid days, shall be three dollars per medicaid day. The department shall adjust the mean payment for subsequent fiscal years by the same adjustment factors the department uses to adjust, pursuant to division (B) of section 5111.222 of the Revised Code, nursing facilities' rates otherwise determined under divisions (A)(1), (2), (3), and (6) of that section.~~

(C)(1) ~~Except as provided by~~ For fiscal year 2012 only and subject to division (C)(2) of this section, the department shall ~~annually~~ award each nursing facility participating in the medicaid program ~~one point~~ points for ~~each of~~ meeting the following accountability measures ~~the facility meets~~:

(a) The facility had no health deficiencies on the facility's most recent standard survey.

(b) The facility had no health deficiencies with a scope and severity level greater than E, as determined under nursing facility certification standards established under Title XIX, on the facility's most recent standard survey.

(c) The facility's resident satisfaction is above the statewide average.

(d) The facility's family satisfaction is above the statewide average.

(e) The number of hours the facility employs nurses is above the statewide average.

(f) The facility's employee retention rate is above the average for the facility's peer group established in division (C) of section 5111.231 of the

Revised Code.

(g) The facility's occupancy rate is above the statewide average.

(h) ~~The facility's medicaid utilization rate is above the statewide average.~~

~~(i)~~ The facility's case-mix score is above the statewide average.

(i) The facility's medicaid utilization rate is above the statewide average.

(2) A nursing facility shall be awarded one point for each of the accountability measures specified in divisions (C)(1)(a) to (h) of this section that the nursing facility meets. A nursing facility shall be awarded three points for meeting the accountability measure specified in division (C)(1)(i) of this section. The department shall award points pursuant to division (C)(1)(c) or (d) of this section to a nursing facility only ~~for a fiscal year immediately following a calendar year for which~~ if a survey of resident or family satisfaction ~~has been~~ was conducted under section 173.47 of the Revised Code for the nursing facility in calendar year 2010.

(D)(1) For fiscal year 2013 and thereafter, the department shall award each nursing facility participating in the medicaid program points for meeting accountability measures in accordance with amendments to be made to this section not later than December 31, 2011, that provide for all of the following:

(a) Meaningful accountability measures of quality of care, quality of life, and nursing facility staffing;

(b) The maximum number of points that a nursing facility may earn for meeting accountability measures;

(c) A methodology for calculating the quality incentive payment that recognizes different business and care models in nursing facilities by providing flexibility in nursing facilities' ability to earn the entire quality incentive payment;

(d) A quality bonus to be paid at the end of a fiscal year in a manner that provides for all funds that the general assembly intends to be used for the quality incentive payment for that fiscal year are distributed to nursing facilities.

(2) For the purpose of division (D)(1)(d) of this section, the amount of funds that the general assembly intends to be used for the quality incentive payment for a fiscal year shall be the product of the following:

(a) The number of medicaid days in the fiscal year;

(b) The maximum quality incentive payment the general assembly has specified in law to be paid to nursing facilities for that fiscal year.

(E) The director of job and family services shall adopt rules under section 5111.02 of the Revised Code as necessary to implement this section.

~~The rules shall include rules establishing the system for awarding points under division (C) of this section.~~

Sec. 5111.25. (A) As used in this section~~, "applicable~~:

(1) "Applicable calendar year" means the following:

~~(1)~~(a) For the purpose of the department of job and family services' initial determination under division (D) of this section of each peer group's ~~median~~ rate for capital costs, calendar year 2003;

~~(2)~~(b) For the purpose of the department's ~~subsequent determinations under division (D) of this section of each peer group's median rate for capital costs~~ rebasings, the calendar year the department selects.

(2) "Rebasing" means a redetermination under division (D) of this section of each peer groups' rate for capital costs using information from cost reports for an applicable calendar year that is later than the applicable calendar year used for the previous determination of such rates.

(B) The department of job and family services shall pay a provider for each of the provider's eligible nursing facilities a per resident per day rate for capital costs~~. A nursing facility's rate for capital costs shall be the median rate for capital costs for the nursing facilities in~~ determined for the nursing facility's peer group ~~as determined~~ under division (D) of this section.

(C) For the purpose of determining nursing facilities' rate for capital costs, the department shall establish six peer groups.

Each nursing facility located in any of the following counties shall be placed in peer group one or two: Brown, Butler, Clermont, Clinton, Hamilton, and Warren. Each nursing facility located in any of those counties that has fewer than one hundred beds shall be placed in peer group one. Each nursing facility located in any of those counties that has one hundred or more beds shall be placed in peer group two.

Each nursing facility located in any of the following counties shall be placed in peer group three or four: Ashtabula, Champaign, Clark, Cuyahoga, Darke, Delaware, Fairfield, Fayette, Franklin, Fulton, Geauga, Greene, Hancock, Knox, Lake, Licking, Lorain, Lucas, Madison, Marion, Medina, Miami, Montgomery, Morrow, Ottawa, Pickaway, Portage, Preble, Ross, Sandusky, Seneca, Summit, Union, and Wood. Each nursing facility located in any of those counties that has fewer than one hundred beds shall be placed in peer group three. Each nursing facility located in any of those counties that has one hundred or more beds shall be placed in peer group four.

Each nursing facility located in any of the following counties shall be placed in peer group five or six: Adams, Allen, Ashland, Athens, Auglaize,

Belmont, Carroll, Columbiana, Coshocton, Crawford, Defiance, Erie, Gallia, Guernsey, Hardin, Harrison, Henry, Highland, Hocking, Holmes, Huron, Jackson, Jefferson, Lawrence, Logan, Mahoning, Meigs, Mercer, Monroe, Morgan, Muskingum, Noble, Paulding, Perry, Pike, Putnam, Richland, Scioto, Shelby, Stark, Trumbull, Tuscarawas, Van Wert, Vinton, Washington, Wayne, Williams, and Wyandot. Each nursing facility located in any of those counties that has fewer than one hundred beds shall be placed in peer group five. Each nursing facility located in any of those counties that has one hundred or more beds shall be placed in peer group six.

(D)(1) ~~At least once every ten years, the~~ The department shall determine the ~~median~~ rate for capital costs for each peer group established under division (C) of this section. The ~~median~~ department is not required to conduct a rebasing more than once every ten years. Except as necessary to implement the amendments made by this act to this section, the rate for capital costs determined under this division for a peer group shall be used for subsequent years until the department ~~redetermines it~~ conducts a rebasing. ~~To determine a~~ A peer group's ~~median~~ rate for capital costs shall be the rate for capital costs determined for the nursing facility in the peer group that is at the twenty-fifth percentile of the rate for capital costs for the applicable calendar year. In identifying that nursing facility, the department shall do both of the following:

(a) Subject to division (D)(2) of this section, use the greater of each nursing facility's actual inpatient days for the applicable calendar year or the inpatient days the nursing facility would have had for the applicable calendar year if its occupancy rate had been one hundred per cent~~.~~;

(b) Exclude both of the following:

(i) Nursing facilities that participated in the medicaid program under the same provider for less than twelve months in the applicable calendar year;

(ii) Nursing facilities whose capital costs are more than one standard deviation from the mean desk-reviewed, actual, allowable, per diem capital cost for all nursing facilities in the nursing facility's peer group for the applicable calendar year.

(2) For the purpose of determining a nursing facility's occupancy rate under division (D)(1)(a) of this section, the department shall include any beds that the nursing facility removes from its medicaid-certified capacity after June 30, 2005, unless the nursing facility also removes the beds from its licensed bed capacity.

(3) The department shall not redetermine a peer group's rate for capital costs under this division based on additional information that it receives

after the rate is determined. The department shall redetermine a peer group's rate for capital costs only if the department made an error in determining the rate based on information available to the department at the time of the original determination.

(E) Buildings shall be depreciated using the straight line method over forty years or over a different period approved by the department. Components and equipment shall be depreciated using the straight-line method over a period designated in rules adopted under section 5111.02 of the Revised Code, consistent with the guidelines of the American hospital association, or over a different period approved by the department. Any rules authorized by this division that specify useful lives of buildings, components, or equipment apply only to assets acquired on or after July 1, 1993. Depreciation for costs paid or reimbursed by any government agency shall not be included in capital costs unless that part of the payment under sections 5111.20 to ~~5111.33~~ 5111.331 of the Revised Code is used to reimburse the government agency.

(F) The capital cost basis of nursing facility assets shall be determined in the following manner:

(1) Except as provided in division (F)(3) of this section, for purposes of calculating the rates to be paid for facilities with dates of licensure on or before June 30, 1993, the capital cost basis of each asset shall be equal to the desk-reviewed, actual, allowable, capital cost basis that is listed on the facility's cost report for the calendar year preceding the fiscal year during which the rate will be paid.

(2) For facilities with dates of licensure after June 30, 1993, the capital cost basis shall be determined in accordance with the principles of the medicare program established under Title XVIII, except as otherwise provided in sections 5111.20 to ~~5111.33~~ 5111.331 of the Revised Code.

(3) Except as provided in division (F)(4) of this section, if a provider transfers an interest in a facility to another provider after June 30, 1993, there shall be no increase in the capital cost basis of the asset if the providers are related parties or the provider to which the interest is transferred authorizes the provider that transferred the interest to continue to operate the facility under a lease, management agreement, or other arrangement. If the previous sentence does not prohibit the adjustment of the capital cost basis under this division, the basis of the asset shall be adjusted by ~~the lesser of the following:~~

~~(a) One-half of the change in construction costs during the time that the transferor held the asset, as calculated by the department of job and family services using the "Dodge building cost indexes, northeastern and north~~

~~central states," published by Marshall and Swift;~~

~~(b) One-half~~ one-half of the change in the consumer price index for all items for all urban consumers, as published by the United States bureau of labor statistics, during the time that the transferor held the asset.

(4) If a provider transfers an interest in a facility to another provider who is a related party, the capital cost basis of the asset shall be adjusted as specified in division (F)(3) of this section if all of the following conditions are met:

(a) The related party is a relative of owner;

(b) Except as provided in division (F)(4)(c)(ii) of this section, the provider making the transfer retains no ownership interest in the facility;

(c) The department of job and family services determines that the transfer is an arm's length transaction pursuant to rules adopted under section 5111.02 of the Revised Code. The rules shall provide that a transfer is an arm's length transaction if all of the following apply:

(i) Once the transfer goes into effect, the provider that made the transfer has no direct or indirect interest in the provider that acquires the facility or the facility itself, including interest as an owner, officer, director, employee, independent contractor, or consultant, but excluding interest as a creditor.

(ii) The provider that made the transfer does not reacquire an interest in the facility except through the exercise of a creditor's rights in the event of a default. If the provider reacquires an interest in the facility in this manner, the department shall treat the facility as if the transfer never occurred when the department calculates its reimbursement rates for capital costs.

(iii) The transfer satisfies any other criteria specified in the rules.

(d) Except in the case of hardship caused by a catastrophic event, as determined by the department, or in the case of a provider making the transfer who is at least sixty-five years of age, not less than twenty years have elapsed since, for the same facility, the capital cost basis was adjusted most recently under division (F)(4) of this section or actual, allowable cost of ownership was determined most recently under division (G)(9) of this section.

(G) As used in this division:

"Imputed interest" means the lesser of the prime rate plus two per cent or ten per cent.

"Lease expense" means lease payments in the case of an operating lease and depreciation expense and interest expense in the case of a capital lease.

"New lease" means a lease, to a different lessee, of a nursing facility that previously was operated under a lease.

(1) Subject to division (B) of this section, for a lease of a facility that

was effective on May 27, 1992, the entire lease expense is an actual, allowable capital cost during the term of the existing lease. The entire lease expense also is an actual, allowable capital cost if a lease in existence on May 27, 1992, is renewed under either of the following circumstances:

(a) The renewal is pursuant to a renewal option that was in existence on May 27, 1992;

(b) The renewal is for the same lease payment amount and between the same parties as the lease in existence on May 27, 1992.

(2) Subject to division (B) of this section, for a lease of a facility that was in existence but not operated under a lease on May 27, 1992, actual, allowable capital costs shall include the lesser of the annual lease expense or the annual depreciation expense and imputed interest expense that would be calculated at the inception of the lease using the lessor's entire historical capital asset cost basis, adjusted by ~~the lesser of the following amounts:~~

~~(a) One-half of the change in construction costs during the time the lessor held each asset until the beginning of the lease, as calculated by the department using the "Dodge building cost indexes, northeastern and north central states," published by Marshall and Swift;~~

~~(b) One-half~~ one-half of the change in the consumer price index for all items for all urban consumers, as published by the United States bureau of labor statistics, during the time the lessor held each asset until the beginning of the lease.

(3) Subject to division (B) of this section, for a lease of a facility with a date of licensure on or after May 27, 1992, that is initially operated under a lease, actual, allowable capital costs shall include the annual lease expense if there was a substantial commitment of money for construction of the facility after December 22, 1992, and before July 1, 1993. If there was not a substantial commitment of money after December 22, 1992, and before July 1, 1993, actual, allowable capital costs shall include the lesser of the annual lease expense or the sum of the following:

(a) The annual depreciation expense that would be calculated at the inception of the lease using the lessor's entire historical capital asset cost basis;

(b) The greater of the lessor's actual annual amortization of financing costs and interest expense at the inception of the lease or the imputed interest expense calculated at the inception of the lease using seventy per cent of the lessor's historical capital asset cost basis.

(4) Subject to division (B) of this section, for a lease of a facility with a date of licensure on or after May 27, 1992, that was not initially operated under a lease and has been in existence for ten years, actual, allowable

capital costs shall include the lesser of the annual lease expense or the annual depreciation expense and imputed interest expense that would be calculated at the inception of the lease using the entire historical capital asset cost basis of ~~the lessor, adjusted by the lesser of the following:~~

~~(a) One-half of the change in construction costs during the time the lessor held each asset until the beginning of the lease, as calculated by the department using the "Dodge building cost indexes, northeastern and north central states," published by Marshall and Swift;~~

~~(b) One-half~~ one-half of the change in the consumer price index for all items for all urban consumers, as published by the United States bureau of labor statistics, during the time the lessor held each asset until the beginning of the lease.

(5) Subject to division (B) of this section, for a new lease of a facility that was operated under a lease on May 27, 1992, actual, allowable capital costs shall include the lesser of the annual new lease expense or the annual old lease payment. If the old lease was in effect for ten years or longer, the old lease payment from the beginning of the old lease shall be adjusted by ~~the lesser of the following:~~

~~(a) One-half of the change in construction costs from the beginning of the old lease to the beginning of the new lease, as calculated by the department using the "Dodge building cost indexes, northeastern and north central states," published by Marshall and Swift;~~

~~(b) One-half~~ one-half of the change in the consumer price index for all items for all urban consumers, as published by the United States bureau of labor statistics, from the beginning of the old lease to the beginning of the new lease.

(6) Subject to division (B) of this section, for a new lease of a facility that was not in existence or that was in existence but not operated under a lease on May 27, 1992, actual, allowable capital costs shall include the lesser of annual new lease expense or the annual amount calculated for the old lease under division (G)(2), (3), (4), or (6) of this section, as applicable. If the old lease was in effect for ten years or longer, the lessor's historical capital asset cost basis shall be ~~adjusted by the lesser of the following,~~ for purposes of calculating the annual amount under division (G)(2), (3), (4), or (6) of this section~~:~~

~~(a) One-half of the change in construction costs from the beginning of the old lease to the beginning of the new lease, as calculated by the department using the "Dodge building cost indexes, northeastern and north central states," published by Marshall and Swift;~~

~~(b) One-half~~, adjusted by one-half of the change in the consumer price

index for all items for all urban consumers, as published by the United States bureau of labor statistics, from the beginning of the old lease to the beginning of the new lease.

In the case of a lease under division (G)(3) of this section of a facility for which a substantial commitment of money was made after December 22, 1992, and before July 1, 1993, the old lease payment shall be adjusted for the purpose of determining the annual amount.

(7) For any revision of a lease described in division (G)(1), (2), (3), (4), (5), or (6) of this section, or for any subsequent lease of a facility operated under such a lease, other than execution of a new lease, the portion of actual, allowable capital costs attributable to the lease shall be the same as before the revision or subsequent lease.

(8) Except as provided in division (G)(9) of this section, if a provider leases an interest in a facility to another provider who is a related party or previously operated the facility, the related party's or previous operator's actual, allowable capital costs shall include the lesser of the annual lease expense or the reasonable cost to the lessor.

(9) If a provider leases an interest in a facility to another provider who is a related party, regardless of the date of the lease, the related party's actual, allowable capital costs shall include the annual lease expense, subject to the limitations specified in divisions (G)(1) to (7) of this section, if all of the following conditions are met:

(a) The related party is a relative of owner;

(b) If the lessor retains an ownership interest, it is, except as provided in division (G)(9)(c)(ii) of this section, in only the real property and any improvements on the real property;

(c) The department of job and family services determines that the lease is an arm's length transaction pursuant to rules adopted under section 5111.02 of the Revised Code. The rules shall provide that a lease is an arm's length transaction if all of the following apply:

(i) Once the lease goes into effect, the lessor has no direct or indirect interest in the lessee or, except as provided in division (G)(9)(b) of this section, the facility itself, including interest as an owner, officer, director, employee, independent contractor, or consultant, but excluding interest as a lessor.

(ii) The lessor does not reacquire an interest in the facility except through the exercise of a lessor's rights in the event of a default. If the lessor reacquires an interest in the facility in this manner, the department shall treat the facility as if the lease never occurred when the department calculates its reimbursement rates for capital costs.

(iii) The lease satisfies any other criteria specified in the rules.

(d) Except in the case of hardship caused by a catastrophic event, as determined by the department, or in the case of a lessor who is at least sixty-five years of age, not less than twenty years have elapsed since, for the same facility, the capital cost basis was adjusted most recently under division (F)(4) of this section or actual, allowable capital costs were determined most recently under division (G)(9) of this section.

(10) This division does not apply to leases of specific items of equipment.

Sec. 5111.251. (A) The department of job and family services shall pay a provider for each of the provider's eligible intermediate care facilities for the mentally retarded for its reasonable capital costs, a per resident per day rate established prospectively each fiscal year for each intermediate care facility for the mentally retarded. Except as otherwise provided in sections 5111.20 to ~~5111.33~~ 5111.331 of the Revised Code, the rate shall be based on the facility's capital costs for the calendar year preceding the fiscal year in which the rate will be paid. The rate shall equal the sum of the following:

(1) The facility's desk-reviewed, actual, allowable, per diem cost of ownership for the preceding cost reporting period, limited as provided in divisions (C) and (F) of this section;

(2) Any efficiency incentive determined under division (B) of this section;

(3) Any amounts for renovations determined under division (D) of this section;

(4) Any amounts for return on equity determined under division ~~(I)~~(H) of this section.

Buildings shall be depreciated using the straight line method over forty years or over a different period approved by the department. Components and equipment shall be depreciated using the straight line method over a period designated by the director of job and family services in rules adopted under section 5111.02 of the Revised Code, consistent with the guidelines of the American hospital association, or over a different period approved by the department of job and family services. Any rules authorized by this division that specify useful lives of buildings, components, or equipment apply only to assets acquired on or after July 1, 1993. Depreciation for costs paid or reimbursed by any government agency shall not be included in costs of ownership or renovation unless that part of the payment under sections 5111.20 to ~~5111.33~~ 5111.331 of the Revised Code is used to reimburse the government agency.

(B) The department of job and family services shall pay to a provider

for each of the provider's eligible intermediate care facilities for the mentally retarded an efficiency incentive equal to fifty per cent of the difference between any desk-reviewed, actual, allowable cost of ownership and the applicable limit on cost of ownership payments under division (C) of this section. For purposes of computing the efficiency incentive, depreciation for costs paid or reimbursed by any government agency shall be considered as a cost of ownership, and the applicable limit under division (C) of this section shall apply both to facilities with more than eight beds and facilities with eight or fewer beds. The efficiency incentive paid to a provider for a facility with eight or fewer beds shall not exceed three dollars per patient day, adjusted annually for the inflation rate for the twelve-month period beginning on the first day of July of the calendar year preceding the calendar year that precedes the fiscal year for which the efficiency incentive is determined and ending on the thirtieth day of the following June, using the consumer price index for shelter costs for all urban consumers for the north central region, as published by the United States bureau of labor statistics.

(C) Cost of ownership payments for intermediate care facilities for the mentally retarded with more than eight beds shall not exceed the following limits:

(1) For facilities with dates of licensure prior to January 1, l958, not exceeding two dollars and fifty cents per patient day;

(2) For facilities with dates of licensure after December 31, l957, but prior to January 1, l968, not exceeding:

(a) Three dollars and fifty cents per patient day if the cost of construction was three thousand five hundred dollars or more per bed;

(b) Two dollars and fifty cents per patient day if the cost of construction was less than three thousand five hundred dollars per bed.

(3) For facilities with dates of licensure after December 31, l967, but prior to January 1, l976, not exceeding:

(a) Four dollars and fifty cents per patient day if the cost of construction was five thousand one hundred fifty dollars or more per bed;

(b) Three dollars and fifty cents per patient day if the cost of construction was less than five thousand one hundred fifty dollars per bed, but exceeds three thousand five hundred dollars per bed;

(c) Two dollars and fifty cents per patient day if the cost of construction was three thousand five hundred dollars or less per bed.

(4) For facilities with dates of licensure after December 31, l975, but prior to January 1, l979, not exceeding:

(a) Five dollars and fifty cents per patient day if the cost of construction

was six thousand eight hundred dollars or more per bed;

(b) Four dollars and fifty cents per patient day if the cost of construction was less than six thousand eight hundred dollars per bed but exceeds five thousand one hundred fifty dollars per bed;

(c) Three dollars and fifty cents per patient day if the cost of construction was five thousand one hundred fifty dollars or less per bed, but exceeds three thousand five hundred dollars per bed;

(d) Two dollars and fifty cents per patient day if the cost of construction was three thousand five hundred dollars or less per bed.

(5) For facilities with dates of licensure after December 31, l978, but prior to January 1, l980, not exceeding:

(a) Six dollars per patient day if the cost of construction was seven thousand six hundred twenty-five dollars or more per bed;

(b) Five dollars and fifty cents per patient day if the cost of construction was less than seven thousand six hundred twenty-five dollars per bed but exceeds six thousand eight hundred dollars per bed;

(c) Four dollars and fifty cents per patient day if the cost of construction was six thousand eight hundred dollars or less per bed but exceeds five thousand one hundred fifty dollars per bed;

(d) Three dollars and fifty cents per patient day if the cost of construction was five thousand one hundred fifty dollars or less but exceeds three thousand five hundred dollars per bed;

(e) Two dollars and fifty cents per patient day if the cost of construction was three thousand five hundred dollars or less per bed.

(6) For facilities with dates of licensure after December 31, 1979, but prior to January 1, 1981, not exceeding:

(a) Twelve dollars per patient day if the beds were originally licensed as residential facility beds by the department of developmental disabilities;

(b) Six dollars per patient day if the beds were originally licensed as nursing home beds by the department of health.

(7) For facilities with dates of licensure after December 31, 1980, but prior to January 1, 1982, not exceeding:

(a) Twelve dollars per patient day if the beds were originally licensed as residential facility beds by the department of developmental disabilities;

(b) Six dollars and forty-five cents per patient day if the beds were originally licensed as nursing home beds by the department of health.

(8) For facilities with dates of licensure after December 31, 1981, but prior to January 1, 1983, not exceeding:

(a) Twelve dollars per patient day if the beds were originally licensed as residential facility beds by the department of developmental disabilities;

(b) Six dollars and seventy-nine cents per patient day if the beds were originally licensed as nursing home beds by the department of health.

(9) For facilities with dates of licensure after December 31, 1982, but prior to January 1, 1984, not exceeding:

(a) Twelve dollars per patient day if the beds were originally licensed as residential facility beds by the department of developmental disabilities;

(b) Seven dollars and nine cents per patient day if the beds were originally licensed as nursing home beds by the department of health.

(10) For facilities with dates of licensure after December 31, 1983, but prior to January 1, 1985, not exceeding:

(a) Twelve dollars and twenty-four cents per patient day if the beds were originally licensed as residential facility beds by the department of developmental disabilities;

(b) Seven dollars and twenty-three cents per patient day if the beds were originally licensed as nursing home beds by the department of health.

(11) For facilities with dates of licensure after December 31, 1984, but prior to January 1, 1986, not exceeding:

(a) Twelve dollars and fifty-three cents per patient day if the beds were originally licensed as residential facility beds by the department of developmental disabilities;

(b) Seven dollars and forty cents per patient day if the beds were originally licensed as nursing home beds by the department of health.

(12) For facilities with dates of licensure after December 31, 1985, but prior to January 1, 1987, not exceeding:

(a) Twelve dollars and seventy cents per patient day if the beds were originally licensed as residential facility beds by the department of developmental disabilities;

(b) Seven dollars and fifty cents per patient day if the beds were originally licensed as nursing home beds by the department of health.

(13) For facilities with dates of licensure after December 31, 1986, but prior to January 1, 1988, not exceeding:

(a) Twelve dollars and ninety-nine cents per patient day if the beds were originally licensed as residential facility beds by the department of developmental disabilities;

(b) Seven dollars and sixty-seven cents per patient day if the beds were originally licensed as nursing home beds by the department of health.

(14) For facilities with dates of licensure after December 31, 1987, but prior to January 1, 1989, not exceeding thirteen dollars and twenty-six cents per patient day;

(15) For facilities with dates of licensure after December 31, 1988, but

prior to January 1, 1990, not exceeding thirteen dollars and forty-six cents per patient day;

(16) For facilities with dates of licensure after December 31, 1989, but prior to January 1, 1991, not exceeding thirteen dollars and sixty cents per patient day;

(17) For facilities with dates of licensure after December 31, 1990, but prior to January 1, 1992, not exceeding thirteen dollars and forty-nine cents per patient day;

(18) For facilities with dates of licensure after December 31, 1991, but prior to January 1, 1993, not exceeding thirteen dollars and sixty-seven cents per patient day;

(19) For facilities with dates of licensure after December 31, 1992, not exceeding fourteen dollars and twenty-eight cents per patient day.

(D) Beginning January 1, 1981, regardless of the original date of licensure, the department of job and family services shall pay a rate for the per diem capitalized costs of renovations to intermediate care facilities for the mentally retarded made after January 1, l981, not exceeding six dollars per patient day using 1980 as the base year and adjusting the amount annually until June 30, 1993, for fluctuations in construction costs calculated by the department using the "Dodge building cost indexes, northeastern and north central states," published by Marshall and Swift. The payment provided for in this division is the only payment that shall be made for the capitalized costs of a nonextensive renovation of an intermediate care facility for the mentally retarded. Nonextensive renovation costs shall not be included in cost of ownership, and a nonextensive renovation shall not affect the date of licensure for purposes of division (C) of this section. This division applies to nonextensive renovations regardless of whether they are made by an owner or a lessee. If the tenancy of a lessee that has made renovations ends before the depreciation expense for the renovation costs has been fully reported, the former lessee shall not report the undepreciated balance as an expense.

For a nonextensive renovation to qualify for payment under this division, both of the following conditions must be met:

(1) At least five years have elapsed since the date of licensure or date of an extensive renovation of the portion of the facility that is proposed to be renovated, except that this condition does not apply if the renovation is necessary to meet the requirements of federal, state, or local statutes, ordinances, rules, or policies.

(2) The provider has obtained prior approval from the department of job and family services. The provider shall submit a plan that describes in detail

the changes in capital assets to be accomplished by means of the renovation and the timetable for completing the project. The time for completion of the project shall be no more than eighteen months after the renovation begins. The director of job and family services shall adopt rules under section 5111.02 of the Revised Code that specify criteria and procedures for prior approval of renovation projects. No provider shall separate a project with the intent to evade the characterization of the project as a renovation or as an extensive renovation. No provider shall increase the scope of a project after it is approved by the department of job and family services unless the increase in scope is approved by the department.

(E) The amounts specified in divisions (C) and (D) of this section shall be adjusted beginning July 1, 1993, for the estimated inflation for the twelve-month period beginning on the first day of July of the calendar year preceding the calendar year that precedes the fiscal year for which rate will be paid and ending on the thirtieth day of the following June, using the consumer price index for shelter costs for all urban consumers for the north central region, as published by the United States bureau of labor statistics.

(F)(1) For facilities of eight or fewer beds that have dates of licensure or have been granted project authorization by the department of developmental disabilities before July 1, 1993, and for facilities of eight or fewer beds that have dates of licensure or have been granted project authorization after that date if the providers of the facilities demonstrate that they made substantial commitments of funds on or before that date, cost of ownership shall not exceed eighteen dollars and thirty cents per resident per day. The eighteen-dollar and thirty-cent amount shall be increased by the change in the "Dodge building cost indexes, northeastern and north central states," published by Marshall and Swift, during the period beginning June 30, 1990, and ending July 1, 1993, and by the change in the consumer price index for shelter costs for all urban consumers for the north central region, as published by the United States bureau of labor statistics, annually thereafter.

(2) For facilities with eight or fewer beds that have dates of licensure or have been granted project authorization by the department of developmental disabilities on or after July 1, 1993, for which substantial commitments of funds were not made before that date, cost of ownership payments shall not exceed the applicable amount calculated under division (F)(1) of this section, if the department of job and family services gives prior approval for construction of the facility. If the department does not give prior approval, cost of ownership payments shall not exceed the amount specified in division (C) of this section.

(3) Notwithstanding divisions (D) and (F)(1) and (2) of this section, the total payment for cost of ownership, cost of ownership efficiency incentive, and capitalized costs of renovations for an intermediate care facility for the mentally retarded with eight or fewer beds shall not exceed the sum of the limitations specified in divisions (C) and (D) of this section.

(G) Notwithstanding any provision of this section or section 5111.241 of the Revised Code, the director of job and family services may adopt rules under section 5111.02 of the Revised Code that provide for a calculation of a combined maximum payment limit for indirect care costs and cost of ownership for intermediate care facilities for the mentally retarded with eight or fewer beds.

(H) ~~After the date on which a transaction of sale is closed, the provider shall refund to the department the amount of excess depreciation paid to the provider for the facility by the department for each year the provider has operated the facility under a provider agreement and prorated according to the number of medicaid patient days for which the provider has received payment for the facility. For the purposes of this division, "depreciation paid to the provider for the facility" means the amount paid to the provider for the intermediate care facility for the mentally retarded for cost of ownership pursuant to this section less any amount paid for interest costs. For the purposes of this division, "excess depreciation" is the intermediate care facility for the mentally retarded's depreciated basis, which is the provider's cost less accumulated depreciation, subtracted from the purchase price but not exceeding the amount of depreciation paid to the provider for the facility.~~

~~(I)~~ The department of job and family services shall pay a provider for each of the provider's eligible proprietary intermediate care facilities for the mentally retarded a return on the facility's net equity computed at the rate of one and one-half times the average of interest rates on special issues of public debt obligations issued to the federal hospital insurance trust fund for the cost reporting period. No facility's return on net equity paid under this division shall exceed one dollar per patient day.

In calculating the rate for return on net equity, the department shall use the greater of the facility's inpatient days during the applicable cost reporting period or the number of inpatient days the facility would have had during that period if its occupancy rate had been ninety-five per cent.

~~(J)~~(I)(1) Except as provided in division ~~(J)~~(I)(2) of this section, if a provider leases or transfers an interest in a facility to another provider who is a related party, the related party's allowable cost of ownership shall include the lesser of the following:

(a) The annual lease expense or actual cost of ownership, whichever is applicable;

(b) The reasonable cost to the lessor or provider making the transfer.

(2) If a provider leases or transfers an interest in a facility to another provider who is a related party, regardless of the date of the lease or transfer, the related party's allowable cost of ownership shall include the annual lease expense or actual cost of ownership, whichever is applicable, subject to the limitations specified in divisions (B) to ~~(I)~~(H) of this section, if all of the following conditions are met:

(a) The related party is a relative of owner;

(b) In the case of a lease, if the lessor retains any ownership interest, it is, except as provided in division ~~(J)~~(I)(2)(d)(ii) of this section, in only the real property and any improvements on the real property;

(c) In the case of a transfer, the provider making the transfer retains, except as provided in division ~~(J)~~(I)(2)(d)(iv) of this section, no ownership interest in the facility;

(d) The department of job and family services determines that the lease or transfer is an arm's length transaction pursuant to rules adopted under section 5111.02 of the Revised Code. The rules shall provide that a lease or transfer is an arm's length transaction if all of the following, as applicable, apply:

(i) In the case of a lease, once the lease goes into effect, the lessor has no direct or indirect interest in the lessee or, except as provided in division ~~(J)~~(I)(2)(b) of this section, the facility itself, including interest as an owner, officer, director, employee, independent contractor, or consultant, but excluding interest as a lessor.

(ii) In the case of a lease, the lessor does not reacquire an interest in the facility except through the exercise of a lessor's rights in the event of a default. If the lessor reacquires an interest in the facility in this manner, the department shall treat the facility as if the lease never occurred when the department calculates its reimbursement rates for capital costs.

(iii) In the case of a transfer, once the transfer goes into effect, the provider that made the transfer has no direct or indirect interest in the provider that acquires the facility or the facility itself, including interest as an owner, officer, director, employee, independent contractor, or consultant, but excluding interest as a creditor.

(iv) In the case of a transfer, the provider that made the transfer does not reacquire an interest in the facility except through the exercise of a creditor's rights in the event of a default. If the provider reacquires an interest in the facility in this manner, the department shall treat the facility as if the transfer

never occurred when the department calculates its reimbursement rates for capital costs.

(v) The lease or transfer satisfies any other criteria specified in the rules.

(e) Except in the case of hardship caused by a catastrophic event, as determined by the department, or in the case of a lessor or provider making the transfer who is at least sixty-five years of age, not less than twenty years have elapsed since, for the same facility, allowable cost of ownership was determined most recently under this division.

Sec. 5111.254. (A) The department of job and family services shall establish initial rates for a nursing facility with a first date of licensure that is on or after July 1, 2006, including a facility that replaces one or more existing facilities, or for a nursing facility with a first date of licensure before that date that was initially certified for the medicaid program on or after that date, in the following manner:

(1) The rate for direct care costs shall be the product of the cost per case-mix unit determined under division (D) of section 5111.231 of the Revised Code for the facility's peer group and the nursing facility's case-mix score. For the purpose of division (A)(1) of this section, the nursing facility's case-mix score shall be the following:

(a) Unless the nursing facility replaces an existing nursing facility that participated in the medicaid program immediately before the replacement nursing facility begins participating in the medicaid program, the median annual average case-mix score for the nursing facility's peer group;

(b) If the nursing facility replaces an existing nursing facility that participated in the medicaid program immediately before the replacement nursing facility begins participating in the medicaid program, the semiannual case-mix score most recently determined under section 5111.232 of the Revised Code for the replaced nursing facility as adjusted, if necessary, to reflect any difference in the number of beds in the replaced and replacement nursing facilities.

(2) The rate for ancillary and support costs shall be the rate for the facility's peer group determined under division (D) of section 5111.24 of the Revised Code.

(3) The rate for capital costs shall be the ~~median~~ rate for the facility's peer group determined under division (D) of section 5111.25 of the Revised Code.

(4) The rate for tax costs as defined in section 5111.242 of the Revised Code shall be the median rate for tax costs for the facility's peer group in which the facility is placed under division (C) of section 5111.24 of the Revised Code.

(5) The quality incentive payment shall be the mean payment ~~specified in division (B) of~~ made to nursing facilities under section 5111.244 of the Revised Code.

(B) Subject to division (C) of this section, the department shall adjust the rates established under division (A) of this section effective the first day of July, to reflect new rate calculations for all nursing facilities under sections 5111.20 to ~~5111.33~~ 5111.331 of the Revised Code.

(C) If a rate for direct care costs is determined under this section for a nursing facility using the median annual average case-mix score for the nursing facility's peer group, the rate shall be redetermined to reflect the replacement nursing facility's actual semiannual case-mix score determined under section 5111.232 of the Revised Code after the nursing facility submits its first two quarterly assessment data that qualify for use in calculating a case-mix score in accordance with rules authorized by division (E) of section 5111.232 of the Revised Code. If the nursing facility's quarterly submissions do not qualify for use in calculating a case-mix score, the department shall continue to use the median annual average case-mix score for the nursing facility's peer group in lieu of the nursing facility's semiannual case-mix score until the nursing facility submits two consecutive quarterly assessment data that qualify for use in calculating a case-mix score.

Sec. 5111.255. (A) The department of job and family services shall establish initial rates for an intermediate care facility for the mentally retarded with a first date of licensure that is on or after January 1, 1993, including a facility that replaces one or more existing facilities, or for an intermediate care facility for the mentally retarded with a first date of licensure before that date that was initially certified for the medicaid program on or after that date, in the following manner:

(1) The rate for direct care costs shall be determined as follows:

(a) If there are no cost or resident assessment data as necessary to calculate a rate under section 5111.23 of the Revised Code, the rate shall be the median cost per case-mix unit calculated under division (B)(1) of that section for the relevant peer group for the calendar year preceding the fiscal year in which the rate will be paid, multiplied by the median annual average case-mix score for the peer group for that period and by the rate of inflation estimated under division (B)(3) of that section. This rate shall be recalculated to reflect the facility's actual quarterly average case-mix score, in accordance with that section, after it submits its first quarterly assessment data that qualifies for use in calculating a case-mix score in accordance with rules authorized by division (E) of section 5111.232 of the Revised Code. If

the facility's first two quarterly submissions do not contain assessment data that qualifies for use in calculating a case-mix score, the department shall continue to calculate the rate using the median annual case-mix score for the peer group in lieu of an assigned quarterly case-mix score. The department shall assign a case-mix score or, if necessary, a cost per case-mix unit under division (D) of section 5111.232 of the Revised Code for any subsequent submissions that do not contain assessment data that qualifies for use in calculating a case-mix score.

(b) If the facility is a replacement facility and the facility or facilities that are being replaced are in operation immediately before the replacement facility opens, the rate shall be the same as the rate for the replaced facility or facilities, proportionate to the number of beds in each replaced facility. If one or more of the replaced facilities is not in operation immediately before the replacement facility opens, its proportion shall be determined under division (A)(1)(a) of this section.

(2) The rate for other protected costs shall be one hundred fifteen per cent of the median rate for intermediate care facilities for the mentally retarded calculated for the fiscal year under section 5111.235 of the Revised Code.

(3) The rate for indirect care costs shall be the applicable maximum rate for the facility's peer group as specified in division (B) of section 5111.241 of the Revised Code.

(4) The rate for capital costs shall be determined under section 5111.251 of the Revised Code using the greater of actual inpatient days or an imputed occupancy rate of eighty per cent.

(B) The department shall adjust the rates established under division (A) of this section at both of the following times:

(1) Effective the first day of July, to reflect new rate calculations for all facilities under sections 5111.20 to ~~5111.33~~ 5111.331 of the Revised Code;

(2) Following the provider's submission of the facility's cost report under division (A)(1)(b) of section 5111.26 of the Revised Code.

The department shall pay the rate adjusted based on the cost report beginning the first day of the calendar quarter that begins more than ninety days after the department receives the cost report.

Sec. 5111.258. (A) Notwithstanding sections 5111.20 to ~~5111.33~~ 5111.331 of the Revised Code (except section 5111.259 of the Revised Code), the director of job and family services shall adopt rules under section 5111.02 of the Revised Code that establish a methodology for calculating the prospective rates that will be paid each fiscal year to a provider for each of the provider's eligible nursing facilities and intermediate care facilities for

the mentally retarded, and discrete units of the provider's nursing facilities or intermediate care facilities for the mentally retarded, that serve residents who have diagnoses or special care needs that require direct care resources that are not measured adequately by the applicable assessment instrument specified in rules authorized by section 5111.232 of the Revised Code, or who have diagnoses or special care needs specified in the rules as otherwise qualifying for consideration under this section. The facilities and units of facilities whose rates are established under this division may include, but shall not be limited to, any of the following:

(1) In the case of nursing facilities, facilities and units of facilities that serve medically fragile pediatric residents, residents who are dependent on ventilators, or residents who have severe traumatic brain injury, end-stage Alzheimer's disease, or end-stage acquired immunodeficiency syndrome;

(2) In the case of intermediate care facilities for the mentally retarded, facilities and units of facilities that serve residents who have complex medical conditions or severe behavioral problems.

The department shall use the methodology established under this division to pay for services rendered by such facilities and units after June 30, 1993.

The rules authorized by this division shall specify the criteria and procedures the department will apply when designating facilities and units that qualify for calculation of rates under this division. The criteria shall include consideration of whether all of the allowable costs of the facility or unit would be paid by rates established under sections 5111.20 to ~~5111.33~~ 5111.331 of the Revised Code, and shall establish a minimum bed size for a facility or unit to qualify to have its rates established under this division. The criteria shall not be designed to require that residents be served only in facilities located in large cities. The methodology established by the rules shall consider the historical costs of providing care to the residents of the facilities or units.

The rules may require that a facility designated under this division or containing a unit designated under this division receive authorization from the department to admit or retain a resident to the facility or unit and shall specify the criteria and procedures the department will apply when granting that authorization.

Notwithstanding any other provision of sections 5111.20 to ~~5111.33~~ 5111.331 of the Revised Code (except section 5111.259 of the Revised Code), the costs incurred by facilities or units whose rates are established under this division shall not be considered in establishing payment rates for other facilities or units.

(B) The director may adopt rules under section 5111.02 of the Revised Code under which the department, notwithstanding any other provision of sections 5111.20 to ~~5111.33~~ 5111.331 of the Revised Code (except section 5111.259 of the Revised Code), may adjust the rates determined under sections 5111.20 to ~~5111.33~~ 5111.331 of the Revised Code for a facility that serves a resident who has a diagnosis or special care need that, in the rules authorized by division (A) of this section, would qualify a facility or unit of a facility to have its rate determined under that division, but who is not in such a unit. The rules may require that a facility that qualifies for a rate adjustment under this division receive authorization from the department to admit or retain a resident who qualifies the facility for the rate adjustment and shall specify the criteria and procedures the department will apply when granting that authorization.

Sec. 5111.259. The director of job and family services may submit a request to the United States secretary of health and human services for approval to establish a centers of excellence component of the medicaid program. The purpose of the centers of excellence component is to increase the efficiency and quality of nursing facility services provided to medicaid recipients with complex nursing facility service needs. If federal approval for the centers of excellence component is granted, the director may adopt rules under section 5111.02 of the Revised Code governing the component, including rules that establish a method of determining the medicaid reimbursement rates for nursing facilities providing nursing facility services to medicaid recipients participating in the component. The rules may specify the extent to which, if any, of the provisions of section 5111.258 of the Revised Code are to apply to the centers of excellence component. If such rules are adopted, the nursing facilities that provide nursing facility services to medicaid recipients participating in the centers of excellence component shall be paid for those services in accordance with the method established in the rules notwithstanding anything to the contrary in sections 5111.20 to 5111.331 of the Revised Code.

Sec. 5111.261. (A) Except as provided in division (B) of this section and not later than three years after a provider files a cost report with the department of job and family services under section 5111.26 of the Revised Code, the provider may amend the cost report if the provider discovers a material error in the cost report or additional information to be included in the cost report. The department shall review the amended cost report for accuracy and notify the provider of its determination.

(B) A provider may not amend a cost report if the department has notified the provider that an audit of the cost report or a cost report of the

provider for a subsequent cost reporting period is to be conducted under section 5111.27 of the Revised Code. The provider may, however, provide the department information that affects the costs included in the cost report. Such information may not be provided after the adjudication of the final settlement of the cost report.

Sec. 5111.262. No person, other than the provider of a nursing facility, shall submit a claim for medicaid reimbursement for a service provided to a nursing facility resident if the service is included in a medicaid payment made to the provider of a nursing facility under sections 5111.20 to 5111.33 of the Revised Code or in the reimbursable expenses reported on a provider's cost report for a nursing facility. No provider of a nursing facility shall submit a separate claim for medicaid reimbursement for a service provided to a resident of the nursing facility if the service is included in a medicaid payment made to the provider under sections 5111.20 to ~~5111.33~~ 5111.331 of the Revised Code or in the reimbursable expenses on the provider's cost report for the nursing facility.

Sec. ~~5111.261~~ 5111.263. Except as otherwise provided in section 5111.264 of the Revised Code, the department of job and family services, in determining whether an intermediate care facility for the mentally retarded's direct care costs and indirect care costs are allowable, shall place no limit on specific categories of reasonable costs other than compensation of owners, compensation of relatives of owners, and compensation of administrators.

Compensation cost limits for owners and relatives of owners shall be based on compensation costs for individuals who hold comparable positions but who are not owners or relatives of owners, as reported on facility cost reports. As used in this section, "comparable position" means the position that is held by the owner or the owner's relative, if that position is listed separately on the cost report form, or if the position is not listed separately, the group of positions that is listed on the cost report form and that includes the position held by the owner or the owner's relative. In the case of an owner or owner's relative who serves the facility in a capacity such as corporate officer, proprietor, or partner for which no comparable position or group of positions is listed on the cost report form, the compensation cost limit shall be based on civil service equivalents and shall be specified in rules adopted under section 5111.02 of the Revised Code.

Compensation cost limits for administrators shall be based on compensation costs for administrators who are not owners or relatives of owners, as reported on facility cost reports. Compensation cost limits for administrators of four or more intermediate care facilities for the mentally retarded shall be the same as the limits for administrators of intermediate

care facilities for the mentally retarded with one hundred fifty or more beds.

Sec. 5111.27. (A) The department of job and family services shall conduct a desk review of each cost report it receives under section 5111.26 of the Revised Code. Based on the desk review, the department shall make a preliminary determination of whether the reported costs are allowable costs. The department shall notify each provider of whether any of the reported costs are preliminarily determined not to be allowable, the rate calculation under sections 5111.20 to ~~5111.33~~ 5111.331 of the Revised Code that results from that determination, and the reasons for the determination and resulting rate. The department shall allow the provider to verify the calculation and submit additional information.

(B) The department may conduct an audit, as defined by rule adopted under section 5111.02 of the Revised Code, of any cost report ~~and shall notify the provider of its findings.~~

~~Audits shall be conducted by auditors under contract with or employed by the department~~. The decision whether to conduct an audit and the scope of the audit, which may be a desk or field audit, ~~shall~~ may be determined based on prior performance of the provider ~~and may be based on~~, a risk analysis, or other evidence that gives the department reason to believe that the provider has reported costs improperly. A desk or field audit may be performed annually, but is required whenever a provider does not pass the risk analysis tolerance factors. An audit shall be conducted by auditors under contract with or employed by the department. The department shall notify a provider of the findings of an audit by issuing an audit report. An audit report regarding a nursing facility shall include notice of any fine imposed under section 5111.271 of the Revised Code. The department shall issue the audit report no later than three years after the cost report is filed, or upon the completion of a desk or field audit on the report or a report for a subsequent cost reporting period, whichever is earlier. ~~During the time within which the department may issue an audit report, the provider may amend the cost report upon discovery of a material error or material additional information. The department shall review the amended cost report for accuracy and notify the provider of its determination.~~

The department may establish a contract for the auditing of facilities by outside firms. Each contract entered into by bidding shall be effective for one to two years. The department shall establish an audit manual and program which shall require that all field audits, conducted either pursuant to a contract or by department employees:

(1) Comply with the applicable rules prescribed pursuant to Titles XVIII and XIX;

(2) Consider generally accepted auditing standards prescribed by the American institute of certified public accountants;

(3) Include a written summary as to whether the costs included in the report examined during the audit are allowable and are presented ~~fairly~~ in accordance with ~~generally accepted accounting principles and department rules~~ state and federal laws and regulations, and whether, in all material respects, allowable costs are documented, reasonable, and related to patient care;

(4) Are conducted by accounting firms or auditors who, during the period of the auditors' professional engagement or employment and during the period covered by the cost reports, do not have nor are committed to acquire any direct or indirect financial interest in the ownership, financing, or operation of a nursing facility or intermediate care facility for the mentally retarded in this state;

(5) Are conducted by accounting firms or auditors who, as a condition of the contract or employment, shall not audit any facility that has been a client of the firm or auditor;

(6) Are conducted by auditors who are otherwise independent as determined by the standards of independence ~~established by~~ included in the ~~American institute of certified public accountants~~ government auditing standards produced by the United States government accountability office;

(7) Are completed within the time period specified by the department;

(8) Provide to the provider complete written interpretations that explain in detail the application of all relevant contract provisions, regulations, auditing standards, rate formulae, and departmental policies, with explanations and examples, that are sufficient to permit the provider to calculate with reasonable certainty those costs that are allowable and the rate to which the provider's facility is entitled.

For the purposes of division (B)(4) of this section, employment of a member of an auditor's family by a nursing facility or intermediate care facility for the mentally retarded that the auditor does not review does not constitute a direct or indirect financial interest in the ownership, financing, or operation of the facility.

(C) The department, pursuant to rules adopted under section 5111.02 of the Revised Code, may conduct an exception review of assessment data submitted under section 5111.232 of the Revised Code. The department may conduct an exception review based on the findings of a certification survey conducted by the department of health, a risk analysis, or prior performance of the provider.

Exception reviews shall be conducted at the facility by appropriate

health professionals under contract with or employed by the department of job and family services. The professionals may review resident assessment forms and supporting documentation, conduct interviews, and observe residents to identify any patterns or trends of inaccurate assessments and resulting inaccurate case-mix scores.

The rules shall establish an exception review program that requires that exception reviews do all of the following:

(1) Comply with Titles XVIII and XIX;

(2) Provide a written summary that states whether the resident assessment forms have been completed accurately;

(3) Are conducted by health professionals who, during the period of their professional engagement or employment with the department, neither have nor are committed to acquire any direct or indirect financial interest in the ownership, financing, or operation of a nursing facility or intermediate care facility for the mentally retarded in this state;

(4) Are conducted by health professionals who, as a condition of their engagement or employment with the department, shall not review any provider that has been a client of the professional.

For the purposes of division (C)(3) of this section, employment of a member of a health professional's family by a nursing facility or intermediate care facility for the mentally retarded that the professional does not review does not constitute a direct or indirect financial interest in the ownership, financing, or operation of the facility.

If an exception review is conducted before the effective date of the rate that is based on the case-mix data subject to the review and the review results in findings that exceed tolerance levels specified in the rules adopted under this division, the department, in accordance with those rules, may use the findings to recalculate individual resident case-mix scores, quarterly average facility case-mix scores, and annual average facility case-mix scores. The department may use the recalculated quarterly and annual facility average case-mix scores to calculate the facility's rate for direct care costs for the appropriate calendar quarter or quarters.

(D) The department shall prepare a written summary of any audit disallowance or exception review finding that is made after the effective date of the rate that is based on the cost or case-mix data. Where the provider is pursuing judicial or administrative remedies in good faith regarding the disallowance or finding, the department shall not withhold from the provider's current payments any amounts the department claims to be due from the provider pursuant to section 5111.28 of the Revised Code.

(E) The department shall not reduce rates calculated under sections

5111.20 to ~~5111.33~~ 5111.331 of the Revised Code on the basis that the provider charges a lower rate to any resident who is not eligible for the medicaid program.

(F) The department shall adjust the rates calculated under sections 5111.20 to ~~5111.33~~ 5111.331 of the Revised Code to account for reasonable additional costs that must be incurred by intermediate care facilities for the mentally retarded to comply with requirements of federal or state statutes, rules, or policies enacted or amended after January 1, 1992, or with orders issued by state or local fire authorities.

Sec. 5111.271. (A) Subject to division (D) of this section, the department of job and family services shall fine the provider of a nursing facility if the report of an audit conducted under division (B) of section 5111.27 of the Revised Code regarding a cost report for the nursing facility includes either of the following:

(1) Adverse findings that exceed three per cent of the total amount of medicaid-reimbursable costs reported in the cost report;

(2) Adverse findings that exceed twenty per cent of medicaid-reimbursable costs for a particular cost center reported in the cost report.

(B) A fine issued under this section shall equal the greatest of the following:

(1) If the adverse findings exceed three per cent but do not exceed ten per cent of the total amount of medicaid-reimbursable costs reported in the cost report, the greater of three per cent of those reported costs or ten thousand dollars;

(2) If the adverse findings exceed ten per cent but do not exceed twenty per cent of the total amount of medicaid-reimbursable costs reported in the cost report, the greater of six per cent of those reported costs or twenty-five thousand dollars;

(3) If the adverse findings exceed twenty per cent of the total amount of medicaid-reimbursable costs reported in the cost report, the greater of ten per cent of those reported costs or fifty thousand dollars;

(4) If the adverse findings exceed twenty per cent but do not exceed twenty-five per cent of medicaid-reimbursable costs for a particular cost center reported in the cost report, the greater of three per cent of the total amount of medicaid-reimbursable costs reported in the cost report or ten thousand dollars;

(5) If the adverse findings exceed twenty-five per cent but do not exceed thirty per cent of medicaid-reimbursable costs for a particular cost center reported in the cost report, the greater of six per cent of the total amount of

medicaid-reimbursable costs reported in the cost report or twenty-five thousand dollars;

(6) If the adverse findings exceed thirty per cent of medicaid-reimbursable costs for a particular cost center reported in the cost report, the greater of ten per cent of the total amount of medicaid-reimbursable costs reported in the cost report or fifty thousand dollars.

(C) Fines paid under this section shall be deposited into the health care services administration fund created under section 5111.94 of the Revised Code.

(D) The department may not collect a fine under this section until all appeal rights relating to the audit report that is the basis for the fine are exhausted.

Sec. 5111.28. (A) If a provider properly amends its cost report under section ~~5111.27~~ 5111.261 of the Revised Code and the amended report shows that the provider received a lower rate under the original cost report than it was entitled to receive, the department of job and family services shall adjust the provider's rate prospectively to reflect the corrected information. The department shall pay the adjusted rate beginning two months after the first day of the month after the provider files the amended cost report. If the department finds, from an exception review of resident assessment information conducted after the effective date of the rate for direct care costs that is based on the assessment information, that inaccurate assessment information resulted in the provider receiving a lower rate than it was entitled to receive, the department prospectively shall adjust the provider's rate accordingly and shall make payments using the adjusted rate for the remainder of the calendar quarter for which the assessment information is used to determine the rate, beginning one month after the first day of the month after the exception review is completed.

(B) If the provider properly amends its cost report under section ~~5111.27~~ 5111.261 of the Revised Code, the department makes a finding based on an audit under ~~that~~ section 5111.27 of the Revised Code, or the department makes a finding based on an exception review of resident assessment information conducted under ~~that~~ section 5111.27 of the Revised Code after the effective date of the rate for direct care costs that is based on the assessment information, any of which results in a determination that the provider has received a higher rate than it was entitled to receive, the department shall recalculate the provider's rate using the revised information. The department shall apply the recalculated rate to the periods when the provider received the incorrect rate to determine the amount of the

overpayment. The provider shall refund the amount of the overpayment.

In addition to requiring a refund under this division, the department may charge the provider interest at the applicable rate specified in this division from the time the overpayment was made.

(1) If the overpayment resulted from costs reported for calendar year 1993, the interest shall be no greater than one and one-half times the average bank prime rate.

(2) If the overpayment resulted from costs reported for subsequent calendar years:

(a) The interest shall be no greater than two times the average bank prime rate if the overpayment was equal to or less than one per cent of the total medicaid payments to the provider for the fiscal year for which the incorrect information was used to establish a rate.

(b) The interest shall be no greater than two and one-half times the current average bank prime rate if the overpayment was greater than one per cent of the total medicaid payments to the provider for the fiscal year for which the incorrect information was used to establish a rate.

(C) The department also may impose the following penalties:

(1) If a provider does not furnish invoices or other documentation that the department requests during an audit within sixty days after the request, no more than the greater of one thousand dollars per audit or twenty-five per cent of the cumulative amount by which the costs for which documentation was not furnished increased the total medicaid payments to the provider during the fiscal year for which the costs were used to establish a rate;

(2) If an exiting operator or owner fails to provide notice of a facility closure, voluntary termination, or voluntary withdrawal of participation in the medicaid program as required by section 5111.66 of the Revised Code, or an exiting operator or owner and entering operator fail to provide notice of a change of operator as required by section 5111.67 of the Revised Code, no more than the current average bank prime rate plus four per cent of the last two monthly payments.

(D) If the provider continues to participate in the medicaid program, the department shall deduct any amount that the provider is required to refund under this section, and the amount of any interest charged or penalty imposed under this section, from the next available payment from the department to the provider. The department and the provider may enter into an agreement under which the amount, together with interest, is deducted in installments from payments from the department to the provider.

(E) The department shall transmit refunds and penalties to the treasurer of state for deposit in the general revenue fund.

(F) For the purpose of this section, the department shall determine the average bank prime rate using statistical release H.15, "selected interest rates," a weekly publication of the federal reserve board, or any successor publication. If statistical release H.15, or its successor, ceases to contain the bank prime rate information or ceases to be published, the department shall request a written statement of the average bank prime rate from the federal reserve bank of Cleveland or the federal reserve board.

Sec. 5111.29. (A) The director of job and family services shall adopt rules under section 5111.02 of the Revised Code that establish a process under which a provider, or a group or association of providers, may seek reconsideration of rates established under sections 5111.20 to ~~5111.33~~ 5111.331 of the Revised Code, including a rate for direct care costs recalculated before the effective date of the rate as a result of an exception review of resident assessment information conducted under section 5111.27 of the Revised Code.

(1) Except as provided in divisions (A)(2) to (4) of this section, the only issue that a provider, group, or association may raise in the rate reconsideration shall be whether the rate was calculated in accordance with sections 5111.20 to ~~5111.33~~ 5111.331 of the Revised Code and the rules adopted under section 5111.02 of the Revised Code. The rules shall permit a provider, group, or association to submit written arguments or other materials that support its position. The rules shall specify time frames within which the provider, group, or association and the department must act. If the department determines, as a result of the rate reconsideration, that the rate established for one or more facilities of a provider is less than the rate to which the facility is entitled, the department shall increase the rate. If the department has paid the incorrect rate for a period of time, the department shall pay the provider the difference between the amount the provider was paid for that period for the facility and the amount the provider should have been paid for the facility.

(2) The rules shall provide that during a fiscal year, the department, by means of the rate reconsideration process, may increase the rate determined for an intermediate care facility for the mentally retarded as calculated under sections 5111.20 to ~~5111.33~~ 5111.331 of the Revised Code if the provider of the facility demonstrates that the facility's actual, allowable costs have increased because of extreme circumstances. A facility may qualify for a rate increase only if the facility's per diem, actual, allowable costs have increased to a level that exceeds its total rate. The rules shall specify the circumstances that would justify a rate increase under division (A)(2) of this section. The rules shall provide that the extreme circumstances include

natural disasters, renovations approved under division (D) of section 5111.251 of the Revised Code, an increase in workers' compensation experience rating of greater than five per cent for a facility that has an appropriate claims management program, increased security costs for an inner-city facility, and a change of ownership that results from bankruptcy, foreclosure, or findings of violations of certification requirements by the department of health. An increase under division (A)(2) of this section is subject to any rate limitations or maximum rates established by sections 5111.20 to ~~5111.33~~ 5111.331 of the Revised Code for specific cost centers. Any rate increase granted under division (A)(2) of this section shall take effect on the first day of the first month after the department receives the request.

(3) The rules shall provide that the department, through the rate reconsideration process, may increase an intermediate care facility for the mentally retarded's rate as calculated under sections 5111.20 to ~~5111.33~~ 5111.331 of the Revised Code if the department, in the department's sole discretion, determines that the rate as calculated under those sections works an extreme hardship on the facility.

(4) The rules shall provide that when beds certified for the medicaid program are added to an existing intermediate care facility for the mentally retarded or replaced at the same site, the department, through the rate reconsideration process, shall increase the intermediate care facility for the mentally retarded's rate for capital costs proportionately, as limited by any applicable limitation under section 5111.251 of the Revised Code, to account for the costs of the beds that are added or replaced. The department shall make this increase one month after the first day of the month after the department receives sufficient documentation of the costs. Any rate increase granted under division (A)(4) of this section after June 30, 1993, shall remain in effect until the effective date of a rate calculated under section 5111.251 of the Revised Code that includes costs incurred for a full calendar year for the bed addition or bed replacement. The facility shall report double accumulated depreciation in an amount equal to the depreciation included in the rate adjustment on its cost report for the first year of operation. During the term of any loan used to finance a project for which a rate adjustment is granted under division (A)(4) of this section, if the facility is operated by the same provider, the provider shall subtract from the interest costs it reports on its cost report an amount equal to the difference between the following:

(a) The actual, allowable interest costs for the loan during the calendar year for which the costs are being reported;

(b) The actual, allowable interest costs attributable to the loan that were

used to calculate the rates paid to the provider for the facility during the same calendar year.

(5) The department's decision at the conclusion of the reconsideration process shall not be subject to any administrative proceedings under Chapter 119. or any other provision of the Revised Code.

(B) All of the following are subject to an adjudication conducted in accordance with Chapter 119. of the Revised Code:

(1) Any audit disallowance that the department makes as the result of an audit under section 5111.27 of the Revised Code;

(2) Any adverse finding that results from an exception review of resident assessment information conducted under section 5111.27 of the Revised Code after the effective date of the facility's rate that is based on the assessment information;

(3) Any medicaid payment deemed an overpayment under section 5111.683 of the Revised Code;

(4) Any penalty the department imposes under division (C) of section 5111.28 of the Revised Code or section 5111.683 of the Revised Code.

Sec. 5111.291. Notwithstanding sections 5111.20 to ~~5111.33~~ 5111.331 of the Revised Code, the department of job and family services may compute the rate for intermediate care facilities for the mentally retarded operated by the department of developmental disabilities or the department of mental health according to the reasonable cost principles of Title XVIII.

Sec. 5111.33. Reimbursement to a provider of an intermediate care facility for the mentally retarded under sections 5111.20 to ~~5111.32~~ 5111.331 of the Revised Code shall include payments to the provider, at a rate equal to the percentage of the per resident per day rates that the department of job and family services has established for the provider's ~~nursing facility or intermediate care~~ facility ~~for the mentally retarded~~ under sections 5111.20 to ~~5111.33~~ 5111.331 of the Revised Code for the fiscal year for which the cost of services is reimbursed, to reserve a bed for a recipient during a temporary absence under conditions prescribed by the department, to include hospitalization for an acute condition, visits with relatives and friends, and participation in therapeutic programs outside the facility, when the resident's plan of care provides for such absence and federal participation in the payments is available. The maximum period during which payments may be made to reserve a bed shall not exceed the maximum period specified under federal regulations, and shall not be more than thirty days during any calendar year for hospital stays, visits with relatives and friends, and participation in therapeutic programs.

Recipients ~~who have been identified by the department as requiring the~~

~~level of care of an intermediate care facility for the mentally retarded~~ shall not be subject to a maximum period during which payments may be made to reserve a bed in an intermediate care facility for the mentally retarded if prior authorization of the department is obtained for hospital stays, visits with relatives and friends, and participation in therapeutic programs. The director of job and family services shall adopt rules under section 5111.02 of the Revised Code establishing conditions under which prior authorization may be obtained.

Sec. 5111.331. (A) The department of job and family services may make payments to a provider of a nursing facility under sections 5111.20 to 5111.331 of the Revised Code to reserve a bed for a recipient during a temporary absence under conditions prescribed by the department, to include hospitalization for an acute condition, visits with relatives and friends, and participation in therapeutic programs outside the facility, when the resident's plan of care provides for such absence and federal participation in the payments is available.

(B) The maximum period for which payments may be made to reserve a bed in a nursing facility shall not exceed thirty days in a calendar year.

(C) The department shall establish the per diem rates to be paid to providers of nursing facilities for reserving beds under this section. In establishing the per diem rates, the department shall do the following:

(1) In the case of a payment to reserve a bed for a day during calendar year 2011, set the per diem rate at an amount not exceeding fifty per cent of the per diem rate the provider would be paid if the recipient were not absent from the nursing facility that day;

(2) In the case of a payment to reserve a bed for a day during calendar year 2012 and each calendar year thereafter, set the per diem rate at an amount equal to the following:

(a) In the case of a nursing facility that had an occupancy rate in the preceding calendar year exceeding ninety-five per cent, an amount not exceeding fifty per cent of the per diem rate the provider would be paid if the recipient were not absent from the nursing facility that day;

(b) In the case of a nursing facility that had an occupancy rate in the preceding calendar year not exceeding ninety-five per cent, an amount not exceeding eighteen per cent of the per diem rate the provider would be paid if the recipient were not absent from the nursing facility that day.

Sec. 5111.35. As used in this section "a resident's rights" means the rights of a nursing facility resident under sections 3721.10 to 3721.17 of the Revised Code and subsection (c) of section 1819 or 1919 of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended, and

regulations issued under those subsections.

As used in sections 5111.35 to 5111.62 of the Revised Code:

(A) "Certification requirements" means the requirements for nursing facilities established under sections 1819 and 1919 of the "Social Security Act."

(B) "Compliance" means substantially meeting all applicable certification requirements.

(C) "Contracting agency" means a state agency that has entered into a contract with the department of job and family services under section 5111.38 of the Revised Code.

(D)(1) "Deficiency" means a finding cited by the department of health during a survey, on the basis of one or more actions, practices, situations, or incidents occurring at a nursing facility, that constitutes a severity level three finding, severity level four finding, scope level three finding, or scope level four finding. Whenever the finding is a repeat finding, "deficiency" also includes any finding that is a severity level two and scope level one finding, a severity level two and scope level two finding, or a severity level one and scope level two finding.

(2) "Cluster of deficiencies" means deficiencies that result from noncompliance with two or more certification requirements and are causing or resulting from the same action, practice, situation, or incident.

(E) "Emergency" means either of the following:

(1) A deficiency or cluster of deficiencies that creates a condition of immediate jeopardy;

(2) An unexpected situation or sudden occurrence of a serious or urgent nature that creates a substantial likelihood that one or more residents of a nursing facility may be seriously harmed if allowed to remain in the facility, including the following:

(a) A flood or other natural disaster, civil disaster, or similar event;

(b) A labor strike that suddenly causes the number of staff members in a nursing facility to be below that necessary for resident care.

(F) "Finding" means a finding of noncompliance with certification requirements determined by the department of health under section 5111.41 of the Revised Code.

(G) "Immediate jeopardy" means that one or more residents of a nursing facility are in imminent danger of serious physical or life-threatening harm.

(H) "Medicaid eligible resident" means a person who is a resident of a nursing facility, or is applying for admission to a nursing facility, and is eligible to receive financial assistance under the medical assistance program for the care the person receives in such a facility.

(I) "Noncompliance" means failure to substantially meet all applicable certification requirements.

(J) "Nursing facility" has the same meaning as in section 5111.20 of the Revised Code.

(K) "Provider" means a person, institution, or entity that furnishes nursing facility services under a medical assistance program provider agreement.

(L) "Provider agreement" means a contract between the department of job and family services and a provider for the provision of nursing facility services under the medicaid program.

(M) "Repeat finding" or "repeat deficiency" means a finding or deficiency cited pursuant to a survey, to which both of the following apply:

(1) The finding or deficiency involves noncompliance with the same certification requirement, and the same kind of actions, practices, situations, or incidents caused by or resulting from the noncompliance, as were cited in the immediately preceding standard survey or another survey conducted subsequent to the immediately preceding standard survey of the facility. For purposes of this division, actions, practices, situations, or incidents may be of the same kind even though they involve different residents, staff, or parts of the facility.

(2) The finding or deficiency is cited subsequent to a determination by the department of health that the finding or deficiency cited on the immediately preceding standard survey, or another survey conducted subsequent to the immediately preceding standard survey, had been corrected.

~~(M)~~(N)(1) "Scope level one finding" means a finding of noncompliance by a nursing facility in which the actions, situations, practices, or incidents causing or resulting from the noncompliance affect one or a very limited number of facility residents and involve one or a very limited number of facility staff members.

(2) "Scope level two finding" means a finding of noncompliance by a nursing facility in which the actions, situations, practices, or incidents causing or resulting from the noncompliance affect more than a limited number of facility residents or involve more than a limited number of facility staff members, but the number or percentage of facility residents affected or staff members involved and the number or frequency of the actions, situations, practices, or incidents in short succession does not establish any reasonable degree of predictability of similar actions, situations, practices, or incidents occurring in the future.

(3) "Scope level three finding" means a finding of noncompliance by a

nursing facility in which the actions, situations, practices, or incidents causing or resulting from the noncompliance affect more than a limited number of facility residents or involve more than a limited number of facility staff members, and the number or percentage of facility residents affected or staff members involved or the number or frequency of the actions, situations, practices, or incidents in short succession establishes a reasonable degree of predictability of similar actions, situations, practices, or incidents occurring in the future.

(4) "Scope level four finding" means a finding of noncompliance by a nursing facility causing or resulting from actions, situations, practices, or incidents that involve a sufficient number or percentage of facility residents or staff members or occur with sufficient regularity over time that the noncompliance can be considered systemic or pervasive in the facility.

~~(N)~~(O)(1) "Severity level one finding" means a finding of noncompliance by a nursing facility that has not caused and, if continued, is unlikely to cause physical harm to a facility resident, mental or emotional harm to a resident, or a violation of a resident's rights that results in physical, mental, or emotional harm to the resident.

(2) "Severity level two finding" means a finding of noncompliance by a nursing facility that, if continued over time, will cause, or is likely to cause, physical harm to a facility resident, mental or emotional harm to a resident, or a violation of a resident's rights that results in physical, mental, or emotional harm to the resident.

(3) "Severity level three finding" means a finding of noncompliance by a nursing facility that has caused physical harm to a facility resident, mental or emotional harm to a resident, or a violation of a resident's rights that results in physical, mental, or emotional harm to the resident.

(4) "Severity level four finding" means a finding of noncompliance by a nursing facility that has caused life-threatening harm to a facility resident or caused a resident's death.

~~(O)~~(P) "State agency" has the same meaning as in section 1.60 of the Revised Code.

~~(P)~~(Q) "Substandard care" means care furnished in a facility in which the department of health has cited a deficiency or deficiencies that constitute one of the following:

(1) A severity level four finding, regardless of scope;

(2) A severity level three and scope level four finding, in the quality of care provided to residents;

(3) A severity level three and scope level three finding, in the quality of care provided to residents.

~~(Q)~~(R)(1) "Survey" means a survey of a nursing facility conducted under section 5111.39 of the Revised Code.

(2) "Standard survey" means a survey conducted by the department of health under division (A) of section 5111.39 of the Revised Code and includes an extended survey.

(3) "Follow-up survey" means a survey conducted by the department of health to determine whether a nursing facility has substantially corrected deficiencies cited in a previous survey.

Sec. 5111.511. (A) If the department of job and family services determines that a nursing facility is experiencing or is likely to experience a serious financial loss or failure that jeopardizes or is likely to jeopardize the health, safety, and welfare of its residents, the department, subject to the provider's consent, may appoint a temporary resident safety assurance manager in the nursing facility to take actions the department determines are appropriate to ensure the health, safety, and welfare of the residents.

(B) A temporary resident safety assurance manager appointed under this section is vested with the authority necessary to take actions the department of job and family services determines are appropriate to ensure the health, safety, and welfare of the residents.

(C) A temporary resident safety assurance manager appointed under this section may use any of the following funds to pay for costs the manager incurs on behalf of the nursing facility:

(1) Medicaid payments made in accordance with the provider agreement for the nursing facility;

(2) Funds from the residents protection fund that the department provides the manager under section 5111.62 of the Revised Code;

(3) Other funds the department determines are appropriate if such use of the funds is consistent with the appropriations that authorize the use of the funds and all other state and federal laws governing the use of the funds.

(D) The provider is liable to the department for the amount of any payments the department makes to the temporary resident safety assurance manager, other than payments specified in division (C)(1) of this section. The department may recover the amount the provider owes the department by doing any of the following:

(1) Offsetting medicaid payments made to the provider in accordance with the provider agreement;

(2) Placing a lien on any of the provider's real and personal property;

(3) Initiating other collection actions.

(E) No action the department takes under this section is subject to appeal under Chapter 119. of the Revised Code.

(F) In rules adopted under section 5111.36 of the Revised Code, the director of job and family services may establish all of the following:

(1) Qualifications persons must meet to be appointed temporary resident safety assurance managers under this section;

(2) Procedures for maintaining a list of qualified temporary resident safety assurance managers;

(3) Procedures consistent with federal law for paying for the services of temporary resident safety assurance managers;

(4) Accounting and reporting requirements for temporary resident safety assurance managers;

(5) Other procedures and requirements the director determines are necessary to implement this section.

Sec. 5111.52. (A) As used in this section~~:~~

~~(1) "Provider agreement" means a contract between the department of job and family services and a nursing facility for the provision of nursing facility services under the medical assistance program.~~

~~(2) "Terminating"~~, "terminating" includes not renewing.

(B) A nursing facility's participation in the medical assistance program shall be terminated under sections 5111.35 to 5111.62 of the Revised Code as follows:

(1) If the department of job and family services is terminating the facility's participation, it shall issue an order terminating the facility's provider agreement.

(2) If the department of health, acting as a contracting agency, is terminating the facility's participation, it shall issue an order terminating certification of the facility's compliance with certification requirements. When the department of health terminates certification, the department of job and family services shall terminate the facility's provider agreement. The department of job and family services is not required to provide an adjudication hearing when it terminates a provider agreement following termination of certification by the department of health.

(3) If a state agency other than the department of health, acting as a contracting agency, is terminating the facility's participation, it shall notify the department of job and family services, and the department of job and family services shall issue an order terminating the facility's provider agreement. The contracting agency shall conduct any administrative proceedings concerning the order.

(C) If the following conditions are met, the department of job and family services may make medical assistance payments to a nursing facility for a period not exceeding thirty days after the effective date of termination

under sections 5111.35 to 5111.62 of the Revised Code of the facility's participation in the medical assistance program:

(1) The payments are for medicaid eligible residents admitted to the facility prior to the effective date of the termination;

(2) The provider is making reasonable efforts to transfer medicaid eligible residents to other care settings.

The period during which payments may be made under this division begins on the later of the effective date of the termination or, if the facility has appealed a termination order, the date of issuance of the adjudication order upholding termination.

Sec. 5111.54. (A) A temporary manager of a nursing facility appointed by the department of job and family services or a contracting agency under sections 5111.35 to 5111.62 of the Revised Code shall meet all of the following qualifications:

(1) Be licensed as a nursing home administrator under Chapter 4751. of the Revised Code;

(2) Have demonstrated competence as a nursing home administrator;

(3) Have had no disciplinary action taken against the temporary manager by any licensing board or professional society in this state.

(B) The salary of a temporary manager or special master appointed under sections 5111.35 to 5111.62 of the Revised Code shall be paid by the facility and set by the department of job and family services or contracting agency, in the case of a temporary manager, or by the court, in the case of a special master, at a rate not to exceed the maximum allowable compensation for an administrator under the medical assistance program. The extent to which this compensation is allowable under the medical assistance program is subject to and limited by this chapter and rules of the department.

Subject to division (C) of this section, any costs incurred on behalf of a nursing facility by a temporary manager or special master appointed under sections 5111.35 to 5111.62 of the Revised Code shall be paid by the facility. The allowability of these costs under the medical assistance program shall be subject to and governed by this chapter and the rules of the department. This division does not prohibit a facility from applying for or receiving any waiver of cost ceilings available under rules of the department.

(C) No temporary manager or special master appointed under sections 5111.35 to 5111.62 of the Revised Code shall enter into any employment contract on behalf of a facility, or purchase any capital goods using facility funds totaling more than ten thousand dollars, unless the temporary manager or special master has obtained prior approval for the contract or purchase

from either the provider or the court.

(D)(1) A temporary manager appointed for a nursing facility under section 5111.46 of the Revised Code is hereby vested, subject to division (C) of this section, with the legal authority necessary to correct any deficiency or cluster of deficiencies at a facility, bring the facility into compliance with certification requirements, and otherwise ensure the health and safety of the residents.

(2) A temporary manager appointed under section 5111.51 of the Revised Code is hereby vested, subject to division (C) of this section, with the authority necessary to eliminate the emergency, bring the facility into compliance with certification requirements, and otherwise ensure the health and safety of the residents.

(3) A temporary manager appointed under section 5111.53 of the Revised Code is hereby vested, subject to division (C) of this section, with the authority necessary to ensure the transfer of medicaid eligible residents to other appropriate care settings and, if applicable, the orderly closure of the facility, and to otherwise ensure the health and safety of the residents.

(E) Prior to acting under division (A)(1)(b) or (2)(b) of section 5111.46 of the Revised Code to appoint a temporary manager or apply for a special master, the department of job and family services or contracting agency shall order the facility to substantially correct the deficiency or deficiencies within five days after receiving the statement and inform the facility, in the statement it provides pursuant to division (B) of section 5111.49 of the Revised Code, of the order and that it will not take that action unless the facility fails to substantially correct the deficiency or deficiencies within that five-day period. At the end of the five-day period, the department of health shall conduct a follow-up survey that focuses on the deficiency or deficiencies. If the department of health determines that the facility has substantially corrected the deficiency or deficiencies within that time, the department of job and family services or contracting agency shall not appoint a temporary manager or apply for a special master. If the department of health determines that the facility has failed to substantially correct the deficiency or deficiencies within that time, the department of job and family services or contracting agency may proceed with appointment of the temporary manager or application for a special master. Until the statement required under division (B) of section 5111.49 of the Revised Code is actually delivered, no action taken by the department or agency to appoint a temporary manager or apply for a temporary manager under division (A)(1)(b) or (2)(b) of section 5111.46 of the Revised Code shall have any legal effect. No action taken by a facility under this division to substantially

correct a deficiency or deficiencies shall be considered an admission by the facility of the existence of a deficiency or deficiencies.

(F) Appointment of a temporary manager under division (A)(1)(b) or (2)(b) of section 5111.46 or division (A)(1)(d) of section 5111.51 of the Revised Code shall expire at the end of the seventh day following the appointment. If the department of job and family services or contracting agency finds that the deficiency or deficiencies that prompted the appointment under division (A)(1)(b) or (2)(b) of section 5111.46 of the Revised Code cannot be substantially corrected, or the condition of immediate jeopardy that prompted the appointment under division (A)(1)(d) of section 5111.51 of the Revised Code cannot be eliminated, prior to the expiration of the appointment, it may take one of the following actions:

(1) Appoint, subject to the continuing consent of the provider, a temporary manager for the facility;

(2) Apply to the common pleas court of the county in which the facility is located for an order appointing a special master who, under the authority and direct supervision of the court and subject to divisions (B) and (C) of this section, may take such additional actions as are necessary to correct the deficiency or deficiencies or eliminate the condition of immediate jeopardy and bring the facility into compliance with certification requirements.

(G) The court, on finding that the deficiency or deficiencies for which a special master was appointed under division (F)(2) of this section or division (A)(1)(b) or (2)(b) of section 5111.46 of the Revised Code has been substantially corrected, or the emergency for which a special master was appointed under division (F)(2) of this section or division (A)(1)(b) or (B)(2) of section 5111.51 of the Revised Code has been eliminated, that the facility has been brought into compliance with certification requirements, and that the provider has established the management capability to ensure continued compliance with the certification requirements, shall immediately terminate its jurisdiction over the facility and return control and management of the facility to the provider. If the deficiency or deficiencies cannot be substantially corrected, or the emergency cannot be eliminated practicably within a reasonable time following appointment of the special master, the court may order the special master to close the facility and transfer all residents to other nursing facilities or other appropriate care settings.

(H) This section does not apply to temporary resident safety assurance managers appointed under section 5111.511 of the Revised Code.

Sec. 5111.62. The proceeds of all fines, including interest, collected under sections 5111.35 to 5111.62 of the Revised Code shall be deposited in

the state treasury to the credit of the residents protection fund, which is hereby created. The proceeds of all fines, including interest, collected under section 173.42 of the Revised Code shall be deposited in the state treasury to the credit of the residents protection fund.

~~Moneys~~ Money in the fund shall be used for the protection of the health or property of residents of nursing facilities in which the department of health finds deficiencies, including payment for the costs of relocation of residents to other facilities, maintenance of operation of a facility pending correction of deficiencies or closure, and reimbursement of residents for the loss of money managed by the facility under section 3721.15 of the Revised Code. Money in the fund may also be used to make payments under section 5111.511 of the Revised Code.

The fund shall be maintained and administered by the department of job and family services under rules developed in consultation with the departments of health and aging and adopted by the director of job and family services under Chapter 119. of the Revised Code.

Sec. 5111.65. As used in sections 5111.65 to 5111.689 of the Revised Code:

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

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

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

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

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

(a) A change in an exiting operator's form of legal organization, including the formation of a partnership or corporation from a sole proprietorship;

(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;

(c) A lease of the facility to the entering operator or the exiting operator's termination of the exiting operator's lease;

(d) If the exiting operator is a partnership, dissolution of the partnership;

(e) If the exiting operator is a partnership, a change in composition of the partnership unless both of the following apply:

(i) The change in composition does not cause the partnership's dissolution under state law.

(ii) The partners agree that the change in composition does not constitute a change in operator.

(f) If the operator is a corporation, dissolution of the corporation, a merger of the corporation into another corporation that is the survivor of the merger, or a consolidation of one or more other corporations to form a new corporation.

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

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

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

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

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

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

(E) "Effective date of an involuntary termination" means the following:

(1) In the context of a nursing facility, the date the department of job and family services terminates the operator's provider agreement for the nursing facility;

(2) In the context of an intermediate care facility for the mentally retarded, the date the department terminates the operator's provider agreement for the facility or the last day that such a provider agreement is in effect when the department cancels or refuses to renew it.

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

~~(F)~~(G) "Effective date of a voluntary withdrawal of participation" means

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

~~(G)~~(H) "Entering operator" means the person or government entity that will become the operator of a nursing facility or intermediate care facility for the mentally retarded when a change of operator occurs or following an involuntary termination.

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

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

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

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

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

(5) An operator of a nursing facility or intermediate care facility for the mentally retarded that is undergoing or has undergone an involuntary termination.

~~(I)~~(J)(1) ~~"Facility~~ Subject to divisions (J)(2) and (3) of this section, "facility closure" means ~~discontinuance~~ either of the following:

(a) Discontinuance of the use of the building, or part of the building, that houses the facility as a nursing facility or intermediate care facility for the mentally retarded that results in the relocation of all of the facility's residents;

(b) Conversion of the building, or part of the building, that houses a nursing facility or intermediate care facility for the mentally retarded to a different use with any necessary license or other approval needed for that use being obtained and one or more of the facility's residents remaining in the facility to receive services under the new use. ~~A~~

(2) A facility closure occurs regardless of any of the following:

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

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

(c) Any action the department of health takes regarding the facility's certification under Title XIX of the "Social Security Act," 79 Stat. 286

(1965), 42 U.S.C. 1396, as amended, that may result in the transfer of part of the facility's survey findings to another of the operator's facilities;

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

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

~~(2)~~(3) 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.

~~(J)~~(K) "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.

~~(K)~~(L) "Involuntary termination" means the following:

(1) In the context of a nursing facility, the department of job and family services' termination of the operator's provider agreement for the nursing facility when the termination is not taken at the operator's request;

(2) In the context of an intermediate care facility for the mentally retarded, the department's termination of, cancellation of, or refusal to renew the operator's provider agreement for the facility when such action is not taken at the operator's request.

(M) "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.

~~(L)~~(N) "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. 5111.66. An exiting operator or owner of a nursing facility or intermediate care facility for the mentally retarded participating in the medicaid program shall provide the department of job and family services written notice of a facility closure, voluntary termination, or voluntary withdrawal of participation not less than ninety days before the effective date of the facility closure, voluntary termination, or voluntary withdrawal of participation. The written notice shall be provided to the department in accordance with the method specified in rules adopted under section 5111.689 of the Revised Code.

The written notice shall include all of the following:

(A) The name of the exiting operator and, if any, the exiting operator's authorized agent;

(B) The name of the nursing facility or intermediate care facility for the mentally retarded that is the subject of the written notice;

(C) The exiting operator's medicaid provider agreement number for the facility that is the subject of the written notice;

(D) The effective date of the facility closure, voluntary termination, or voluntary withdrawal of participation;

(E) The signature of the exiting operator's or owner's representative.

Sec. 5111.67. (A) An exiting operator or owner and entering operator shall provide the department of job and family services written notice of a change of operator if the nursing facility or intermediate care facility for the mentally retarded participates in the medicaid program and the entering operator seeks to continue the facility's participation. The written notice shall be provided to the department in accordance with the method specified in rules adopted under section 5111.689 of the Revised Code. The written notice shall be provided to the department not later than forty-five days before the effective date of the change of operator if the change of operator does not entail the relocation of residents. The written notice shall be provided to the department not later than ninety days before the effective date of the change of operator if the change of operator entails the relocation of residents. ~~The~~

The written notice shall include all of the following:

(1) The name of the exiting operator and, if any, the exiting operator's authorized agent;

(2) The name of the nursing facility or intermediate care facility for the mentally retarded that is the subject of the change of operator;

(3) The exiting operator's ~~medicaid provider agreement~~ seven-digit medicaid legacy number and ten-digit national provider identifier number for the facility that is the subject of the change of operator;

(4) The name of the entering operator;

(5) The effective date of the change of operator;

(6) The manner in which the entering operator becomes the facility's operator, including through sale, lease, merger, or other action;

(7) If the manner in which the entering operator becomes the facility's operator involves more than one step, a description of each step;

(8) Written authorization from the exiting operator or owner and entering operator for the department to process a provider agreement for the entering operator;

(9) The names and addresses of the persons to whom the department should send initial correspondence regarding the change of operator;

(10) If the nursing facility also participates in the medicare program, notification of whether the entering operator intends to accept assignment of the exiting operator's medicare provider agreement;

(11) The signature of the exiting operator's or owner's representative.

(B) ~~The entering operator shall include a completed application for a provider agreement with the written notice to the department. The entering operator shall attach to the application the following:~~

~~(1) If the written notice is provided to the department before the date the exiting operator or owner and entering operator complete the transaction for the change of operator, all the proposed leases, management agreements, merger agreements and supporting documents, and sales contracts and supporting documents relating to the facility's change of operator;~~

~~(2) If the written notice is provided to the department on or after the date the exiting operator or owner and entering operator complete the transaction for the change of operator, copies of all the executed leases, management agreements, merger agreements and supporting documents, and sales contracts and supporting documents relating to the facility's change of operator.~~ An exiting operator or owner and entering operator immediately shall provide the department written notice of any changes to information included in a written notice of a change of operator that occur after that notice is provided to the department. The notice of the changes shall be provided to the department in accordance with the method specified in rules adopted under section 5111.689 of the Revised Code.

Sec. 5111.671. The department of job and family services may enter into a provider agreement with an entering operator that goes into effect at 12:01 a.m. on the effective date of the change of operator if all of the following requirements are met:

(A) The department receives a properly completed written notice required by section 5111.67 of the Revised Code on or before the date required by that section.

(B) The ~~entering operator furnishes to the~~ department ~~copies of all the fully executed leases, management agreements, merger agreements and supporting documents, and sales contracts and supporting documents relating to the change of operator not later than ten days after the effective date of the change of operator~~ receives both of the following in accordance with the method specified in rules adopted under section 5111.689 of the Revised Code and not later than ten days after the effective date of the change of operator:

(1) From the entering operator, a completed application for a provider agreement and all other forms and documents specified in rules adopted under section 5111.689 of the Revised Code;

(2) From the exiting operator or owner, all forms and documents specified in rules adopted under section 5111.689 of the Revised Code.

(C) The entering operator is eligible for medicaid payments as provided in section 5111.21 of the Revised Code.

Sec. 5111.672. (A) The department of job and family services may enter into a provider agreement with an entering operator that goes into effect at 12:01 a.m. on the date determined under division (B) of this section if all of the following are the case:

(1) The department receives a properly completed written notice required by section 5111.67 of the Revised Code.

(2) The ~~entering operator furnishes to the~~ department ~~copies of all the fully executed leases, management agreements, merger agreements and supporting documents, and sales contracts and supporting documents relating to the change of operator~~ receives, from the entering operator and in accordance with the method specified in rules adopted under section 5111.689 of the Revised Code, a completed application for a provider agreement and all other forms and documents specified in rules adopted under that section.

(3) The department receives, from the exiting operator or owner and in accordance with the method specified in rules adopted under section 5111.689 of the Revised Code, all forms and documents specified in rules adopted under that section.

~~(3) The~~ (4) One or more of the following apply:

(a) The requirement of division (A)(1) of this section is met after the time required by section 5111.67 of the Revised Code~~, the~~;

(b) The requirement of division (A)(2) of this section is met more than ten days after the effective date of the change of operator~~, or both~~;

(c) The requirement of division (A)(3) of this section is met more than ten days after the effective date of the change of operator.

~~(4)~~(5) The entering operator is eligible for medicaid payments as provided in section 5111.21 of the Revised Code.

(B) The department shall determine the date a provider agreement entered into under this section is to go into effect as follows:

(1) The effective date shall give the department sufficient time to process the change of operator, assure no duplicate payments are made, and make the withholding required by section 5111.681 of the Revised Code~~, and withhold the final payment to the exiting operator until one hundred~~

~~eighty days after either of the following:~~

~~(a) The date that the exiting operator submits to the department a properly completed cost report under section 5111.682 of the Revised Code;~~

~~(b) The date that the department waives the cost report requirement of section 5111.682 of the Revised Code~~.

(2) The effective date shall be not earlier than the ~~later~~ latest of the following:

(a) The effective date of the change of operator ~~or the~~;

(b) The date that the ~~exiting operator or owner and~~ entering operator ~~comply~~ complies with section 5111.67 of the Revised Code and division (A)(2) of this section;

(c) The date that the exiting operator or owner complies with section 5111.67 of the Revised Code and division (A)(3) of this section.

(3) The effective date shall be not later than the following after the later of the dates specified in division (B)(2) of this section:

(a) Forty-five days if the change of operator does not entail the relocation of residents;

(b) Ninety days if the change of operator entails the relocation of residents.

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~~, on receipt of a written notice under section 5111.67 of the Revised Code of a change of operator, or on the effective date of an involuntary termination, the department of job and family services shall estimate the amount of any overpayments made under the medicaid program to the exiting operator, including overpayments the exiting operator disputes, and other actual and potential debts the exiting operator owes or may owe to the department and United States centers for medicare and medicaid services under the medicaid program, including a franchise permit fee.

(B) In estimating the exiting operator's other actual and potential debts to the department and the United States centers for medicare and medicaid services under the medicaid program, the department shall 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 the department determines are applicable:

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

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

medicare and medicaid services;

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

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

(5) Other amounts the department determines are applicable.

(C) The department shall provide the exiting operator written notice of the department's estimate under division (A) of this section not later than thirty days after the department receives the notice under section 5111.66 of the Revised Code of the facility closure, voluntary termination, or voluntary withdrawal of participation ~~or~~; the department receives the notice under section 5111.67 of the Revised Code of the change of operator; or the effective date of the involuntary termination. The department's written notice shall include the basis for the estimate.

Sec. 5111.681. (A) Except as provided in divisions (B) ~~and~~, (C), and (D) of this section, the department of job and family services may withhold from payment due an exiting operator under the medicaid program the total amount specified in the notice provided under division (C) of section 5111.68 of the Revised Code that the exiting operator owes or may owe to the department and United States centers for medicare and medicaid services under the medicaid program.

(B) In the case of a change of operator and subject to division ~~(D)~~(E) 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)~~(F) of this section:

(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 shall not make the withholding.

(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 assumes liability.

(C) In the case of a voluntary termination, voluntary withdrawal of participation, or facility closure and subject to division ~~(D)~~(E) 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)~~(F) of this section:

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

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

(D) In the case of an involuntary termination and subject to division (E) of this section, the following shall apply regarding a withholding under division (A) of this section if the exiting operator, the entering operator, or an affiliated operator executes a successor liability agreement meeting the requirements of division (F) of this section and the department approves the successor liability agreement:

(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 shall not make the withholding.

(2) If the exiting operator, entering operator, or affiliated operator assumes liability for only the portion of the amount specified in division (D)(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 assumes liability.

(E) For an exiting operator or affiliated operator to be eligible to enter into a successor liability agreement under division (B) ~~or,~~ (C), or (D) of this

section, both of the following must apply:

(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 involuntary termination, voluntary termination, voluntary withdrawal of participation, facility closure, or change of operator;

(2) During the twelve-month period preceding either the effective date of the involuntary termination or the month in which the department receives the notice of the voluntary termination, voluntary withdrawal of participation, or facility closure under section 5111.66 of the Revised Code or the notice of the change of operator under section 5111.67 of the Revised Code, the average monthly medicaid payment made to the exiting operator or affiliated operator pursuant to the exiting operator's or affiliated operator's one or more 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 involuntary termination, voluntary termination, voluntary withdrawal of participation, facility closure, or change of operator, must equal at least ninety per cent of the sum of the following:

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

(b) Whichever of the following apply:

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

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

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

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

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

(b) The portion of the amount specified in division ~~(E)~~(F)(1)(a) of this

section that represents the franchise permit fee the exiting 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 the department, after determining under section 5111.685 of the Revised Code the actual amount of debt the exiting operator owes the department and United States centers for medicare and medicaid services under the medicaid program, may deduct the lesser of the following from medicaid payments made to the operator who executes the successor liability agreement:

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

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

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

(5) It must provide that, if the attorney general determines the number of months for which the deductions authorized by division ~~(E)~~(F)(3) of this section are to be made, the operator who executes the successor liability agreement shall 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 division ~~(G)~~(H) of this section, would be required by section 109.081 of the Revised Code to be paid into the attorney general claims fund.

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

~~(G)~~(H) Notwithstanding section 109.081 of the Revised Code, the entire amount that the attorney general, whether by employees or agents of the attorney general or by special counsel appointed pursuant to section 109.08 of the Revised Code, collects under a successor liability agreement, other than the additional amount the operator who executes the agreement is required by division ~~(E)~~(F)(5) of this section to pay, shall be paid to the

department of job and family services for deposit into the appropriate fund. The additional amount that the operator is required to pay shall be paid into the state treasury to the credit of the attorney general claims fund created under section 109.081 of the Revised Code.

Sec. 5111.687. The department of job and family services, at its sole discretion, may release the amount withheld under division (A) of section 5111.681 of the Revised Code if the exiting operator submits to the department written notice of a postponement of a change of operator, facility closure, voluntary termination, or voluntary withdrawal of participation and the transactions leading to the change of operator, facility closure, voluntary termination, or voluntary withdrawal of participation are postponed for at least thirty days but less than ninety days after the date originally proposed for the change of operator, facility closure, voluntary termination, or voluntary withdrawal of participation as reported in the written notice required by section 5111.66 or 5111.67 of the Revised Code. The department shall release the amount withheld if the exiting operator submits to the department written notice of a cancellation or postponement of a change of operator, facility closure, voluntary termination, or voluntary withdrawal of participation and the transactions leading to the change of operator, facility closure, voluntary termination, or voluntary withdrawal of participation are canceled or postponed for more than ninety days after the date originally proposed for the change of operator, facility closure, voluntary termination, or voluntary withdrawal of participation as reported in the written notice required by section 5111.66 or 5111.67 of the Revised Code. A written notice shall be provided to the department in accordance with the method specified in rules adopted under section 5111.689 of the Revised Code.

After the department receives a written notice regarding a cancellation or postponement of a facility closure, voluntary termination, or voluntary withdrawal of participation, the exiting operator or owner shall provide new written notice to the department under section 5111.66 of the Revised Code regarding any transactions leading to a facility closure, voluntary termination, or voluntary withdrawal of participation at a future time. After the department receives a written notice regarding a cancellation or postponement of a change of operator, the exiting operator or owner and entering operator shall provide new written notice to the department under section 5111.67 of the Revised Code regarding any transactions leading to a change of operator at a future time.

Sec. 5111.689. The director of job and family services shall adopt rules under section 5111.02 of the Revised Code to implement sections 5111.65

to 5111.689 of the Revised Code, including rules applicable to an exiting operator that provides written notification under section 5111.66 of the Revised Code of a voluntary withdrawal of participation. Rules adopted under this section shall comply with section 1919(c)(2)(F) of the "Social Security Act," 79 Stat. 286 (1965), 42 U.S.C. 1396r(c)(2)(F), regarding restrictions on transfers or discharges of nursing facility residents in the case of a voluntary withdrawal of participation. The rules may prescribe a medicaid reimbursement methodology and other procedures that are applicable after the effective date of a voluntary withdrawal of participation that differ from the reimbursement methodology and other procedures that would otherwise apply. The rules shall specify all of the following:

(A) The method by which written notices to the department required by sections 5111.65 to 5111.689 of the Revised Code are to be provided;

(B) The forms and documents that are to be provided to the department under sections 5111.671 and 5111.672 of the Revised Code, which shall include, in the case of such forms and documents provided by entering operators, all the fully executed leases, management agreements, merger agreements and supporting documents, and fully executed sales contracts and any other supporting documents culminating in the change of operator;

(C) The method by which the forms and documents identified in division (B) of this section are to be provided to the department.

Sec. 5111.83. (A) Not later than January 1, 2012, the director of job and family services shall apply to the United States secretary of health and human services for approval of a medicaid administrative claiming program under which federal financial participation is received as reimbursement for administrative costs incurred by the department of health and the Arthur G. James and Richard J. Solove research institute of the Ohio state university in analyzing and evaluating both of the following pursuant to sections 3701.261 to 3701.236 of the Revised Code:

(1) Cancer reports under the Ohio cancer incidence surveillance system;

(2) The incidence, prevalence, costs, and medical consequences of cancer on medicaid recipients and other low-income populations.

(B) The director of job and family services shall consult with the director of health in seeking approval of the medicaid administrative claiming program. The directors shall cooperate in seeking the approval to the extent they find the approval necessary for the effective and efficient administration of the medicaid program.

Sec. 5111.85. (A) As used in this section and sections 5111.851 to 5111.856 of the Revised Code:

"Home and community-based services medicaid waiver component"

means a medicaid waiver component under which home and community-based services are provided as an alternative to hospital, nursing facility, or intermediate care facility for the mentally retarded services.

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

"Intermediate care facility for the mentally retarded" has the same meaning as in section 5111.20 of the Revised Code.

"Medicaid waiver component" means a component of the medicaid program authorized by a waiver granted by the United States department of health and human services under section 1115 or 1915 of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 1315 or 1396n. "Medicaid waiver component" does not include a care management system established under section 5111.16 of the Revised Code.

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

(B) The director of job and family services may adopt rules under Chapter 119. of the Revised Code governing medicaid waiver components that establish all of the following:

(1) Eligibility requirements for the medicaid waiver components;

(2) The type, amount, duration, and scope of services the medicaid waiver components provide;

(3) The conditions under which the medicaid waiver components cover services;

(4) The amount the medicaid waiver components pay for services or the method by which the amount is determined;

(5) The manner in which the medicaid waiver components pay for services;

(6) Safeguards for the health and welfare of medicaid recipients receiving services under a medicaid waiver component;

(7) Procedures for ~~both of the following:~~

~~(a) Identifying individuals who meet all of the following requirements:~~

~~(i) Are~~ prioritizing and approving for enrollment individuals who are eligible for a home and community-based services medicaid waiver component and ~~on a waiting list for the component;~~

~~(ii) Are receiving inpatient hospital services or residing in an intermediate care facility for the mentally retarded or nursing facility (as appropriate for the component);~~

~~(iii) Choose~~ choose to be enrolled in the component~~.~~

~~(b) Approving the enrollment of individuals identified under the procedures established under division (B)(7)(a) of this section into the home~~

~~and community-based services medicaid waiver component.~~;

(8) Procedures for enforcing the rules, including establishing corrective action plans for, and imposing financial and administrative sanctions on, persons and government entities that violate the rules. Sanctions shall include terminating medicaid provider agreements. The procedures shall include due process protections.

(9) Other policies necessary for the efficient administration of the medicaid waiver components.

(C) The director of job and family services may adopt different rules for the different medicaid waiver components. The rules shall be consistent with the terms of the waiver authorizing the medicaid waiver component.

(D) ~~Any~~ The following apply to procedures established under division (B)(7) of this section:

(1) Any such procedures established for the medicaid-funded component of the PASSPORT program shall be consistent with section 173.401 of the Revised Code. ~~Any~~

(2) Any such procedures established for the Ohio home care program shall be consistent with section 5111.862 of the Revised Code.

(3) Any such procedures established for the unified long-term services and support medicaid waiver program shall be consistent with section 5111.865 of the Revised Code.

(4) Any such procedures established ~~under division (B)(7) of this section~~ for the medicaid-funded component of the assisted living program shall be consistent with section 5111.894 of the Revised Code.

Sec. 5111.861. (A) As used in this section:

"Medicaid waiver component" has the same meaning as in section 5111.85 of the Revised Code.

"Unified long-term services and support medicaid waiver component" means the medicaid waiver component authorized by section 5111.864 of the Revised Code.

(B) Subject to division (C) of this section, there is hereby created the Ohio home care program. The program shall provide home and community-based services. The department of job and family services shall administer the program.

(C) If the unified long-term services and support medicaid waiver component is created, the departments of aging and job and family services shall work together to determine whether the Ohio home care program should continue to operate as a separate medicaid waiver component or be terminated. If the departments determine that the Ohio home care program should be terminated, the program shall cease to exist on a date the

departments shall specify.

Sec. 5111.862. (A) As used in this section:

"Hospital long-term care unit" has the same meaning as in section 3721.50 of the Revised Code.

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

"Ohio home care program" means the medicaid waiver component created under section 5111.861 of the Revised Code.

"Residential treatment facility" means a residential facility licensed by the department of mental health under section 5119.22 of the Revised Code that serves children and either has more than sixteen beds or is part of a campus of multiple facilities that, combined, have a total of more than sixteen beds.

(B) Subject to division (C) of section 5111.861 of the Revised Code, the department of job and family services shall establish a home first component for the Ohio home care program. An individual is eligible for the Ohio home care program's home first component if the individual has been determined to be eligible for the Ohio home care program and at least one of the following applies:

(1) If the individual is under twenty-one years of age, the individual received inpatient hospital services for at least fourteen consecutive days, or had at least three inpatient hospital stays during the twelve months, immediately preceding the date the individual applies for the Ohio home care program.

(2) If the individual is at least twenty-one but less than sixty years of age, the individual received inpatient hospital services for at least fourteen consecutive days immediately preceding the date the individual applies for the Ohio home care program.

(3) The individual received private duty nursing services under the medicaid program for at least twelve consecutive months immediately preceding the date the individual applies for the Ohio home care program.

(4) The individual does not reside in a nursing facility or hospital long-term care unit at the time the individual applies for the Ohio home care program but is at risk of imminent admission to a nursing facility or hospital long-term care unit due to a documented loss of a primary caregiver.

(5) The individual resides in a nursing facility at the time the individual applies for the Ohio home care program.

(6) At the time the individual applies for the Ohio home care program, the individual participates in the money follows the person demonstration project authorized by section 6071 of the "Deficit Reduction Act of 2005,"

Pub. L. No. 109-171, as amended, and either resides in a residential treatment facility or inpatient hospital setting.

(C) An individual determined to be eligible for the home first component of the Ohio home care program shall be enrolled in the Ohio home care program in accordance with rules adopted under section 5111.85 of the Revised Code.

Sec. 5111.863. (A) As used in this section:

"Medicaid waiver component" has the same meaning as in section 5111.85 of the Revised Code.

"Unified long-term services and support medicaid waiver component" means the medicaid waiver component authorized by section 5111.864 of the Revised Code.

(B) Subject to division (C) of this section, there is hereby created the Ohio transitions II aging carve-out program. The program shall provide home and community-based services. The department of job and family services shall administer the program.

(C) If the unified long-term services and support medicaid waiver component is created, the departments of aging and job and family services shall work together to determine whether the Ohio transitions II aging carve-out program should continue to operate as a separate medicaid waiver component or be terminated. If the departments determine that the Ohio transitions II aging carve-out program should be terminated, the program shall cease to exist on a date the departments shall specify.

Sec. 5111.864. (A) As used in this section:

"Medicaid waiver component" has the same meaning as in section 5111.85 of the Revised Code.

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

(B) The director of job and family services shall submit a request to the United States secretary of health and human services pursuant to section 1915n of the "Social Security Act," 95 Stat. 809 (1981), 42 U.S.C. 1396n, as amended, to obtain approval to create a unified long-term services and support medicaid waiver component to provide home and community-based services to eligible individuals of any age who require the level of care provided by nursing facilities. The director of job and family services shall work with the director of aging in seeking approval of the unified long-term services and support medicaid waiver component and, if the approval is obtained, in creating and implementing the component.

If the request to create the unified long-term services and support medicaid waiver component is approved, the director of job and family

services, working with the director of aging, shall adopt rules under section 5111.85 of the Revised Code to implement the component. The rules may authorize the director of aging to adopt rules in accordance with Chapter 119. of the Revised Code governing aspects of the unified long-term services and support medicaid waiver component.

Sec. 5111.865. (A) As used in this section, "unified long-term services and support medicaid waiver program" or "program" means the medicaid waiver component authorized by section 5111.864 of the Revised Code.

(B) If the United States secretary of health and human services approves the request submitted under section 5111.864 of the Revised Code to create the unified long-term services and support medicaid waiver program, the department of job and family services shall establish a home first component for the program. The home first component shall be similar to the home first component of the medicaid-funded component of the PASSPORT program established under section 173.401 of the Revised Code, the home first component of the Ohio home care program established under section 5111.862 of the Revised Code, and the home first component of the medicaid-funded component of the assisted living program established under section 5111.894 of the Revised Code.

Sec. 5111.871. The department of job and family services shall enter into a contract with the department of developmental disabilities under section 5111.91 of the Revised Code with regard to one or more of the medicaid waiver components ~~of the medicaid program~~ established by the department of job and family services under ~~one or more of the medicaid waivers sought under~~ section 5111.87 of the Revised Code. Subject, if needed, to the approval of the United States secretary of health and human services, the contract shall include the medicaid waiver component known as the transitions developmental disabilities waiver. The contract shall provide for the department of developmental disabilities to administer the components in accordance with the terms of the waivers. The contract shall include a schedule for the department of developmental disabilities to begin administering the transitions developmental disabilities waiver. The directors of job and family services and developmental disabilities shall adopt rules in accordance with Chapter 119. of the Revised Code governing the components.

If the department of developmental disabilities or the department of job and family services denies an individual's application for home and community-based services provided under any of these medicaid components, the department that denied the services shall give timely notice to the individual that the individual may request a hearing under section

5101.35 of the Revised Code.

The departments of developmental disabilities and job and family services may approve, reduce, deny, or terminate a service included in the individualized service plan developed for a medicaid recipient eligible for home and community-based services provided under any of these medicaid components. The departments shall consider the recommendations a county board of developmental disabilities makes under division (A)(1)(c) of section 5126.055 of the Revised Code. If either department approves, reduces, denies, or terminates a service, that department shall give timely notice to the medicaid recipient that the recipient may request a hearing under section 5101.35 of the Revised Code.

If supported living, as defined in section 5126.01 of the Revised Code, is to be provided as a service under any of these components, any person or government entity with a current, valid medicaid provider agreement and a current, valid certificate under section 5123.161 of the Revised Code may provide the service.

If a service is to be provided under any of these components by a residential facility, as defined in section 5123.19 of the Revised Code, any person or government entity with a current, valid medicaid provider agreement and a current, valid license under section 5123.19 of the Revised Code may provide the service.

Sec. 5111.872. ~~When~~ (A) Subject to division (B) of this section, when the department of developmental disabilities allocates enrollment numbers to a county board of developmental disabilities for home and community-based services specified in division (B)(1) of section 5111.87 of the Revised Code and provided under any of the medicaid waiver components ~~of the medicaid program~~ that the department administers under section 5111.871 of the Revised Code, the department shall consider all of the following:

~~(A)~~(1) The number of individuals with mental retardation or other developmental disability who are on a waiting list the county board establishes under ~~division (C) of~~ section 5126.042 of the Revised Code for those services and are given priority on the waiting list ~~pursuant to division (D) or (E) of that section~~;

~~(B)~~(2) The implementation component required by division (A)(3) of section 5126.054 of the Revised Code of the county board's plan approved under section 5123.046 of the Revised Code;

~~(C)~~(3) Anything else the department considers necessary to enable county boards to provide those services to individuals in accordance with the priority requirements ~~of divisions (D) and (E) of~~ for waiting lists

established under section 5126.042 of the Revised Code for those services.

(B) Division (A) of this section applies to home and community-based services provided under the medicaid waiver component known as the transitions developmental disabilities waiver only to the extent, if any, provided by the contract required by section 5111.871 of the Revised Code regarding the waiver.

Sec. 5111.873. (A) ~~Not later than the effective date of the first of any medicaid waivers the United States secretary of health and human services grants pursuant to a request made under section 5111.87 of the Revised Code~~ Subject to division (D) of this section, the director of job and family services shall adopt rules in accordance with Chapter 119. of the Revised Code establishing ~~statewide fee schedules~~ the amount of reimbursement or the methods by which amounts of reimbursement are to be determined for home and community-based services specified in division (B)(1) of section 5111.87 of the Revised Code and provided under the components of the medicaid program that the department of developmental disabilities administers under section 5111.871 of the Revised Code. ~~The~~ With respect to these rules ~~shall provide for,~~ all of the following apply:

(1) The rules shall establish procedures for the department of developmental disabilities to follow in arranging for the initial and ongoing collection of cost information from a comprehensive, statistically valid sample of persons and government entities providing the services at the time the information is obtained~~;~~.

(2) The rules shall establish procedures for the collection of consumer-specific information through an assessment instrument the department of developmental disabilities shall provide to the department of job and family services~~;~~.

(3) With the information collected pursuant to divisions (A)(1) and (2) of this section, an analysis of that information, and other information the director determines relevant, ~~methods and~~ the rules shall establish reimbursement standards ~~for calculating the fee schedules~~ that do all of the following:

(a) Assure that ~~the fees are~~ reimbursement is consistent with efficiency, economy, and quality of care;

(b) Consider the intensity of consumer resource need;

(c) Recognize variations in different geographic areas regarding the resources necessary to assure the health and welfare of consumers;

(d) Recognize variations in environmental supports available to consumers.

(B) As part of the process of adopting rules under this section, the

director shall consult with the director of developmental disabilities, representatives of county boards of developmental disabilities, persons who provide the home and community-based services, and other persons and government entities the director identifies.

(C) The directors of job and family services and developmental disabilities shall review the rules adopted under this section at times they determine are necessary to ensure that the ~~methods and~~ amount of reimbursement or the methods by which the amounts of reimbursement are to be determined continue to meet the reimbursement standards established ~~by the rules for calculating the fee schedules continue to do everything that~~ under division (A)(3) of this section ~~requires~~.

(D) This section applies to home and community-based services provided under the medicaid waiver component known as the transitions developmental disabilities waiver only to the extent, if any, provided by the contract required by section 5111.871 of the Revised Code regarding the waiver.

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

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

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

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

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

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

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

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

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

(3) ~~The~~ If the operator intends to convert all of the facility's beds, the operator notifies each of the facility's residents that the facility is to cease providing ICF/MR services and inform each resident that the resident may do either of the following:

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

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

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

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

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

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

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

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

~~(5)~~(6) The ~~director~~ directors of developmental disabilities ~~approves~~ and job and family services approve the conversion.

(C) A decision by the directors to approve or refuse to approve a proposed conversion of beds is final. In making a decision, the directors shall consider all of the following:

(1) The fiscal impact on the facility if some but not all of the beds are converted;

(2) The fiscal impact on the medical assistance program;

(3) The availability of home and community-based services.

(D) The notice provided to the directors under division (B)(1) of this section shall specify whether some or all of the facility's beds are to be converted. If some but not all of the beds are to be converted, the notice shall specify how many of the facility's beds are to be converted and how many of the beds are to continue to provide ICF/MR services. The notice to the director of developmental disabilities ~~under division (B)(1) of this section~~ shall specify whether the operator wishes to surrender the facility's license as a residential facility under section 5123.19 of the Revised Code.

~~(D)~~(E)(1) If the ~~director~~ directors of developmental disabilities ~~approves~~ and job and family services approve a conversion under division ~~(B)~~(C) of this section, the director of health shall ~~terminate~~ do the following:

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

(b) Reduce the facility's certified capacity by the number of beds being converted if the notice specifies that some but not all of the beds are to be converted. ~~The~~

(2) The director of health shall notify the director of job and family services of the termination or reduction. On receipt of the director of health's notice, the director of job and family services shall ~~terminate~~ do the following:

(a) Terminate the operator's medicaid provider agreement that authorizes the operator to provide ICF/MR services at the facility if the facility's certification was terminated;

(b) Amend the operator's medicaid provider agreement to reflect the facility's reduced certified capacity if the facility's certified capacity is reduced. ~~The~~

(3) In the case of action taken under division (E)(2)(a) of this section, the operator is not entitled to notice or a hearing under Chapter 119. of the Revised Code before the director of job and family services terminates the medicaid provider agreement.

Sec. 5111.877. The director of job and family services may seek approval from the United States secretary of health and human services for not more than a total of ~~one~~ two hundred slots for home and community-based services for the purposes of sections 5111.874, 5111.875, and 5111.876 of the Revised Code.

Sec. 5111.88. (A) As used in sections 5111.88 to 5111.8811 of the Revised Code:

(1) "Adult" means an individual at least eighteen years of age.

(2) "Authorized representative" means the following:

(a) In the case of a consumer who is a minor, the consumer's parent, custodian, or guardian;

(b) In the case of a consumer who is an adult, an individual selected by the consumer pursuant to section 5111.8810 of the Revised Code to act on the consumer's behalf for purposes regarding home care attendant services.

(3) "Authorizing health care professional" means a health care professional who, pursuant to section 5111.887 of the Revised Code, authorizes a home care attendant to assist a consumer with self-administration of medication, nursing tasks, or both.

(4) "Consumer" means an individual to whom all of the following apply:

(a) The individual is enrolled in a participating medicaid waiver component.

(b) The individual has a medically determinable physical impairment to which both of the following apply:

(i) It is expected to last for a continuous period of not less than twelve months.

(ii) It causes the individual to require assistance with activities of daily living, self-care, and mobility, including either assistance with self-administration of medication or the performance of nursing tasks, or both.

(c) In the case of an individual who is an adult, the individual is mentally alert and is, or has an authorized representative who is, capable of selecting, directing the actions of, and dismissing a home care attendant.

(d) In the case of an individual who is a minor, the individual has an authorized representative who is capable of selecting, directing the actions of, and dismissing a home care attendant.

(5) "Controlled substance" has the same meaning as in section 3719.01 of the Revised Code.

(6) "Custodian" has the same meaning as in section 2151.011 of the Revised Code.

(7) "Gastrostomy tube" means a percutaneously inserted catheter that terminates in the stomach.

(8) "Guardian" has the same meaning as in section 2111.01 of the Revised Code.

(9) "Health care professional" means a physician or registered nurse.

(10) "Home care attendant" means an individual holding a valid medicaid provider agreement in accordance with section 5111.881 of the Revised Code that authorizes the individual to provide home care attendant services to consumers.

(11) "Home care attendant services" means all of the following as provided by a home care attendant:

(a) Personal care aide services;

(b) Assistance with the self-administration of medication;

(c) Assistance with nursing tasks.

(12) "Jejunostomy tube" means a percutaneously inserted catheter that terminates in the jejunum.

(13) "Medicaid waiver component" has the same meaning as in section 5111.85 of the Revised Code.

(14) "Medication" means a drug as defined in section 4729.01 of the Revised Code.

(15) "Minor" means an individual under eighteen years of age.

(16) "Participating medicaid waiver component" means both of the following:

(a) The ~~medicaid waiver component known as~~ Ohio home care ~~that the department of job and family services administers~~ program created under section 5111.861 of the Revised Code;

(b) The ~~medicaid waiver component known as~~ Ohio transitions II aging carve-out ~~that the department of job and family services administers~~ program created under section 5111.863 of the Revised Code.

(17) "Physician" means an individual authorized under Chapter 4731. of the Revised Code to practice medicine and surgery or osteopathic medicine and surgery.

(18) "Practice of nursing as a registered nurse," "practice of nursing as a licensed practical nurse," and "registered nurse" have the same meanings as in section 4723.01 of the Revised Code. "Registered nurse" includes an advanced practice nurse, as defined in section 4723.01 of the Revised Code.

(19) "Schedule II," "schedule III," "schedule IV," and "schedule V" have the same meanings as in section 3719.01 of the Revised Code.

(B) The director of job and family services may submit requests to the United States secretary of health and human services to amend the federal

medicaid waivers authorizing the participating medicaid waiver components to have those components cover home care attendant services in accordance with sections 5111.88 to 5111.8810 and rules adopted under section 5111.8811 of the Revised Code. Notwithstanding sections 5111.881 to 5111.8811 of the Revised Code, those sections shall be implemented regarding a participating medicaid waiver component only if the secretary approves a waiver amendment for the component.

Sec. 5111.89. (A) As used in sections 5111.89 to 5111.894 of the Revised Code:

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

"Assisted living program" means the program created under this section.

"Assisted living services" means the following home and community-based services: personal care, homemaker, chore, attendant care, companion, medication oversight, and therapeutic social and recreational programming.

"Assisted living waiver" means the federal medicaid waiver granted by the United States secretary of health and human services that authorizes the medicaid-funded component of the assisted living program.

"County or district home" means a county or district home operated under Chapter 5155. of the Revised Code.

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

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

"Medicaid waiver component" has the same meaning as in section 5111.85 of the Revised Code.

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

"Residential care facility" has the same meaning as in section 3721.01 of the Revised Code.

~~"State administrative agency" means the department of job and family services if the department of job and family services administers the assisted living program or the department of aging if the department of aging administers the assisted living program.~~

"Unified long-term services and support medicaid waiver component" means the medicaid waiver component authorized by section 5111.864 of

the Revised Code.

(B) There is hereby created the assisted living program. The program shall provide assisted living services to individuals who meet the program's applicable eligibility requirements ~~established under section 5111.891 of the Revised Code~~. ~~The~~ Subject to division (C) of this section, the program ~~may not serve more individuals than the number that is set by the United States secretary of health and human services when the medicaid waiver authorizing the program is approved~~ shall have a medicaid-funded component and a state-funded component.

(C)(1) Unless the medicaid-funded component of the assisted living program is terminated under division (C)(2) of this section, all of the following apply:

(a) The department of aging shall administer the medicaid-funded component through a contract entered into with the department of job and family services under section 5111.91 of the Revised Code.

(b) The contract shall include an estimate of the medicaid-funded component's costs. ~~The program~~

(c) The medicaid-funded component shall be operated as a separate medicaid waiver component ~~until the United States secretary approves the consolidated federal medicaid waiver sought under section 5111.861 of the Revised Code. The program shall be part of the consolidated federal medicaid waiver sought under that section if the United States secretary approves the waiver.~~

~~If the director of budget and management approves the contract, the department of job and family services shall enter into a contract with the department of aging under section 5111.91 of the Revised Code that provides for the department of aging to administer the assisted living program. The contract shall include an estimate of the program's costs.~~

~~The~~ (d) The medicaid-funded component may not serve more individuals than is set by the United States secretary of health and human services in the assisted living waiver.

(e) The director of job and family services may adopt rules under section 5111.85 of the Revised Code regarding the ~~assisted living program~~ medicaid-funded component. ~~The~~

(f) The director of aging may adopt rules under Chapter 119. of the Revised Code regarding the ~~program~~ medicaid-funded component that the rules adopted by the director of job and family services under division (C)(1)(e) of this section authorize the director of aging to adopt.

(2) If the unified long-term services and support medicaid waiver component is created, the departments of aging and job and family services

shall work together to determine whether the medicaid-funded component of the assisted living program should continue to operate as a separate medicaid waiver component or be terminated. If the departments determine that the medicaid-funded component of the assisted living program should be terminated, the medicaid-funded component shall cease to exist on a date the departments shall specify.

(D) The department of aging shall administer the state-funded component of the assisted living program. The state-funded component shall not be administered as part of the medicaid program.

An individual who is eligible for the state-funded component may participate in the component for not more than three months.

The director of aging shall adopt rules in accordance with section 111.15 of the Revised Code to implement the state-funded component.

Sec. 5111.891. To be eligible for the medicaid-funded component of the assisted living program, an individual must meet all of the following requirements:

(A) Need an intermediate level of care as determined under rule 5101:3-3-06 of the Administrative Code;

(B) ~~At the time the individual applies for the assisted living program, be one of the following:~~

~~(1) A nursing facility resident who is seeking to move to a residential care facility and would remain in a nursing facility for long-term care if not for the assisted living program;~~

~~(2) A participant of any of the following medicaid waiver components who would move to a nursing facility if not for the assisted living program:~~

~~(a) The PASSPORT program created under section 173.40 of the Revised Code;~~

~~(b) The choices program created under section 173.403 of the Revised Code;~~

~~(c) A medicaid waiver component that the department of job and family services administers.~~

~~(3) A resident of a residential care facility who has resided in a residential care facility for at least six months immediately before the date the individual applies for the assisted living program.~~

~~(C) At the time the individual receives~~ While receiving assisted living services under the ~~assisted living program~~ medicaid-funded component, reside in a residential care facility that is authorized by a valid medicaid provider agreement to participate in the ~~assisted living program~~ component, including both of the following:

(1) A residential care facility that is owned or operated by a

metropolitan housing authority that has a contract with the United States department of housing and urban development to receive an operating subsidy or rental assistance for the residents of the facility;

(2) A county or district home licensed as a residential care facility.

~~(D)~~(C) Meet all other eligibility requirements for the ~~assisted living program~~ medicaid-funded component established in rules adopted ~~under~~ pursuant to division (C) of section ~~5111.85~~ 5111.89 of the Revised Code.

Sec. 5111.892. To be eligible for the state-funded component of the assisted living program, an individual must meet all of the following requirements:

(A) The individual must need an intermediate level of care as determined under rule 5101:3-3-06 of the Administrative Code;

(B) The individual must have an application for the medicaid-funded component of the assisted living program (or, if the medicaid-funded component is terminated under division (C)(2) of section 5111.89 of the Revised Code, the unified long-term services and support medicaid waiver component) pending and the department or the department's designee must have determined that the individual meets the nonfinancial eligibility requirements of the medicaid-funded component (or, if the medicaid-funded component is terminated under division (C)(2) of section 5111.89 of the Revised Code, the unified long-term services and support medicaid waiver component) and not have reason to doubt that the individual meets the financial eligibility requirements of the medicaid-funded component (or, if the medicaid-funded component is terminated under division (C)(2) of section 5111.89 of the Revised Code, the unified long-term services and support medicaid waiver component).

(C) While receiving assisted living services under state-funded component, the individual must reside in a residential care facility that is authorized by a valid provider agreement to participate in the component, including both of the following:

(1) A residential care facility that is owned or operated by a metropolitan housing authority that has a contract with the United States department of housing and urban development to receive an operating subsidy or rental assistance for the residents of the facility;

(2) A county or district home licensed as a residential care facility.

(D) The individual must meet all other eligibility requirements for the state-funded component established in rules adopted under division (D) of section 5111.89 of the Revised Code.

Sec. ~~5111.892~~ 5111.893. A residential care facility providing services covered by the assisted living program to an individual enrolled in the

program shall have staff on-site twenty-four hours each day who are able to do all of the following:

(A) Meet the scheduled and unpredicted needs of the individuals enrolled in the assisted living program in a manner that promotes the individuals' dignity and independence;

(B) Provide supervision services for those individuals;

(C) Help keep the individuals safe and secure.

Sec. 5111.894. (A) ~~The state administrative agency~~ Subject to division (C)(2) of section 5111.89 of the Revised Code, the department of aging shall establish a home first component of the assisted living program under which eligible individuals may be enrolled in the medicaid-funded component of the assisted living program in accordance with this section. An individual is eligible for the assisted living program's home first component if ~~all~~ both of the following apply:

(1) The individual ~~is~~ has been determined to be eligible for the medicaid-funded component of the assisted living program.

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

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

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

(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 assisted living program, will require the individual to be admitted to a nursing facility within thirty days of the physician's determination.

(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 assisted living program, the individual is to be transported directly from the hospital to a nursing facility and admitted.

(d) Both of the following apply:

(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.

(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.

(e) The individual resided in a residential care facility for at least six months immediately before applying for the medicaid-funded component of 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.

(B) Each month, each area agency on aging shall identify individuals residing in the area that the area agency on aging serves who are eligible for the home first component of the assisted living program. When an area agency on aging identifies such an individual and determines that there is a vacancy in a residential care facility participating in the medicaid-funded component of the assisted living program that is acceptable to the individual, the agency shall notify the long-term care consultation program administrator serving the area in which the individual resides. The administrator shall determine whether the assisted living program is appropriate for the individual and whether the individual would rather participate in the assisted living program than continue or begin to reside in a nursing facility. If the administrator determines that the assisted living program is appropriate for the individual and the individual would rather participate in the assisted living program than continue or begin to reside in a nursing facility, the administrator shall so notify the ~~state administrative agency~~ department of aging. On receipt of the notice from the administrator, the ~~state administrative agency~~ department shall approve the individual's enrollment in the medicaid-funded component of the assisted living program regardless of the unified waiting list established under section 173.404 of the Revised Code, unless the enrollment would cause the ~~assisted living program~~ component to exceed any limit on the number of individuals who may participate in the ~~program~~ component as set by the United States secretary of health and human services ~~when the medicaid waiver authorizing~~ in the ~~program is approved~~ assisted living waiver.

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

Sec. 5111.911. Any contract the department of job and family services enters into with the department of mental health or department of alcohol and drug addiction services under section 5111.91 of the Revised Code is subject to the approval of the director of budget and management and shall require or specify all of the following:

(A) In the case of a contract with the department of mental health, that section 5111.912 of the Revised Code be complied with;

(B) In the case of a contract with the department of alcohol and drug addiction services, that section 5111.913 of the Revised Code be complied with;

(C) How providers will be paid for providing the services;

(D) The department of mental health's or department of alcohol and drug addiction services' responsibilities ~~for reimbursing~~ with regard to providers, including program oversight and quality assurance.

Sec. 5111.912. If the department of job and family services enters into a contract with the department of mental health under section 5111.91 of the Revised Code, the department of ~~mental health and boards of alcohol, drug addiction, and mental health~~ job and family services shall pay the nonfederal share of any medicaid payment to a provider for services under the component, or aspect of the component, the department of mental health administers. If necessary, the director of job and family services shall submit a medicaid state plan amendment to the United States secretary of health and human services regarding the department of job and family services' duty under this section.

Sec. 5111.913. If the department of job and family services enters into a contract with the department of alcohol and drug addiction services under section 5111.91 of the Revised Code, the department of ~~alcohol and drug addiction services and boards of alcohol, drug addiction, and mental health~~ job and family services shall pay the nonfederal share of any medicaid payment to a provider for services under the component, or aspect of the component, the department of alcohol and drug addiction services administers. If necessary, the director of job and family services shall submit a medicaid state plan amendment to the United States secretary of health and human services regarding the department of job and family services' duty under this section.

Sec. 5111.94. (A) As used in this section, "vendor offset" means a reduction of a medicaid payment to a medicaid provider to correct a previous, incorrect medicaid payment to that provider.

(B) There is hereby created in the state treasury the health care services administration fund. Except as provided in division (C) of this section, all the following shall be deposited into the fund:

(1) Amounts deposited into the fund pursuant to sections 5111.92 and 5111.93 of the Revised Code;

(2) The amount of the state share of all money the department of job and family services, in fiscal year 2003 and each fiscal year thereafter, recovers

pursuant to a tort action under the department's right of recovery under section 5101.58 of the Revised Code that exceeds the state share of all money the department, in fiscal year 2002, recovers pursuant to a tort action under that right of recovery;

(3) Subject to division (D) of this section, the amount of the state share of all money the department of job and family services, in fiscal year 2003 and each fiscal year thereafter, recovers through audits of medicaid providers that exceeds the state share of all money the department, in fiscal year 2002, recovers through such audits;

(4) Amounts from assessments on hospitals under section 5112.06 of the Revised Code and intergovernmental transfers by governmental hospitals under section 5112.07 of the Revised Code that are deposited into the fund in accordance with the law;

(5) Amounts that the department of education pays to the department of job and family services, if any, pursuant to an interagency agreement entered into under section 5111.713 of the Revised Code;

(6) The application fees charged to providers under section 5111.063 of the Revised Code;

(7) The fines collected under section 5111.271 of the Revised Code.

(C) No funds shall be deposited into the health care services administration fund in violation of federal statutes or regulations.

(D) In determining under division (B)(3) of this section the amount of money the department, in a fiscal year, recovers through audits of medicaid providers, the amount recovered in the form of vendor offset shall be excluded.

(E) The director of job and family services shall use funds available in the health care services administration fund to pay for costs associated with the administration of the medicaid program.

Sec. 5111.941. ~~(A)~~ The medicaid revenue and collections fund is hereby created in the state treasury. Except as otherwise provided by statute or as authorized by the controlling board, ~~both of the following shall be credited to the fund:~~

~~(1) The~~ the nonfederal share of all medicaid-related revenues, collections, and recoveries~~;~~

~~(2) The monthly premiums charged under the children's buy-in program pursuant to section 5101.5213 of the Revised Code~~ shall be credited to the fund.

~~(B)~~ The department of job and family services shall use money credited to the medicaid revenue and collections fund to pay for medicaid services and contracts ~~and the children's buy-in program established under sections~~

~~5101.5211 to 5101.5216 of the Revised Code~~.

Sec. 5111.944. (A) As used in this section:

"Dual eligible individual" has the same meaning as in section 1915(h)(2)(B) of the "Social Security Act," 124 Stat. 315 (2010), 42 U.S.C. 1396n(h)(2)(B).

"Dual eligible integrated care demonstration project" means the demonstration project authorized by section 5111.981 of the Revised Code.

"Medicare program" means the program created under Title XVIII of the "Social Security Act," 79 Stat. 286 (1965), 42 U.S.C. 1395, as amended.

(B) There is created in the state treasury the integrated care delivery systems fund. If the terms of the federal approval for the dual eligible integrated care demonstration project provide for the state to receive a portion of the amounts that the demonstration project saves the medicare program, such amounts shall be deposited into the fund. The department of job and family services shall use the money in the fund to further develop integrated delivery systems and improved care coordination for dual eligible individuals.

Sec. 5111.945. There is created in the state treasury the health care special activities fund. The department of job and family services shall deposit all funds it receives pursuant to the administration of the medicaid program into the fund, other than any such funds that are required by law to be deposited into another fund. The department shall use the money in the fund to pay for expenses related to the services provided under, and the administration of, the medicaid program.

Sec. 5111.97. (A) As used in this section ~~and in section 5111.971 of the Revised Code~~, "nursing facility" has the same meaning as in section 5111.20 of the Revised Code.

(B) To the extent funds are available, the director of job and family services may establish the Ohio access success project to help medicaid recipients make the transition from residing in a nursing facility to residing in a community setting. The ~~program~~ project may be established as a separate ~~non-medicaid~~ nonmedicaid program or integrated into a new or existing program of medicaid-funded home and community-based services authorized by a waiver approved by the United States department of health and human services. The director shall permit any recipient of medicaid-funded nursing facility services to apply for participation in the ~~program~~ project, but may limit the number of ~~program~~ project participants. ~~If an application is received before the applicant has been a recipient of medicaid-funded nursing facility services for six months, the~~

The director shall ensure that an assessment of an applicant is conducted

as soon as practicable to determine whether the applicant is eligible for participation in the ~~program~~ project. To the maximum extent possible, the assessment and eligibility determination shall be completed not later than the date that occurs six months after the applicant became a recipient of medicaid-funded nursing facility services.

(C) To be eligible for benefits under the project, a medicaid recipient must satisfy all of the following requirements:

(1) ~~Be~~ The medicaid recipient must be a recipient of medicaid-funded nursing facility services, at the time of applying for the project benefits~~;~~.

(2) ~~Need the level of care provided by nursing facilities;~~

~~(3) For participation in a non-medicaid~~ If the project is established as a nonmedicaid program, ~~receive services~~ the medicaid recipient must be able to remain in the community ~~with a~~ as a result of receiving project benefits and the projected cost of the benefits to the project does not ~~exceeding~~ exceed eighty per cent of the average monthly medicaid cost of a medicaid recipient in a nursing facility~~;~~

~~(4) For participation in a program established as part of~~.

(3) If the project is integrated into a medicaid-funded home and community-based services waiver program, the medicaid recipient must meet waiver enrollment criteria.

(D) If the director establishes the Ohio access success project, the benefits provided under the project may include payment of all of the following:

(1) The first month's rent in a community setting;

(2) Rental deposits;

(3) Utility deposits;

(4) Moving expenses;

(5) Other expenses not covered by the medicaid program that facilitate a medicaid recipient's move from a nursing facility to a community setting.

(E) If the project is established as a ~~non-medicaid~~ nonmedicaid program, no participant may receive more than two thousand dollars worth of benefits under the project.

(F) The director may submit a request to the United States secretary of health and human services pursuant to section 1915 of the "Social Security Act," 79 Stat. 286 (1965), 42 U.S.C. 1396n, as amended, to create a medicaid home and community-based services waiver program to serve individuals who meet the criteria for participation in the Ohio access success project. The director may adopt rules under Chapter 119. of the Revised Code for the administration and operation of the ~~program~~ project.

Sec. 5111.981. (A) As used in this section:

"Dual eligible individual" has the same meaning as in section 1915(h)(2)(B) of the "Social Security Act," 124 Stat. 315 (2010), 42 U.S.C. 1396n(h)(2)(B).

"Medicare program" means the program created under Title XVIII of the "Social Security Act," 79 Stat. 286 (1965), 42 U.S.C. 1395, as amended.

(B) Subject to division (C) of this section, the director of job and family services may implement a demonstration project to test and evaluate the integration of the care that dual eligible individuals receive under the medicare and medicaid programs. No provision of Title LI of the Revised Code applies to the demonstration project if that provision implements or incorporates a provision of federal law governing the medicaid program and that provision of federal law does not apply to the demonstration project.

(C) Before implementing the demonstration project under division (B) of this section, the director shall obtain the approval of the United States secretary of health and human services in the form of a federal medicaid waiver, medicaid state plan amendment, or demonstration grant. The director is required to seek the federal approval only if the director seeks to implement the demonstration project. The director shall implement the demonstration project in accordance with the terms of the federal approval, including the terms regarding the duration of the demonstration project.

Sec. 5112.30. As used in sections 5112.30 to 5112.39 of the Revised Code:

(A) "Franchise permit fee rate" means the following:

(1) ~~Until August 1, 2009, eleven dollars and ninety-eight cents;~~

~~(2) For the period beginning August 1, 2009, and ending June 30, 2010, fourteen dollars and seventy-five cents;~~

~~(3)~~ For fiscal year ~~2011~~ 2012, ~~thirteen~~ seventeen dollars and ~~fifty-five~~ ninety-nine cents;

~~(4)~~(2) For fiscal year ~~2012~~ 2013 and each fiscal year thereafter, ~~the rate used for the immediately preceding fiscal year as adjusted in accordance with the composite inflation factor established in rules adopted under section 5112.39 of the Revised Code~~ eighteen dollars and thirty-two cents.

(B) "Indirect guarantee percentage" means the percentage specified in section 1903(w)(4)(C)(ii) of the "Social Security Act," 120 Stat. 2994 (2006), 42 U.S.C. 1396b(w)(4)(C)(ii), as amended, that is to be used in determining whether a class of providers is indirectly held harmless for any portion of the costs of a broad-based health-care-related tax. If the indirect guarantee percentage changes during a fiscal year, the indirect guarantee percentage is the following:

(1) For the part of the fiscal year before the change takes effect, the