

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 ~~3722.04~~ 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 disbursement 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:

~~(+)~~(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 rebasing, 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)~~ (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)~~ (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

rebasings 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)(e)(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 ~~(H)~~(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, 1958, not exceeding two dollars and fifty cents per patient day;

(2) For facilities with dates of licensure after December 31, 1957, but prior to January 1, 1968, 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, 1967, but prior to January 1, 1976, 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, 1975, but prior to January 1, 1979, 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, 1978, but prior to January 1, 1980, 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, 1981, not exceeding six dollars per patient day using 1980 as the base year and adjusting the amount annually until June 30, 1993, for fluctuations in construction costs calculated by the department using the "Dodge building cost indexes, northeastern and north central states," published by Marshall and Swift. The payment provided for in this division is the only payment that shall be made for the capitalized costs of a nonextensive renovation of an intermediate care facility for the mentally retarded. Nonextensive renovation costs shall not be included in cost of ownership, and a nonextensive renovation shall not affect the date of licensure for purposes of division (C) of this section. This division applies to nonextensive renovations regardless of whether they are made by an owner or a lessee. If the tenancy of a lessee that has made renovations ends before the depreciation expense for the renovation costs has been fully reported, the former lessee shall not report the undepreciated balance as an expense.

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.~~

(4) 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 ~~(H)~~(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.

~~(H)~~(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)~~ (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 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)~~ (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)~~ (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)~~ (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)~~ (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)~~ (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 ~~at~~ 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

percentage in effect before the change;

(2) For the part of the fiscal year beginning with the date the indirect guarantee percentage changes, the new percentage.

(C) "Intermediate care facility for the mentally retarded" has the same meaning as in section 5111.20 of the Revised Code, except that, until August 1, 2009, it does not include any such facility operated by the department of developmental disabilities.

~~(C)~~(D) "Medicaid" has the same meaning as in section 5111.01 of the Revised Code.

Sec. 5112.31. The department of job and family services shall do all of the following:

(A) Subject to ~~division~~ divisions (B) and (C) of this section and for the purposes specified in sections 5112.37 and 5112.371 of the Revised Code, assess for each fiscal year each intermediate care facility for the mentally retarded a franchise permit fee equal to the franchise permit fee rate multiplied by the product of the following:

(1) The number of beds certified under Title XIX of the "Social Security Act" on the first day of May of the calendar year in which the assessment is determined pursuant to division (A) of section 5112.33 of the Revised Code;

(2) ~~The following number of days:~~

~~(a) For fiscal year 2010, the following:~~

~~(i) For the part of fiscal year 2010 during which the franchise permit fee rate is eleven dollars and ninety-eight cents, the number of days during fiscal year 2010 during which the franchise permit fee rate is that amount;~~

~~(ii) For the part of fiscal year 2010 during which the franchise permit fee rate is fourteen dollars and seventy-five cents, the number of days during fiscal year 2010 during which the franchise permit fee is that amount;~~

~~(iii) For fiscal year 2011 and each fiscal year thereafter, the number of days in the fiscal year.~~

(B) If the total amount of the franchise permit fee assessed under division (A) of this section for a fiscal year exceeds ~~five and one-half per cent~~ the indirect guarantee percentage of the actual net patient revenue for all intermediate care facilities for the mentally retarded for that fiscal year, do both of the following:

(1) Recalculate the assessments under division (A) of this section using a per bed per day rate equal to ~~five and one-half per cent~~ the indirect guarantee percentage of actual net patient revenue for all intermediate care facilities for the mentally retarded for that fiscal year;

(2) Refund the difference between the amount of the franchise permit fee assessed for that fiscal year under division (A) of this section and the

amount recalculated under division (B)(1) of this section as a credit against the assessments imposed under division (A) of this section for the subsequent fiscal year.

(C) If the United States secretary of health and human services determines that the franchise permit fee established by sections 5112.30 to 5112.39 of the Revised Code would be an impermissible health care-related tax under section 1903(w) of the "Social Security Act," 42 U.S.C.A. 1396b(w), as amended, take all necessary actions to cease implementation of those sections in accordance with rules adopted under section 5112.39 of the Revised Code.

Sec. 5112.37. There is hereby created in the state treasury the home and community-based services for the mentally retarded and developmentally disabled fund. ~~Eighty-four~~ Eighty-one and ~~two-tenths~~ seventy-seven hundredths per cent of all installment payments and penalties paid by an intermediate care facility for the mentally retarded under sections 5112.33 and 5112.34 of the Revised Code for state fiscal year ~~2010~~ 2012 shall be deposited into the fund. ~~Seventy-nine~~ Eighty-two and ~~twelve-hundredths~~ two tenths per cent of all installment payments and penalties paid by an intermediate care facility for the mentally retarded under sections 5112.33 and 5112.34 of the Revised Code for state fiscal year ~~2011~~ 2013 and thereafter shall be deposited into the fund. The department of job and family services shall distribute the money in the fund in accordance with rules adopted under section 5112.39 of the Revised Code. The departments of job and family services and developmental disabilities shall use the money for the medicaid program established under Chapter 5111. of the Revised Code and home and community-based services to mentally retarded and developmentally disabled persons.

Sec. 5112.371. There is hereby created in the state treasury the department of developmental disabilities operating and services fund. ~~Fifteen and eight tenths per cent of all~~ All installment payments and penalties paid by an intermediate care facility for the mentally retarded under sections 5112.33 and 5112.34 of the Revised Code ~~for state fiscal year 2010 that are not deposited into the home and community-based services for the mentally retarded and developmentally disabled fund~~ shall be deposited into the department of developmental disabilities operating and services fund. ~~Twenty and eighty-eight hundredths per cent of all installment payments and penalties paid by an intermediate care facility for the mentally retarded under sections 5112.33 and 5112.34 of the Revised Code for state fiscal year 2011 and thereafter shall be deposited into the fund.~~ The money in the fund shall be used for the expenses of the programs that the

department of ~~mental retardation and~~ developmental disabilities administers and the department's administrative expenses.

Sec. 5112.39. The director of job and family services shall adopt rules in accordance with Chapter 119. of the Revised Code to do all of the following:

~~(A)~~ Establish a composite inflation factor for the purpose of division ~~(A)(4)~~ of section 5112.30 of the Revised Code;

~~(B)~~ Prescribe the actions the department will take to cease implementation of sections 5112.30 to 5112.39 of the Revised Code if the United States secretary of health and human services determines that the franchise permit fee imposed under section 5112.31 of the Revised Code is an impermissible health care-related tax under section 1903(w) of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 1396b(w), as amended;

~~(C)~~(B) Establish the method of distributing the money in the home and community-based services for the mentally retarded and developmentally disabled fund created by section 5112.37 of the Revised Code;

~~(D)~~(C) Establish any other requirements or procedures the director considers necessary to implement sections 5112.30 to 5112.39 of the Revised Code.

Sec. 5112.40. As used in sections 5112.40 to 5112.48 of the Revised Code:

(A) "Applicable assessment percentage" means the percentage specified in rules adopted under section 5112.46 of the Revised Code that is used in calculating a hospital's assessment under section 5112.41 of the Revised Code.

(B) "Assessment program year" means the twelve-month period beginning the first day of October of a calendar year and ending the last day of September of the following calendar year.

~~(B)~~(C) "Cost reporting period" means the period of time used by a hospital in reporting costs for purposes of the medicare program.

~~(C)~~(D) "Federal fiscal year" means the twelve-month period beginning the first day of October of a calendar year and ending the last day of September of the following calendar year.

~~(D)~~(E)(1) Except as provided in division ~~(D)~~(E)(2) of this section, "hospital" means a hospital to which any of the following applies:

(a) The hospital is registered under section 3701.07 of the Revised Code as a general medical and surgical hospital or a pediatric general hospital and provides inpatient hospital services, as defined in 42 C.F.R. 440.10.

(b) The hospital is recognized under the medicare program as a cancer

hospital and is exempt from the medicare prospective payment system.

(c) The hospital is a psychiatric hospital licensed under section 5119.20 of the Revised Code.

(2) "Hospital" does not include either of the following:

(a) A federal hospital;

(b) A hospital that does not charge any of its patients for its services.

~~(E)~~(F) "Hospital care assurance program" means the program established under sections 5112.01 to 5112.21 of the Revised Code.

~~(F)~~(G) "Medicaid" has the same meaning as in section 5111.01 of the Revised Code.

~~(G)~~(H) "Medicare" means the program established under Title XVIII of the Social Security Act.

~~(H)~~(I) "State fiscal year" means the twelve-month period beginning the first day of July of a calendar year and ending the last day of June of the following calendar year.

~~(I)~~(J)(1) Except as provided in divisions ~~(I)~~(J)(2) and (3) of this section, "total facility costs" means the total costs to a hospital for all care provided to all patients, including the direct, indirect, and overhead costs to the hospital of all services, supplies, equipment, and capital related to the care of patients, regardless of whether patients are enrolled in a health insuring corporation.

(2) "Total facility costs" excludes all of the following of a hospital's costs as shown on the cost-reporting data used for purposes of determining the hospital's assessment under section 5112.41 of the Revised Code:

(a) Skilled nursing services provided in distinct-part nursing facility units;

(b) Home health services;

(c) Hospice services;

(d) Ambulance services;

(e) Renting durable medical equipment;

(f) Selling durable medical equipment.

(3) "Total facility costs" excludes any costs excluded from a hospital's total facility costs pursuant to rules, if any, adopted under division (B)(1) of section 5112.46 of the Revised Code.

Sec. 5112.41. (A) For the purposes specified in section 5112.45 of the Revised Code and subject to section 5112.48 of the Revised Code, there is hereby imposed an assessment on all hospitals each assessment program year. The amount of a hospital's assessment for an assessment program year shall equal, ~~except as provided in division (D) of this section, the applicable assessment percentage specified in division (B) of this section~~ of the

hospital's total facility costs for the period of time specified in division ~~(C)~~(B) of this section. The amount of a hospital's total facility costs shall be derived from cost-reporting data for the hospital submitted to the department of job and family services for purposes of the hospital care assurance program. If a hospital has not submitted that cost-reporting data to the department, the amount of a hospital's total facility costs shall be derived from other financial statements that the hospital shall provide to the department as directed by the department. The cost-reporting data or financial statements used to determine a hospital's assessment is subject to the same type of adjustments made to the cost-reporting data under the hospital care assurance program.

(B) ~~The percentage specified in this division is the following:~~

~~(1) For the first assessment program year beginning after the effective date of this section, one and fifty-two hundredths per cent;~~

~~(2) Subject to division (D) of this section, for the second assessment program year after the effective date of this section and each successive assessment program year, one and sixty-one hundredths per cent.~~

~~(C)~~ The period of time specified in this division is the hospital's cost reporting period that ends in the state fiscal year that ends in the federal fiscal year that precedes the federal fiscal year that precedes the assessment program year for which the assessment is imposed.

~~(D) The department of job and family services shall apply to the United States secretary of health and human services for a waiver under 42 U.S.C. 1396b(w)(3)(E) to establish, for the second assessment program year after the effective date of this section and each successive assessment program year, a tiered assessment on hospitals' total facility costs instead of applying the percentage specified in division (B)(2) of this section. If the United States secretary denies the waiver, the department shall apply the percentage specified in division (B)(2) of this section for the second assessment program year after the effective date of this section and each successive assessment program year.~~

~~(E)~~(C) The assessment imposed by this section on a hospital is in addition to the assessment imposed by section 5112.06 of the Revised Code.

Sec. 5112.46. (A) The director of job and family services ~~may~~ shall adopt, amend, and rescind rules in accordance with Chapter 119. of the Revised Code as necessary to implement sections 5112.40 to 5112.48 of the Revised Code, including rules that specify the percentage of hospitals' total facility costs to be used in calculating hospitals' assessments under section 5112.41 of the Revised Code.

(B) The rules adopted under this section may ~~provide~~ do the following:

(1) Provide that a hospital's total facility costs for the purpose of the assessment under section 5112.41 of the Revised Code exclude any of the following:

~~(1)(a)~~ A hospital's costs associated with providing care to recipients of any of the following:

~~(a)(i)~~ The medicaid program;

~~(b)(ii)~~ The medicare program;

~~(c)(iii)~~ The disability financial assistance program established under Chapter 5115. of the Revised Code;

~~(d)(iv)~~ The program for medically handicapped children established under section 3701.023 of the Revised Code;

~~(e)(v)~~ Services provided under the maternal and child health services block grant established under Title V of the Social Security Act.

~~(2)(b)~~ Any other category of hospital costs the director deems appropriate under federal law and regulations governing the medicaid program.

(2) Subject to division (C) of this section, provide for the percentage of hospitals' total facility costs used in calculating hospitals' assessments to vary for different hospitals;

(3) To reduce hospitals' cash flow difficulties, establish a schedule for hospitals to pay their assessments that is different from the schedule established under section 5112.43 of the Revised Code.

(C) Before adopting rules authorized by division (B)(2) of this section that establish varied percentages to be used in calculating hospitals' assessments, the director shall obtain a waiver from the United States secretary of health and human services under section 1903(w)(3)(E) of the "Social Security Act," 105 Stat. 1796 (1991), 42 U.S.C. 1396b(w)(3)(E), as amended, if the varied percentages would cause the assessments to not be imposed uniformly.

Sec. 5112.99. (A) The director of job and family services shall impose a penalty for each day that a hospital fails to report the information required under section 5112.04 of the Revised Code on or before the dates specified in that section. The amount of the penalty shall be established by the director in rules adopted under section 5112.03 of the Revised Code.

(B) In addition to any other remedy available to the department of job and family services under law to collect unpaid assessments and transfers under sections 5112.01 to 5112.21 of the Revised Code, the director shall impose a penalty of ten per cent of the amount due on any hospital that fails to pay assessments or make intergovernmental transfers by the dates required by rules adopted under section 5112.03 of the Revised Code.

(C) In addition to any other remedy available to the department of job and family services under law to collect unpaid assessments imposed under section 5112.41 of the Revised Code, the director shall impose a penalty of ten per cent of the amount due on any hospital that fails to pay the assessment by the date it is due.

(D) The director shall waive the penalties provided for in ~~divisions (A) and (B)~~ of this section for good cause shown by the hospital.

~~(D)~~(E) All penalties imposed under this section shall be deposited into the health care administration fund created by section 5111.94 of the Revised Code.

Sec. 5112.991. The department of job and family services may offset the amount of a hospital's unpaid penalty imposed under section 5112.99 of the Revised Code from one or more payments due the hospital under the medicaid program. The total amount that may be offset from one or more payments shall not exceed the amount of the unpaid penalty.

Sec. 5119.01. The director of mental health is the chief executive and administrative officer of the department of mental health. The director may establish procedures for the governance of the department, conduct of its employees and officers, performance of its business, and custody, use, and preservation of departmental records, papers, books, documents, and property. Whenever the Revised Code imposes a duty upon or requires an action of the department or any of its institutions, the director shall perform the action or duty in the name of the department, except that the medical director appointed pursuant to section 5119.07 of the Revised Code shall be responsible for decisions relating to medical diagnosis, treatment, rehabilitation, quality assurance, and the clinical aspects of the following: licensure of hospitals and residential facilities, research, community mental health plans, and delivery of mental health services.

The director shall:

(A) Adopt rules for the proper execution of the powers and duties of the department with respect to the institutions under its control, and require the performance of additional duties by the officers of the institutions as necessary to fully meet the requirements, intents, and purposes of this chapter. In case of an apparent conflict between the powers conferred upon any managing officer and those conferred by such sections upon the department, the presumption shall be conclusive in favor of the department.

(B) Adopt rules for the nonpartisan management of the institutions under the department's control. An officer or employee of the department or any officer or employee of any institution under its control who, by solicitation or otherwise, exerts influence directly or indirectly to induce any

other officer or employee of the department or any of its institutions to adopt the exerting officer's or employee's political views or to favor any particular person, issue, or candidate for office shall be removed from the exerting officer's or employee's office or position, by the department in case of an officer or employee, and by the governor in case of the director.

(C) Appoint such employees, including the medical director, as are necessary for the efficient conduct of the department, and prescribe their titles and duties;

(D) Prescribe the forms of affidavits, applications, medical certificates, orders of hospitalization and release, and all other forms, reports, and records that are required in the hospitalization or admission and release of all persons to the institutions under the control of the department, or are otherwise required under this chapter or Chapter 5122. of the Revised Code;

(E) Contract with hospitals licensed by the department under section 5119.20 of the Revised Code for the care and treatment of mentally ill patients, or with persons, organizations, or agencies for the custody, evaluation, supervision, care, or treatment of mentally ill persons receiving services elsewhere than within the enclosure of a hospital operated under section 5119.02 of the Revised Code;

(F) Exercise the powers and perform the duties relating to community mental health facilities and services that are assigned to the director under this chapter and Chapter 340. of the Revised Code;

(G) Develop and implement clinical evaluation and monitoring of services that are operated by the department;

~~(H) At the director's discretion, adopt rules establishing standards for the adequacy of services provided by community mental health facilities, and certify the compliance of such facilities with the standards for the purpose of authorizing their participation in the health care plans of health insuring corporations under Chapter 1751. and sickness and accident insurance policies issued under Chapter 3923. of the Revised Code. The director shall cease to certify such compliance two years after June 6, 2001. The director shall rescind the rules after the date the director ceases to certify such compliance.~~

(H) Adopt rules establishing standards for the performance of evaluations by a forensic center or other psychiatric program or facility of the mental condition of defendants ordered by the court under section 2919.271, or 2945.371 of the Revised Code, and for the treatment of defendants who have been found incompetent to stand trial and ordered by the court under section 2945.38, 2945.39, 2945.401, or 2945.402 of the Revised Code to receive treatment in facilities;

~~(J)~~(I) On behalf of the department, have the authority and responsibility for entering into contracts and other agreements;

~~(K)~~(J) Prepare and publish regularly a state mental health plan that describes the department's philosophy, current activities, and long-term and short-term goals and activities;

~~(L)~~(K) Adopt rules in accordance with Chapter 119. of the Revised Code specifying the supplemental services that may be provided through a trust authorized by section 5815.28 of the Revised Code;

~~(M)~~(L) Adopt rules in accordance with Chapter 119. of the Revised Code establishing standards for the maintenance and distribution to a beneficiary of assets of a trust authorized by section 5815.28 of the Revised Code.

Sec. 5119.012. The department of mental health has all the authority necessary to carry out its powers and duties under this chapter and Chapters 340., 2919., 2945., and 5122. of the Revised Code.

Sec. 5119.013. Pursuant to the director of mental health's authority under division (I) of section 5119.01 of the Revised Code, the director may contract with agencies, institutions, and other entities both public and private, as necessary for the department of mental health to carry out its duties under this chapter and Chapters 340., 2919., 2945., and 5122. of the Revised Code. Chapter 125. of the Revised Code does not apply to contracts the director enters into under this section for services provided to individuals with mental illness by agencies, institutions, and other entities not owned or operated by the department of mental health.

Sec. 5119.02. (A) The department of mental health shall maintain, operate, manage, and govern state institutions for the care and treatment of mentally ill persons.

(B) The department of mental health may designate all institutions under its jurisdiction by appropriate respective names, regardless of present statutory designation.

(C) Subject to section 5139.08 and pursuant to Chapter 5122. of the Revised Code and on the agreement of the departments of mental health and youth services, the department of mental health may receive from the department of youth services for psychiatric observation, diagnosis, or treatment any person eighteen years of age or older in the custody of the department of youth services. The departments shall enter into a written agreement specifying the procedures necessary to implement this division.

(D) The department of mental health shall ~~provide and~~ designate hospitals, facilities, and community mental health agencies for the custody, care, and special treatment of, and authorize payment for such custody, care,

and special treatment provided to, persons who are charged with a crime and who are found incompetent to stand trial or not guilty by reason of insanity.

(E) The department of mental health may do all of the following:

(1) Require reports from the managing officer of any institution under the department's jurisdiction, relating to the admission, examination, comprehensive evaluation, diagnosis, release, or discharge of any patient;

(2) Visit each institution regularly to review its operations and to investigate complaints made by any patient or by any person on behalf of a patient, provided these duties may be performed by a person designated by the director.

(F) The department of mental health shall divide the state into districts for the purpose of designating the institution in which mentally ill persons are hospitalized, and may change the districts.

(G) In addition to the powers expressly conferred, the department of mental health shall have all powers and authority necessary for the full and efficient exercise of the executive, administrative, and fiscal supervision over the state institutions described in this section.

(H) The department of mental health may provide for the custody, supervision, control, treatment, and training of mentally ill persons hospitalized elsewhere than within the enclosure of a hospital, if the department so determines with respect to any individual or group of individuals. In all such cases, the department shall ensure adequate and proper supervision for the protection of such persons and of the public.

Sec. 5119.06. ~~(A)~~ The department of mental health shall:

~~(1) Establish and~~ (A) To the extent the department has available resources and in consultation with boards of alcohol, drug addiction, and mental health services, support a program at the state level to promote a community support system in accordance with section 340.03 of the Revised Code to be available for every alcohol, drug addiction, and mental health service district on a district or multi-district basis. The department shall define the essential elements of a community support system, shall assist in identifying resources, and ~~coordinating the planning, evaluation, and delivery of services to facilitate the access of mentally ill people to public services at federal, state, and local levels, and shall operate~~ may prioritize support for one or more of the elements.

~~(B) Operate~~ inpatient and other mental health services pursuant to the approved community mental health plan.

~~(2);~~

(C) Provide training, consultation, and technical assistance regarding mental health programs and services and appropriate prevention and mental

health promotion activities, including those that are culturally sensitive, to employees of the department, community mental health agencies and boards, and other agencies providing mental health services;

~~(3)~~ Promote (D) To the extent the department has available resources, promote and support a full range of mental health services that are available and accessible to all residents of this state, especially for severely mentally disabled children, adolescents, and adults, and other special target populations, including racial and ethnic minorities, as determined by the department-;

~~(4)~~ (E) Design and set criteria for the determination of severe mental disability;

~~(5)~~ (F) Establish standards for evaluation of mental health programs;

~~(6)~~ (G) Promote, direct, conduct, and coordinate scientific research, taking ethnic and racial differences into consideration, concerning the causes and prevention of mental illness, methods of providing effective services and treatment, and means of enhancing the mental health of all residents of this state;

~~(7)~~ (H) Foster the establishment and availability of vocational rehabilitation services and the creation of employment opportunities for consumers of mental health services, including members of racial and ethnic minorities;

~~(8)~~ (I) Establish a program to protect and promote the rights of persons receiving mental health services, including the issuance of guidelines on informed consent and other rights;

~~(9)~~ (J) Establish, in consultation with board of alcohol, drug addiction, and mental health services representatives and after consideration of the recommendations of the medical director, guidelines for the development of community mental health plans and the review and approval or disapproval of such plans submitted pursuant to section 340.03 of the Revised Code;

~~(10)~~ (K) Promote the involvement of persons who are receiving or have received mental health services, including families and other persons having a close relationship to a person receiving mental health services, in the planning, evaluation, delivery, and operation of mental health services-;

~~(11)~~ (L) Notify and consult with the relevant constituencies that may be affected by rules, standards, and guidelines issued by the department of mental health. These constituencies shall include consumers of mental health services and their families, and may include public and private providers, employee organizations, and others when appropriate. Whenever the department proposes the adoption, amendment, or rescission of rules under Chapter 119. of the Revised Code, the notification and consultation

required by this division shall occur prior to the commencement of proceedings under Chapter 119. The department shall adopt rules under Chapter 119. of the Revised Code that establish procedures for the notification and consultation required by this division.

~~(12)(M)~~ In cooperation with board of alcohol, drug addiction, and mental health services representatives, provide training regarding the provision of community-based mental health services to those department employees who are utilized in state-operated, community-based mental health services;

~~(13)(N)~~ Provide consultation to the department of rehabilitation and correction concerning the delivery of mental health services in state correctional institutions;

~~(B) The department of mental health may negotiate and enter into agreements with other agencies and institutions, both public and private, for the joint performance of its duties.~~

Sec. 5119.18. There is hereby created in the state treasury the department of mental health trust fund. Not later than the first day of September of each year, the director of mental health shall certify to the director of budget and management the amount of all of the unexpended, unencumbered balances of general revenue fund appropriations made to the department of mental health for the previous fiscal year, excluding funds appropriated for rental payments to the Ohio public facilities commission. On receipt of the certification, the director of budget and management shall transfer cash to the trust fund in an amount up to, but not exceeding, the total of the amounts certified by the director of mental health.

In addition, the trust fund shall receive all amounts, subject to any provisions in bond documents, received from the sale or lease of lands and facilities by the department.

All moneys in the trust fund shall be used by the department of mental health ~~for mental health purposes specified in division (A) of section 5119.06 of the Revised Code~~ to pay for expenditures the department incurs in performing any of its duties under this chapter. The use of moneys in the trust fund pursuant to this section does not represent an ongoing commitment to the continuation of the trust fund or to the use of moneys in the trust fund.

Sec. 5119.22. (A)(1) As used in this section and section 5119.221 of the Revised Code:

(a) "Community mental health agency" means a community mental health agency as defined in division (H) of section 5122.01 of the Revised Code, ~~or, until two years after the effective date of this amendment, a~~

~~community mental health facility certified by the department of mental health pursuant to division (H) of section 5119.01 of the Revised Code.~~

(b) "Community mental health services" means any of the services listed in section 340.09 of the Revised Code.

(c) "Personal care services" means services including, but not limited to, the following:

- (i) Assisting residents with activities of daily living;
- (ii) Assisting residents with self-administration of medication in accordance with rules adopted under this section;
- (iii) Preparing special diets, other than complex therapeutic diets, for residents pursuant to the instructions of a physician or a licensed dietitian, in accordance with rules adopted under this section.

"Personal care services" does not include "skilled nursing care" as defined in section 3721.01 of the Revised Code. A facility need not provide more than one of the services listed in division (A)(1)(c) of this section to be considered to be providing personal care services.

(d) "Residential facility" means a publicly or privately operated home or facility that provides one of the following:

- (i) Room and board, personal care services, and community mental health services to one or more persons with mental illness or persons with severe mental disabilities who are referred by or are receiving community mental health services from a community mental health agency, hospital, or practitioner;
- (ii) Room and board and personal care services to one or two persons with mental illness or persons with severe mental disabilities who are referred by or are receiving community mental health services from a community mental health agency, hospital, or practitioner;
- (iii) Room and board to five or more persons with mental illness or persons with severe mental disabilities who are referred by or are receiving community mental health services from a community mental health agency, hospital, or practitioner.

The following are not residential facilities: the residence of a relative or guardian of a mentally ill individual, a hospital subject to licensure under section 5119.20 of the Revised Code, a residential facility as defined in section 5123.19 of the Revised Code, a facility providing care for a child in the custody of a public children services agency or a private agency certified under section 5103.03 of the Revised Code, a foster care facility subject to section 5103.03 of the Revised Code, an adult care facility subject to licensure under ~~Chapter 3722~~, sections 5119.70 to 5119.88 of the Revised Code, and a nursing home, residential care facility, or home for the aging

subject to licensure under section 3721.02 of the Revised Code.

(2) Nothing in division (A)(1)(d) of this section shall be construed to permit personal care services to be imposed on a resident who is capable of performing the activity in question without assistance.

(3) Except in the case of a residential facility described in division (A)(1)(d)(i) of this section, members of the staff of a residential facility shall not administer medication to residents, all medication taken by residents of a residential facility shall be self-administered, and no person shall be admitted to or retained by a residential facility unless the person is capable of taking the person's own medication and biologicals, as determined in writing by the person's personal physician. Members of the staff of a residential facility may do any of the following:

(a) Remind a resident when to take medication and watch to ensure that the resident follows the directions on the container;

(b) Assist a resident in the self-administration of medication by taking the medication from the locked area where it is stored, in accordance with rules adopted pursuant to this section, and handing it to the resident. If the resident is physically unable to open the container, a staff member may open the container for the resident.

(c) Assist a physically impaired but mentally alert resident, such as a resident with arthritis, cerebral palsy, or Parkinson's disease, in removing oral or topical medication from containers and in consuming or applying the medication, upon request by or with the consent of the resident. If a resident is physically unable to place a dose of medicine to the resident's mouth without spilling it, a staff member may place the dose in a container and place the container to the mouth of the resident.

(B) Every person operating or desiring to operate a residential facility shall apply for licensure of the facility to the department of mental health and shall send a copy of the application to the board of alcohol, drug addiction, and mental health services whose service district includes the county in which the person operates or desires to operate a residential facility. The board shall review such applications and recommend approval or disapproval to the department. Each recommendation shall be consistent with the board's community mental health plan.

(C) The department of mental health shall inspect and license the operation of residential facilities. The department shall consider the past record of the facility and the applicant or licensee in arriving at its licensure decision. The department may issue full, probationary, and interim licenses. A full license shall expire two years after the date of issuance, a probationary license shall expire in a shorter period of time as prescribed by

rule adopted by the director of mental health pursuant to Chapter 119. of the Revised Code, and an interim license shall expire ninety days after the date of issuance. The department may refuse to issue or renew and may revoke a license if it finds the facility is not in compliance with rules adopted by the department pursuant to division (G) of this section or if any facility operated by the applicant or licensee has had repeated violations of statutes or rules during the period of previous licenses. Proceedings initiated to deny applications for full or probationary licenses or to revoke such licenses are governed by Chapter 119. of the Revised Code.

(D) The department may issue an interim license to operate a residential facility if both of the following conditions are met:

(1) The department determines that the closing of or the need to remove residents from another residential facility has created an emergency situation requiring immediate removal of residents and an insufficient number of licensed beds are available.

(2) The residential facility applying for an interim license meets standards established for interim licenses in rules adopted by the director under Chapter 119. of the Revised Code.

An interim license shall be valid for ninety days and may be renewed by the director no more than twice. Proceedings initiated to deny applications for or to revoke interim licenses under this division are not subject to Chapter 119. of the Revised Code.

(E) The department of mental health may conduct an inspection of a residential facility:

(1) Prior to the issuance of a license to a prospective operator;

(2) Prior to the renewal of any operator's license;

(3) To determine whether a facility has completed a plan of correction required pursuant to this division and corrected deficiencies to the satisfaction of the department and in compliance with this section and rules adopted pursuant to it;

(4) Upon complaint by any individual or agency;

(5) At any time the director considers an inspection to be necessary in order to determine whether a residential facility is in compliance with this section and rules adopted pursuant to this section.

In conducting inspections the department may conduct an on-site examination and evaluation of the residential facility, its personnel, activities, and services. The department shall have access to examine all records, accounts, and any other documents relating to the operation of the residential facility, and shall have access to the facility in order to conduct interviews with the operator, staff, and residents. Following each inspection

and review, the department shall complete a report listing any deficiencies, and including, when appropriate, a time table within which the operator shall correct the deficiencies. The department may require the operator to submit a plan of correction describing how the deficiencies will be corrected.

(F) No person shall do any of the following:

- (1) Operate a residential facility unless the facility holds a valid license;
- (2) Violate any of the conditions of licensure after having been granted a license;
- (3) Interfere with a state or local official's inspection or investigation of a residential facility;
- (4) Violate any of the provisions of this section or any rules adopted pursuant to this section.

(G) The director shall adopt and may amend and rescind rules pursuant to Chapter 119. of the Revised Code, prescribing minimum standards for the health, safety, adequacy, and cultural specificity and sensitivity of treatment of and services for persons in residential facilities; establishing procedures for the issuance, renewal or revocation of the licenses of such facilities; establishing the maximum number of residents of a facility; establishing the rights of residents and procedures to protect such rights; and requiring an affiliation agreement approved by the board between a residential facility and a mental health agency. Such affiliation agreement must be consistent with the residential portion of the community mental health plan submitted pursuant to section 340.03 of the Revised Code.

(H) The department may investigate any facility that has been reported to the department or that the department has reasonable cause to believe is operating as a residential facility without a valid license.

(I) The department may withhold the source of any complaint reported as a violation of this act when the department determines that disclosure could be detrimental to the department's purposes or could jeopardize the investigation. The department may disclose the source of any complaint if the complainant agrees in writing to such disclosure and shall disclose the source upon order by a court of competent jurisdiction.

(J) The director of mental health may petition the court of common pleas of the county in which a residential facility is located for an order enjoining any person from operating a residential facility without a license or from operating a licensed facility when, in the director's judgment, there is a real and present danger to the health or safety of any of the occupants of the facility. The court shall have jurisdiction to grant such injunctive relief upon a showing that the respondent named in the petition is operating a

facility without a license or there is a real and present danger to the health or safety of any residents of the facility.

(K) Whoever violates division (F) of this section or any rule adopted under this section is liable for a civil penalty of one hundred dollars for the first offense; for each subsequent offense, such violator is liable for a civil penalty of five hundred dollars. If the violator does not pay, the attorney general, upon the request of the director of mental health, shall bring a civil action to collect the penalty. Fines collected pursuant to this section shall be deposited into the state treasury to the credit of the mental health sale of goods and services fund.

Sec. 5119.61. Any provision in this chapter that refers to a board of alcohol, drug addiction, and mental health services also refers to the community mental health board in an alcohol, drug addiction, and mental health service district that has a community mental health board.

The director of mental health with respect to all facilities and programs established and operated under Chapter 340. of the Revised Code for mentally ill and emotionally disturbed persons, shall do all of the following:

(A) Adopt rules pursuant to Chapter 119. of the Revised Code that may be necessary to carry out the purposes of Chapter 340. and sections 5119.61 to 5119.63 of the Revised Code.

(1) The rules shall include all of the following:

(a) Rules governing a community mental health agency's services under section 340.091 of the Revised Code to an individual referred to the agency under division (C)(2) of section ~~473.35~~ 5119.69 of the Revised Code;

(b) For the purpose of division (A)(16) of section 340.03 of the Revised Code, rules governing the duties of mental health agencies and boards of alcohol, drug addiction, and mental health services under section ~~3722.18~~ 5119.88 of the Revised Code regarding referrals of individuals with mental illness or severe mental disability to adult care facilities and effective arrangements for ongoing mental health services for the individuals. The rules shall do at least the following:

(i) Provide for agencies and boards to participate fully in the procedures owners and managers of adult care facilities must follow under division (A) of section ~~3722.18~~ 5119.88 of the Revised Code;

(ii) Specify the manner in which boards are accountable for ensuring that ongoing mental health services are effectively arranged for individuals with mental illness or severe mental disability who are referred by the board or mental health agency under contract with the board to an adult care facility.

(c) Rules governing a board of alcohol, drug addiction, and mental

health services when making a report to the director of mental health under section ~~3722.17~~ 5119.87 of the Revised Code regarding the quality of care and services provided by an adult care facility to a person with mental illness or a severe mental disability.

(2) Rules may be adopted to govern the method of paying a community mental health facility, as defined in section 5111.023 of the Revised Code, for providing services listed in division (B) of that section. Such rules must be consistent with the contract entered into between the departments of job and family services and mental health under section 5111.91 of the Revised Code and include requirements ensuring appropriate service utilization.

(B) Review and evaluate, and, taking into account the findings and recommendations of the board of alcohol, drug addiction, and mental health services of the district served by the program and the requirements and priorities of the state mental health plan, including the needs of residents of the district now residing in state mental institutions, ~~approve and allocate funds to support community programs,~~ and make recommendations for needed improvements to boards of alcohol, drug addiction, and mental health services;

~~(C) Withhold state and federal funds for any program, in whole or in part, from a board of alcohol, drug addiction, and mental health services in the event of failure of that program to comply with Chapter 340. or section 5119.61, 5119.611, 5119.612, or 5119.62 of the Revised Code or rules of the department of mental health. The director shall identify the areas of noncompliance and the action necessary to achieve compliance. The director shall offer technical assistance to the board to achieve compliance. The director shall give the board a reasonable time within which to comply or to present its position that it is in compliance. Before withholding funds, a hearing shall be conducted to determine if there are continuing violations and that either assistance is rejected or the board is unable to achieve compliance. Subsequent to the hearing process, if it is determined that compliance has not been achieved, the director may allocate all or part of the withheld funds to a public or private agency to provide the services not in compliance until the time that there is compliance. The director shall establish rules pursuant to Chapter 119. of the Revised Code to implement this division.~~

~~(D) Withhold state or federal funds from a board of alcohol, drug addiction, and mental health services that denies available service on the basis of religion, race, color, creed, sex, national origin, age, disability as defined in section 4112.01 of the Revised Code, developmental disability, or the inability to pay;~~

~~(E)~~ Provide consultative services to community mental health agencies with the knowledge and cooperation of the board of alcohol, drug addiction, and mental health services;

~~(F)~~ Provide (D) At the director's discretion, provide to boards of alcohol, drug addiction, and mental health services state or federal funds, in addition to those allocated under section 5119.62 of the Revised Code, for special programs or projects the director considers necessary but for which local funds are not available;

~~(G)~~(E) Establish criteria by which a board of alcohol, drug addiction, and mental health services reviews and evaluates the quality, effectiveness, and efficiency of services provided through its community mental health plan. The criteria shall include requirements ensuring appropriate service utilization. The department shall assess a board's evaluation of services and the compliance of each board with this section, Chapter 340. or section 5119.62 of the Revised Code, and other state or federal law and regulations. The department, in cooperation with the board, periodically shall review and evaluate the quality, effectiveness, and efficiency of services provided through each board. The department shall collect information that is necessary to perform these functions.

~~(H)~~ Develop (F) To the extent the director determines necessary and after consulting with boards of alcohol, drug addiction, and mental health services, develop and operate, or contract for the operation of, a community mental health information system or systems.

Boards of alcohol, drug abuse, and mental health services shall submit information requested by the department in the form and manner prescribed by the department. Information collected by the department shall include, but not be limited to, all of the following:

(1) Information regarding units of services provided in whole or in part under contract with a board, including diagnosis and special needs, demographic information, the number of units of service provided, past treatment, financial status, and service dates in accordance with rules adopted by the department in accordance with Chapter 119. of the Revised Code;

(2) Financial information other than price or price-related data regarding expenditures of boards and community mental health agencies, including units of service provided, budgeted and actual expenses by type, and sources of funds.

Boards shall submit the information specified in division ~~(H)~~(F)(1) of this section no less frequently than annually for each client, and each time the client's case is opened or closed. The department shall not collect any

personal information from the boards except as required or permitted by state or federal law for purposes related to payment, health care operations, program and service evaluation, reporting activities, research, system administration, and oversight.

(H)(G) Review each board's community mental health plan submitted pursuant to section 340.03 of the Revised Code and approve or disapprove it in whole or in part. Periodically, in consultation with representatives of boards and after considering the recommendations of the medical director, the director shall issue criteria for determining when a plan is complete, criteria for plan approval or disapproval, and provisions for conditional approval. The factors that the director considers may include, but are not limited to, the following:

(1) The mental health needs of all persons residing within the board's service district, especially severely mentally disabled children, adolescents, and adults;

(2) The demonstrated quality, effectiveness, efficiency, and cultural relevance of the services provided in each service district, the extent to which any services are duplicative of other available services, and whether the services meet the needs identified above;

(3) The adequacy of the board's accounting for the expenditure of funds.

If the director disapproves all or part of any plan, the director shall provide the board an opportunity to present its position. The director shall inform the board of the reasons for the disapproval and of the criteria that must be met before the plan may be approved. The director shall give the board a reasonable time within which to meet the criteria, and shall offer technical assistance to the board to help it meet the criteria.

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

Sec. 5119.611. (A) A community mental health agency that seeks certification of its community mental health services shall submit an application to the director of mental health. On receipt of the application, the director may visit and shall evaluate the agency to determine whether its

services satisfy the standards established by rules adopted under division (C) of this section. The director shall make the evaluation, and, if the director visits the agency, shall make the visit, in cooperation with the board of alcohol, drug addiction, and mental health services with which the agency seeks to contract under division (A)(8)(a) of section 340.03 of the Revised Code.

(B) Subject to section 5119.612 of the Revised Code, the director shall determine whether the services of an applicant's community mental health agency satisfy the standards for certification of the services. If the director determines that a community mental health agency's services satisfy the standards for certification and the agency has paid the fee required under division ~~(B)(D)~~ of this section, the director shall certify the services.

(C) If the director determines that a community mental health agency's services do not satisfy the standards for certification, the director shall identify the areas of noncompliance, specify what action is necessary to satisfy the standards, and offer technical assistance to the board of alcohol, drug addiction, and mental health services so that the board may assist the agency in satisfying the standards. The director shall give the agency a reasonable time within which to demonstrate that its services satisfy the standards or to bring the services into compliance with the standards. If the director concludes that the services continue to fail to satisfy the standards, the director may request that the board reallocate the funds for the community mental health services the agency was to provide to another community mental health agency whose community mental health services satisfy the standards. If the board does not reallocate those funds in a reasonable period of time, the director may withhold state and federal funds for the community mental health services and allocate those funds directly to a community mental health agency whose community mental health services satisfy the standards.

~~(B)(D)~~ Each community mental health agency seeking certification of its community mental health services under this section shall pay a fee for the certification ~~review~~ required by this section. Fees shall be paid into the sale of goods and services fund created pursuant to section 5119.161 of the Revised Code.

~~(C)~~(E) The director shall adopt rules in accordance with Chapter 119. of the Revised Code to implement this section. The rules shall do all of the following:

(1) Establish certification standards for community mental health services, including assertive community treatment and intensive home-based mental health services, that are consistent with nationally recognized

applicable standards and facilitate participation in federal assistance programs. The rules shall include as certification standards only requirements that improve the quality of services or the health and safety of clients of community mental health services. The standards shall address at a minimum all of the following:

- (a) Reporting major unusual incidents to the director;
- (b) Procedures for applicants for and clients of community mental health services to file grievances and complaints;
- (c) Seclusion;
- (d) Restraint;
- (e) Development of written policies addressing the rights of clients, including all of the following:
 - (i) The right to a copy of the written policies addressing client rights;
 - (ii) The right at all times to be treated with consideration and respect for the client's privacy and dignity;
 - (iii) The right to have access to the client's own psychiatric, medical, or other treatment records unless access is specifically restricted in the client's treatment plan for clear treatment reasons;
 - (iv) The right to have a client rights officer provided by the agency or board of alcohol, drug addiction, and mental health services advise the client of the client's rights, including the client's rights under Chapter 5122. of the Revised Code if the client is committed to the agency or board.
- (2) Establish standards for qualifications of mental health professionals as defined in section 340.02 of the Revised Code and personnel who provide the community mental health services;
- (3) Establish the process for certification of community mental health services;
- (4) Set the amount of certification review fees based on a portion of the cost of performing the review;
- (5) Specify the type of notice and hearing to be provided prior to a decision on whether to reallocate funds.

Sec. 5119.612. (A) In lieu of a determination by the director of mental health of whether the services of a community mental health agency satisfy the standards for certification under section 5119.611 of the Revised Code, the director shall accept appropriate accreditation of an applicant's mental health services, integrated mental health and alcohol and other drug addiction services, or integrated mental health and physical health services being provided in this state from any of the following national accrediting organizations as evidence that the applicant satisfies the standards for certification:

(1) The joint commission;

(2) The commission on accreditation of rehabilitation facilities;

(3) The council on accreditation.

(B) If the director determines that an applicant's accreditation is current, is appropriate for the services for which the applicant is seeking certification, and the applicant meets any other requirements established under this section or in rules adopted under this section, the director shall certify the applicant's services that are accredited. Except as provided in division (C)(2) of this section, the director shall issue the certification without further evaluation of the services.

(C) For purposes of this section, all of the following apply:

(1) The director may review the accrediting organizations listed in division (A) of this section to evaluate whether the accreditation standards and processes used by the organizations are consistent with service delivery models the director considers appropriate for mental health services, physical health services, or both. The director may communicate to an accrediting organization any identified concerns, trends, needs, and recommendations.

(2) The director may visit or otherwise evaluate a community mental health agency at any time based on cause, including complaints made by or on behalf of consumers and confirmed or alleged deficiencies brought to the attention of the director.

(3) The director shall require a community mental health agency to notify the director not later than ten days after any change in the agency's accreditation status. The agency may notify the director by providing a copy of the relevant document the agency received from the accrediting organization.

(4) The director shall require a community mental health agency to submit to the director reports of major unusual incidents.

(5) The director may require a community mental health agency to submit to the director cost reports pertaining to the agency.

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

(1) Specify the documentation that must be submitted as evidence of holding appropriate accreditation;

(2) Establish a process by which the director may review the accreditation standards and processes used by the national accrediting organizations listed in division (A) of this section;

(3) Specify the circumstances under which reports of major unusual

incidents and agency cost reports must be submitted to the director:

(4) Specify the circumstances under which the director may visit or otherwise evaluate a community mental health agency for cause;

(5) Establish a process by which the director, based on deficiencies identified as a result of visiting or evaluating a community mental health agency under division (C)(2) of this section, may take any of a range of corrective actions, with the most stringent being revocation of the certification of the agency's services.

Sec. ~~5119.612~~ 5119.613. The director of mental health shall require that each board of alcohol, drug addiction, and mental health services ensure that each community mental health agency with which it contracts under division (A)(8)(a) of section 340.03 of the Revised Code to provide community mental health services establish grievance procedures consistent with rules adopted under section 5119.611 of the Revised Code that are available to all applicants for and clients of the community mental health services.

Sec. ~~5119.613~~ 5119.614. For purposes of ~~Chapter 3722~~, sections 5119.70 to 5119.88 of the Revised Code, the director of mental health shall approve a standardized form to be used in all areas of this state by adult care facilities and boards of alcohol, drug addiction, and mental health services when entering into mental health resident program participation agreements. As part of approving the form, the director shall specify the requirements that adult care facilities must meet in order to be authorized to admit residents who are receiving or are eligible for publicly funded mental health services.

Sec. 5119.62. (A) ~~Upon approving the plan submitted pursuant to section 340.03 of the Revised Code, the director~~ The department of mental health shall authorize the payment of funds establish a methodology for allocating to a board boards of alcohol, drug addiction, and mental health services from the funds appropriated for such purpose by the general assembly to the department for the purpose of local mental health systems of care. ~~The director department shall release all or part of such~~ establish the methodology after notifying and consulting with relevant constituencies as required by division (L) of section 5119.06 of the Revised Code. The methodology may provide for the funds to be allocated to boards on a district or multi-district basis. Subject to sections 5119.622 and 5119.623 of the Revised Code, the department shall allocate the funds as is to the boards in a manner consistent with the methodology, this section, other state and federal laws, rules, and regulations, and the approved plan.

~~(B)(1) The director, in consultation with relevant constituencies as~~

~~required by division (A)(11) of section 5119.06 of the Revised Code, shall establish a formula for allocating to boards of alcohol, drug addiction, and mental health services appropriations from the general revenue fund for the purpose of local management of mental health services as this purpose is identified in appropriations to the department of mental health in appropriation acts. The formula shall include as a factor the number of severely mentally disabled persons residing in each alcohol, drug addiction, and mental health service district and may include other factors, including, but not limited to, the historical utilization of public hospitals by persons in each service district. The appropriations shall be allocated to each board in accordance with the formula but shall be distributed only to those boards that elect the option provided under division (B)(3)(a) of this section.~~

~~(2) The director shall allocate each fiscal year to boards of alcohol, drug addiction, and mental health services for services to severely mentally disabled persons a percentage of the appropriations to the department from the general revenue fund for the purposes of hospital personal services, hospital maintenance, and hospital equipment as those purposes are identified in appropriations to the department in appropriation acts. After excluding funds for providing services to persons committed to the department pursuant to section 2945.38, 2945.39, 2945.40, 2945.401, 2945.402, or 5139.08 of the Revised Code, the percentage of those appropriations so allocated each year shall equal ten per cent in fiscal year 1990, twenty per cent in fiscal year 1991, forty per cent in fiscal year 1992, sixty per cent in fiscal year 1993, eighty per cent in fiscal year 1994, and one hundred per cent in fiscal year 1995 and thereafter. The amounts so allocated shall be transferred from the appropriations for the purposes of hospital personal services, hospital maintenance, and hospital equipment and credited to appropriations for the purpose of local management of mental health services. Appropriations for the purpose of local management of mental health services may be used by the department and by the boards~~
The department may allocate to boards a portion of the funds appropriated by the general assembly to the department for the operation of state hospital services. If the department allocates the funds, the department shall do all of the following:

(1) In consultation with the boards:

(a) Annually determine the unit costs of providing state hospital services; and

(b) Establish the methodology for allocating the funds to the boards.

(2) Determine the type of unit costs of providing state hospital services to be included as a factor in the methodology and include that unit cost as a

factor in the methodology:

(3) Subject to sections 5119.622 and 5119.623 of the Revised Code, allocate the funds to the boards in a manner consistent with the methodology, this section, other state and federal laws, rules, and regulations.

~~(3) No(c)~~ Not later than the first day of April of each year, the department ~~of mental health~~ shall notify each board ~~of alcohol, drug addiction, and mental health services~~ of the department's estimate of the amount of ~~general revenue~~ funds to be allocated to the board under ~~division (D)~~ of this section during the fiscal year beginning on the next July first. ~~No~~ If the department makes an allocation under division (B) of this section, the department shall also notify each board of the unit costs of providing state hospital services for the upcoming fiscal year as determined under that division. Not later than the first day of May of each year, each board shall notify the ~~director~~ department as to which of the following options it has elected for ~~that~~ the upcoming fiscal year:

~~(a)(1)~~ The board elects to accept distribution of the amount allocated to it under ~~division (B)(1)~~ of this section. Any board that makes such an election shall agree to make payments into the risk fund established in ~~division (E)~~ of this section, to make any payments for utilization of state hospitals that are required under ~~division (E)(3)~~ of this section, to use the funds distributed to it within the limitations set forth in ~~division (B)(2)~~ of this section, and to provide the department with a statement of projected utilization of state hospitals and other state-operated services by residents of its service district during the fiscal year.

~~The department shall retain and expend the funds projected to be utilized for state hospitals and other state-operated services section.~~ Funds distributed to each board shall be used to supplement and not to supplant other state, local, or federal funds that are being used to support community-based programs for severely mentally disabled children, adolescents, and adults, unless the funds have been specifically designated for the initiation of programs in accordance with the community mental health plan developed and submitted under section 340.03 and approved under section 5119.61 of the Revised Code. Notwithstanding section 131.33 of the Revised Code, any board may expend unexpended funds distributed to the board from appropriations for the purpose of local management of mental health services in the fiscal year following the fiscal year ~~in~~ for which the appropriations are made, in accordance with the approved community mental health plan.

~~(b)~~ The (2) Subject to division (D) of this section, the board elects not to

accept the amount allocated to it under ~~division (B)(1)~~ of this section, authorizes the department to determine the use of its allocation, and agrees to provide the department with a statement of projected utilization of state hospitals and other state-operated services by residents of its service district during the fiscal year.

~~(4) Beginning with the notification required to be made by May 1, 1995, under division (B)(3) of this section, no (D) No board of alcohol, drug addiction, and mental health services shall elect the option in division (B)(3)(b)(C)(2) of this section unless one all of the following applies apply:~~

~~(a) The (1) Either the total general revenue funds estimated by the department to be allocated to the board under this section for the next fiscal year is are reduced by a substantial amount, as defined in guidelines adopted by the director of mental health under division (B)(4)(E) of this section, in comparison to the amount allocated for the current fiscal year, for reasons not related to performance;~~

~~(b) The amount of estimated general revenue funds to be allocated to the board is not reduced by a substantial amount but or the board has experienced other circumstances specified in the guidelines adopted by the director under division (B)(4) of this section.~~

~~The director shall consult with boards of alcohol, drug addiction, and mental health services and other relevant constituencies to develop guidelines for determining what constitutes a substantial reduction of general revenue funds for the purpose of electing the option under division (B)(3)(b) of this section, and what other circumstances qualify a board to elect that option.~~

~~Beginning with the notification required to be made by May 1, 1995, under division (B)(3) of this section, no board shall notify the director that it elects the option under division (B)(3)(b) of this section unless it has conducted (2) The board provides the department written confirmation that the board has received input about the impact that the board's election will have on the mental health system in the board's district from all of the following:~~

~~(a) Individuals who receive mental health services and such individuals' families;~~

~~(b) Boards of county commissioners;~~

~~(c) Judges of juvenile and probate courts;~~

~~(d) County sheriffs, jail administrators, and other local law enforcement officials.~~

~~(3) Not later than seven days before notifying the department of its election and after providing the department the written confirmation~~

required by division (D)(2) of this section, the board conducts a public hearing on the issue no later than seven days before making the notification.

~~(C) Boards of alcohol, drug addiction, and mental health services and community mental health agencies~~ (E) For the purpose of division (D)(1) of this section, the director of mental health shall consult with the boards and other relevant constituencies to develop guidelines for determining what constitutes a substantial reduction of funds and what other circumstances qualify a board to elect the option in division (C)(2) of this section.

~~(F) No board shall not use state funds for the purpose of influencing employees with respect to unionization. As used in this division, "influencing" means discouraging employees from seeking collective bargaining representation or encouraging employees to decertify a recognized collective bargaining agent.~~

~~(D) The director shall develop, and review at least annually, a methodology, including the formula developed under division (B)(1) of this section, for distributing and allocating funds to boards. The methodology shall be consistent with state and federal law and regulations. A portion of the funds shall be distributed based on the ratio of the population of the district served by the board to the total population of the state as determined from the federal census or the most recent estimates produced by the United States census bureau's federal state cooperative program for population program series P-26 or the population estimates and projections program series P-25, whichever is most recent.~~

~~(E)(1) There is hereby created in the state treasury the department of mental health risk fund, which shall receive payments from boards that have elected the option provided in division (B)(3)(a) of this section. All investment earnings of the fund shall be credited to the fund. Moneys in the fund shall be used for the following purposes:~~

~~(a) To assist boards that elect the option provided in division (B)(3)(a) of this section and that serve service districts in which the costs of utilization of state hospitals by residents in a fiscal year exceed the amount allocated to the district under the formula developed under division (B)(1) of this section. The department shall define such costs by unit and establish them annually after consultation with representatives of such boards.~~

~~(b) To make payments to boards that elect the option provided in division (B)(3)(a) of this section and that experience conditions of financial hardship, as determined by the director.~~

~~The director of mental health, in consultation with representatives of the boards, shall develop guidelines for the use of moneys in the risk fund.~~

~~(2) On or before the first day of April of each year, the department shall~~

~~specify the percentage of the amount of money allocated under division (B)(1) of this section for distribution to boards subject to division (E) of this section that each such board is to transmit to the director of mental health for deposit in the risk fund for the following fiscal year. On or before the first day of August of each year, each such board shall transmit to the director for deposit to the credit of the risk fund the amount obtained by multiplying that percentage by the amount allocated for distribution to such boards.~~

~~(3) Whenever the costs of utilization of state hospitals by residents in a district served by a board subject to division (E) of this section exceed the amount allocated to the district under the formula, responsibility for payment of the excess costs shall be borne by the board of that district and the risk fund as follows:~~

~~(a) The board and the risk fund each are responsible for payment of one-half of any costs that exceed one hundred per cent of the amount allocated under the formula but do not exceed one hundred five per cent of that amount.~~

~~(b) The board is responsible for payment of one-fourth, and the risk fund responsible for three-fourths, of any costs that exceed one hundred five per cent of the amount allocated under the formula but do not exceed one hundred ten per cent of that amount.~~

~~(c) The risk fund is responsible for payment of any costs that exceed one hundred ten per cent of the amount allocated under the formula but do not exceed one hundred fifteen per cent of that amount.~~

~~(d) The board is responsible for payment of all costs that exceed one hundred fifteen per cent of the amount allocated under the formula.~~

~~(F)(G) The department shall charge against the allocation made to a board under division (B)(4) of this section, if any, any unreimbursed costs for services provided by the department. This requirement is not affected by any election a board makes under division (B)(3) of this section.~~

(H) A board's use of funds allocated under this section is subject to audit by county, state, and federal authorities.

Sec. 5119.621. (A) As used in this section, "administrative function" means a function related to one or more of the following:

- (1) Continuous quality improvement;
- (2) Utilization review;
- (3) Resource development;
- (4) Fiscal administration;
- (5) General administration;
- (6) Any other function related to administration that is required by

Chapter 340. of the Revised Code.

(B) Each board of alcohol, drug addiction, and mental health services shall submit an annual report to the department of mental health specifying how the board used ~~state and federal~~ funds allocated to the board, ~~according to the formula the director of mental health establishes~~ under section 5119.62 of the Revised Code, for administrative functions in the year preceding the report's submission. The director of mental health shall establish the date by which the report must be submitted each year.

Sec. 5119.622. The director of mental health, in whole or in part, may withhold funds otherwise to be allocated to a board of alcohol, drug addiction, and mental health services under section 5119.62 of the Revised Code if the board fails to comply with Chapter 340. or section 5119.61, 5119.611, 5119.612, or 5119.621 of the Revised Code or rules of the department of mental health regarding a community mental health service. The director shall identify the areas of noncompliance and the action necessary to achieve compliance. The director shall offer technical assistance to the board to achieve compliance. The director shall give the board a reasonable time within which to comply or to present its position that it is in compliance. Before withholding funds, a hearing shall be conducted to determine if there are continuing violations and that either assistance is rejected or the board is unable to achieve compliance. Subsequent to the hearing process, if it is determined that compliance has not been achieved, the director may allocate all or part of the withheld funds to a public or private agency to provide the community mental health service for which the board is not in compliance until the time that there is compliance. The director shall adopt rules in accordance with Chapter 119. of the Revised Code to implement this section.

Sec. 5119.623. The director of mental health may withhold funds otherwise to be allocated to a board of alcohol, drug addiction, and mental health services under section 5119.62 of the Revised Code if the board denies available service on the basis of religion, race, color, creed, sex, national origin, age, disability as defined in section 4112.01 of the Revised Code, or developmental disability.

~~Sec. 173.35 5119.69. (A) As used in this section, "PASSPORT administrative agency" means an entity under contract with the department of aging to provide administrative services regarding the PASSPORT program created under section 173.40 of the Revised Code.~~

~~(B) The department of aging mental health shall administer implement the residential state supplement program under which the state supplements the supplemental security income payments received by aged, blind, or~~

disabled adults under Title XVI of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A., as amended. Residential state supplement payments shall be used for the provision of accommodations, supervision, and personal care services to supplemental security income recipients who the department determines are at risk of needing institutional care.

(B) In implementing the program, the department may designate one or more entities to be responsible for providing administrative services regarding the program. The department may designate an entity to be a residential state supplement administrative agency under this division either by entering into a contract with the entity to serve in that capacity or by otherwise delegating to the entity the responsibility to serve in that capacity.

(C) For an individual to be eligible for residential state supplement payments, all of the following must be the case:

(1) Except as provided by division (G) of this section, the individual must reside in one of the following:

(a) An adult foster home certified under section ~~473.36~~ 5119.692 of the Revised Code;

(b) A home or facility, other than a nursing home or nursing home unit of a home for the aging, licensed by the department of health under Chapter 3721. ~~or 3722.~~ of the Revised Code ~~and certified in accordance with standards established by the director of aging under division (D)(2) of this section~~ or the department of mental health under sections 5119.70 to 5119.88 of the Revised Code;

(c) A residential facility as defined in division (A)(1)(d)(ii) of section 5119.22 of the Revised Code licensed by the department of mental health ~~and certified in accordance with standards established by the director of aging under division (D)(2) of this section;~~

(d) An apartment or room used to provide community mental health housing services certified by the department of mental health under section 5119.611 of the Revised Code and approved by a board of alcohol, drug addiction, and mental health services under division (A)(14) of section 340.03 of the Revised Code ~~and certified in accordance with standards established by the director of aging under division (D)(2) of this section.~~

(2) ~~Effective July 1, 2000, a PASSPORT~~ A residential state supplement administrative agency must have determined that the environment in which the individual will be living while receiving the payments is appropriate for the individual's needs. If the individual is eligible for supplemental security income payments or social security disability insurance benefits because of a mental disability, the PASSPORT residential state supplement administrative agency shall refer the individual to a community mental

health agency for the community mental health agency to issue in accordance with section 340.091 of the Revised Code a recommendation on whether the PASSPORT residential state supplement administrative agency should determine that the environment in which the individual will be living while receiving the payments is appropriate for the individual's needs. ~~Division (C)(2) of this section does not apply to an individual receiving residential state supplement payments on June 30, 2000, until the individual's first eligibility redetermination after that date.~~

(3) The individual satisfies all eligibility requirements established by rules adopted under division (D) of this section.

(D)(4) The directors of aging mental health and job and family services shall adopt rules in accordance with section 111.15 of the Revised Code as necessary to implement the residential state supplement program.

To the extent permitted by Title XVI of the "Social Security Act," and any other provision of federal law, the director of job and family services ~~shall~~ may adopt rules establishing standards for adjusting the eligibility requirements concerning the level of impairment a person must have so that the amount appropriated for the program by the general assembly is adequate for the number of eligible individuals. The rules shall not limit the eligibility of disabled persons solely on a basis classifying disabilities as physical or mental. The director of job and family services also ~~shall~~ may adopt rules that establish eligibility standards for aged, blind, or disabled individuals who reside in one of the homes or facilities specified in division (C)(1) of this section but who, because of their income, do not receive supplemental security income payments. The rules may provide that these individuals may include individuals who receive other types of benefits, including, social security disability insurance benefits provided under Title II of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 401, as amended. Notwithstanding division ~~(B)~~(A) of this section, such payments may be made if funds are available for them.

The director of ~~aging shall~~ aging shall mental health may adopt rules establishing the method to be used to determine the amount an eligible individual will receive under the program. The amount the general assembly appropriates for the program ~~shall~~ may be a factor included in the method that ~~department~~ director establishes.

~~(2) The director of aging shall adopt rules in accordance with Chapter 119. of the Revised Code establishing standards for certification of living facilities described in division (C)(1) of this section.~~

~~The directors of aging and mental health shall enter into an agreement to certify facilities that apply for certification and meet the standards~~

~~established by the director of aging under this division.~~

(E) The county department of job and family services of the county in which an applicant for the residential state supplement program resides shall determine whether the applicant meets income and resource requirements for the program.

(F) The department of ~~aging~~ mental health shall maintain a waiting list of any individuals eligible for payments under this section but not receiving them because moneys appropriated to the department for the purposes of this section are insufficient to make payments to all eligible individuals. An individual may apply to be placed on the waiting list even though the individual does not reside in one of the homes or facilities specified in division (C)(1) of this section at the time of application. The director of ~~aging~~ mental health, by rules adopted in accordance with Chapter 119. of the Revised Code, ~~shall~~ may specify procedures and requirements for placing an individual on the waiting list and priorities for the order in which individuals placed on the waiting list are to begin to receive residential state supplement payments. The rules specifying priorities may give priority to individuals placed on the waiting list on or after July 1, 2006, who receive supplemental security income benefits under Title XVI of the "Social Security Act," 86 Stat. 1475 (1972), 42 U.S.C. 1381, as amended. The rules shall not affect the place on the waiting list of any person who was on the list on July 1, 2006. The rules specifying priorities may also set additional priorities based on living arrangement, such as whether an individual resides in a facility listed in division (C)(1) of this section or has been admitted to a nursing facility.

(G) An individual in a licensed or certified living arrangement receiving state supplementation on November 15, 1990, under former section 5101.531 of the Revised Code shall not become ineligible for payments under this section solely by reason of the individual's living arrangement as long as the individual remains in the living arrangement in which the individual resided on November 15, 1990.

(H) The department of ~~aging~~ mental health shall notify each person denied approval for payments under this section of the person's right to a hearing. On request, the hearing shall be provided ~~by the department of job and family services~~ in accordance with ~~section 5101.35~~ Chapter 119. of the Revised Code.

~~Sec. 473.351~~ 5119.691. (A) As used in this section:

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

"Long-term care consultation program" means the program the

department of aging is required to develop under section 173.42 of the Revised Code.

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

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

"Residential state supplement administrative agency" means an entity designated as such by the department of mental health under section 5119.69 of the Revised Code.

"Residential state supplement program" means the program administered pursuant to section ~~173.35~~ 5119.69 of the Revised Code.

(B) ~~Each month, each area agency on aging~~ On a periodic schedule determined by the department of mental health, each residential state supplement administrative agency shall determine whether individuals who reside in the area that the ~~area agency on aging~~ serves and are on a waiting list for the residential state supplement program have been admitted to a nursing facility. If ~~an area~~ a residential state supplement administrative agency on aging determines that such an individual has been admitted to a nursing facility, the agency shall notify the long-term care consultation program administrator serving the area in which the individual resides about the determination. The administrator shall determine whether the residential state supplement program is appropriate for the individual and whether the individual would rather participate in the program than continue residing in the nursing facility. If the administrator determines that the residential state supplement program is appropriate for the individual and the individual would rather participate in the program than continue residing in the nursing facility, the administrator shall so notify the department of ~~aging mental health~~ aging mental health. On receipt of the notice from the administrator, the department of ~~aging mental health~~ aging mental health shall approve the individual's enrollment in the residential state supplement program in accordance with the priorities specified in rules adopted under division (F) of section ~~173.35~~ 5119.69 of the Revised Code. Each quarter, the department of ~~aging mental health~~ aging mental health shall certify to the director of budget and management the estimated increase in costs of the residential state supplement program resulting from enrollment of individuals in the program pursuant to this section.

(C) ~~Not later than the last day of each calendar year, the director of aging shall submit to the general assembly a report regarding the number of individuals enrolled in the residential state supplement program pursuant to~~

~~this section and the costs incurred and savings achieved as a result of the enrollments.~~

~~Sec. 473.36~~ 5119.692. As used in this section, "adult foster home" means a residence, other than a ~~residence certified or~~ residential facility licensed by the department of mental health under section 5119.22 of the Revised Code, in which accommodations and personal care services, as defined in section ~~3722.04~~ 5119.70 of the Revised Code, are provided to one or two adults who are unrelated to the owners of the residence.

The department of ~~aging~~ mental health shall adopt rules in accordance with Chapter 119. of the Revised Code establishing standards for the certification of adult foster homes. The department or its designee shall certify adult foster homes that apply for certification and meet the standards established by the department.

Sec. 5119.693. (A) As used in this section:

(1) "Adult resident" means an individual residing in an adult foster home certified by the department of mental health.

(2) "Applicant" means a person who is under final consideration for employment with an adult foster home in a full-time, part-time, or temporary position that involves providing direct care to an adult resident. "Applicant" does not include a person who provides direct care as a volunteer without receiving or expecting to receive any form of remuneration other than reimbursement for actual expenses.

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

(B)(1) Except as provided in division (I) of this section, the owner or administrator of an adult foster home shall request that the superintendent of the bureau of criminal identification and investigation conduct a criminal records check with respect to each applicant. If an applicant for whom a criminal records check request is required under this division does not present proof of having been a resident of this state for the five-year period immediately prior to the date the criminal records check is requested or provide evidence that within that five-year period the superintendent has requested information about the applicant from the federal bureau of investigation in a criminal records check, the owner or administrator shall request that the superintendent obtain information from the federal bureau of investigation as part of the criminal records check of the applicant. Even if an applicant for whom a criminal records check request is required under this division presents proof of having been a resident of this state for the five-year period, the owner or administrator may request that the superintendent include information from the federal bureau of investigation

in the criminal records check.

(2) A person required by division (B)(1) of this section to request a criminal records check shall do both of the following:

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

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

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

(C)(1) Except as provided in rules adopted by the department of mental health in accordance with division (F) of this section and subject to division (C)(2) of this section, no adult foster home shall employ a person in a position that involves providing direct care to an adult resident if the person has been convicted of or pleaded guilty to any of the following:

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

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

(2)(a) An adult foster home may employ conditionally an applicant for whom a criminal records check request is required under division (B) of this section prior to obtaining the results of a criminal records check regarding the individual, provided that the foster home shall request a criminal records check regarding the individual in accordance with division (B)(1) of this section not later than five business days after the individual begins conditional employment. In the circumstances described in division (I)(2) of this section, an adult foster home may employ conditionally an applicant who has been referred to the adult foster home by an employment service

that supplies full-time, part-time, or temporary staff for positions involving the direct care of adult residents and for whom, pursuant to that division, a criminal records check is not required under division (B) of this section.

(b) An adult foster home that employs an individual conditionally under authority of division (C)(2)(a) of this section shall terminate the individual's employment if the results of the criminal records check requested under division (B) of this section or described in division (I)(2) of this section, other than the results of any request for information from the federal bureau of investigation, are not obtained within the period ending thirty days after the date the request is made. Regardless of when the results of the criminal records check are obtained, if the results indicate that the individual has been convicted of or pleaded guilty to any of the offenses listed or described in division (C)(1) of this section, the foster home shall terminate the individual's employment unless the foster home chooses to employ the individual pursuant to division (F) of this section. Termination of employment under this division shall be considered just cause for discharge for purposes of division (D)(2) of section 4141.29 of the Revised Code if the individual makes any attempt to deceive the foster home about the individual's criminal record.

(D)(1) Each adult foster home shall pay to the bureau of criminal identification and investigation the fee prescribed pursuant to division (C)(3) of section 109.572 of the Revised Code for each criminal records check conducted pursuant to a request made under division (B) of this section.

(2) An adult foster home may charge an applicant a fee not exceeding the amount the foster home pays under division (D)(1) of this section. An adult foster home may collect a fee only if it notifies the person at the time of initial application for employment of the amount of the fee and that, unless the fee is paid, the person will not be considered for employment.

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

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

(2) The owner or administrator of the foster home requesting the criminal records check or the owner's or administrator's representative;

(3) The administrator of any other facility, agency, or program that provides direct care to adult residents that is owned or operated by the same entity that owns or operates the adult foster home;

(4) A court, hearing officer, or other necessary individual involved in a

case dealing with a denial of employment of the applicant or dealing with employment or unemployment benefits of the applicant;

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

(F) The department of mental health may adopt rules in accordance with Chapter 119. of the Revised Code to implement this section. The rules may specify circumstances under which an adult foster home may employ a person who has been convicted of or pleaded guilty to an offense listed or described in division (C)(1) of this section but meets personal character standards set by the department.

(G) The owner or administrator of an adult foster home shall inform each individual, at the time of initial application for a position that involves providing direct care to an adult resident, that the individual is required to provide a set of fingerprint impressions and that a criminal records check is required to be conducted if the individual comes under final consideration for employment.

(H) In a tort or other civil action for damages that is brought as the result of an injury, death, or loss to person or property caused by an individual who an adult foster home employs in a position that involves providing direct care to adult residents, all of the following shall apply:

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

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

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

(I)(1) The owner or administrator of an adult foster home is not required to request that the superintendent of the bureau of criminal identification and investigation conduct a criminal records check of an applicant if the applicant has been referred to the foster home by an employment service

that supplies full-time, part-time, or temporary staff for positions involving the direct care of adult residents and both of the following apply:

(a) The owner or administrator receives from the employment service or the applicant a report of the results of a criminal records check regarding the applicant that has been conducted by the superintendent within the one-year period immediately preceding the applicant's referral:

(b) The report of the criminal records check demonstrates that the person has not been convicted of or pleaded guilty to an offense listed or described in division (C)(1) of this section, or the report demonstrates that the person has been convicted of or pleaded guilty to one or more of those offenses, but the adult foster home chooses to employ the individual pursuant to division (F) of this section.

(2) The owner or administrator of an adult foster home is not required to request that the superintendent of the bureau of criminal identification and investigation conduct a criminal records check of an applicant and may employ the applicant conditionally as described in this division, if the applicant has been referred to the foster home by an employment service that supplies full-time, part-time, or temporary staff for positions involving the direct care of adult residents and if the owner or administrator receives from the employment service or the applicant a letter from the employment service that is on the letterhead of the employment service, dated, and signed by a supervisor or another designated official of the employment service and that states that the employment service has requested the superintendent to conduct a criminal records check regarding the applicant, that the requested criminal records check will include a determination of whether the applicant has been convicted of or pleaded guilty to any offense listed or described in division (C)(1) of this section, that, as of the date set forth on the letter, the employment service had not received the results of the criminal records check, and that, when the employment service receives the results of the criminal records check, it promptly will send a copy of the results to the adult care foster home. If an adult foster home employs an applicant conditionally in accordance with this division, the employment service, upon its receipt of the results of the criminal records check, promptly shall send a copy of the results to the adult foster home, and division (C)(2)(b) of this section applies regarding the conditional employment.

Sec. ~~3722.04~~ 5119.70. (A) As used in this chapter sections 5119.70 to 5119.88:

(1) "Owner" means the person who owns the business of and who ultimately controls the operation of an adult care facility and to whom the

manager, if different from the owner, is responsible.

(2) "Manager" means the person responsible for the daily operation of an adult care facility. The manager and the owner of a facility may be the same person.

(3) "Adult" means an individual eighteen years of age or older.

(4) "Unrelated" means that an adult resident is not related to the owner or manager of an adult care facility or to the owner's or manager's spouse as a parent, grandparent, child, stepchild, grandchild, brother, sister, niece, nephew, aunt, or uncle, or as the child of an aunt or uncle.

(5) "Skilled nursing care" means skilled nursing care as defined in section 3721.01 of the Revised Code.

(6)(a) "Personal care services" means services including, but not limited to, the following:

(i) Assistance with activities of daily living;

(ii) Assistance with self-administration of medication, in accordance with rules adopted ~~by the public health council pursuant to this chapter~~ under section 5119.79 of the Revised Code;

(iii) Preparation of special diets, other than complex therapeutic diets, for residents pursuant to the instructions of a physician or a licensed dietitian, in accordance with rules adopted ~~by the public health council pursuant to this chapter~~ under section 5119.79 of the Revised Code.

(b) "Personal care services" does not include "skilled nursing care" as defined in section 3721.01 of the Revised Code. A facility need not provide more than one of the services listed in division (A)(6)(a) of this section for the facility to be considered to be providing personal care services.

(7) "Adult family home" means a residence or facility that provides accommodations and supervision to three to five unrelated adults, at least three of whom require personal care services.

(8) "Adult group home" means a residence or facility that provides accommodations and supervision to six to sixteen unrelated adults, at least three of whom require personal care services.

(9) "Adult care facility" means an adult family home or an adult group home. For the purposes of ~~this chapter~~ sections 5119.70 to 5119.88 of the Revised Code, any residence, facility, institution, hotel, congregate housing project, or similar facility that provides accommodations and supervision to three to sixteen unrelated adults, at least three of whom require personal care services, is an adult care facility regardless of how the facility holds itself out to the public. "Adult care facility" does not include:

(a) A facility operated by a hospice care program licensed under section 3712.04 of the Revised Code that is used exclusively for care of hospice

patients;

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

(c) An alcohol and drug addiction program as defined in section 3793.01 of the Revised Code;

(d) A residential facility for the mentally ill licensed by the department of mental health under section 5119.22 of the Revised Code;

(e) A facility licensed to provide methadone treatment under section 3793.11 of the Revised Code;

(f) A residential facility licensed under section 5123.19 of the Revised Code or otherwise regulated by the department of developmental disabilities;

(g) Any residence, institution, hotel, congregate housing project, or similar facility that provides personal care services to fewer than three residents or that provides, for any number of residents, only housing, housekeeping, laundry, meal preparation, social or recreational activities, maintenance, security, transportation, and similar services that are not personal care services or skilled nursing care;

(h) Any facility that receives funding for operating costs from the department of development under any program established to provide emergency shelter housing or transitional housing for the homeless;

(i) A terminal care facility for the homeless that has entered into an agreement with a hospice care program under section 3712.07 of the Revised Code;

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

(10) "Residents' rights advocate" means:

~~(a) An employee or representative of any state or local government entity that has a responsibility for residents of adult care facilities and has registered with the department of health under section 3701.07 of the Revised Code;~~

~~(b) An employee or representative, other than a manager or employee of an adult care facility or nursing home, of any private nonprofit corporation or association that qualifies for tax-exempt status under section 501(a) of the "Internal Revenue Code of 1986," 100 Stat. 2085, 26 U.S.C.A. 501(a), as amended, that has registered with the department of health under section 3701.07 of the Revised Code, and whose purposes include educating and counseling residents, assisting residents in resolving problems and~~

~~complaints concerning their care and treatment, and assisting them in securing adequate services.~~

(11) "Sponsor" means an adult relative, friend, or guardian of a resident of an adult care facility who has an interest in or responsibility for the resident's welfare.

(11) "Ombudsperson" means a "representative of the office of the state long-term care ombudsperson program" as defined in section 173.14 of the Revised Code.

(12) "Mental health agency" means a community mental health agency, as defined in division (H) of section 5119.22 5122.01 of the Revised Code, under contract with an ADAMHS board pursuant to division (A)(8)(a) of section 340.03 of the Revised Code.

(13) "ADAMHS board" means a board of alcohol, drug addiction, and mental health services;

(14) "Mental health resident program participation agreement" means a written agreement between an adult care facility and the ADAMHS board serving the alcohol, drug addiction, and mental health service district in which the facility is located, under which the facility is authorized to admit residents who are receiving or are eligible for publicly funded mental health services.

(15) "PASSPORT RSS administrative agency" means an entity ~~under contract with the department of aging to provide that provides administrative services regarding the PASSPORT residential state supplement program created under section 173.40 of the Revised Code on behalf of the department of mental health, either by having entered into a contract with the department to serve in that capacity or by having the department otherwise delegate to it the responsibility to serve in that capacity.~~

(B) For purposes of ~~this chapter~~ sections 5119.70 to 5119.88 of the Revised Code, personal care services or skilled nursing care shall be considered to be provided by a facility if they are provided by a person employed by or associated with the facility or by another person pursuant to an agreement to which neither the resident who receives the services nor the resident's sponsor is a party.

(C) Nothing in division (A)(6) of this section shall be construed to permit personal care services to be imposed upon a resident who is capable of performing the activity in question without assistance.

Sec. ~~3722.011~~ 5119.701. (A) All medication taken by residents of an adult care facility shall be self-administered, except that medication may be administered to a resident as part of the skilled nursing care provided in

accordance with division (B) of section ~~3722.16~~ 5119.86 of the Revised Code. No person shall be admitted to or retained by an adult care facility unless the person is capable of self-administering the person's medication, as determined in writing by a physician, except that a person may be admitted to or retained by such a facility if the person's medication is administered as part of the skilled nursing care provided in accordance with division (B) of section ~~3722.16~~ 5119.86 of the Revised Code.

(B) Members of the staff of an adult care facility shall not administer medication to residents but may do any of the following:

Remind a resident when to take medication and watch to ensure that the resident follows the directions on the container;

Assist a resident in the self-administration of medication by taking the medication from the locked area where it is stored, in accordance with rules adopted ~~by the public health council pursuant to this chapter~~ under section 5119.79 of the Revised Code, and handing it to the resident. If the resident is physically unable to open the container, a staff member may open the container for the resident.

Assist a physically impaired but mentally alert resident, such as a resident with arthritis, cerebral palsy, or Parkinson's disease, in removing oral or topical medication from containers and in consuming or applying the medication, upon request by or with the consent of the resident. If a resident is physically unable to place a dose of medicine to the resident's mouth without spilling it, a staff member may place the dose in a container and place the container to the mouth of the resident.

Sec. ~~3722.02~~ 5119.71. A person seeking a license to operate an adult care facility shall submit to the director of mental health an application on a form prescribed by the director and the following:

(A) In the case of an adult group home seeking licensure as an adult care facility, evidence that the home has been inspected and approved by a local certified building department or by the division of labor in the department of commerce as meeting the applicable requirements of sections 3781.06 to 3781.18 and 3791.04 of the Revised Code and any rules adopted under those sections and evidence that the home has been inspected by the state fire marshal or fire prevention officer of a municipal, township, or other legally constituted fire department approved by the state fire marshal and found to be in compliance with rules adopted under section 3737.83 of the Revised Code regarding fire prevention and safety in adult group homes;

(B) Valid approvals of the facility's water and sewage systems issued by the responsible governmental entity, if applicable;

(C) A statement of ownership containing the following information:

(1) If the owner is an individual, the owner's name, address, telephone number, business address, business telephone number, and occupation. If the owner is an association, corporation, or partnership, the business activity, address, and telephone number of the entity and the name of every person who has an ownership interest of five per cent or more in the entity.

(2) If the owner does not own the building or if the owner owns only part of the building in which the facility is housed, the name of each person who has an ownership interest of five per cent or more in the building;

(3) The address of any adult care facility and any facility described in divisions (A)(9)(a) to (j) of section ~~3722.04~~ 5119.70 of the Revised Code in which the owner has an ownership interest of five per cent or more;

(4) The identity of the manager of the adult care facility, if different from the owner;

(5) The name and address of any adult care facility and any facility described in divisions (A)(9)(a) to (j) of section ~~3722.04~~ 5119.70 of the Revised Code with which either the owner or manager has been affiliated through ownership or employment in the five years prior to the date of the application;

(6) The names and addresses of three persons not employed by or associated in business with the owner who will provide information about the character, reputation, and competence of the owner and the manager and the financial responsibility of the owner;

(7) Information about any arrest of the owner or manager for, or adjudication or conviction of, a criminal offense related to the provision of care in an adult care facility or any facility described in divisions (A)(9)(a) to (j) of section ~~3722.04~~ 5119.70 of the Revised Code or the ability to operate a facility;

(8) Any other information the director may require regarding the owner's ability to operate the facility.

(D) If the facility is an adult group home, a balance sheet showing the assets and liabilities of the owner and a statement projecting revenues and expenses for the first twelve months of the facility's operation;

(E) A statement containing the following information regarding admissions to the facility:

(1) The intended bed capacity of the facility;

(2) If the facility will admit persons referred by or receiving services from an ADAMHS board or a mental health agency, the total number of beds anticipated to be occupied as a result of those admissions.

(F) A nonrefundable license application fee in an amount established in rules adopted by the public health council pursuant to this chapter under

section 5119.79 of the Revised Code.

Sec. ~~3722.024~~ 5119.711. In determining the number of residents in a facility for the purpose of licensure ~~under this chapter as an adult care facility~~, the director of mental health shall consider all the individuals for whom the facility provides accommodations as one group unless either of the following is the case:

(A) In addition to being an adult care facility, the facility is a nursing home licensed under Chapter 3721. of the Revised Code, a residential facility licensed under that chapter, or both. In that case, all the individuals in the part or unit licensed as a nursing home, residential care facility, or both, shall be considered as one group and all the individuals in the part or unit licensed as an adult care facility shall be considered as another group.

(B) The facility maintains, in addition to an adult care facility, a separate and discrete part or unit that provides accommodations to individuals who do not receive supervision or personal care services from the adult care facility, in which case the individuals in the separate and discrete part or unit shall not be considered in determining the number of residents in the adult care facility if the separate and discrete part or unit is in compliance with the Ohio basic building code established by the board of building standards under Chapters 3781. and 3791. of the Revised Code and the adult care facility, to the extent of its authority, permits the director, on request, to inspect the separate and discrete part or unit and speak with the individuals residing there, if they consent, to determine whether the separate and discrete part or unit meets the requirements of this division.

Sec. ~~3722.022~~ 5119.712. A person may not apply for a license to operate an adult care facility if the person is or has been the owner or manager of an adult care facility for which a license to operate was revoked or for which renewal of a license was refused for any reason other than nonpayment of the license renewal fee, unless both of the following conditions are met:

(A) A period of not less than two years has elapsed since the date the director of mental health issued the order revoking or refusing to renew the facility's license.

(B) The director's revocation or refusal to renew the license was not based on an act or omission at the facility that violated a resident's right to be free from abuse, neglect, or exploitation.

Sec. ~~3722.03~~ 5119.72. (A) Any person may operate an adult family home licensed as an adult care facility as a permitted use in any residential district or zone, including any single-family residential district or zone of any political subdivision. Such adult family homes may be required to

comply with area, height, yard, and architectural compatibility requirements that are uniformly imposed upon all single-family residences within the district or zone.

(B) Any person may operate an adult group home licensed as an adult care facility as a permitted use in any multiple-family residential district or zone of any political subdivision, except that a political subdivision that has enacted a zoning ordinance or resolution establishing planned-unit development districts as defined in section 519.021 of the Revised Code may exclude adult group homes from such districts, and a political subdivision that has enacted a zoning ordinance or resolution may regulate adult group homes in multiple-family residential districts or zones as a conditionally permitted use or special exception, in either case, under reasonable and specific standards and conditions set out in the zoning ordinance or resolution to:

(1) Require the architectural design and site layout of the home and the location, nature, and height of any walls, screens, and fences to be compatible with adjoining land uses and the residential character of the neighborhood;

(2) Require compliance with yard, parking, and sign regulation.

(C) This section does not affect any right of a political subdivision to permit a person to operate an adult group home licensed under this chapter in a single-family residential district or zone under conditions established by the political subdivision.

(D)(1) Notwithstanding divisions (A) and (B) of this section and except as otherwise provided in division (D)(2) of this section, a political subdivision that has enacted a zoning ordinance or resolution may limit the excessive concentration of adult family homes and adult group homes required to be licensed as adult care facilities.

(2) Nothing in division (D)(1) of this section authorizes a political subdivision to prevent or limit the continued existence and operation of adult family homes and adult group homes existing and operating on the effective date of this section and required to be licensed as adult care facilities. A political subdivision may consider the existence of such homes for the purpose of limiting the excessive concentration of adult family homes or adult group homes required to be licensed as adult care facilities that are not existing and operating on the effective date of this section.

Sec. ~~3722.04~~ 5119.73. (A) The director of mental health shall inspect, license, and regulate adult care facilities. Except as otherwise provided in division (D) of this section, the director shall issue a license to an adult care facility that meets the requirements of section ~~3722.02~~ 5119.71 of the

Revised Code and that the director determines to be in substantial compliance with the rules adopted ~~by the public health council pursuant to this chapter~~ sections 5119.70 to 5119.88 of the Revised Code. The director shall consider the past record of the owner and manager and any individuals who are principal participants in an entity that is the owner or manager in operating facilities providing care to adults. The director may, in accordance with Chapter 119. of the Revised Code, deny a license if the past record indicates that the owner or manager is not suitable to own or manage an adult care facility.

The license shall contain the name and address of the facility for which it was issued, the date of expiration of the license, and the maximum number of residents that may be accommodated by the facility. A license for an adult care facility shall be valid for a period of two years after the date of issuance. No single facility may be licensed to operate as more than one adult care facility.

(B) The director shall renew a license for a two-year period if the facility continues to be in compliance with the requirements of this chapter and in substantial compliance with the rules adopted ~~under this chapter pursuant to sections 5119.70 to 5119.88 of the Revised Code~~. The owner shall submit a nonrefundable license renewal application fee in an amount established in rules adopted ~~by the public health council pursuant to this chapter~~ under section 5119.79 of the Revised Code. Before the license of an adult group home is renewed, if any alterations have been made to the buildings, a certificate of occupancy for the facility shall have been issued by the division of labor in the department of commerce or a local certified building department. The facility shall have water and sewage system approvals, if required by law, and, in the case of an adult group home, documentation of continued compliance with the rules adopted by the state fire marshal under division (F) of section 3737.83 of the Revised Code.

(C)(1) During each licensure period, the director shall make at least one unannounced inspection of an adult care facility in addition to inspecting the facility to determine whether a license should be issued or renewed, and may make additional unannounced inspections as the director considers necessary. Other inspections may be made at any time that the director considers appropriate. Inspections may be conducted as desk audits or on-site inspections.

The director shall take all reasonable actions to avoid giving notice of an inspection by the manner in which the inspection is scheduled or performed.

If an inspection is conducted to investigate an alleged violation of the

requirements of ~~this chapter~~ sections 5119.70 to 5119.88 of the Revised Code in a facility with residents referred by or receiving services from a mental health agency or ADAMHS board or a facility with residents receiving assistance under the residential state supplement program administered by the department of ~~aging mental health~~ pursuant to section ~~173.35~~ 5119.69 of the Revised Code, the director ~~shall~~ may coordinate the inspection with the appropriate mental health agency, ADAMHS board, or ~~PASSPORT~~ residential state supplement administrative agency designated under section 5119.69 of the Revised Code. ~~As the director considers appropriate, the~~ The director ~~shall~~ may conduct the inspection jointly with the mental health agency, ADAMHS board, or ~~PASSPORT~~ residential state supplement administrative agency.

Not later than sixty days after the date of an inspection of a facility, the director shall send a report of the inspection to the regional long-term care ombudsperson in whose region representing the program in the area in which the facility is located.

(2) The state fire marshal or fire prevention officer of a municipal, township, or other legally constituted fire department approved by the state fire marshal shall inspect an adult group home seeking a license or renewal ~~under this chapter~~ as an adult care facility prior to issuance of a license or renewal, at least once annually thereafter, and at any other time at the request of the director, to determine compliance with the rules adopted under division (F) of section 3737.83 of the Revised Code.

(D) The director may waive any of the licensing requirements established by rule ~~adopted by the public health council~~ pursuant to ~~this chapter~~ sections 5119.70 to 5119.88 of the Revised Code upon written request of the facility. The director may grant a waiver if the director determines that the strict application of the licensing requirement would cause undue hardship to the facility and that granting the waiver would not jeopardize the health or safety of any resident. The director may provide a facility with an informal hearing concerning the denial of a waiver request, but the facility shall not be entitled to a hearing under Chapter 119. of the Revised Code unless the director takes an action that requires a hearing to be held under section ~~3722.05~~ 5119.74 of the Revised Code.

(E)(1) Not later than thirty days after each of the following, the owner of an adult care facility shall submit an inspection fee of twenty dollars for each bed for which the facility is licensed:

(a) Issuance or renewal of a license;

(b) The unannounced inspection required by division (C)(1) of this section that is in addition to the inspection conducted to determine whether a

license should be issued or renewed;

(c) If, during an inspection conducted in addition to the two inspections required by division (C)(1) of this section, the facility was found to be in violation of ~~this chapter~~ sections 5119.70 to 5119.88 of the Revised Code or the rules adopted under ~~it~~ those sections, receipt by the facility of the report of that investigation.

(2) The director may revoke the license of any adult care facility that fails to submit the fee within the thirty-day period.

(3) All inspection fees received by the director, all civil penalties assessed under section ~~3722.08~~ 5119.77 of the Revised Code, all fines imposed under section ~~3722.99~~ 5119.99 of the Revised Code, and all license application and renewal application fees received under division (F) of section ~~3722.02~~ 5119.71 of the Revised Code or under division (B) of this section ~~shall be deposited into the general operations fund created in section 3701.83 of the Revised Code~~ and shall be used only to pay the costs of administering and enforcing the requirements of ~~this chapter~~ sections 5119.70 to 5119.88 of the Revised Code and rules adopted under ~~it~~ those sections.

(F)(1) An owner shall inform the director in writing of any changes in the information contained in the statement of ownership made pursuant to division (C) of section ~~3722.02~~ 5119.71 of the Revised Code or in the identity of the manager, not later than ten days after the change occurs.

(2) An owner who sells or transfers an adult care facility shall be responsible and liable for the following:

(a) Any civil penalties imposed against the facility under section ~~3722.08~~ 5119.77 of the Revised Code for violations that occur before the date of transfer of ownership or during any period in which the seller or the seller's agent operates the facility;

(b) Any outstanding liability to the state, unless the buyer or transferee has agreed, as a condition of the sale or transfer, to accept the outstanding liabilities and to guarantee their payment, except that if the buyer or transferee fails to meet these obligations the seller or transferor shall remain responsible for the outstanding liability.

(G) The director shall annually publish a list of licensed adult care facilities, facilities for which licenses have been revoked, facilities for which license renewal has been refused, any facilities under an order suspending admissions pursuant to section ~~3722.07~~ 5119.76 of the Revised Code, and any facilities that have been assessed a civil penalty pursuant to section ~~3722.08~~ 5119.77 of the Revised Code. The director shall furnish information concerning the status of licensure of any facility to any person upon request.

The director shall annually send a copy of the list to the department of job and family services, ~~to the department of mental health,~~ and to the department of aging.

Sec. ~~3722.044~~ 5119.731. (A) Sections 3781.06 to 3781.18 and 3791.04 of the Revised Code do not apply to an adult family home for which application is made to the director of mental health for licensure as an adult care facility ~~under this chapter~~. Adult family homes shall not be required to submit evidence to the director of ~~health~~ that the home has been inspected by a local certified building department or the division of labor in the department of commerce or by the state fire marshal or a fire prevention officer under section ~~3722.02~~ 5119.71 of the Revised Code, but shall be inspected by the director of ~~health~~ to determine compliance with this section. An inspection made under this section may be made at the same time as an inspection made under section ~~3722.04~~ 5119.73 of the Revised Code.

(B) The director shall not license or renew the license of an adult family home unless it meets the fire protection standards established by rules adopted ~~by the public health council pursuant to this chapter~~ under section 5119.79 of the Revised Code.

Sec. ~~3722.05~~ 5119.74. If an adult care facility fails to comply with any requirement of ~~this chapter~~ sections 5119.70 to 5119.88 of the Revised Code or with any rule adopted ~~pursuant to this chapter~~ under those sections, the director of mental health may do any one or all of the following:

(A) In accordance with Chapter 119. of the Revised Code, deny, revoke, or refuse to renew the license of the facility;

(B) Give the facility an opportunity to correct the violation, in accordance with section ~~3722.06~~ 5119.75 of the Revised Code;

(C) Issue an order suspending the admission of residents to the facility, in accordance with section ~~3722.07~~ 5119.76 of the Revised Code;

(D) Impose a civil penalty in accordance with section ~~3722.08~~ 5119.77 of the Revised Code;

(E) Petition the court of common pleas for injunctive relief in accordance with section ~~3722.09~~ 5119.78 of the Revised Code.

Sec. ~~3722.06~~ 5119.75. Except as otherwise provided in sections ~~3722.07~~ 5119.76 to ~~3722.09~~ 5119.78 of the Revised Code and except in cases of violations that jeopardize the health and safety of any of the residents, if the director of mental health determines that a licensed adult care facility is in violation of ~~this chapter~~ sections 5119.70 to 5119.88 of the Revised Code or of rules adopted ~~pursuant to this chapter~~ under those sections, the director shall give the facility an opportunity to correct the violation. The director

shall notify the facility of the violation and specify a reasonable time for making the corrections. Notice of the violation shall be in writing and shall include a citation to the statute or rule violated. The director shall state the action that the director will take if the corrections are not made within the specified period of time.

The facility shall submit to the director a plan of correction stating the actions that will be taken to correct the violation. The director shall conduct an inspection to determine whether the facility has corrected the violation in accordance with the plan of correction.

If the director determines that the facility has failed to correct the violation in accordance with the plan of correction, the director may impose a penalty under section ~~3722.08~~ 5119.77 of the Revised Code. If the director determines that the license of the facility should be revoked or should not be renewed because the facility has failed to correct the violation within the time specified or because the violation jeopardizes the health or safety of any of the residents, the director shall revoke or refuse to renew the license in accordance with Chapter 119. of the Revised Code.

Sec. ~~3722.07~~ 5119.76. (A) If the director of mental health determines that an adult care facility is in violation of ~~this chapter~~ sections 5119.70 to 5119.88 of the Revised Code or of rules adopted ~~pursuant to it~~ under those sections, the director may immediately issue an order suspending the admission of residents to the facility. This order shall be effective immediately without prior hearing, and no resident shall be admitted to the facility until termination of the order. The director shall send a copy of the order to each organization known by the director to have placed residents in the facility and upon termination of the order shall send written notice of the termination to each of these organizations. Upon inquiry by any person about the licensure status of the facility, the director shall disclose the existence of an order of suspension. If the director discloses the existence of such an order to any person pursuant to this division, ~~he~~ the director shall also notify that person, and any other person upon inquiry, of any subsequent termination of the order of suspension. The facility shall post the notice provided for in division (B) of this section prominently and shall inform any person who inquires about residence or placement in the facility of the order.

(B) The director shall give written notice of the order of suspension to the facility by certified mail, return receipt requested, or shall provide for delivery of the notice in person. If requested by the facility in a letter mailed or delivered not later than two working days after it has received the notice, the director shall hold a conference with representatives of the facility

concerning the suspension. The conference shall be held not later than seven days after the director receives the request.

The notice sent by the director shall contain all of the following:

- (1) A description of the violation;
- (2) A citation to the statute or rule violated;
- (3) A description of the corrections required for termination of the order of suspension;
- (4) Procedures for the facility to follow to request a conference on the order of suspension.

(C) At the conference the director shall discuss with the representatives of the facility the violation cited in the notice provided for in division (B) of this section and shall advise the representatives in regard to correcting the violations. Not later than five days after the conference, the director shall issue another order either upholding or terminating the suspension. If the director issues an order upholding the suspension, the facility may request an adjudication hearing pursuant to Chapter 119. of the Revised Code, but the notice and hearing under that chapter shall be provided after the order is issued, and the suspension shall remain in effect during the hearing process unless terminated by the director or until ninety days have elapsed after a timely request for an adjudication hearing is received by the director, whichever is sooner.

Sec. ~~3722.08~~ 5119.77. (A) If the director of mental health determines that an adult care facility is in violation of ~~this chapter~~ sections 5119.70 to 5119.88 of the Revised Code or rules adopted under ~~it~~ those sections, the director may impose a civil penalty on the owner of the facility, pursuant to rules adopted ~~by the public health council~~ under this chapter sections 5119.79 and 5119.80 of the Revised Code. The director shall determine the classification and amount of the penalty by considering the following factors:

(1) The gravity of the violation, the severity of the actual or potential harm, and the extent to which the provisions of this chapter or rules adopted under it were violated;

(2) Actions taken by the owner or manager to correct the violation;

(3) The number, if any, of previous violations by the adult care facility.

(B) The director shall give written notice of the order imposing a civil penalty to the adult care facility by certified mail, return receipt requested, or shall provide for delivery of the notice in person. The notice shall specify the classification of the violation as determined by rules adopted ~~by the public health council pursuant to this chapter~~ under section 5119.80 of the Revised Code, the amount of the penalty and the rate of interest, the action

that is required to be taken to correct the violation, the time within which it is to be corrected as specified in division (C) of this section, and the procedures for the facility to follow to request a conference on the order imposing a civil penalty. If the facility requests a conference in a letter mailed or delivered not later than two working days after it has received the notice, the director shall hold a conference with representatives of the facility concerning the civil penalty. The conference shall be held not later than seven days after the director receives the request. The conference shall be conducted as prescribed in division (C) of section ~~3722.07~~ 5119.76 of the Revised Code. If the director issues an order upholding the civil penalty, the facility may request an adjudication hearing pursuant to Chapter 119. of the Revised Code, but the order of the director shall be in effect during proceedings instituted pursuant to that chapter until a final adjudication is made.

(C) The director shall order that the condition or practice constituting a class I violation be abated or eliminated within twenty-four hours or any longer period that the director considers reasonable. The notice for a class II or a class III violation shall specify a time within which the violation is required to be corrected.

(D) If the facility does not request a conference or if, after a conference, it fails to take action to correct a violation in the time prescribed by the director, the director shall issue an order upholding the penalty, plus interest at the rate specified in section 1343.03 of the Revised Code for each day beyond the date set for payment of the penalty. The director may waive the interest payment for the period prior to the conference if the director concludes that the conference was necessitated by a legitimate dispute.

(E) The director may cancel or reduce the penalty for a class I violation if the facility corrects the violation within the time specified in the notice, except that the director shall impose the penalty even though the facility has corrected the violation if a resident suffers physical harm because of the violation or the facility has been cited previously for the same violation. The director may cancel the penalty for a class II or class III violation if the facility corrects the violation within the time specified in the notice and the facility has not been cited previously for the same violation. Each day of a violation of any class, after the date the director sets for abatement or elimination, constitutes a separate and additional violation.

(F) If an adult care facility fails to pay a penalty imposed under this section, the director may commence a civil action to collect the penalty. The license of an adult care facility that has failed to pay a penalty imposed under this section shall not be renewed until the penalty has been paid.

(G) If a penalty is imposed under this section, a fine shall not be imposed under section ~~3722.99~~ 5119.99 of the Revised Code for the same violation.

Sec. ~~3722.09~~ 5119.78. (A) If the director of mental health determines that the operation of an adult care facility jeopardizes the health or safety of any of the residents of the facility or if the director determines that an adult care facility is operating without a license, the director may petition the court of common pleas in the county in which the facility is located for appropriate injunctive relief against the facility. If injunctive relief is granted against a facility for operating without a license and the facility continues to operate without a license, the director shall refer the case to the attorney general for further action.

(B) The court petitioned under division (A) of this section shall grant injunctive relief upon a showing that the operation of the facility jeopardizes the health or safety of any of the residents of the facility or that the facility is operating without a license. When the court grants injunctive relief in the case of a facility operating without a license, the court shall issue, at a minimum, an order enjoining the facility from admitting new residents to the facility and an order requiring the facility to assist ~~resident rights advocates~~ with the safe and orderly relocation of the facility's residents.

Sec. ~~3722.10~~ 5119.79. (A) ~~The public health council shall have the exclusive authority to adopt, and the council~~ department of mental health shall adopt, rules governing the licensing and operation of adult care facilities. The rules shall be adopted in accordance with Chapter 119. of the Revised Code ~~and shall~~. Subject to any provision of sections 5119.70 to 5119.88 of the Revised Code for which rules are required to be adopted, the rules may specify all any of the following:

(1) Procedures for the issuance, renewal, and revocation of licenses, for the granting and denial of waivers, and for the issuance and termination of orders of suspension of admission pursuant to section ~~3722.07~~ 5119.76 of the Revised Code;

(2) The qualifications required for owners, managers, and employees of adult care facilities, including character, training, education, experience, and financial resources and the number of staff members required in a facility;

(3) Adequate space, equipment, safety, and sanitation standards for the premises of adult care facilities, and fire protection standards for adult family homes as required by section ~~3722.041~~ 5119.731 of the Revised Code;

(4) The personal, social, dietary, and recreational services to be provided to each resident of adult care facilities;

(5) Rights of residents of adult care facilities, in addition to the rights enumerated under section ~~3722.12~~ 5119.81 of the Revised Code, and procedures to protect and enforce the rights of these residents;

(6) Provisions for keeping records of residents and for maintaining the confidentiality of the records as required by division (B) of section ~~3722.12~~ 5119.81 of the Revised Code. The provisions for maintaining the confidentiality of records shall, at the minimum, meet the requirements for maintaining the confidentiality of records under Title XIX of the "Social Security Act," 49 Stat. 620, 42 U.S.C. 301, as amended, and regulations promulgated thereunder.

(7) Measures to be taken by adult care facilities relative to residents' medication, including policies and procedures concerning medication, storage of medication in a locked area, and disposal of medication and assistance with self-administration of medication, if the facility provides assistance;

(8) Requirements for initial and periodic health assessments of prospective and current adult care facility residents by physicians or other health professionals to ensure that they do not require a level of care beyond that which is provided by the adult care facility, including assessment of their capacity to self-administer the medications prescribed for them;

(9) Requirements relating to preparation of special diets;

(10) The amount of the fees for new and renewal license applications made pursuant to sections ~~3722.02~~ 5119.71 and ~~3722.04~~ 5119.73 of the Revised Code;

(11) Measures to be taken by any employee of the state or any political subdivision of the state authorized by this chapter to enter an adult care facility to inspect the facility or for any other purpose, to ensure that the employee respects the privacy and dignity of residents of the facility, cooperates with residents of the facility and behaves in a congenial manner toward them, and protects the rights of residents;

(12) How an owner or manager of an adult care facility is to comply with section ~~3722.18~~ 5119.88 of the Revised Code. ~~At a minimum, the~~ The rules ~~shall~~ may establish the procedures an owner or manager is to follow under division (A) of section ~~3722.18~~ 5119.88 of the Revised Code regarding referrals to the facility of prospective residents with mental illness or severe mental disability and effective arrangements for ongoing mental health services for such prospective residents. The procedures may provide for any of the following:

(a) That the owner or manager and the ADAMHS board serving the alcohol, drug addiction, and mental health service district in which the

facility is located sign a mental health resident program participation agreement, as developed by the director of mental health under section ~~5119.613~~ 5119.614 of the Revised Code;

(b) That the owner or manager comply with the requirements of its mental health resident program participation agreement;

(c) That the owner or manager and the mental health agencies and ADAMHS boards that refer such prospective residents to the facility develop and sign a mental health plan for ongoing mental health services for each such prospective resident;

(d) Any other process established by the ~~public health council in consultation with the director of health and~~ director of mental health regarding referrals and effective arrangements for ongoing mental health services for prospective residents with mental illness.

(13) Any other rules necessary for the administration and enforcement of ~~this chapter~~ sections 5119.70 to 5119.88 of the Revised Code.

~~(B) After consulting with relevant constituencies, the director of mental health shall prepare and submit to the director of health recommendations for the content of rules to be adopted under division (A)(12) of this section.~~

~~(C)~~ The director of mental health shall advise adult care facilities regarding compliance with the requirements of ~~this chapter~~ sections 5119.70 to 5119.88 of the Revised Code and with the rules adopted pursuant to ~~this chapter~~ those sections.

~~(D)~~(C) Any duty or responsibility imposed upon the director of mental health by this chapter may be carried out by ~~an employee of the department of health~~ persons designated by the director.

~~(E)~~(D) Employees of the department of mental health may enter, for the purposes of investigation, any institution, residence, facility, or other structure which has been reported to the department as, or that the department has reasonable cause to believe is, operating as an adult care facility without a valid license.

~~Sec. 3722.14~~ 5119.80. The ~~public health council~~ department of mental health shall, ~~not later than twelve months after the effective date of this section,~~ adopt rules under Chapter 119. of the Revised Code that set guidelines for classifying violations of ~~this chapter~~ sections 5119.70 to 5119.88 of the Revised Code or rules adopted under ~~it~~ those sections for the purpose of imposing civil penalties. The rules shall establish the following classifications:

(A) Class I violations are conditions or occurrences that present an immediate and serious threat to the physical or emotional health, safety, or security of residents of an adult care facility. Whoever is determined to have

committed a class I violation is subject to a civil penalty of not less than seven hundred dollars nor more than one thousand dollars for each violation.

(B) Class II violations are conditions or occurrences, other than class I violations, that directly threaten the physical or emotional health, safety, or security of residents of an adult care facility. Whoever is determined to have committed a class II violation is subject to a civil penalty of not less than five hundred dollars nor more than seven hundred dollars for each violation.

(C) Class III violations are conditions or occurrences, other than class I or class II violations, that indirectly or potentially threaten the physical or emotional health, safety, or security of residents of a facility. Whoever is determined to have committed a class III violation is subject to a civil penalty of not less than one hundred dollars nor more than five hundred dollars for each violation.

Sec. ~~3722.12~~ 5119.81. (A) As used in this section:

(1) "Abuse" means the unreasonable confinement or intimidation of a resident, or the infliction of injury or cruel punishment upon a resident, resulting in physical harm, pain, or mental anguish.

(2) "Exploitation" means the unlawful or improper utilization of an adult resident or ~~his~~ the resident's resources for personal or monetary benefit, profit, or gain.

(3) "Mechanical restraint" means any method of restricting a resident's freedom of movement, physical activity, or normal use of the resident's body, using an appliance or device manufactured for this purpose.

(4) "Neglect" means failure to provide a resident with the goods or services necessary to prevent physical harm, mental anguish, or mental illness.

~~(4)(5) "Physical restraint," includes, but is not limited to, the locked door of a room or any article, device, or garment that interferes with the free movement of the resident and that he is unable to remove easily also known as "manual restraint,"~~ means any method of physically restricting a resident's freedom of movement, physical activity, or normal use of the resident's body without the use of a mechanical restraint.

(6) "Seclusion" means the involuntary confinement of a resident alone in a room in which the resident is physically prevented from leaving.

(B) The rights of a resident of an adult care facility include all of the following:

(1) The right to a safe, healthy, clean, and decent living environment;

(2) The right to be treated at all times with courtesy and respect, and with full recognition of personal dignity and individuality;

(3) The right to practice a religion of ~~his~~ the resident's choice or to

abstain from the practice of religion;

(4) The right to manage personal financial affairs;

(5) The right to retain and use personal clothing;

(6) The right to ownership and reasonable use of personal property so as to maintain personal dignity and individuality;

(7) The right to participate in activities within the facility and to use the common areas of the facility;

(8) The right to engage in or refrain from engaging in activities of ~~his~~ the resident's own choosing within reason;

(9) The right to private and unrestricted communications, including:

(a) The right to receive, send, and mail sealed, unopened correspondence;

(b) The right to reasonable access to a telephone for private communications;

(c) The right to private visits at any reasonable hour.

(10) The right to initiate and maintain contact with the community, including the right to participate in the activities of community groups at ~~his~~ the resident's initiative or at the initiative of community groups;

(11) The right to state grievances to the owner or the manager of the facility, to any governmental agency, or to any other person without reprisal;

(12) Prior to becoming a resident, the right to visit the facility alone or with ~~his~~ the prospective resident's sponsor;

(13) The right to retain the services of any health or social services practitioner at ~~his~~ the resident's own expense;

(14) The right to refuse medical treatment or services, or if the resident has been adjudicated incompetent pursuant to Chapter 2111. of the Revised Code and has not been restored to legal capacity, the right to have ~~his~~ the resident's legal guardian make decisions about medical treatment and services for ~~him~~ the resident;

(15) The right to be free from abuse, neglect, or exploitation;

(16) The right to be free from seclusion and mechanical and physical restraints;

(17) The right not to be deprived of any legal rights solely by reason of residence in an adult care facility;

(18) The right to examine records maintained by the adult care facility concerning ~~him~~ the resident, upon request;

(19) The right to confidential treatment of ~~his~~ the resident's personal records, and the right to approve or refuse the release of these records to any individual outside the facility, except upon transfer to another adult care facility or a nursing home, residential care facility, home for the aging,

hospital, or other health care facility or provider, and except as required by law or rule or as required by a third-party payment contract;

(20) The right to be informed in writing of the rates charged by the facility as well as any additional charges, and to receive thirty days notice in writing of any change in the rates and charges;

(21) The right to have any significant change in ~~his~~ the resident's health reported to ~~his~~ the resident's sponsor;

(22) The right to share a room with a spouse if both are residents of the facility.

(C) A sponsor, or the director of mental health, the director of aging, or a residents' rights advocate registered under section 3701.07 of the Revised Code may assert on behalf of a resident any of the rights enumerated under this section, ~~section 3722.14~~ 5119.83 of the Revised Code, or rules adopted ~~by the public health council pursuant to this chapter~~ sections 5119.70 to 5119.88 of the Revised Code. Any attempted waiver of these rights is void. No adult care facility or person associated with an adult care facility shall deny a resident any of these rights.

(D) Any resident whose rights under this section or ~~section 3722.13~~ 5119.82 or ~~3722.14~~ 5119.83 of the Revised Code are violated has a cause of action against any person or facility committing the violation. ~~The action may be commenced by the resident or by his sponsor on his behalf.~~ The court may award actual and punitive damages for violation of the rights. The court may award to the prevailing party reasonable attorney's fees limited to the work reasonably performed.

Sec. ~~3722.13~~ 5119.82. (A) Each adult care facility shall establish a written residents' rights policy containing the text of sections ~~3722.12~~ 5119.81 and ~~3722.14~~ 5119.83 of the Revised Code and rules adopted by the ~~public health council pursuant to this chapter~~ sections 5119.70 to 5119.88 of the Revised Code, a discussion of the rights and responsibilities of residents under ~~that section~~ sections 5119.81 to 5119.83 of the Revised Code, and the text of any additional rule for residents promulgated by the facility. At the time of admission the manager shall give a copy of the residents' rights policy to the resident and the resident's sponsor, if any, and explain the contents of the policy to them. The facility shall establish procedures for facilitating the residents' exercise of their rights.

(B) Each adult care facility shall post prominently within the facility a copy of the residents' rights listed in division (B) of section ~~3722.12~~ 5119.81 of the Revised Code and any additional residents' rights established by rules adopted ~~by the public health council pursuant to this chapter~~ sections 5119.70 to 5119.88 of the Revised Code, the addresses and telephone

numbers of the state long-term care ombudsperson and the regional long-term care ombudsperson program for the area in which the facility is located, and the telephone number maintained by the department of health for accepting complaints.

Sec. ~~3722.14~~ 5119.83. (A)(1) Except as provided in division (A)(2) of this section, an adult care facility may transfer or discharge a resident, in the absence of a request from the resident, only for the following reasons:

(a) Charges for the resident's accommodations and services have not been paid within thirty days after the date on which they became due;

(b) The mental, emotional, or physical condition of the resident requires a level of care that the facility is unable to provide;

(c) The health, safety, or welfare of the resident or of another resident requires a transfer or discharge;

(d) The facility's license has been revoked or renewal has been denied pursuant to this chapter by the director of mental health;

(e) The owner closes the facility;

(f) The resident is relocated as the result of a court's order issued under section ~~3722.09~~ 5119.78 of the Revised Code as part of the injunctive relief granted against a facility that is operating without a license;

(g) The resident is receiving publicly funded mental health services and the facility's mental health resident program participation agreement is terminated by the facility or ADAMHS board.

(2) An adult family home may transfer or discharge a resident if transfer or discharge is required for the health, safety, or welfare of an individual who resides in the home but is not a resident for whom supervision or personal services are provided.

(B)(1) The facility shall give a resident thirty days' advance notice, in writing, of a proposed transfer or discharge, except that if the transfer or discharge is for a reason given in divisions (A)(1)(b) to (g) or (A)(2) of this section and an emergency exists, the notice need not be given thirty days in advance. The facility shall state in the written notice the reasons for the proposed transfer or discharge. If the resident is entitled to a hearing as specified in division (B)(2) of this section, the written notice shall outline the procedure for the resident to follow in requesting a hearing.

(2) A resident may request a hearing if a proposed transfer or discharge is based on reason given in ~~division~~ divisions (A)(1)(a) to (c) or (A)(2) of this section. If the resident seeks a hearing, the resident shall submit a request to the director of mental health not later than ten days after receiving the written notice. The director shall hold the hearing not later than ten days after receiving the request. A representative of the director shall preside over

the hearing and shall issue a written recommendation of action to be taken by the director not later than three days after the hearing. The director shall issue an order regarding the transfer or discharge not later than two days after receipt of the recommendation. The order may prohibit or place conditions on the discharge or transfer. In the case of a transfer, the order may require that the transfer be to an institution or facility specified by the director. The hearing is not subject to section 121.22 of the Revised Code. The ~~public health council~~ department of mental health shall adopt rules governing any additional procedures necessary for conducting the hearing.

(C)(1) The owner of an adult care facility who is closing the facility shall inform the director ~~of health~~ in writing at least thirty days prior to the proposed date of closing. At the same time, the owner or manager shall inform each resident, the resident's guardian, the resident's sponsor, or any organization or agency acting on behalf of the resident, of the closing of the facility and the date of the closing.

(2) Immediately upon receiving notice that a facility is to be closed, the director shall monitor the transfer of residents to other facilities and ensure that residents' rights are protected. The director shall notify the ombudsperson in the region in which the facility is located of the closing.

(3) All charges shall be prorated as of the date on which the facility closes. If payments have been made in advance, the payments for services not rendered shall be refunded to the resident or the resident's guardian not later than seven days after the closing of the facility.

(4) Immediately upon the closing of a facility, the owner shall surrender the license to the director, and the license shall be canceled.

Sec. ~~3722.15~~ 5119.84. (A) The following may enter an adult care facility at any time:

- (1) Employees designated by the director of mental health;
- (2) Employees designated by the director of aging;
- (3) Employees designated by the attorney general;
- (4) Employees designated by a county department of job and family services to implement sections 5101.60 to 5101.71 of the Revised Code;
- (5) Persons employed pursuant to division (M) of section 173.01 of the Revised Code in the long-term care ombudsperson program;
- (6) ~~Employees of the department of mental health designated by the director of mental health;~~
- (7) Employees of a mental health agency under any of the following circumstances:
 - (a) When the agency has a client residing in the facility;
 - (b) When the agency is acting as an agent of an ADAMHS board other

than the board with which it is under contract;

(c) When there is a mental health resident program participation agreement between the facility and the ADAMHS board with which the agency is under contract.

~~(8)~~(7) Employees of an ADAMHS board under any of the following circumstances:

(a) When authorized by section 340.05 of the Revised Code;

(b) When a resident of the facility is receiving mental health services provided by that ADAMHS board or another ADAMHS board pursuant to division (A)(8)(b) of section 340.03 of the Revised Code;

(c) When a resident of the facility is receiving services from a mental health agency under contract with that ADAMHS board or another ADAMHS board;

(d) When there is a mental health resident program participation agreement between the facility and that ADAMHS board.

The employees specified in divisions (A)(1) to ~~(8)~~(7) of this section shall be afforded access to all records of the facility, including records pertaining to residents, and may copy the records. Neither these employees nor the director of mental health shall release, without consent, any information obtained from the records of an adult care facility that reasonably would tend to identify a specific resident of the facility, except as ordered by a court of competent jurisdiction or when the release is otherwise authorized by law.

(B) The following persons may enter any adult care facility during reasonable hours:

(1) ~~A resident's sponsor;~~

~~(2) Residents' rights advocates;~~

~~(3) A resident's attorney;~~

~~(4)~~(2) A minister, priest, rabbi, or other person ministering to a resident's religious needs;

~~(5)~~(3) A physician or other person providing health care services to a resident;

~~(6)~~(4) Employees authorized by county departments of job and family services and local boards of health or health departments to enter adult care facilities;

~~(7)~~(5) A prospective resident ~~and prospective resident's sponsor.~~

(C) The manager of an adult care facility may require a person seeking to enter the facility to present identification sufficient to identify the person as an authorized person under this section.

Sec. ~~3722.151~~ 5119.85. (A) As used in this section:

(1) "~~Adult care facility~~" ~~has the same meaning as in section 3722.01 of the Revised Code~~ resident means an individual residing in an adult care facility licensed by the department of mental health.

(2) "Applicant" means a person who is under final consideration for employment with an adult care facility in a full-time, part-time, or temporary position that involves providing direct care to an ~~older~~ adult resident. "Applicant" does not include a person who provides direct care as a volunteer without receiving or expecting to receive any form of remuneration other than reimbursement for actual expenses.

(3) "Criminal records check" ~~and "older adult"~~ has the same ~~meanings meaning~~ as in section 109.572 of the Revised Code.

(B)(1) Except as provided in division (I) of this section, the chief administrator of an adult care facility shall request that the superintendent of the bureau of criminal identification and investigation conduct a criminal records check with respect to each applicant. If an applicant for whom a criminal records check request is required under this division does not present proof of having been a resident of this state for the five-year period immediately prior to the date the criminal records check is requested or provide evidence that within that five-year period the superintendent has requested information about the applicant from the federal bureau of investigation in a criminal records check, the chief administrator shall request that the superintendent obtain information from the federal bureau of investigation as part of the criminal records check of the applicant. Even if an applicant for whom a criminal records check request is required under this division presents proof of having been a resident of this state for the five-year period, the chief administrator may request that the superintendent include information from the federal bureau of investigation in the criminal records check.

(2) A person required by division (B)(1) of this section to request a criminal records check shall do both of the following:

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

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

(3) An applicant provided the form and fingerprint impression sheet under division (B)(2)(a) of this section who fails to complete the form or

provide fingerprint impressions shall not be employed in any position for which a criminal records check is required by this section.

(C)(1) Except as provided in rules adopted by the ~~public health council~~ department of mental health in accordance with division (F) of this section and subject to division (C)(2) of this section, no adult care facility shall employ a person in a position that involves providing direct care to an ~~older~~ adult resident if the person has been convicted of or pleaded guilty to any of the following:

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

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

(2)(a) An adult care facility may employ conditionally an applicant for whom a criminal records check request is required under division (B) of this section prior to obtaining the results of a criminal records check regarding the individual, provided that the facility shall request a criminal records check regarding the individual in accordance with division (B)(1) of this section not later than five business days after the individual begins conditional employment. In the circumstances described in division (I)(2) of this section, an adult care facility may employ conditionally an applicant who has been referred to the adult care facility by an employment service that supplies full-time, part-time, or temporary staff for positions involving the direct care of ~~older adults~~ adult residents and for whom, pursuant to that division, a criminal records check is not required under division (B) of this section.

(b) An adult care facility that employs an individual conditionally under authority of division (C)(2)(a) of this section shall terminate the individual's employment if the results of the criminal records check requested under division (B) of this section or described in division (I)(2) of this section, other than the results of any request for information from the federal bureau of investigation, are not obtained within the period ending thirty days after the date the request is made. Regardless of when the results of the criminal records check are obtained, if the results indicate that the individual has

been convicted of or pleaded guilty to any of the offenses listed or described in division (C)(1) of this section, the facility shall terminate the individual's employment unless the facility chooses to employ the individual pursuant to division (F) of this section. Termination of employment under this division shall be considered just cause for discharge for purposes of division (D)(2) of section 4141.29 of the Revised Code if the individual makes any attempt to deceive the facility about the individual's criminal record.

(D)(1) Each adult care facility shall pay to the bureau of criminal identification and investigation the fee prescribed pursuant to division (C)(3) of section 109.572 of the Revised Code for each criminal records check conducted pursuant to a request made under division (B) of this section.

(2) An adult care facility may charge an applicant a fee not exceeding the amount the facility pays under division (D)(1) of this section. A facility may collect a fee only if it notifies the person at the time of initial application for employment of the amount of the fee and that, unless the fee is paid, the person will not be considered for employment.

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

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

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

(3) The administrator of any other facility, agency, or program that provides direct care to ~~older adults~~ adult residents that is owned or operated by the same entity that owns or operates the adult care facility;

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

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

(F) The ~~public health council shall~~ department may adopt rules in accordance with Chapter 119. of the Revised Code to implement this section. The rules ~~shall~~ may specify circumstances under which an adult care facility may employ a person who has been convicted of or pleaded guilty to an offense listed or described in division (C)(1) of this section but meets personal character standards set by the council.

(G) The chief administrator of an adult care facility shall inform each individual, at the time of initial application for a position that involves

providing direct care to an ~~older~~ adult resident, that the individual is required to provide a set of fingerprint impressions and that a criminal records check is required to be conducted if the individual comes under final consideration for employment.

(H) In a tort or other civil action for damages that is brought as the result of an injury, death, or loss to person or property caused by an individual who an adult care facility employs in a position that involves providing direct care to ~~older adults~~ adult residents, all of the following shall apply:

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

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

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

(I)(1) The chief administrator of an adult care facility is not required to request that the superintendent of the bureau of criminal identification and investigation conduct a criminal records check of an applicant if the applicant has been referred to the facility by an employment service that supplies full-time, part-time, or temporary staff for positions involving the direct care of ~~older adults~~ adult residents and both of the following apply:

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

(b) The report of the criminal records check demonstrates that the person has not been convicted of or pleaded guilty to an offense listed or described in division (C)(1) of this section, or the report demonstrates that the person has been convicted of or pleaded guilty to one or more of those offenses, but the adult care facility chooses to employ the individual pursuant to division (F) of this section.

(2) The chief administrator of an adult care facility is not required to

request that the superintendent of the bureau of criminal identification and investigation conduct a criminal records check of an applicant and may employ the applicant conditionally as described in this division, if the applicant has been referred to the facility by an employment service that supplies full-time, part-time, or temporary staff for positions involving the direct care of ~~elder adults~~ adult residents and if the chief administrator receives from the employment service or the applicant a letter from the employment service that is on the letterhead of the employment service, dated, and signed by a supervisor or another designated official of the employment service and that states that the employment service has requested the superintendent to conduct a criminal records check regarding the applicant, that the requested criminal records check will include a determination of whether the applicant has been convicted of or pleaded guilty to any offense listed or described in division (C)(1) of this section, that, as of the date set forth on the letter, the employment service had not received the results of the criminal records check, and that, when the employment service receives the results of the criminal records check, it promptly will send a copy of the results to the adult care facility. If an adult care facility employs an applicant conditionally in accordance with this division, the employment service, upon its receipt of the results of the criminal records check, promptly shall send a copy of the results to the adult care facility, and division (C)(2)(b) of this section applies regarding the conditional employment.

Sec. ~~3722.16~~ 5119.86. (A) No person shall:

(1) Operate an adult care facility unless the facility is validly licensed by the director of mental health under section ~~3722.04~~ 5119.73 of the Revised Code;

(2) Admit to an adult care facility more residents than the number authorized in the facility's license;

(3) Admit a resident to an adult care facility after the director has issued an order pursuant to section ~~3722.07~~ 5119.76 of the Revised Code suspending admissions to the facility. Violation of division (A)(3) of this section is cause for revocation of the facility's license.

(4) Interfere with any authorized inspection of an adult care facility conducted pursuant to section ~~3722.02~~ 5119.71 or ~~3722.04~~ 5119.73 of the Revised Code;

(5) Admit to an adult care facility a resident requiring publicly funded mental health services, unless both of the following conditions are met:

(a) The ADAMHS board serving the alcohol, drug addiction, and mental health service district in which the facility is located is notified;

(b) The facility and ADAMHS board have entered into a mental health resident program participation agreement by using the standardized form approved by the director of mental health under section ~~5119.613~~ 5119.614 of the Revised Code.

(6) Violate any of the provisions of ~~this chapter~~ sections 5119.70 to 5119.88 of the Revised Code or any of the rules adopted pursuant to ~~those sections.~~

(B) No adult care facility shall provide, or admit or retain any resident in need of, skilled nursing care unless all of the following conditions are met:

(1) The care will be provided on a part-time, intermittent basis for not more than a total of one hundred twenty days in any twelve-month period.

(2) The care will be provided by one or more of the following:

(a) A home health agency certified under Title XVIII of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended;

(b) A hospice care program licensed under Chapter 3712. of the Revised Code;

(c) A nursing home licensed under Chapter 3721. of the Revised Code and owned and operated by the same person and located on the same site as the adult care facility;

(d) A mental health agency or, pursuant to division (A)(8)(b) of section 340.03 of the Revised Code, an ADAMHS board.

(3) Each individual employed by, under contract with, or otherwise used by any of the entities specified in division (B)(2) of this section to perform the skilled nursing care is authorized under the laws of this state to perform the care by being appropriately licensed, as specified in rules adopted under division (G) of this section.

(4) The staff of the one or more entities providing the skilled nursing care does not train the adult care facility staff to provide the skilled nursing care;

(5) The individual to whom the skilled nursing care is provided is suffering from a short-term illness;

(6) If the skilled nursing care is to be provided by the nursing staff of a nursing home, all of the following are the case:

(a) The adult care facility evaluates the individual receiving the skilled nursing care at least once every seven days to determine whether the individual should be transferred to a nursing home;

(b) The adult care facility meets at all times staffing requirements established by rules adopted under section ~~3722.10~~ 5119.79 of the Revised Code;

(c) The nursing home does not include the cost of providing skilled nursing care to the adult care facility residents in a cost report filed under section 5111.26 of the Revised Code;

(d) The nursing home meets at all times the nursing home licensure staffing ratios established by rules adopted under section 3721.04 of the Revised Code;

(e) The nursing home staff providing skilled nursing care to adult care facility residents are registered nurses or licensed practical nurses licensed under Chapter 4723. of the Revised Code and meet the personnel qualifications for nursing home staff established by rules adopted under section 3721.04 of the Revised Code;

(f) The skilled nursing care is provided in accordance with rules established for nursing homes under section 3721.04 of the Revised Code;

(g) The nursing home meets the skilled nursing care needs of the adult care facility residents;

(h) Using the nursing home's nursing staff does not prevent the nursing home or adult care facility from meeting the needs of the nursing home and adult care facility residents in a quality and timely manner.

(7) No adult care facility staff shall provide skilled nursing care.

Notwithstanding section 3721.01 of the Revised Code, an adult care facility in which residents receive skilled nursing care as described in division (B) of this section is not a nursing home.

(C) A home health agency or hospice care program that provides skilled nursing care pursuant to division (B) of this section may not be associated with the adult care facility unless the facility is part of a home for the aged as defined in section 5701.13 of the Revised Code or the adult care facility is owned and operated by the same person and located on the same site as a nursing home licensed under Chapter 3721. of the Revised Code that is associated with the home health agency or hospice care program. In addition, the following requirements shall be met:

(1) The adult care facility shall evaluate the individual receiving the skilled nursing care not less than once every seven days to determine whether the individual should be transferred to a nursing home;

(2) If the costs of providing the skilled nursing care are included in a cost report filed pursuant to section 5111.26 of the Revised Code by the nursing home that is part of the same home for the aged, the home health agency or hospice care program shall not seek reimbursement for the care under the medical assistance program established under Chapter 5111. of the Revised Code.

(D) No person knowingly shall place or recommend placement of any

person in an adult care facility that is operating without a license.

(E) No employee of a unit of local or state government, ADAMHS board, mental health agency, or ~~PASSPORT~~ RSS administrative agency shall place or recommend placement of any person in an adult care facility if the employee knows any of the following:

- (1) That the facility cannot meet the needs of the potential resident;
- (2) That placement of the resident would cause the facility to exceed its licensed capacity;
- (3) That an enforcement action initiated by the director of mental health is pending and may result in the revocation of or refusal to renew the facility's license;
- (4) That the potential resident is receiving or is eligible for publicly funded mental health services and the facility has not entered into a mental health resident program participation agreement.

(F) No person who has reason to believe that an adult care facility is operating without a license shall fail to report this information to the director of mental health.

(G) In accordance with Chapter 119. of the Revised Code, the ~~public health council~~ department of mental health shall adopt rules for purposes of division (B) of this section that do all of the following:

- (1) Define a short-term illness for purposes of division (B)(5) of this section;
- (2) Specify, consistent with rules pertaining to home health care adopted by the director of job and family services under the medical assistance program established under Chapter 5111. of the Revised Code and Title XIX of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C. 301, as amended, what constitutes a part-time, intermittent basis for purposes of division (B)(1) of this section;
- (3) Specify what constitutes being appropriately licensed for purposes of division (B)(3) of this section.

Sec. ~~3722.17~~ 5119.87. (A) Any person who believes that an adult care facility is in violation of ~~this chapter~~ sections 5119.70 to 5119.88 of the Revised Code or of any of the rules ~~promulgated~~ adopted pursuant to ~~it~~ those sections may report the information to the director of mental health. The director shall investigate each report made under this section or section ~~3722.16~~ 5119.86 of the Revised Code and shall inform the facility of the results of the investigation. When investigating a report made pursuant to section 340.05 of the Revised Code, the director shall consult with the ADAMHS board that made the report. The director shall keep a record of the investigation and the action taken as a result of the investigation.

The director shall not reveal, without consent, the identity of a person who makes a report under this section or division (G) of section ~~3722.16~~ 5119.86 of the Revised Code, the identity of a specific resident or residents referred to in such a report, or any other information that could reasonably be expected to reveal the identity of the person making the report or the resident or residents referred to in the report, except that the director may provide this information to a government agency responsible for enforcing laws applying to adult care facilities.

(B) Any person who believes that a resident's rights under sections ~~3722.12~~ 5119.81 to ~~3722.15~~ 5119.84 of the Revised Code have been violated may report the information to the state long-term care ombudsperson, the regional long-term care ombudsperson program for the area in which the facility is located, or the director of mental health. If the person believes that the resident has mental illness or severe mental disability and is suffering abuse or neglect, the person may report the information to the ADAMHS board serving the alcohol, drug addiction, and mental health service district in which the adult care facility is located or a mental health agency under contract with the board in addition to or instead of the ombudsperson, regional program, or director.

(C) Any person who makes a report pursuant to division (A) or (B) of this section or division (G) of section ~~3722.16~~ 5119.86 of the Revised Code or any person who participates in an administrative or judicial proceeding resulting from such a report is immune from any civil liability or criminal liability, other than perjury, that might otherwise be incurred or imposed as a result of these actions, unless the person has acted in bad faith or with malicious purpose.

Sec. ~~3722.18~~ 5119.88. Before an adult care facility admits a prospective resident who the owner or manager of the facility knows has been assessed as having a mental illness or severe mental disability, the owner or manager is subject to both of the following:

(A) If the prospective resident is referred to the facility by a mental health agency or ADAMHS board, the owner or manager shall follow procedures established in rules adopted under division (A)(12) of section ~~3722.10~~ 5119.79 of the Revised Code regarding referrals and effective arrangements for ongoing mental health services.

(B) If the prospective resident is not referred to the facility by a mental health agency or ADAMHS board, the owner or manager shall offer to assist the prospective resident in obtaining appropriate mental health services and document the offer of assistance in accordance with rules adopted under division (A)(12) of section ~~3722.10~~ 5119.79 of the Revised Code.

Sec. 5119.99. (A) Whoever violates section 5119.21 of the Revised Code is guilty of a misdemeanor of the first degree.

(B) Whoever violates division (A)(1) of section 5119.86 of the Revised Code shall be fined two thousand dollars for a first offense; for each subsequent offense, such person shall be fined five thousand dollars.

(C) Whoever violates division (C) of section 5119.81 or division (A)(2), (3), (4), (5), or (6), (B), (C), (D), (E), or (F) of section 5119.86 of the Revised Code shall be fined five hundred dollars for a first offense; for each subsequent offense, such person shall be fined one thousand dollars.

Sec. 5120.092. There is hereby created in the state treasury the adult and juvenile correctional facilities bond retirement fund. The fund shall receive proceeds derived from the sale of state adult or juvenile correctional facilities. Investment income with respect to moneys on deposit in the fund shall be retained by the fund. No investment of moneys in, or transfer of moneys from, the fund shall be made if the effect of the investment or transfer would be to adversely affect the exclusion from gross income of the interest payable on state bonds issued for state adult or juvenile correctional facilities that have been sold under authority of Section 753.10 or 753.30 of the act in which this section was enacted. To the extent necessary to maintain the exclusion from gross income of the interest payable on those bonds, moneys in the fund shall first be used to redeem or defease the outstanding portion of such bonds. To accomplish the redemption or defeasance, the director of budget and management, at the request of the Ohio building authority, may direct that moneys in the fund be transferred to the appropriate trustees under the applicable bond trust agreements. Upon receipt of both (i) one or more opinions of a nationally recognized bond counsel firm appointed by the Ohio building authority stating that the aforementioned bonds have been redeemed or defeased and that the transfer of such moneys will not adversely affect the exclusion from gross income of the interest payable on such bonds, and (ii) a certification by both the director of administrative services and the director of rehabilitation and correction stating either that all sales of state adult and juvenile correctional facilities contemplated by Sections 753.10 and 753.30 of the act in which this section was enacted have been completed or that no further sales of any such facilities will be undertaken, the director of budget and management may direct that any moneys remaining in the fund after the redemption or defeasance of the aforementioned bonds shall be transferred to the general revenue fund. Upon completion of that transfer, the adult and juvenile correctional facilities bond retirement fund shall be abolished.

Sec. 5120.105. (A) The department of administrative services shall

provide for the construction of a halfway house facility in conformity with Chapter 153. of the Revised Code, except that construction services may be provided by the department of rehabilitation and correction.

(B) The director of rehabilitation and correction may enter into an agreement with a halfway house organization for the management of a halfway house facility. The halfway house organization that occupies, will occupy, or is responsible for the management of a halfway house facility shall pay the costs of management of and general building services for the halfway house facility as provided in an agreement between the department of rehabilitation and correction and the halfway house organization.

(C) No state funds, including state bond proceeds, shall be spent on the construction of a halfway house facility under sections 5120.102 to 5120.105 of the Revised Code, unless the general assembly has specifically authorized the spending of money on, or has made an appropriation to the department of rehabilitation and correction for, the construction of the halfway house facility or rental payments relating to the financing of the construction of that facility. An authorization to spend money or an appropriation for planning a halfway house facility does not constitute an authorization to spend money on, or an appropriation for, the construction of that facility. Capital funds for the construction of halfway house facilities under sections 5120.102 to 5120.105 of the Revised Code shall be paid from the adult correctional building fund created ~~by the general assembly in the custody of the state treasurer~~ in division (F) of section 154.24 of the Revised Code.

Sec. 5120.135. (A) As used in this section, "laboratory services" includes the performance of medical laboratory analysis; professional laboratory and pathologist consultation; the procurement, storage, and distribution of laboratory supplies; and the performance of phlebotomy services.

(B) The department of rehabilitation and correction ~~shall~~ may provide laboratory services to the departments of mental health, developmental disabilities, youth services, and rehabilitation and correction. The department of rehabilitation and correction may also provide laboratory services to other state, county, or municipal agencies and to private persons that request laboratory services if the department of rehabilitation and correction determines that the provision of laboratory services is in the public interest and considers it advisable to provide such services. The department of rehabilitation and correction may also provide laboratory services to agencies operated by the United States government and to public and private entities funded in whole or in part by the state if the director of

rehabilitation and correction designates them as eligible to receive such services.

The department of rehabilitation and correction shall provide laboratory services from a laboratory that complies with the standards for certification set by the United States department of health and human services under the "Clinical Laboratory Improvement Amendments of 1988," 102 Stat. 293, 42 U.S.C.A. 263a. In addition, the laboratory shall maintain accreditation or certification with an appropriate accrediting or certifying organization as considered necessary by the recipients of its laboratory services and as authorized by the director of rehabilitation and correction.

(C) The cost of administering this section shall be determined by the department of rehabilitation and correction and shall be paid by entities that receive laboratory services to the department for deposit in the state treasury to the credit of the laboratory services fund, which is hereby created. The fund shall be used to pay the costs the department incurs in administering this section.

~~(D) If the department of rehabilitation and correction does not provide laboratory services under this section in a satisfactory manner to the department of developmental disabilities, youth services, or mental health, the director of developmental disabilities, youth services, or mental health shall attempt to resolve the matter of the unsatisfactory provision of services with the director of rehabilitation and correction. If, after this attempt, the provision of laboratory services continues to be unsatisfactory, the director of developmental disabilities, youth services, or mental health shall notify the director of rehabilitation and correction regarding the continued unsatisfactory provision of laboratory services. If, within thirty days after the director receives this notice, the department of rehabilitation and correction does not provide the specified laboratory services in a satisfactory manner, the director of developmental disabilities, youth services, or mental health shall notify the director of rehabilitation and correction of the notifying director's intent to cease obtaining laboratory services from the department of rehabilitation and correction. Following the end of a cancellation period of sixty days that begins on the date of the notice, the department that sent the notice may obtain laboratory services from a provider other than the department of rehabilitation and correction, if the department that sent the notice certifies to the department of administrative services that the requirements of this division have been met.~~

(E) Whenever a state agency fails to make a payment for laboratory services provided to it by the department of rehabilitation and correction under this section within thirty-one days after the date the payment was due,

the office of budget and management may transfer moneys from that state agency to the department of rehabilitation and correction for deposit to the credit of the laboratory services fund. The amount transferred shall not exceed the amount of the overdue payments. Prior to making a transfer under this division, the office shall apply any credits the state agency has accumulated in payment for laboratory services provided under this section.

Sec. 5120.17. (A) As used in this section:

(1) "Mental illness" means a substantial disorder of thought, mood, perception, orientation, or memory that grossly impairs judgment, behavior, capacity to recognize reality, or ability to meet the ordinary demands of life.

(2) "Mentally ill person subject to hospitalization" means a mentally ill person to whom any of the following applies because of the person's mental illness:

(a) The person represents a substantial risk of physical harm to the person as manifested by evidence of threats of, or attempts at, suicide or serious self-inflicted bodily harm.

(b) The person represents a substantial risk of physical harm to others as manifested by evidence of recent homicidal or other violent behavior, evidence of recent threats that place another in reasonable fear of violent behavior and serious physical harm, or other evidence of present dangerousness.

(c) The person represents a substantial and immediate risk of serious physical impairment or injury to the person as manifested by evidence that the person is unable to provide for and is not providing for the person's basic physical needs because of the person's mental illness and that appropriate provision for those needs cannot be made immediately available in the correctional institution in which the inmate is currently housed.

(d) The person would benefit from treatment in a hospital for the person's mental illness and is in need of treatment in a hospital as manifested by evidence of behavior that creates a grave and imminent risk to substantial rights of others or the person.

(3) "Psychiatric hospital" means all or part of a facility that is operated and managed by the department of rehabilitation and correction, is designated as a psychiatric hospital, mental health to provide psychiatric hospitalization services in accordance with the requirements of this section pursuant to an agreement between the directors of rehabilitation and correction and mental health or, is licensed by the department of mental health pursuant to section 5119.20 of the Revised Code, as a psychiatric hospital and is in substantial compliance with the standards set by the joint commission on accreditation of healthcare organizations accredited by a

healthcare accrediting organization approved by the department of mental health and the psychiatric hospital is any of the following:

(a) Operated and managed by the department of rehabilitation and correction within a facility that is operated by the department of rehabilitation and correction;

(b) Operated and managed by a contractor for the department of rehabilitation and correction within a facility that is operated by the department of rehabilitation and correction;

(c) Operated and managed in the community by an entity that has contracted with the department of rehabilitation and correction to provide psychiatric hospitalization services in accordance with the requirements of this section.

(4) "Inmate patient" means an inmate who is admitted to a psychiatric hospital.

(5) "Admitted" to a psychiatric hospital means being accepted for and staying at least one night at the psychiatric hospital.

(6) "Treatment plan" means a written statement of reasonable objectives and goals for an inmate patient that is based on the needs of the inmate patient and that is established by the treatment team, with the active participation of the inmate patient and with documentation of that participation. "Treatment plan" includes all of the following:

(a) The specific criteria to be used in evaluating progress toward achieving the objectives and goals;

(b) The services to be provided to the inmate patient during the inmate patient's hospitalization;

(c) The services to be provided to the inmate patient after discharge from the hospital, including, but not limited to, housing and mental health services provided at the state correctional institution to which the inmate patient returns after discharge or community mental health services.

(7) "Mentally retarded person subject to institutionalization by court order" has the same meaning as in section 5123.01 of the Revised Code.

(8) "Emergency transfer" means the transfer of a mentally ill inmate to a psychiatric hospital when the inmate presents an immediate danger to self or others and requires hospital-level care.

(9) "Uncontested transfer" means the transfer of a mentally ill inmate to a psychiatric hospital when the inmate has the mental capacity to, and has waived, the hearing required by division (B) of this section.

(10)(a) "Independent decision-maker" means a person who is employed or retained by the department of rehabilitation and correction and is appointed by the chief or chief clinical officer of mental health services as a

hospitalization hearing officer to conduct due process hearings.

(b) An independent decision-maker who presides over any hearing or issues any order pursuant to this section shall be a psychiatrist, psychologist, or attorney, shall not be specifically associated with the institution in which the inmate who is the subject of the hearing or order resides at the time of the hearing or order, and previously shall not have had any treatment relationship with nor have represented in any legal proceeding the inmate who is the subject of the order.

(B)(1) Except as provided in division (C) of this section, if the warden of a state correctional institution or the warden's designee believes that an inmate should be transferred from the institution to a psychiatric hospital, the department shall hold a hearing to determine whether the inmate is a mentally ill person subject to hospitalization. The department shall conduct the hearing at the state correctional institution in which the inmate is confined, and the department shall provide qualified independent assistance to the inmate for the hearing. An independent decision-maker provided by the department shall preside at the hearing and determine whether the inmate is a mentally ill person subject to hospitalization.

(2) Except as provided in division (C) of this section, prior to the hearing held pursuant to division (B)(1) of this section, the warden or the warden's designee shall give written notice to the inmate that the department is considering transferring the inmate to a psychiatric hospital, that it will hold a hearing on the proposed transfer at which the inmate may be present, that at the hearing the inmate has the rights described in division (B)(3) of this section, and that the department will provide qualified independent assistance to the inmate with respect to the hearing. The department shall not hold the hearing until the inmate has received written notice of the proposed transfer and has had sufficient time to consult with the person appointed by the department to provide assistance to the inmate and to prepare for a presentation at the hearing.

(3) At the hearing held pursuant to division (B)(1) of this section, the department shall disclose to the inmate the evidence that it relies upon for the transfer and shall give the inmate an opportunity to be heard. Unless the independent decision-maker finds good cause for not permitting it, the inmate may present documentary evidence and the testimony of witnesses at the hearing and may confront and cross-examine witnesses called by the department.

(4) If the independent decision-maker does not find clear and convincing evidence that the inmate is a mentally ill person subject to hospitalization, the department shall not transfer the inmate to a psychiatric

hospital but shall continue to confine the inmate in the same state correctional institution or in another state correctional institution that the department considers appropriate. If the independent decision-maker finds clear and convincing evidence that the inmate is a mentally ill person subject to hospitalization, the decision-maker shall order that the inmate be transported to a psychiatric hospital for observation and treatment for a period of not longer than thirty days. After the hearing, the independent decision-maker shall submit to the department a written decision that states one of the findings described in division (B)(4) of this section, the evidence that the decision-maker relied on in reaching that conclusion, and, if the decision is that the inmate should be transferred, the reasons for the transfer.

(C)(1) The department may transfer an inmate to a psychiatric hospital under an emergency transfer order if the chief clinical officer of mental health services of the department or that officer's designee and either a psychiatrist employed or retained by the department or, in the absence of a psychiatrist, a psychologist employed or retained by the department determines that the inmate is mentally ill, presents an immediate danger to self or others, and requires hospital-level care.

(2) The department may transfer an inmate to a psychiatric hospital under an uncontested transfer order if both of the following apply:

(a) A psychiatrist employed or retained by the department determines all of the following apply:

(i) The inmate has a mental illness or is a mentally ill person subject to hospitalization.

(ii) The inmate requires hospital care to address the mental illness.

(iii) The inmate has the mental capacity to make a reasoned choice regarding the inmate's transfer to a hospital.

(b) The inmate agrees to a transfer to a hospital.

(3) The written notice and the hearing required under divisions (B)(1) and (2) of this section are not required for an emergency transfer or uncontested transfer under division (C)(1) or (2) of this section.

(4) After an emergency transfer under division (C)(1) of this section, the department shall hold a hearing for continued hospitalization within five working days after admission of the transferred inmate to the psychiatric hospital. The department shall hold subsequent hearings pursuant to division (F) of this section at the same intervals as required for inmate patients who are transported to a psychiatric hospital under division (B)(4) of this section.

(5) After an uncontested transfer under division (C)(2) of this section, the inmate may withdraw consent to the transfer in writing at any time. Upon the inmate's withdrawal of consent, the hospital shall discharge the

inmate, or, within five working days, the department shall hold a hearing for continued hospitalization. The department shall hold subsequent hearings pursuant to division (F) of this section at the same time intervals as required for inmate patients who are transported to a psychiatric hospital under division (B)(4) of this section.

(D)(1) If an independent decision-maker, pursuant to division (B)(4) of this section, orders an inmate transported to a psychiatric hospital or if an inmate is transferred pursuant to division (C)(1) or (2) of this section, the staff of the psychiatric hospital shall examine the inmate patient when admitted to the psychiatric hospital as soon as practicable after the inmate patient arrives at the hospital and no later than twenty-four hours after the time of arrival. The attending physician responsible for the inmate patient's care shall give the inmate patient all information necessary to enable the patient to give a fully informed, intelligent, and knowing consent to the treatment the inmate patient will receive in the hospital. The attending physician shall tell the inmate patient the expected physical and medical consequences of any proposed treatment and shall give the inmate patient the opportunity to consult with another psychiatrist at the hospital and with the inmate advisor.

(2) No inmate patient who is transported or transferred pursuant to division (B)(4) or (C)(1) or (2) of this section to a psychiatric hospital ~~pursuant to division (B)(4) or (C)(1) or (2) of this section and who is in the physical custody of~~ within a facility that is operated by the department of rehabilitation and correction shall be subjected to any of the following procedures:

- (a) Convulsive therapy;
- (b) Major aversive interventions;
- (c) Any unusually hazardous treatment procedures;
- (d) Psychosurgery.

(E) ~~The warden of the psychiatric hospital or the warden's designee~~ department of rehabilitation and correction shall ensure that an inmate patient hospitalized pursuant to this section receives or has all of the following:

(1) Receives sufficient professional care within twenty days of admission to ensure that an evaluation of the inmate patient's current status, differential diagnosis, probable prognosis, and description of the current treatment plan have been formulated and are stated on the inmate patient's official chart;

(2) Has a written treatment plan consistent with the evaluation, diagnosis, prognosis, and goals of treatment;

- (3) Receives treatment consistent with the treatment plan;
- (4) Receives periodic reevaluations of the treatment plan by the professional staff at intervals not to exceed thirty days;
- (5) Is provided with adequate medical treatment for physical disease or injury;
- (6) Receives humane care and treatment, including, without being limited to, the following:
 - (a) Access to the facilities and personnel required by the treatment plan;
 - (b) A humane psychological and physical environment;
 - (c) The right to obtain current information concerning the treatment program, the expected outcomes of treatment, and the expectations for the inmate patient's participation in the treatment program in terms that the inmate patient reasonably can understand;
 - (d) Opportunity for participation in programs designed to help the inmate patient acquire the skills needed to work toward discharge from the psychiatric hospital;
 - (e) The right to be free from unnecessary or excessive medication and from unnecessary restraints or isolation;
 - (f) All other rights afforded inmates in the custody of the department consistent with rules, policy, and procedure of the department.
- (F) The department shall hold a hearing for the continued hospitalization of an inmate patient who is transported or transferred to a psychiatric hospital pursuant to division (B)(4) or (C)(1) of this section prior to the expiration of the initial thirty-day period of hospitalization. The department shall hold any subsequent hearings, if necessary, not later than ninety days after the first thirty-day hearing and then not later than each one hundred and eighty days after the immediately prior hearing. An independent decision-maker shall conduct the hearings at the psychiatric hospital in which the inmate patient is confined. The inmate patient shall be afforded all of the rights set forth in this section for the hearing prior to transfer to the psychiatric hospital. The department may not waive a hearing for continued commitment. A hearing for continued commitment is mandatory for an inmate patient transported or transferred to a psychiatric hospital pursuant to division (B)(4) or (C)(1) of this section unless the inmate patient has the capacity to make a reasoned choice to execute a waiver and waives the hearing in writing. An inmate patient who is transferred to a psychiatric hospital pursuant to an uncontested transfer under division (C)(2) of this section and who has scheduled hearings after withdrawal of consent for hospitalization may waive any of the scheduled hearings if the inmate has the capacity to make a reasoned choice and

executes a written waiver of the hearing.

If upon completion of the hearing the independent decision-maker does not find by clear and convincing evidence that the inmate patient is a mentally ill person subject to hospitalization, the independent decision-maker shall order the inmate patient's discharge from the psychiatric hospital. If the independent decision-maker finds by clear and convincing evidence that the inmate patient is a mentally ill person subject to hospitalization, the independent decision-maker shall order that the inmate patient remain at the psychiatric hospital for continued hospitalization until the next required hearing.

If at any time prior to the next required hearing for continued hospitalization, the medical director of the hospital or the attending physician determines that the treatment needs of the inmate patient could be met equally well in an available and appropriate less restrictive state correctional institution or unit, the medical director or attending physician may discharge the inmate to that facility.

(G) An inmate patient is entitled to the credits toward the reduction of the inmate patient's stated prison term pursuant to Chapters 2967. and 5120. of the Revised Code under the same terms and conditions as if the inmate patient were in any other institution of the department of rehabilitation and correction.

(H) The adult parole authority may place an inmate patient on parole or under post-release control directly from a psychiatric hospital.

(I) If an inmate patient who is a mentally ill person subject to hospitalization is to be released from a psychiatric hospital because of the expiration of the inmate patient's stated prison term, the ~~warden of the psychiatric hospital~~ director of rehabilitation and correction or the director's designee, at least fourteen days before the expiration date, may file an affidavit under section 5122.11 or 5123.71 of the Revised Code with the probate court in the county where the psychiatric hospital is located or the probate court in the county where the inmate will reside, alleging that the inmate patient is a mentally ill person subject to hospitalization by court order or a mentally retarded person subject to institutionalization by court order, whichever is applicable. The proceedings in the probate court shall be conducted pursuant to Chapter 5122. or 5123. of the Revised Code except as modified by this division.

Upon the request of the inmate patient, the probate court shall grant the inmate patient an initial hearing under section 5122.141 of the Revised Code or a probable cause hearing under section 5123.75 of the Revised Code before the expiration of the stated prison term. After holding a full hearing,

the probate court shall make a disposition authorized by section 5122.15 or 5123.76 of the Revised Code before the date of the expiration of the stated prison term. No inmate patient shall be held in the custody of the department of rehabilitation and correction past the date of the expiration of the inmate patient's stated prison term.

(J) The department of rehabilitation and correction shall set standards for treatment provided to inmate patients, ~~consistent where applicable with the standards set by the joint commission on accreditation of healthcare organizations.~~

(K) A certificate, application, record, or report that is made in compliance with this section and that directly or indirectly identifies an inmate or former inmate whose hospitalization has been sought under this section is confidential. No person shall disclose the contents of any certificate, application, record, or report of that nature or any other psychiatric or medical record or report regarding a mentally ill inmate unless one of the following applies:

(1) The person identified, or the person's legal guardian, if any, consents to disclosure, and the chief clinical officer or designee of mental health services of the department of rehabilitation and correction determines that disclosure is in the best interests of the person.

(2) Disclosure is required by a court order signed by a judge.

(3) An inmate patient seeks access to the inmate patient's own psychiatric and medical records, unless access is specifically restricted in the treatment plan for clear treatment reasons.

(4) Hospitals and other institutions and facilities within the department of rehabilitation and correction may exchange psychiatric records and other pertinent information with other hospitals, institutions, and facilities of the department, but the information that may be released about an inmate patient is limited to medication history, physical health status and history, summary of course of treatment in the hospital, summary of treatment needs, and a discharge summary, if any.

(5) An inmate patient's family member who is involved in planning, providing, and monitoring services to the inmate patient may receive medication information, a summary of the inmate patient's diagnosis and prognosis, and a list of the services and personnel available to assist the inmate patient and family if the attending physician determines that disclosure would be in the best interest of the inmate patient. No disclosure shall be made under this division unless the inmate patient is notified of the possible disclosure, receives the information to be disclosed, and does not object to the disclosure.

(6) The department of rehabilitation and correction may exchange psychiatric hospitalization records, other mental health treatment records, and other pertinent information with county sheriffs' offices, hospitals, institutions, and facilities of the department of mental health and with community mental health agencies and boards of alcohol, drug addiction, and mental health services with which the department of mental health has a current agreement for patient care or services to ensure continuity of care. Disclosure under this division is limited to records regarding a mentally ill inmate's medication history, physical health status and history, summary of course of treatment, summary of treatment needs, and a discharge summary, if any. No office, department, agency, or board shall disclose the records and other information unless one of the following applies:

(a) The mentally ill inmate is notified of the possible disclosure and consents to the disclosure.

(b) The mentally ill inmate is notified of the possible disclosure, an attempt to gain the consent of the inmate is made, and the office, department, agency, or board documents the attempt to gain consent, the inmate's objections, if any, and the reasons for disclosure in spite of the inmate's objections.

(7) Information may be disclosed to staff members designated by the director of rehabilitation and correction for the purpose of evaluating the quality, effectiveness, and efficiency of services and determining if the services meet minimum standards.

The name of an inmate patient shall not be retained with the information obtained during the evaluations.

(L) The director of rehabilitation and correction may adopt rules setting forth guidelines for the procedures required under divisions (B), (C)(1), and (C)(2) of this section.

Sec. 5120.22. (A) The division of business administration shall examine the conditions of all buildings, grounds, and other property connected with the institutions under the control of the department of rehabilitation and correction, the methods of bookkeeping and storekeeping, and all matters relating to the management of such property. The division shall study and become familiar with the advantages and disadvantages of each as to location, freight rates, and efficiency of farm and equipment, for the purpose of aiding in the determination of the local and general requirements both for maintenance and improvements.

(B) The division, with respect to the various types of state-owned housing under jurisdiction of the department, shall adopt, in accordance with section 111.15 of the Revised Code, rules governing maintenance of the

housing and its usage by department personnel. The rules shall include a procedure for determining charges for rent and utilities, which the division shall assess against and collect from department personnel using the housing. All money collected for rent and utilities pursuant to the rules shall be deposited into the property receipts fund, which is hereby created in the state treasury. Money in the fund shall be used for any expenses necessary to provide housing of department employees, including but not limited to expenses for the acquisition, construction, operation, maintenance, repair, reconstruction, or demolition of land and buildings.

(C) The division may enter into a lease or agreement with a state agency, political subdivision of the state, or private entity to use facilities or other property under the jurisdiction of the department that is not being utilized by the department. All money collected for leasing and services performed in accordance with the lease or agreement shall be deposited into the property receipts fund created under division (B) of this section. Money in the fund shall be used for any expenses resulting from the lease or agreement, including, but not limited to, expenses for services performed, construction, maintenance, repair, reconstruction, or demolition of the facilities or other property.

Sec. 5120.28. (A) The department of rehabilitation and correction, subject to the approval of the office of budget and management, shall fix the prices at which all labor and services performed, all agricultural products produced, and all articles manufactured in correctional and penal institutions shall be furnished to the state, the political subdivisions of the state, and the public institutions of the state and the political subdivisions, and to private persons. The prices shall be uniform to all and not higher than the usual market price for like labor, products, services, and articles.

(B) Any money received by the department of rehabilitation and correction for labor and services performed ~~and agricultural products produced~~ shall be deposited into the institutional services ~~and agricultural~~ fund created pursuant to division (A) of section 5120.29 of the Revised Code and shall be used and accounted for as provided in that section and division (B) of section 5145.03 of the Revised Code.

(C) Any money received by the department of rehabilitation and correction for articles manufactured and agricultural products produced in penal and correctional institutions shall be deposited into the Ohio penal industries manufacturing fund created pursuant to division (B) of section 5120.29 of the Revised Code and shall be used and accounted for as provided in that section and division (B) of section 5145.03 of the Revised Code.

Sec. 5120.29. (A) There is hereby created, in the state treasury, the institutional services and agricultural fund, which shall be used for the:

(1) Purchase of material, supplies, and equipment and the erection and extension of buildings used in service industries and agriculture services provided between institutions of the department of rehabilitation and correction;

(2) ~~Purchase of lands and buildings necessary to carry on or extend the service industries and agriculture, upon the approval of the governor;~~

(3) Payment of compensation to employees necessary to carry on the service industries and agriculture institutional services;

~~(4)~~(3) Payment of prisoners confined in state correctional institutions a portion of their earnings in accordance with rules adopted pursuant to section 5145.03 of the Revised Code.

(B) There is hereby created, in the state treasury, the Ohio penal industries manufacturing fund, which shall be used for the:

(1) Purchase of material, supplies, and equipment and the erection and extension of buildings used in manufacturing industries and agriculture;

(2) Purchase of lands and buildings necessary to carry on or extend the manufacturing industries and agriculture upon the approval of the governor;

(3) Payment of compensation to employees necessary to carry on the manufacturing industries and agriculture;

(4) Payment of prisoners confined in state correctional institutions a portion of their earnings in accordance with rules adopted pursuant to section 5145.03 of the Revised Code.

(C) The department of rehabilitation and correction shall, in accordance with rules adopted pursuant to section 5145.03 of the Revised Code and subject to any pledge made as provided in division (D) of this section, place to the credit of each prisoner ~~his~~ the prisoner's earnings and pay the earnings so credited to the prisoner or ~~his~~ the prisoner's family.

(D) Receipts credited to the funds created in divisions (A) and (B) of this section constitute available receipts as defined in section 152.09 of the Revised Code, and may be pledged to the payment of bond service charges on obligations issued by the Ohio building authority pursuant to Chapter 152. of the Revised Code to construct, reconstruct, or otherwise improve capital facilities useful to the department. The authority may, with the consent of the department, provide in the bond proceedings for a pledge of all or such portion of receipts credited to the funds as the authority determines. The authority may provide in the bond proceedings for the transfer of receipts credited to the funds to the appropriate bond service fund or bond service reserve fund as required to pay the bond service charges

when due, and any such provision for the transfer of receipts shall be controlling notwithstanding any other provision of law pertaining to such receipts.

All receipts received by the treasurer of state on account of the department and required by the applicable bond proceedings to be deposited, transferred, or credited to the bond service fund or bond service reserve fund established by such bond proceedings shall be transferred by the treasurer of state to such fund, whether or not such fund is in the custody of the treasurer of state, without necessity for further appropriation, upon receipt of notice from the Ohio building authority as prescribed in the bond proceedings. The authority may covenant in the bond proceedings that so long as any obligations are outstanding to which receipts credited to the fund are pledged, the state and the department shall neither reduce the prices charged pursuant to section 5120.28 of the Revised Code nor the level of manpower collectively devoted to the production of goods and services for which prices are set pursuant to section 5120.28 of the Revised Code, which covenant shall be controlling notwithstanding any other provision of law; provided, that no covenant shall require the general assembly to appropriate money derived from the levying of excises or taxes to purchase such goods and services or to pay rent or bond service charges.

Sec. 5122.01. As used in this chapter and Chapter 5119. of the Revised Code:

(A) "Mental illness" means a substantial disorder of thought, mood, perception, orientation, or memory that grossly impairs judgment, behavior, capacity to recognize reality, or ability to meet the ordinary demands of life.

(B) "Mentally ill person subject to hospitalization by court order" means a mentally ill person who, because of the person's illness:

(1) Represents a substantial risk of physical harm to self as manifested by evidence of threats of, or attempts at, suicide or serious self-inflicted bodily harm;

(2) Represents a substantial risk of physical harm to others as manifested by evidence of recent homicidal or other violent behavior, evidence of recent threats that place another in reasonable fear of violent behavior and serious physical harm, or other evidence of present dangerousness;

(3) Represents a substantial and immediate risk of serious physical impairment or injury to self as manifested by evidence that the person is unable to provide for and is not providing for the person's basic physical needs because of the person's mental illness and that appropriate provision for those needs cannot be made immediately available in the community; or

(4) Would benefit from treatment in a hospital for the person's mental illness and is in need of such treatment as manifested by evidence of behavior that creates a grave and imminent risk to substantial rights of others or the person.

(C)(1) "Patient" means, subject to division (C)(2) of this section, a person who is admitted either voluntarily or involuntarily to a hospital or other place under section 2945.39, 2945.40, 2945.401, or 2945.402 of the Revised Code subsequent to a finding of not guilty by reason of insanity or incompetence to stand trial or under this chapter, who is under observation or receiving treatment in such place.

(2) "Patient" does not include a person admitted to a hospital or other place under section 2945.39, 2945.40, 2945.401, or 2945.402 of the Revised Code to the extent that the reference in this chapter to patient, or the context in which the reference occurs, is in conflict with any provision of sections 2945.37 to 2945.402 of the Revised Code.

(D) "Licensed physician" means a person licensed under the laws of this state to practice medicine or a medical officer of the government of the United States while in this state in the performance of the person's official duties.

(E) "Psychiatrist" means a licensed physician who has satisfactorily completed a residency training program in psychiatry, as approved by the residency review committee of the American medical association, the committee on post-graduate education of the American osteopathic association, or the American osteopathic board of neurology and psychiatry, or who on July 1, 1989, has been recognized as a psychiatrist by the Ohio state medical association or the Ohio osteopathic association on the basis of formal training and five or more years of medical practice limited to psychiatry.

(F) "Hospital" means a hospital or inpatient unit licensed by the department of mental health under section 5119.20 of the Revised Code, and any institution, hospital, or other place established, controlled, or supervised by the department under Chapter 5119. of the Revised Code.

(G) "Public hospital" means a facility that is tax-supported and under the jurisdiction of the department of mental health.

(H) "Community mental health agency" means ~~any an agency, program, or facility with which a board of alcohol, drug addiction, and mental health services contracts to provide the~~ that provides community mental health services listed in that are certified by the director of mental health under section 340.09 5119.611 of the Revised Code.

(I) "Licensed clinical psychologist" means a person who holds a current

valid psychologist license issued under section 4732.12 or 4732.15 of the Revised Code, and in addition, meets either of the following criteria:

(1) Meets the educational requirements set forth in division (B) of section 4732.10 of the Revised Code and has a minimum of two years' full-time professional experience, or the equivalent as determined by rule of the state board of psychology, at least one year of which shall be a predoctoral internship, in clinical psychological work in a public or private hospital or clinic or in private practice, diagnosing and treating problems of mental illness or mental retardation under the supervision of a psychologist who is licensed or who holds a diploma issued by the American board of professional psychology, or whose qualifications are substantially similar to those required for licensure by the state board of psychology when the supervision has occurred prior to enactment of laws governing the practice of psychology;

(2) Meets the educational requirements set forth in division (B) of section 4732.15 of the Revised Code and has a minimum of four years' full-time professional experience, or the equivalent as determined by rule of the state board of psychology, in clinical psychological work in a public or private hospital or clinic or in private practice, diagnosing and treating problems of mental illness or mental retardation under supervision, as set forth in division (I)(1) of this section.

(J) "Health officer" means any public health physician; public health nurse; or other person authorized by or designated by a city health district; a general health district; or a board of alcohol, drug addiction, and mental health services to perform the duties of a health officer under this chapter.

(K) "Chief clinical officer" means the medical director of a hospital, or a community mental health agency, or a board of alcohol, drug addiction, and mental health services, or, if there is no medical director, the licensed physician responsible for the treatment a hospital or community mental health agency provides. The chief clinical officer may delegate to the attending physician responsible for a patient's care the duties imposed on the chief clinical officer by this chapter. Within a community mental health agency, the chief clinical officer shall be designated by the governing body of the agency and shall be a licensed physician or licensed clinical psychologist who supervises diagnostic and treatment services. A licensed physician or licensed clinical psychologist designated by the chief clinical officer may perform the duties and accept the responsibilities of the chief clinical officer in the chief clinical officer's absence.

(L) "Working day" or "court day" means Monday, Tuesday, Wednesday, Thursday, and Friday, except when such day is a holiday.

(M) "Indigent" means unable without deprivation of satisfaction of basic needs to provide for the payment of an attorney and other necessary expenses of legal representation, including expert testimony.

(N) "Respondent" means the person whose detention, commitment, hospitalization, continued hospitalization or commitment, or discharge is being sought in any proceeding under this chapter.

(O) "Legal rights service" means the service established under section 5123.60 of the Revised Code.

(P) "Independent expert evaluation" means an evaluation conducted by a licensed clinical psychologist, psychiatrist, or licensed physician who has been selected by the respondent or the respondent's counsel and who consents to conducting the evaluation.

(Q) "Court" means the probate division of the court of common pleas.

(R) "Expunge" means:

(1) The removal and destruction of court files and records, originals and copies, and the deletion of all index references;

(2) The reporting to the person of the nature and extent of any information about the person transmitted to any other person by the court;

(3) Otherwise insuring that any examination of court files and records in question shall show no record whatever with respect to the person;

(4) That all rights and privileges are restored, and that the person, the court, and any other person may properly reply that no such record exists, as to any matter expunged.

(S) "Residence" means a person's physical presence in a county with intent to remain there, except that:

(1) If a person is receiving a mental health service at a facility that includes nighttime sleeping accommodations, residence means that county in which the person maintained the person's primary place of residence at the time the person entered the facility;

(2) If a person is committed pursuant to section 2945.38, 2945.39, 2945.40, 2945.401, or 2945.402 of the Revised Code, residence means the county where the criminal charges were filed.

When the residence of a person is disputed, the matter of residence shall be referred to the department of mental health for investigation and determination. Residence shall not be a basis for a board's denying services to any person present in the board's service district, and the board shall provide services for a person whose residence is in dispute while residence is being determined and for a person in an emergency situation.

(T) "Admission" to a hospital or other place means that a patient is accepted for and stays at least one night at the hospital or other place.

(U) "Prosecutor" means the prosecuting attorney, village solicitor, city director of law, or similar chief legal officer who prosecuted a criminal case in which a person was found not guilty by reason of insanity, who would have had the authority to prosecute a criminal case against a person if the person had not been found incompetent to stand trial, or who prosecuted a case in which a person was found guilty.

(V) "Treatment plan" means a written statement of reasonable objectives and goals for an individual established by the treatment team, with specific criteria to evaluate progress towards achieving those objectives. The active participation of the patient in establishing the objectives and goals shall be documented. The treatment plan shall be based on patient needs and include services to be provided to the patient while the patient is hospitalized and after the patient is discharged. The treatment plan shall address services to be provided upon discharge, including but not limited to housing, financial, and vocational services.

(W) "Community control sanction" has the same meaning as in section 2929.01 of the Revised Code.

(X) "Post-release control sanction" has the same meaning as in section 2967.01 of the Revised Code.

Sec. 5122.15. (A) Full hearings shall be conducted in a manner consistent with this chapter and with due process of law. The hearings shall be conducted by a judge of the probate court or a referee designated by a judge of the probate court and may be conducted in or out of the county in which the respondent is held. Any referee designated under this division shall be an attorney.

(1) With the consent of the respondent, the following shall be made available to counsel for the respondent:

(a) All relevant documents, information, and evidence in the custody or control of the state or prosecutor;

(b) All relevant documents, information, and evidence in the custody or control of the hospital in which the respondent currently is held, or in which the respondent has been held pursuant to this chapter;

(c) All relevant documents, information, and evidence in the custody or control of any hospital, facility, or person not included in division (A)(1)(a) or (b) of this section.

(2) The respondent has the right to attend the hearing and to be represented by counsel of the respondent's choice. The right to attend the hearing may be waived only by the respondent or counsel for the respondent after consultation with the respondent.

(3) If the respondent is not represented by counsel, is absent from the

hearing, and has not validly waived the right to counsel, the court shall appoint counsel immediately to represent the respondent at the hearing, reserving the right to tax costs of appointed counsel to the respondent, unless it is shown that the respondent is indigent. If the court appoints counsel, or if the court determines that the evidence relevant to the respondent's absence does not justify the absence, the court shall continue the case.

(4) The respondent shall be informed that the respondent may retain counsel and have independent expert evaluation. If the respondent is unable to obtain an attorney, the respondent shall be represented by court-appointed counsel. If the respondent is indigent, court-appointed counsel and independent expert evaluation shall be provided as an expense under section 5122.43 of the Revised Code.

(5) The hearing shall be closed to the public, unless counsel for the respondent, with the permission of the respondent, requests that the hearing be open to the public.

(6) If the hearing is closed to the public, the court, for good cause shown, may admit persons who have a legitimate interest in the proceedings. If the respondent, the respondent's counsel, the designee of the director or of the chief clinical officer objects to the admission of any person, the court shall hear the objection and any opposing argument and shall rule upon the admission of the person to the hearing.

(7) The affiant under section 5122.11 of the Revised Code shall be subject to subpoena by either party.

(8) The court shall examine the sufficiency of all documents filed and shall inform the respondent, if present, and the respondent's counsel of the nature and content of the documents and the reason for which the respondent is being detained, or for which the respondent's placement is being sought.

(9) The court shall receive only reliable, competent, and material evidence.

(10) Unless proceedings are initiated pursuant to section 5120.17 or 5139.08 of the Revised Code or proceedings are initiated regarding a resident of the service district of a board of alcohol, drug addiction, and mental health services that elects under division ~~(B)(3)(b)~~ (C)(2) of section 5119.62 of the Revised Code not to accept the amount allocated to it under ~~division (B)(1)~~ of that section, an attorney that the board designates shall present the case demonstrating that the respondent is a mentally ill person subject to hospitalization by court order. The attorney shall offer evidence of the diagnosis, prognosis, record of treatment, if any, and less restrictive

treatment plans, if any. In proceedings pursuant to section 5120.17 or 5139.08 of the Revised Code and in proceedings in which the respondent is a resident of a service district of a board that elects under division ~~(B)(3)(b)~~(C)(2) of section 5119.62 of the Revised Code not to accept the amount allocated to it under ~~division (B)(1)~~ of that section, the attorney general shall designate an attorney who shall present the case demonstrating that the respondent is a mentally ill person subject to hospitalization by court order. The attorney shall offer evidence of the diagnosis, prognosis, record of treatment, if any, and less restrictive treatment plans, if any.

(11) The respondent or the respondent's counsel has the right to subpoena witnesses and documents and to examine and cross-examine witnesses.

(12) The respondent has the right, but shall not be compelled, to testify, and shall be so advised by the court.

(13) On motion of the respondent or the respondent's counsel for good cause shown, or on the court's own motion, the court may order a continuance of the hearing.

(14) If the respondent is represented by counsel and the respondent's counsel requests a transcript and record, or if the respondent is not represented by counsel, the court shall make and maintain a full transcript and record of the proceeding. If the respondent is indigent and the transcript and record is made, a copy shall be provided to the respondent upon request and be treated as an expense under section 5122.43 of the Revised Code.

(15) To the extent not inconsistent with this chapter, the Rules of Civil Procedure are applicable.

(B) Unless, upon completion of the hearing the court finds by clear and convincing evidence that the respondent is a mentally ill person subject to hospitalization by court order, it shall order the respondent's discharge immediately.

(C) If, upon completion of the hearing, the court finds by clear and convincing evidence that the respondent is a mentally ill person subject to hospitalization by court order, the court shall order the respondent for a period not to exceed ninety days to any of the following:

(1) A hospital operated by the department of mental health if the respondent is committed pursuant to section 5139.08 of the Revised Code;

(2) A nonpublic hospital;

(3) The veterans' administration or other agency of the United States government;

(4) A board of alcohol, drug addiction, and mental health services or agency the board designates;

(5) Receive private psychiatric or psychological care and treatment;

(6) Any other suitable facility or person consistent with the diagnosis, prognosis, and treatment needs of the respondent.

(D) Any order made pursuant to division (C)(2), (3), (5), or (6) of this section shall be conditioned upon the receipt by the court of consent by the hospital, facility, agency, or person to accept the respondent.

(E) In determining the place to which, or the person with whom, the respondent is to be committed, the court shall consider the diagnosis, prognosis, preferences of the respondent and the projected treatment plan for the respondent and shall order the implementation of the least restrictive alternative available and consistent with treatment goals. If the court determines that the least restrictive alternative available that is consistent with treatment goals is inpatient hospitalization, the court's order shall so state.

(F) During such ninety-day period the hospital; facility; board of alcohol, drug addiction, and mental health services; agency the board designates; or person shall examine and treat the individual. If, at any time prior to the expiration of the ninety-day period, it is determined by the hospital, facility, board, agency, or person that the respondent's treatment needs could be equally well met in an available and appropriate less restrictive environment, both of the following apply:

(1) The respondent shall be released from the care of the hospital, agency, facility, or person immediately and shall be referred to the court together with a report of the findings and recommendations of the hospital, agency, facility, or person; and

(2) The hospital, agency, facility, or person shall notify the respondent's counsel or the attorney designated by a board of alcohol, drug addiction, and mental health services or, if the respondent was committed to a board or an agency designated by the board, it shall place the respondent in the least restrictive environment available consistent with treatment goals and notify the court and the respondent's counsel of the placement.

The court shall dismiss the case or order placement in the least restrictive environment.

(G)(1) Except as provided in divisions (G)(2) and (3) of this section, any person who has been committed under this section, or for whom proceedings for hospitalization have been commenced pursuant to section 5122.11 of the Revised Code, may apply at any time for voluntary admission to the hospital, facility, agency that the board designates, or person to which the person was committed. Upon admission as a voluntary patient the chief clinical officer of the hospital, agency, or other facility, or

the person immediately shall notify the court, the patient's counsel, and the attorney designated by the board, if the attorney has entered the proceedings, in writing of that fact, and, upon receipt of the notice, the court shall dismiss the case.

(2) A person who is found incompetent to stand trial or not guilty by reason of insanity and who is committed pursuant to section 2945.39, 2945.40, 2945.401, or 2945.402 of the Revised Code shall not voluntarily commit the person pursuant to this section until after the final termination of the commitment, as described in division (J) of section 2945.401 of the Revised Code.

(H) If, at the end of the first ninety-day period or any subsequent period of continued commitment, there has been no disposition of the case, either by discharge or voluntary admission, the hospital, facility, board, agency, or person shall discharge the patient immediately, unless at least ten days before the expiration of the period the attorney the board designates or the prosecutor files with the court an application for continued commitment. The application of the attorney or the prosecutor shall include a written report containing the diagnosis, prognosis, past treatment, a list of alternative treatment settings and plans, and identification of the treatment setting that is the least restrictive consistent with treatment needs. The attorney the board designates or the prosecutor shall file the written report at least three days prior to the full hearing. A copy of the application and written report shall be provided to the respondent's counsel immediately.

The court shall hold a full hearing on applications for continued commitment at the expiration of the first ninety-day period and at least every two years after the expiration of the first ninety-day period.

Hearings following any application for continued commitment are mandatory and may not be waived.

Upon request of a person who is involuntarily committed under this section, or the person's counsel, that is made more than one hundred eighty days after the person's last full hearing, mandatory or requested, the court shall hold a full hearing on the person's continued commitment. Upon the application of a person involuntarily committed under this section, supported by an affidavit of a psychiatrist or licensed clinical psychologist, alleging that the person no longer is a mentally ill person subject to hospitalization by court order, the court for good cause shown may hold a full hearing on the person's continued commitment prior to the expiration of one hundred eighty days after the person's last full hearing. Section 5122.12 of the Revised Code applies to all hearings on continued commitment.

If the court, after a hearing for continued commitment finds by clear and

convincing evidence that the respondent is a mentally ill person subject to hospitalization by court order, the court may order continued commitment at places specified in division (C) of this section.

(I) Unless the admission is pursuant to section 5120.17 or 5139.08 of the Revised Code, the chief clinical officer of the hospital or agency admitting a respondent pursuant to a judicial proceeding, within ten working days of the admission, shall make a report of the admission to the board of alcohol, drug addiction, and mental health services serving the respondent's county of residence.

(J) A referee appointed by the court may make all orders that a judge may make under this section and sections 5122.11 and 5122.141 of the Revised Code, except an order of contempt of court. The orders of a referee take effect immediately. Within fourteen days of the making of an order by a referee, a party may file written objections to the order with the court. The filed objections shall be considered a motion, shall be specific, and shall state their grounds with particularity. Within ten days of the filing of the objections, a judge of the court shall hold a hearing on the objections and may hear and consider any testimony or other evidence relating to the respondent's mental condition. At the conclusion of the hearing, the judge may ratify, rescind, or modify the referee's order.

(K) An order of the court under division (C), (H), or (J) of this section is a final order.

(L) Before a board, or an agency the board designates, may place an unconsenting respondent in an inpatient setting from a less restrictive placement, the board or agency shall do all of the following:

(1) Determine that the respondent is in immediate need of treatment in an inpatient setting because the respondent represents a substantial risk of physical harm to the respondent or others if allowed to remain in a less restrictive setting;

(2) On the day of placement in the inpatient setting or on the next court day, file with the court a motion for transfer to an inpatient setting or communicate to the court by telephone that the required motion has been mailed;

(3) Ensure that every reasonable and appropriate effort is made to take the respondent to the inpatient setting in the least conspicuous manner possible;

(4) Immediately notify the board's designated attorney and the respondent's attorney.

At the respondent's request, the court shall hold a hearing on the motion and make a determination pursuant to division (E) of this section within five

days of the placement.

(M) Before a board, or an agency the board designates, may move a respondent from one residential placement to another, the board or agency shall consult with the respondent about the placement. If the respondent objects to the placement, the proposed placement and the need for it shall be reviewed by a qualified mental health professional who otherwise is not involved in the treatment of the respondent.

Sec. 5122.21. (A) The chief clinical officer shall as frequently as practicable, and at least once every thirty days, examine or cause to be examined every patient, and, whenever the chief clinical officer determines that the conditions justifying involuntary hospitalization or commitment no longer obtain, shall, ~~except as provided in division (C) of this section,~~ discharge the patient not under indictment or conviction for crime and immediately make a report of the discharge to the department of mental health. The chief clinical officer may discharge a patient who is under an indictment, a sentence of imprisonment, a community control sanction, or a post-release control sanction or on parole ten days after written notice of intent to discharge the patient has been given by personal service or certified mail, return receipt requested, to the court having criminal jurisdiction over the patient. Except when the patient was found not guilty by reason of insanity and the defendant's commitment is pursuant to section 2945.40 of the Revised Code, the chief clinical officer has final authority to discharge a patient who is under an indictment, a sentence of imprisonment, a community control sanction, or a post-release control sanction or on parole.

(B) After a finding pursuant to section 5122.15 of the Revised Code that a person is a mentally ill person subject to hospitalization by court order, the chief clinical officer of the hospital or agency to which the person is ordered or to which the person is transferred under section 5122.20 of the Revised Code, may, ~~except as provided in division (C) of this section,~~ grant a discharge without the consent or authorization of any court.

Upon discharge, the chief clinical officer shall notify the court that caused the judicial hospitalization of the discharge from the hospital.

Sec. 5122.31. (A) All certificates, applications, records, and reports made for the purpose of this chapter and sections 2945.38, 2945.39, 2945.40, 2945.401, and 2945.402 of the Revised Code, other than court journal entries or court docket entries, and directly or indirectly identifying a patient or former patient or person whose hospitalization has been sought under this chapter, shall be kept confidential and shall not be disclosed by any person except:

(1) If the person identified, or the person's legal guardian, if any, or if

the person is a minor, the person's parent or legal guardian, consents, and if the disclosure is in the best interests of the person, as may be determined by the court for judicial records and by the chief clinical officer for medical records;

(2) When disclosure is provided for in this chapter or section 5123.60 of the Revised Code;

(3) That hospitals, boards of alcohol, drug addiction, and mental health services, and community mental health agencies may release necessary medical information to insurers and other third-party payers, including government entities responsible for processing and authorizing payment, to obtain payment for goods and services furnished to the patient;

(4) Pursuant to a court order signed by a judge;

(5) That a patient shall be granted access to the patient's own psychiatric and medical records, unless access specifically is restricted in a patient's treatment plan for clear treatment reasons;

(6) That hospitals and other institutions and facilities within the department of mental health may exchange psychiatric records and other pertinent information with other hospitals, institutions, and facilities of the department, and with community mental health agencies and boards of alcohol, drug addiction, and mental health services with which the department has a current agreement for patient care or services. Records and information that may be released pursuant to this division shall be limited to medication history, physical health status and history, financial status, summary of course of treatment in the hospital, summary of treatment needs, and a discharge summary, if any.

(7) That hospitals within the department, other institutions and facilities within the department, hospitals licensed by the department under section 5119.20 of the Revised Code, and community mental health agencies may exchange psychiatric records and other pertinent information with payers and other providers of treatment and health services if the purpose of the exchange is to facilitate continuity of care for a patient;

(8) That a patient's family member who is involved in the provision, planning, and monitoring of services to the patient may receive medication information, a summary of the patient's diagnosis and prognosis, and a list of the services and personnel available to assist the patient and the patient's family, if the patient's treating physician determines that the disclosure would be in the best interests of the patient. No such disclosure shall be made unless the patient is notified first and receives the information and does not object to the disclosure.

(9) That community mental health agencies may exchange psychiatric

records and certain other information with the board of alcohol, drug addiction, and mental health services and other agencies in order to provide services to a person involuntarily committed to a board. Release of records under this division shall be limited to medication history, physical health status and history, financial status, summary of course of treatment, summary of treatment needs, and discharge summary, if any.

(10) That information may be disclosed to the executor or the administrator of an estate of a deceased patient when the information is necessary to administer the estate;

(11) That records in the possession of the Ohio historical society may be released to the closest living relative of a deceased patient upon request of that relative;

(12) That information may be disclosed to staff members of the appropriate board or to staff members designated by the director of mental health for the purpose of evaluating the quality, effectiveness, and efficiency of services and determining if the services meet minimum standards. Information obtained during such evaluations shall not be retained with the name of any patient.

(13) That records pertaining to the patient's diagnosis, course of treatment, treatment needs, and prognosis shall be disclosed and released to the appropriate prosecuting attorney if the patient was committed pursuant to section 2945.38, 2945.39, 2945.40, 2945.401, or 2945.402 of the Revised Code, or to the attorney designated by the board for proceedings pursuant to involuntary commitment under this chapter.

(14) That the department of mental health may exchange psychiatric hospitalization records, other mental health treatment records, and other pertinent information with the department of rehabilitation and correction to ensure continuity of care for inmates who are receiving mental health services in an institution of the department of rehabilitation and correction. The department shall not disclose those records unless the inmate is notified, receives the information, and does not object to the disclosure. The release of records under this division is limited to records regarding an inmate's medication history, physical health status and history, summary of course of treatment, summary of treatment needs, and a discharge summary, if any.

(15) That a community mental health agency that ceases to operate may transfer to either a community mental health agency that assumes its caseload or to the board of alcohol, drug addiction, and mental health services of the service district in which the patient resided at the time services were most recently provided any treatment records that have not been transferred elsewhere at the patient's request.

(B) Before records are disclosed pursuant to divisions (A)(3), (6), (7), and (9) of this section, the custodian of the records shall attempt to obtain the patient's consent for the disclosure. No person shall reveal the contents of a medical record of a patient except as authorized by law.

(C) The managing officer of a hospital who releases necessary medical information under division (A)(3) of this section to allow an insurance carrier or other third party payor to comply with section 5121.43 of the Revised Code shall neither be subject to criminal nor civil liability.

Sec. 5122.341. (A) As used in this section:

(1) "Facility or agency" means, in the context of a person committed to the department of mental health under sections 2945.37 to 2945.402 of the Revised Code, any entity in which the department of mental health places such a person.

(2) "Person committed to the department" means a person committed to the department of mental health under sections 2945.37 to 2945.402 of the Revised Code.

(B) No member of a board of directors, or employee, of a facility or agency in which the department of mental health places a person committed to the department is liable for injury or damages caused by any action or inaction taken within the scope of the board member's official duties or employee's employment relating to the commitment of, and services provided to, the person committed to the department, unless the action or inaction constitutes willful or wanton misconduct. A board member's or employee's action or inaction does not constitute willful or wanton misconduct if the board member or employee acted in good faith and reasonably under the circumstances and with the knowledge reasonably attributable to the board member or employee.

The immunity from liability conferred by this section is in addition to and not in limitation of any immunity conferred by any other section of the Revised Code or by judicial precedent.

Sec. 5123.01. As used in this chapter:

(A) "Chief medical officer" means the licensed physician appointed by the managing officer of an institution for the mentally retarded with the approval of the director of developmental disabilities to provide medical treatment for residents of the institution.

(B) "Chief program director" means a person with special training and experience in the diagnosis and management of the mentally retarded, certified according to division (C) of this section in at least one of the designated fields, and appointed by the managing officer of an institution for the mentally retarded with the approval of the director to provide

habilitation and care for residents of the institution.

(C) "Comprehensive evaluation" means a study, including a sequence of observations and examinations, of a person leading to conclusions and recommendations formulated jointly, with dissenting opinions if any, by a group of persons with special training and experience in the diagnosis and management of persons with mental retardation or a developmental disability, which group shall include individuals who are professionally qualified in the fields of medicine, psychology, and social work, together with such other specialists as the individual case may require.

(D) "Education" means the process of formal training and instruction to facilitate the intellectual and emotional development of residents.

(E) "Habilitation" means the process by which the staff of the institution assists the resident in acquiring and maintaining those life skills that enable the resident to cope more effectively with the demands of the resident's own person and of the resident's environment and in raising the level of the resident's physical, mental, social, and vocational efficiency. Habilitation includes but is not limited to programs of formal, structured education and training.

(F) "Health officer" means any public health physician, public health nurse, or other person authorized or designated by a city or general health district.

(G) "Home and community-based services" means medicaid-funded home and community-based services specified in division (B)(1) of section 5111.87 of the Revised Code provided under the medicaid waiver components the department of developmental disabilities administers pursuant to section 5111.871 of the Revised Code. However, home and community-based services provided under the medicaid waiver component known as the transitions developmental disabilities waiver are to be considered to be home and community-based services for the purposes of this chapter only to the extent, if any, provided by the contract required by section 5111.871 of the Revised Code regarding the waiver.

(H) "Indigent person" means a person who is unable, without substantial financial hardship, to provide for the payment of an attorney and for other necessary expenses of legal representation, including expert testimony.

(I) "Institution" means a public or private facility, or a part of a public or private facility, that is licensed by the appropriate state department and is equipped to provide residential habilitation, care, and treatment for the mentally retarded.

(J) "Licensed physician" means a person who holds a valid certificate issued under Chapter 4731. of the Revised Code authorizing the person to

practice medicine and surgery or osteopathic medicine and surgery, or a medical officer of the government of the United States while in the performance of the officer's official duties.

(K) "Managing officer" means a person who is appointed by the director of developmental disabilities to be in executive control of an institution for the mentally retarded under the jurisdiction of the department.

(L) "Medicaid" has the same meaning as in section 5111.01 of the Revised Code.

(M) "Medicaid case management services" means case management services provided to an individual with mental retardation or other developmental disability that the state medicaid plan requires.

(N) "Mentally retarded person" means a person having significantly subaverage general intellectual functioning existing concurrently with deficiencies in adaptive behavior, manifested during the developmental period.

(O) "Mentally retarded person subject to institutionalization by court order" means a person eighteen years of age or older who is at least moderately mentally retarded and in relation to whom, because of the person's retardation, either of the following conditions exist:

(1) The person represents a very substantial risk of physical impairment or injury to self as manifested by evidence that the person is unable to provide for and is not providing for the person's most basic physical needs and that provision for those needs is not available in the community;

(2) The person needs and is susceptible to significant habilitation in an institution.

(P) "A person who is at least moderately mentally retarded" means a person who is found, following a comprehensive evaluation, to be impaired in adaptive behavior to a moderate degree and to be functioning at the moderate level of intellectual functioning in accordance with standard measurements as recorded in the most current revision of the manual of terminology and classification in mental retardation published by the American association on mental retardation.

(Q) As used in this division, "substantial functional limitation," "developmental delay," and "established risk" have the meanings established pursuant to section 5123.011 of the Revised Code.

"Developmental disability" means a severe, chronic disability that is characterized by all of the following:

(1) It is attributable to a mental or physical impairment or a combination of mental and physical impairments, other than a mental or physical impairment solely caused by mental illness as defined in division (A) of

section 5122.01 of the Revised Code.

(2) It is manifested before age twenty-two.

(3) It is likely to continue indefinitely.

(4) It results in one of the following:

(a) In the case of a person under three years of age, at least one developmental delay or an established risk;

(b) In the case of a person at least three years of age but under six years of age, at least two developmental delays or an established risk;

(c) In the case of a person six years of age or older, a substantial functional limitation in at least three of the following areas of major life activity, as appropriate for the person's age: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and, if the person is at least sixteen years of age, capacity for economic self-sufficiency.

(5) It causes the person to need a combination and sequence of special, interdisciplinary, or other type of care, treatment, or provision of services for an extended period of time that is individually planned and coordinated for the person.

(R) "Developmentally disabled person" means a person with a developmental disability.

(S) "State institution" means an institution that is tax-supported and under the jurisdiction of the department.

(T) "Residence" and "legal residence" have the same meaning as "legal settlement," which is acquired by residing in Ohio for a period of one year without receiving general assistance prior to July 17, 1995, under former Chapter 5113. of the Revised Code, financial assistance under Chapter 5115. of the Revised Code, or assistance from a private agency that maintains records of assistance given. A person having a legal settlement in the state shall be considered as having legal settlement in the assistance area in which the person resides. No adult person coming into this state and having a spouse or minor children residing in another state shall obtain a legal settlement in this state as long as the spouse or minor children are receiving public assistance, care, or support at the expense of the other state or its subdivisions. For the purpose of determining the legal settlement of a person who is living in a public or private institution or in a home subject to licensing by the department of job and family services, the department of mental health, or the department of developmental disabilities, the residence of the person shall be considered as though the person were residing in the county in which the person was living prior to the person's entrance into the institution or home. Settlement once acquired shall continue until a person

has been continuously absent from Ohio for a period of one year or has acquired a legal residence in another state. A woman who marries a man with legal settlement in any county immediately acquires the settlement of her husband. The legal settlement of a minor is that of the parents, surviving parent, sole parent, parent who is designated the residential parent and legal custodian by a court, other adult having permanent custody awarded by a court, or guardian of the person of the minor, provided that:

(1) A minor female who marries shall be considered to have the legal settlement of her husband and, in the case of death of her husband or divorce, she shall not thereby lose her legal settlement obtained by the marriage.

(2) A minor male who marries, establishes a home, and who has resided in this state for one year without receiving general assistance prior to July 17, 1995, under former Chapter 5113. of the Revised Code, financial assistance under Chapter 5115. of the Revised Code, or assistance from a private agency that maintains records of assistance given shall be considered to have obtained a legal settlement in this state.

(3) The legal settlement of a child under eighteen years of age who is in the care or custody of a public or private child caring agency shall not change if the legal settlement of the parent changes until after the child has been in the home of the parent for a period of one year.

No person, adult or minor, may establish a legal settlement in this state for the purpose of gaining admission to any state institution.

(U)(1) "Resident" means, subject to division (R)(2) of this section, a person who is admitted either voluntarily or involuntarily to an institution or other facility pursuant to section 2945.39, 2945.40, 2945.401, or 2945.402 of the Revised Code subsequent to a finding of not guilty by reason of insanity or incompetence to stand trial or under this chapter who is under observation or receiving habilitation and care in an institution.

(2) "Resident" does not include a person admitted to an institution or other facility under section 2945.39, 2945.40, 2945.401, or 2945.402 of the Revised Code to the extent that the reference in this chapter to resident, or the context in which the reference occurs, is in conflict with any provision of sections 2945.37 to 2945.402 of the Revised Code.

(V) "Respondent" means the person whose detention, commitment, or continued commitment is being sought in any proceeding under this chapter.

(W) "Working day" and "court day" mean Monday, Tuesday, Wednesday, Thursday, and Friday, except when such day is a legal holiday.

(X) "Prosecutor" means the prosecuting attorney, village solicitor, city director of law, or similar chief legal officer who prosecuted a criminal case

in which a person was found not guilty by reason of insanity, who would have had the authority to prosecute a criminal case against a person if the person had not been found incompetent to stand trial, or who prosecuted a case in which a person was found guilty.

(Y) "Court" means the probate division of the court of common pleas.

(Z) "Supported living" ~~has~~ and "residential services" have the same ~~meaning~~ meanings as in section 5126.01 of the Revised Code.

Sec. 5123.0412. (A) The department of developmental disabilities shall charge each county board of developmental disabilities an annual fee equal to one and ~~one-half~~ one-quarter per cent of the total value of all medicaid paid claims for home and community-based services provided during the year to an individual eligible for services from the county board. No county board shall pass the cost of a fee charged to the county board under this section on to another provider of these services.

(B) The fees collected under this section shall be deposited into the ODDD administration and oversight fund and the ODJFS administration and oversight fund, both of which are hereby created in the state treasury. The portion of the fees to be deposited into the ODDD administration and oversight fund and the portion of the fees to be deposited into the ODJFS administration and oversight fund shall be the portion specified in an interagency agreement entered into under division (C) of this section. The department of developmental disabilities shall use the money in the ODDD administration and oversight fund and the department of job and family services shall use the money in the ODJFS administration and oversight fund for both of the following purposes:

(1) Medicaid administrative costs, including administrative and oversight costs of medicaid case management services and home and community-based services. The administrative and oversight costs of medicaid case management services and home and community-based services shall include costs for staff, systems, and other resources the departments need and dedicate solely to the following duties associated with the services:

- (a) Eligibility determinations;
- (b) Training;
- (c) Fiscal management;
- (d) Claims processing;
- (e) Quality assurance oversight;
- (f) Other duties the departments identify.

(2) Providing technical support to county boards' local administrative authority under section 5126.055 of the Revised Code for the services.

(C) The departments of developmental disabilities and job and family services shall enter into an interagency agreement to do both of the following:

(1) Specify which portion of the fees collected under this section is to be deposited into the ODDD administration and oversight fund and which portion is to be deposited into the ODJFS administration and oversight fund;

(2) Provide for the departments to coordinate the staff whose costs are paid for with money in the ODDD administration and oversight fund and the ODJFS administration and oversight fund.

(D) The departments shall submit an annual report to the director of budget and management certifying how the departments spent the money in the ODDD administration and oversight fund and the ODJFS administration and oversight fund for the purposes specified in division (B) of this section.

Sec. 5123.0413. The department of developmental disabilities, in consultation with the department of job and family services, office of budget and management, and county boards of developmental disabilities, shall adopt rules in accordance with Chapter 119. of the Revised Code to establish both of the following in the event a county property tax levy for services for individuals with mental retardation or other developmental disability fails:

(A) A method of paying for home and community-based services;

(B) A method of reducing the number of individuals a county board would otherwise be required by section 5126.0512 of the Revised Code to ensure are enrolled in ~~a medicaid waiver component under which~~ home and community-based services ~~are provided~~.

Sec. 5123.0417. (A) The director of developmental disabilities shall establish one or more programs for individuals under ~~twenty-one~~ twenty-two years of age who have intensive behavioral needs, including such individuals with a primary diagnosis of autism spectrum disorder. The programs may include one or more medicaid waiver components that the director administers pursuant to section 5111.871 of the Revised Code. The programs may do one or more of the following:

(1) Establish models that incorporate elements common to effective intervention programs and evidence-based practices in services for children with intensive behavioral needs;

(2) Design a template for individualized education plans and individual service plans that provide consistent intervention programs and evidence-based practices for the care and treatment of children with intensive behavioral needs;

(3) Disseminate best practice guidelines for use by families of children

with intensive behavioral needs and professionals working with such families;

(4) Develop a transition planning model for effectively mainstreaming school-age children with intensive behavioral needs to their public school district;

(5) Contribute to the field of early and effective identification and intervention programs for children with intensive behavioral needs by providing financial support for scholarly research and publication of clinical findings.

(B) The director of developmental disabilities shall collaborate with the director of job and family services and consult with the executive director of the Ohio center for autism and low incidence and university-based programs that specialize in services for individuals with developmental disabilities when establishing programs under this section.

Sec. 5123.0418. (A) In addition to other authority granted the director of developmental disabilities for use of funds appropriated to the department of developmental disabilities, the director may use such funds for the following purposes:

(1) All of the following to assist persons with mental retardation or a developmental disability remain in the community and avoid institutionalization:

(a) Behavioral and short-term interventions;

(b) Residential services;

(c) Supported living.

(2) Respite care services;

(3) Staff training to help the following personnel serve persons with mental retardation or a developmental disability in the community:

(a) Employees of, and personnel under contract with, county boards of developmental disabilities;

(b) Employees of providers of supported living;

(c) Employees of providers of residential services;

(d) Other personnel the director identifies.

(B) The director may establish priorities for using funds for the purposes specified in division (A) of this section. The director shall use the funds in a manner consistent with the appropriations that authorize the director to use the funds and all other state and federal laws governing the use of the funds.

Sec. 5123.0419. (A) The director of developmental disabilities may establish an interagency workgroup on autism. The purpose of the workgroup shall be to improve the coordination of the state's efforts to address the service needs of individuals with autism spectrum disorders and

the families of those individuals. In fulfilling this purpose, the director may enter into interagency agreements with the government entities represented by the members of the workgroup. The agreements may specify any or all of the following:

(1) The roles and responsibilities of government entities that enter into the agreements;

(2) Procedures regarding the receipt, transfer, and expenditure of funds necessary to achieve the goals of the workgroup;

(3) The projects to be undertaken and activities to be performed by the government entities that enter into the agreements.

(B) Money received from government entities represented by the members of the workgroup shall be deposited into the state treasury to the credit of the interagency workgroup on autism fund, which is hereby created in the state treasury. Money credited to the fund shall be used by the department of developmental disabilities solely to support the activities of the workgroup.

Sec. 5123.051. (A) If the department of developmental disabilities determines pursuant to an audit conducted under section 5123.05 of the Revised Code ~~or a reconciliation conducted under section 5123.18 of the Revised Code~~ that money is owed the state by a provider of a service or program, the department may enter into a payment agreement with the provider. The agreement shall include the following:

(1) A schedule of installment payments whereby the money owed the state is to be paid in full within a period not to exceed one year;

(2) A provision that the provider may pay the entire balance owed at any time during the term of the agreement;

(3) A provision that if any installment is not paid in full within forty-five days after it is due, the entire balance owed is immediately due and payable;

(4) Any other terms and conditions that are agreed to by the department and the provider.

(B) The department may include a provision in a payment agreement that requires the provider to pay interest on the money owed the state. The department, in its discretion, shall determine whether to require the payment of interest and, if it so requires, the rate of interest. Neither the obligation to pay interest nor the rate of interest is subject to negotiation between the department and the provider.

(C) If the provider fails to pay any installment in full within forty-five days after its due date, the department shall certify the entire balance owed to the attorney general for collection under section 131.02 of the Revised

Code. The department may withhold funds from payments made to a provider under section 5123.18 of the Revised Code to satisfy a judgment secured by the attorney general.

~~(D) The purchase of service fund is hereby created. Money credited to the fund shall be used solely for purposes of section 5123.05 of the Revised Code.~~

Sec. 5123.171. As used in this section, "respite care" means appropriate, short-term, temporary care provided to a mentally retarded or developmentally disabled person to sustain the family structure or to meet planned or emergency needs of the family.

The department of developmental disabilities shall provide respite care services to persons with mental retardation or a developmental disability for the purpose of promoting self-sufficiency and normalization, preventing or reducing inappropriate institutional care, and furthering the unity of the family by enabling the family to meet the special needs of a mentally retarded or developmentally disabled person.

In order to be eligible for respite care services under this section, the mentally retarded or developmentally disabled person must be in need of habilitation services as defined in section 5126.01 of the Revised Code.

Respite care may be provided in a facility licensed under section 5123.19 of the Revised Code or certified as an intermediate care facility for the mentally retarded under Title XIX of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C. 301, as amended, or certified as a respite care home under section 5126.05 of the Revised Code.

The department shall develop a system for locating vacant beds that are available for respite care and for making information on vacant beds available to users of respite care services. Facilities certified as intermediate care facilities for the mentally retarded ~~and facilities holding contracts with the department for the provision of residential services under section 5123.18 of the Revised Code~~ shall report vacant beds to the department but shall not be required to accept respite care clients.

The director of developmental disabilities shall adopt, and may amend or rescind, rules in accordance with Chapter 119. of the Revised Code for both of the following:

(A) Certification by county boards of developmental disabilities of respite care homes;

(B) Provision of respite care services authorized by this section. Rules adopted under this division shall establish all of the following:

(1) A formula for distributing funds appropriated for respite care services;

(2) Standards for supervision, training and quality control in the provision of respite care services;

(3) Eligibility criteria for emergency respite care services.

Sec. 5123.18. (A) As used in this section:

~~(1) "Contractor" means a person or government agency that enters into a contract with the department of developmental disabilities under this section.~~

~~(2) "Government agency" means a state agency as defined in section 117.01 of the Revised Code or a similar agency of a political subdivision of the state.~~

~~(3) "Residential services" means the services necessary for an individual with mental retardation or a developmental disability to live in the community, including room and board, clothing, transportation, personal care, habilitation, supervision, and any other services the department considers necessary for the individual to live in the community.~~

~~(B)(1) The department of developmental disabilities may enter into a contract with a person or government agency to provide residential services to individuals with mental retardation or developmental disabilities in need of residential services. Contracts for residential services shall be of the following types:~~

~~(a) Companion home contracts—contracts under which the contractor is an individual, the individual is the primary caregiver, and the individual owns or leases and resides in the home in which the services are provided.~~

~~(b) Agency-operated companion home contracts—contracts under which the contractor subcontracts, for purposes of coordinating the provision of residential services, with one or more individuals who are primary caregivers and own or lease and reside in the homes in which the services are provided.~~

~~(c) Community home contracts—contracts for residential services under which the contractor owns or operates a home that is used solely to provide residential services.~~

~~(d) Combined agency-operated companion home and community home contracts.~~

~~(2) A companion home contract shall cover not more than one home. An agency-operated companion home contract or a community home contract may cover more than one home.~~

~~(C) Contracts shall be in writing and shall provide for payment to be made to the contractor at the times agreed to by the department and the contractor. Each contract shall specify the period during which it is valid, the amount to be paid for residential services, and the number of individuals~~

for whom payment will be made. Contracts may be renewed.

~~(D) services.~~ To be eligible to enter into a contract with the department under this section, ~~the a~~ person or government agency entity and the home in which the residential services are provided must meet all applicable standards for licensing or certification by the appropriate government agency entity. ~~In addition, if the residential facility is operated as a nonprofit entity, the members of the board of trustees or board of directors of the facility must not have a financial interest in or receive financial benefit from the facility, other than reimbursement for actual expenses incurred in attending board meetings.~~

~~(E)(1) The department shall determine the payment amount assigned to an initial contract. To the extent that the department determines sufficient funds are available, the payment amount assigned to an initial contract shall be equal to the average amount assigned to contracts for other homes that are of the same type and size and serve individuals with similar needs; except that if an initial contract is the result of a change of contractor or ownership, the payment amount assigned to the contract shall be the lesser of the amount assigned to the previous contract or the contract's total adjusted predicted funding need calculated under division (I) of this section.~~

~~(2) A renewed contract shall be assigned a payment amount in accordance with division (K) of this section.~~

~~(3) When a contractor relocates a home to another site at which residential services are provided to the same individuals, the payment amount assigned to the contract for the new home shall be the payment amount assigned to the contract at the previous location.~~

~~(F)(1) Annually, a contractor shall complete an assessment of each individual to whom the contractor provides residential services to predict the individual's need for routine direct services staff. The department shall establish by rule adopted in accordance with Chapter 119. of the Revised Code the assessment instrument to be used by contractors to make assessments. Assessments shall be submitted to the department not later than the thirty-first day of January of each year.~~

~~A contractor shall submit a revised assessment for an individual if there is a substantial, long-term change in the nature of the individual's needs. A contractor shall submit revised assessments for all individuals receiving residential services if there is a change in the composition of the home's residents.~~

~~(2) Annually, a contractor shall submit a cost report to the department specifying the costs incurred in providing residential services during the immediately preceding calendar year. Only costs actually incurred by a~~

~~contractor shall be reported on a cost report. Cost reports shall be prepared according to a uniform chart of accounts approved by the department and shall be submitted on forms prescribed by the department.~~

~~(3) The department shall not renew the contract held by a contractor who fails to submit the assessments or cost reports required under this division.~~

~~(4) The department shall adopt rules as necessary regarding the submission of assessments and cost reports under this division. The rules shall be adopted in accordance with Chapter 119. of the Revised Code.~~

~~(G) Prior to renewing a contract entered into under this section, the department shall compute the contract's total predicted funding need and total adjusted predicted funding need. The department shall also compute the contract's unmet funding need if the payment amount assigned to the contract is less than the total adjusted predicted funding need. The results of these calculations shall be used to determine the payment amount assigned to the renewed contract.~~

~~(H)(1) A contract's total predicted funding need is an amount equal to the sum of the predicted funding needs for the following cost categories:~~

- ~~(a) Routine direct services staff;~~
- ~~(b) Dietary, program supplies, and specialized staff;~~
- ~~(c) Facility and general services;~~
- ~~(d) Administration.~~

~~(2) Based on the assessments submitted by the contractor, the department shall compute the contract's predicted funding need for the routine direct services staff cost category by multiplying the number of direct services staff predicted to be necessary for the home by the sum of the following:~~

~~(a) Entry level wages paid during the immediately preceding cost reporting period to comparable staff employed by the county board of developmental disabilities of the county in which the home is located;~~

~~(b) Fringe benefits and payroll taxes as determined by the department using state civil service statistics from the same period as the cost reporting period.~~

~~(3) The department shall establish by rule adopted in accordance with Chapter 119. of the Revised Code the method to be used to compute the predicted funding need for the dietary, program supplies, and specialized staff cost category; the facility and general services cost category; and the administration cost category. The rules shall not establish a maximum amount that may be attributed to the dietary, program supplies, and specialized staff cost category. The rules shall establish a process for~~

determining the combined maximum amount that may be attributed to the facility and general services cost category and the administration cost category.

~~(1)(1) A contract's total adjusted predicted funding need is the contract's total predicted funding need with adjustments made for the following:~~

- ~~(a) Inflation, as provided under division (1)(2) of this section;~~
- ~~(b) The predicted cost of complying with new requirements established under federal or state law that were not taken into consideration when the total predicted funding need was computed;~~

~~(c) Changes in needs based on revised assessments submitted by the contractor.~~

~~(2) In adjusting the total predicted funding need for inflation, the department shall use either the consumer price index compound annual inflation rate calculated by the United States department of labor for all items or another index or measurement of inflation designated in rules that the department shall adopt in accordance with Chapter 119. of the Revised Code.~~

~~When a contract is being renewed for the first time, and the contract is to begin on the first day of July, the inflation adjustment applied to the contract's total predicted funding need shall be the estimated rate of inflation for the calendar year in which the contract is renewed. If the consumer price index is being used, the department shall base its estimate on the rate of inflation calculated for the three-month period ending the thirty-first day of March of that calendar year. If another index or measurement is being used, the department shall base its estimate on the most recent calculations of the rate of inflation available under the index or measurement. Each year thereafter, the inflation adjustment shall be estimated in the same manner, except that if the estimated rate of inflation for a year is different from the actual rate of inflation for that year, the difference shall be added to or subtracted from the rate of inflation estimated for the next succeeding year.~~

~~If a contract begins at any time other than July first, the inflation adjustment applied to the contract's total predicted funding need shall be determined by a method comparable to that used for contracts beginning July first. The department shall adopt rules in accordance with Chapter 119. of the Revised Code establishing the method to be used.~~

~~(J) A contract's unmet funding need is the difference between the payment amount assigned to the contract and the total adjusted predicted funding need, if the payment amount assigned is less than the total adjusted predicted funding need.~~

~~(K) The payment amount to be assigned to a contract being renewed~~

shall be determined by comparing the total adjusted predicted funding need with the payment amount assigned to the current contract.

~~(1) If the payment amount assigned to the current contract equals or exceeds the total adjusted predicted funding need, the payment amount assigned to the renewed contract shall be the same as that assigned to the current contract, unless a reduction is made pursuant to division (L) of this section.~~

~~(2) If the payment amount assigned to the current contract is less than the total adjusted predicted funding need, the payment amount assigned to the renewed contract shall be increased if the department determines that funds are available for such increases. The amount of a contract's increase shall be the same percentage of the available funds that the contract's unmet funding need is of the total of the unmet funding need for all contracts.~~

~~(L) When renewing a contract provided for in division (B) of this section other than a companion home contract, the department may reduce the payment amount assigned to a renewed contract if the sum of the contractor's allowable reported costs and the maximum efficiency incentive is less than ninety one and one half per cent of the amount received pursuant to this section during the immediately preceding contract year.~~

~~The department shall adopt rules in accordance with Chapter 119. of the Revised Code establishing a formula to be used in computing the maximum efficiency incentive, which shall be at least four per cent of the weighted average payment amount to be made to all contractors during the contract year. The maximum efficiency incentive shall be computed annually.~~

~~(M) The department may increase the payment amount assigned to a contract based on the contract's unmet funding need at times other than when the contract is renewed. The department may develop policies for determining priorities in making such increases.~~

~~(N)(1) In addition to the contracts provided for in division (B) of this section, the department may enter into the following contracts:~~

~~(a) A contract to pay the cost of beginning operation of a new home that is to be funded under a companion home contract, agency-operated companion home contract, community home contract, or combined agency-operated companion home and community home contract.~~

~~(b) A contract to pay the cost associated with increasing the number of individuals served by a home funded under a companion home contract, agency-operated companion home contract, community home contract, or combined agency-operated companion home and community home contract.~~

~~(2) The department shall adopt rules as necessary regarding contracts entered into under this division. The rules shall be adopted in accordance~~

with Chapter 119. of the Revised Code.

~~(O) Except for companion home contracts, the department shall conduct a reconciliation of the amount earned under a contract and the actual costs incurred by the contractor. An amount is considered to have been earned for delivering a service at the time the service is delivered. The department shall adopt rules in accordance with Chapter 119. of the Revised Code establishing procedures for conducting reconciliations.~~

~~A reconciliation shall be based on the annual cost report submitted by the contractor. If a reconciliation reveals that a contractor owes money to the state, the amount owed shall be collected in accordance with section 5123.051 of the Revised Code.~~

~~When conducting reconciliations, the department shall review all reported costs that may be affected by transactions required to be reported under division (B)(3) of section 5123.172 of the Revised Code. If the department determines that such transactions have increased the cost reported by a contractor, the department may disallow or adjust the cost allowable for payment. The department shall adopt rules in accordance with Chapter 119. of the Revised Code establishing standards for disallowances or adjustments.~~

~~(P) The department may audit the contracts it enters into under this section. Audits may be conducted by the department or an entity with which the department contracts to perform the audits. The department shall adopt rules in accordance with Chapter 119. of the Revised Code establishing procedures for conducting audits.~~

~~An audit may include the examination of a contractor's financial books and records, the costs incurred by a contractor in providing residential services, and any other relevant information specified by the department. An audit shall not be commenced more than four years after the expiration of the contract to be audited, except in cases where the department has reasonable cause to believe that a contractor has committed fraud.~~

~~If an audit reveals that a contractor owes money to the state, the amount owed, subject to an adjudication hearing under this division, shall be collected in accordance with section 5123.051 of the Revised Code. If an audit reveals that a reconciliation conducted under this section resulted in the contractor erroneously paying money to the state, the department shall refund the money to the contractor, or, in lieu of making a refund, the department may offset the erroneous payment against any money determined as a result of the audit to be owed by the contractor to the state. The department is not required to pay interest on any money refunded under this division.~~

~~In conducting audits or making determinations of amounts owed by a contractor and amounts to be refunded or offset, the department shall not be bound by the results of reconciliations conducted under this section, except with regard to cases involving claims that have been certified pursuant to section 5123.051 of the Revised Code to the attorney general for collection for which a full and final settlement has been reached or a final judgment has been made from which all rights of appeal have expired or been exhausted.~~

~~Not later than ninety days after an audit's completion, the department shall provide the contractor a copy of a report of the audit. The report shall state the findings of the audit, including the amount of any money the contractor is determined to owe the state.~~

~~(Q) The department shall adopt rules specifying the amount that will be allowed under a reconciliation or audit for the cost incurred by a contractor for compensation of owners, administrators, and other personnel. The rules shall be adopted in accordance with Chapter 119. of the Revised Code.~~

~~(R) Each contractor shall, for at least seven years, maintain fiscal records related to payments received pursuant to this section.~~

~~(S) The department may enter into shared funding agreements with other government agencies to fund contracts entered into under this section. The amount of each agency's share of the cost shall be determined through negotiations with the department. The department's share shall not exceed the amount it would have paid without entering into the shared funding agreement, nor shall it be reduced by any amounts contributed by the other parties to the agreement.~~

~~(T) Except as provided in section 5123.194 of the Revised Code, an individual who receives residential services pursuant to divisions (A) through (U) of this section and the individual's liable relatives or guardians shall pay support charges in accordance with Chapter 5121. of the Revised Code.~~

~~(U) The department may make reimbursements or payments for any of the following pursuant to rules adopted under this division:~~

~~(1) Unanticipated, nonrecurring costs associated with the health or habilitation of a person who resides in a home funded under a contract provided for in division (B) of this section;~~

~~(2) The cost of staff development training for contractors if the director of developmental disabilities has given prior approval for the training;~~

~~(3) Fixed costs that the department, pursuant to the rules, determines relate to the continued operation of a home funded under a contract provided for in division (B) of this section when a short term vacancy occurs and the~~

~~contractor has diligently attempted to fill the vacancy.~~

~~The department shall adopt rules in accordance with Chapter 119. of the Revised Code establishing standards for use in determining which costs it may make payment or reimbursements for under this division.~~

~~(V) In addition to the rules required or authorized to be adopted under this section, the department may adopt any other rules necessary to implement divisions (A) through (U) of this section. The rules shall be adopted in accordance with Chapter 119. of the Revised Code.~~

~~(W) The department may delegate to county boards of developmental disabilities its authority under this section to negotiate and enter into contracts or subcontracts for residential services. In the event that it elects to delegate its authority, the department shall adopt rules in accordance with Chapter 119. of the Revised Code for the boards' administration of the contracts or subcontracts. In administering the contracts or subcontracts, the boards shall be subject to all applicable provisions of Chapter 5126. of the Revised Code and shall not be subject to the provisions of divisions (A) to (V) of this section.~~

~~Subject to the department's rules, a board may require the following to contribute to the cost of the residential services an individual receives pursuant to this division: the individual or the individual's estate, the individual's spouse, the individual's guardian, and, if the individual is under age eighteen, either or both of the individual's parents. Chapter 5121. of the Revised Code shall not apply to individuals or entities that are subject to making contributions under this division. In calculating contributions to be made under this division, a board, subject to the department's rules, may allow an amount to be kept for meeting the personal needs of the individual who receives residential services.~~

~~Sec. 5123.19. (A) As used in this section and in sections 5123.191, 5123.193, 5123.194, 5123.196, 5123.197, 5123.198, and 5123.20 of the Revised Code:~~

~~(1)(a) "Residential facility" means a home or facility in which a mentally retarded or developmentally disabled person resides, except the home of a relative or legal guardian in which a mentally retarded or developmentally disabled person resides, a respite care home certified under section 5126.05 of the Revised Code, a county home or district home operated pursuant to Chapter 5155. of the Revised Code, or a dwelling in which the only mentally retarded or developmentally disabled residents are in an independent living arrangement or are being provided supported living.~~

~~(b) "Intermediate care facility for the mentally retarded" means a~~

residential facility that is considered an intermediate care facility for the mentally retarded for the purposes of Chapter 5111. of the Revised Code.

(2) "Political subdivision" means a municipal corporation, county, or township.

(3) "Independent living arrangement" means an arrangement in which a mentally retarded or developmentally disabled person resides in an individualized setting chosen by the person or the person's guardian, which is not dedicated principally to the provision of residential services for mentally retarded or developmentally disabled persons, and for which no financial support is received for rendering such service from any governmental agency by a provider of residential services.

(4) "Licensee" means the person or government agency that has applied for a license to operate a residential facility and to which the license was issued under this section.

(5) "Related party" has the same meaning as in section 5123.16 of the Revised Code except that "provider" as used in the definition of "related party" means a person or government entity that held or applied for a license to operate a residential facility, rather than a person or government entity certified to provide supported living.

(B) Every person or government agency desiring to operate a residential facility shall apply for licensure of the facility to the director of developmental disabilities unless the residential facility is subject to section 3721.02, ~~3722.04~~ 5119.73, 5103.03, or 5119.20 of the Revised Code. Notwithstanding Chapter 3721. of the Revised Code, a nursing home that is certified as an intermediate care facility for the mentally retarded under Title XIX of the "Social Security Act," 79 Stat. 286 (1965), 42 U.S.C.A. 1396, as amended, shall apply for licensure of the portion of the home that is certified as an intermediate care facility for the mentally retarded.

(C) Subject to section 5123.196 of the Revised Code, the director of developmental disabilities shall license the operation of residential facilities. An initial license shall be issued for a period that does not exceed one year, unless the director denies the license under division (D) of this section. A license shall be renewed for a period that does not exceed three years, unless the director refuses to renew the license under division (D) of this section. The director, when issuing or renewing a license, shall specify the period for which the license is being issued or renewed. A license remains valid for the length of the licensing period specified by the director, unless the license is terminated, revoked, or voluntarily surrendered.

(D) If it is determined that an applicant or licensee is not in compliance with a provision of this chapter that applies to residential facilities or the

rules adopted under such a provision, the director may deny issuance of a license, refuse to renew a license, terminate a license, revoke a license, issue an order for the suspension of admissions to a facility, issue an order for the placement of a monitor at a facility, issue an order for the immediate removal of residents, or take any other action the director considers necessary consistent with the director's authority under this chapter regarding residential facilities. In the director's selection and administration of the sanction to be imposed, all of the following apply:

(1) The director may deny, refuse to renew, or revoke a license, if the director determines that the applicant or licensee has demonstrated a pattern of serious noncompliance or that a violation creates a substantial risk to the health and safety of residents of a residential facility.

(2) The director may terminate a license if more than twelve consecutive months have elapsed since the residential facility was last occupied by a resident or a notice required by division (K) of this section is not given.

(3) The director may issue an order for the suspension of admissions to a facility for any violation that may result in sanctions under division (D)(1) of this section and for any other violation specified in rules adopted under division (H)(2) of this section. If the suspension of admissions is imposed for a violation that may result in sanctions under division (D)(1) of this section, the director may impose the suspension before providing an opportunity for an adjudication under Chapter 119. of the Revised Code. The director shall lift an order for the suspension of admissions when the director determines that the violation that formed the basis for the order has been corrected.

(4) The director may order the placement of a monitor at a residential facility for any violation specified in rules adopted under division (H)(2) of this section. The director shall lift the order when the director determines that the violation that formed the basis for the order has been corrected.

(5) If the director determines that two or more residential facilities owned or operated by the same person or government entity are not being operated in compliance with a provision of this chapter that applies to residential facilities or the rules adopted under such a provision, and the director's findings are based on the same or a substantially similar action, practice, circumstance, or incident that creates a substantial risk to the health and safety of the residents, the director shall conduct a survey as soon as practicable at each residential facility owned or operated by that person or government entity. The director may take any action authorized by this section with respect to any facility found to be operating in violation of a provision of this chapter that applies to residential facilities or the rules

adopted under such a provision.

(6) When the director initiates license revocation proceedings, no opportunity for submitting a plan of correction shall be given. The director shall notify the licensee by letter of the initiation of the proceedings. The letter shall list the deficiencies of the residential facility and inform the licensee that no plan of correction will be accepted. The director shall also send a copy of the letter to the county board of developmental disabilities. The county board shall send a copy of the letter to each of the following:

- (a) Each resident who receives services from the licensee;
- (b) The guardian of each resident who receives services from the licensee if the resident has a guardian;
- (c) The parent or guardian of each resident who receives services from the licensee if the resident is a minor.

(7) Pursuant to rules which shall be adopted in accordance with Chapter 119. of the Revised Code, the director may order the immediate removal of residents from a residential facility whenever conditions at the facility present an immediate danger of physical or psychological harm to the residents.

(8) In determining whether a residential facility is being operated in compliance with a provision of this chapter that applies to residential facilities or the rules adopted under such a provision, or whether conditions at a residential facility present an immediate danger of physical or psychological harm to the residents, the director may rely on information obtained by a county board of developmental disabilities or other governmental agencies.

(9) In proceedings initiated to deny, refuse to renew, or revoke licenses, the director may deny, refuse to renew, or revoke a license regardless of whether some or all of the deficiencies that prompted the proceedings have been corrected at the time of the hearing.

(E) The director shall establish a program under which public notification may be made when the director has initiated license revocation proceedings or has issued an order for the suspension of admissions, placement of a monitor, or removal of residents. The director shall adopt rules in accordance with Chapter 119. of the Revised Code to implement this division. The rules shall establish the procedures by which the public notification will be made and specify the circumstances for which the notification must be made. The rules shall require that public notification be made if the director has taken action against the facility in the eighteen-month period immediately preceding the director's latest action against the facility and the latest action is being taken for the same or a

substantially similar violation of a provision of this chapter that applies to residential facilities or the rules adopted under such a provision. The rules shall specify a method for removing or amending the public notification if the director's action is found to have been unjustified or the violation at the residential facility has been corrected.

(F)(1) Except as provided in division (F)(2) of this section, appeals from proceedings initiated to impose a sanction under division (D) of this section shall be conducted in accordance with Chapter 119. of the Revised Code.

(2) Appeals from proceedings initiated to order the suspension of admissions to a facility shall be conducted in accordance with Chapter 119. of the Revised Code, unless the order was issued before providing an opportunity for an adjudication, in which case all of the following apply:

(a) The licensee may request a hearing not later than ten days after receiving the notice specified in section 119.07 of the Revised Code.

(b) If a timely request for a hearing that includes the licensee's current address is made, the hearing shall commence not later than thirty days after the department receives the request.

(c) After commencing, the hearing shall continue uninterrupted, except for Saturdays, Sundays, and legal holidays, unless other interruptions are agreed to by the licensee and the director.

(d) If the hearing is conducted by a hearing examiner, the hearing examiner shall file a report and recommendations not later than ten days after the last of the following:

(i) The close of the hearing;

(ii) If a transcript of the proceedings is ordered, the hearing examiner receives the transcript;

(iii) If post-hearing briefs are timely filed, the hearing examiner receives the briefs.

(e) A copy of the written report and recommendation of the hearing examiner shall be sent, by certified mail, to the licensee and the licensee's attorney, if applicable, not later than five days after the report is filed.

(f) Not later than five days after the hearing examiner files the report and recommendations, the licensee may file objections to the report and recommendations.

(g) Not later than fifteen days after the hearing examiner files the report and recommendations, the director shall issue an order approving, modifying, or disapproving the report and recommendations.

(h) Notwithstanding the pendency of the hearing, the director shall lift the order for the suspension of admissions when the director determines that the violation that formed the basis for the order has been corrected.

(G) Neither a person or government agency whose application for a license to operate a residential facility is denied nor a related party of the person or government agency may apply for a license to operate a residential facility before the date that is one year after the date of the denial. Neither a licensee whose residential facility license is revoked nor a related party of the licensee may apply for a residential facility license before the date that is five years after the date of the revocation.

(H) In accordance with Chapter 119. of the Revised Code, the director shall adopt and may amend and rescind rules for licensing and regulating the operation of residential facilities, including intermediate care facilities for the mentally retarded. The rules for intermediate care facilities for the mentally retarded may differ from those for other residential facilities. The rules shall establish and specify the following:

(1) Procedures and criteria for issuing and renewing licenses, including procedures and criteria for determining the length of the licensing period that the director must specify for each license when it is issued or renewed;

(2) Procedures and criteria for denying, refusing to renew, terminating, and revoking licenses and for ordering the suspension of admissions to a facility, placement of a monitor at a facility, and the immediate removal of residents from a facility;

(3) Fees for issuing and renewing licenses, which shall be deposited into the program fee fund created under section 5123.033 of the Revised Code;

(4) Procedures for surveying residential facilities;

(5) Requirements for the training of residential facility personnel;

(6) Classifications for the various types of residential facilities;

(7) Certification procedures for licensees and management contractors that the director determines are necessary to ensure that they have the skills and qualifications to properly operate or manage residential facilities;

(8) The maximum number of persons who may be served in a particular type of residential facility;

(9) Uniform procedures for admission of persons to and transfers and discharges of persons from residential facilities;

(10) Other standards for the operation of residential facilities and the services provided at residential facilities;

(11) Procedures for waiving any provision of any rule adopted under this section.

(I) Before issuing a license, the director of the department or the director's designee shall conduct a survey of the residential facility for which application is made. The director or the director's designee shall conduct a survey of each licensed residential facility at least once during the

period the license is valid and may conduct additional inspections as needed. A survey includes but is not limited to an on-site examination and evaluation of the residential facility, its personnel, and the services provided there.

In conducting surveys, the director or the director's designee shall be given access to the residential facility; all records, accounts, and any other documents related to the operation of the facility; the licensee; the residents of the facility; and all persons acting on behalf of, under the control of, or in connection with the licensee. The licensee and all persons on behalf of, under the control of, or in connection with the licensee shall cooperate with the director or the director's designee in conducting the survey.

Following each survey, unless the director initiates a license revocation proceeding, the director or the director's designee shall provide the licensee with a report listing any deficiencies, specifying a timetable within which the licensee shall submit a plan of correction describing how the deficiencies will be corrected, and, when appropriate, specifying a timetable within which the licensee must correct the deficiencies. After a plan of correction is submitted, the director or the director's designee shall approve or disapprove the plan. A copy of the report and any approved plan of correction shall be provided to any person who requests it.

The director shall initiate disciplinary action against any department employee who notifies or causes the notification to any unauthorized person of an unannounced survey of a residential facility by an authorized representative of the department.

(J) In addition to any other information which may be required of applicants for a license pursuant to this section, the director shall require each applicant to provide a copy of an approved plan for a proposed residential facility pursuant to section 5123.042 of the Revised Code. This division does not apply to renewal of a license or to an applicant for an initial or modified license who meets the requirements of section 5123.193 or 5123.197 of the Revised Code.

(K) A licensee shall notify the owner of the building in which the licensee's residential facility is located of any significant change in the identity of the licensee or management contractor before the effective date of the change if the licensee is not the owner of the building.

Pursuant to rules which shall be adopted in accordance with Chapter 119. of the Revised Code, the director may require notification to the department of any significant change in the ownership of a residential facility or in the identity of the licensee or management contractor. If the director determines that a significant change of ownership is proposed, the

director shall consider the proposed change to be an application for development by a new operator pursuant to section 5123.042 of the Revised Code and shall advise the applicant within sixty days of the notification that the current license shall continue in effect or a new license will be required pursuant to this section. If the director requires a new license, the director shall permit the facility to continue to operate under the current license until the new license is issued, unless the current license is revoked, refused to be renewed, or terminated in accordance with Chapter 119. of the Revised Code.

(L) A county board of developmental disabilities, the legal rights service, and any interested person may file complaints alleging violations of statute or department rule relating to residential facilities with the department. All complaints shall be in writing and shall state the facts constituting the basis of the allegation. The department shall not reveal the source of any complaint unless the complainant agrees in writing to waive the right to confidentiality or until so ordered by a court of competent jurisdiction.

The department shall adopt rules in accordance with Chapter 119. of the Revised Code establishing procedures for the receipt, referral, investigation, and disposition of complaints filed with the department under this division.

(M) The department shall establish procedures for the notification of interested parties of the transfer or interim care of residents from residential facilities that are closing or are losing their license.

(N) Before issuing a license under this section to a residential facility that will accommodate at any time more than one mentally retarded or developmentally disabled individual, the director shall, by first class mail, notify the following:

(1) If the facility will be located in a municipal corporation, the clerk of the legislative authority of the municipal corporation;

(2) If the facility will be located in unincorporated territory, the clerk of the appropriate board of county commissioners and the fiscal officer of the appropriate board of township trustees.

The director shall not issue the license for ten days after mailing the notice, excluding Saturdays, Sundays, and legal holidays, in order to give the notified local officials time in which to comment on the proposed issuance.

Any legislative authority of a municipal corporation, board of county commissioners, or board of township trustees that receives notice under this division of the proposed issuance of a license for a residential facility may comment on it in writing to the director within ten days after the director

mailed the notice, excluding Saturdays, Sundays, and legal holidays. If the director receives written comments from any notified officials within the specified time, the director shall make written findings concerning the comments and the director's decision on the issuance of the license. If the director does not receive written comments from any notified local officials within the specified time, the director shall continue the process for issuance of the license.

(O) Any person may operate a licensed residential facility that provides room and board, personal care, habilitation services, and supervision in a family setting for at least six but not more than eight persons with mental retardation or a developmental disability as a permitted use in any residential district or zone, including any single-family residential district or zone, of any political subdivision. These residential facilities may be required to comply with area, height, yard, and architectural compatibility requirements that are uniformly imposed upon all single-family residences within the district or zone.

(P) Any person may operate a licensed residential facility that provides room and board, personal care, habilitation services, and supervision in a family setting for at least nine but not more than sixteen persons with mental retardation or a developmental disability as a permitted use in any multiple-family residential district or zone of any political subdivision, except that a political subdivision that has enacted a zoning ordinance or resolution establishing planned unit development districts may exclude these residential facilities from those districts, and a political subdivision that has enacted a zoning ordinance or resolution may regulate these residential facilities in multiple-family residential districts or zones as a conditionally permitted use or special exception, in either case, under reasonable and specific standards and conditions set out in the zoning ordinance or resolution to:

(1) Require the architectural design and site layout of the residential facility and the location, nature, and height of any walls, screens, and fences to be compatible with adjoining land uses and the residential character of the neighborhood;

(2) Require compliance with yard, parking, and sign regulation;

(3) Limit excessive concentration of these residential facilities.

(Q) This section does not prohibit a political subdivision from applying to residential facilities nondiscriminatory regulations requiring compliance with health, fire, and safety regulations and building standards and regulations.

(R) Divisions (O) and (P) of this section are not applicable to municipal

corporations that had in effect on June 15, 1977, an ordinance specifically permitting in residential zones licensed residential facilities by means of permitted uses, conditional uses, or special exception, so long as such ordinance remains in effect without any substantive modification.

(S)(1) The director may issue an interim license to operate a residential facility to an applicant for a license under this section if either of the following is the case:

(a) The director determines that an emergency exists requiring immediate placement of persons in a residential facility, that insufficient licensed beds are available, and that the residential facility is likely to receive a permanent license under this section within thirty days after issuance of the interim license.

(b) The director determines that the issuance of an interim license is necessary to meet a temporary need for a residential facility.

(2) To be eligible to receive an interim license, an applicant must meet the same criteria that must be met to receive a permanent license under this section, except for any differing procedures and time frames that may apply to issuance of a permanent license.

(3) An interim license shall be valid for thirty days and may be renewed by the director for a period not to exceed one hundred fifty days.

(4) The director shall adopt rules in accordance with Chapter 119. of the Revised Code as the director considers necessary to administer the issuance of interim licenses.

(T) Notwithstanding rules adopted pursuant to this section establishing the maximum number of persons who may be served in a particular type of residential facility, a residential facility shall be permitted to serve the same number of persons being served by the facility on the effective date of the rules or the number of persons for which the facility is authorized pursuant to a current application for a certificate of need with a letter of support from the department of developmental disabilities and which is in the review process prior to April 4, 1986.

(U) The director or the director's designee may enter at any time, for purposes of investigation, any home, facility, or other structure that has been reported to the director or that the director has reasonable cause to believe is being operated as a residential facility without a license issued under this section.

The director may petition the court of common pleas of the county in which an unlicensed residential facility is located for an order enjoining the person or governmental agency operating the facility from continuing to operate without a license. The court may grant the injunction on a showing

that the person or governmental agency named in the petition is operating a residential facility without a license. The court may grant the injunction, regardless of whether the residential facility meets the requirements for receiving a license under this section.

Sec. 5123.191. (A) The court of common pleas or a judge thereof in the judge's county, or the probate court, may appoint a receiver to take possession of and operate a residential facility licensed by the department of developmental disabilities, in causes pending in such courts respectively, when conditions existing at the facility present a substantial risk of physical or mental harm to residents and no other remedies at law are adequate to protect the health, safety, and welfare of the residents. Conditions at the facility that may present such risk of harm include, but are not limited to, instances when any of the following occur:

(1) The residential facility is in violation of state or federal law or regulations.

(2) The facility has had its license revoked or procedures for revocation have been initiated, or the facility is closing or intends to cease operations.

(3) Arrangements for relocating residents need to be made.

(4) Insolvency of the operator, licensee, or landowner threatens the operation of the facility.

(5) The facility or operator has demonstrated a pattern and practice of repeated violations of state or federal laws or regulations.

(B) A court in which a petition is filed pursuant to this section shall notify the person holding the license for the facility and the department of developmental disabilities of the filing. The court shall order the department to notify the legal rights service, facility owner, facility operator, county board of developmental disabilities, facility residents, and residents' parents and guardians of the filing of the petition.

The court shall provide a hearing on the petition within five court days of the time it was filed, except that the court may appoint a receiver prior to that time if it determines that the circumstances necessitate such action. Following a hearing on the petition, and upon a determination that the appointment of a receiver is warranted, the court shall appoint a receiver and notify the department of developmental disabilities and appropriate persons of this action.

(C) A residential facility for which a receiver has been named is deemed to be in compliance with section 5123.19 and Chapter 3721. of the Revised Code for the duration of the receivership.

(D) When the operating revenue of a residential facility in receivership is insufficient to meet its operating expenses, including the cost of bringing

the facility into compliance with state or federal laws or regulations, the court may order the state to provide necessary funding, except as provided in division (K) of this section. The state shall provide such funding, subject to the approval of the controlling board. The court may also order the appropriate authorities to expedite all inspections necessary for the issuance of licenses or the certification of a facility, and order a facility to be closed if it determines that reasonable efforts cannot bring the facility into substantial compliance with the law.

(E) In establishing a receivership, the court shall set forth the powers and duties of the receiver. The court may generally authorize the receiver to do all that is prudent and necessary to safely and efficiently operate the residential facility within the requirements of state and federal law, but shall require the receiver to obtain court approval prior to making any single expenditure of more than five thousand dollars to correct deficiencies in the structure or furnishings of a facility. The court shall closely review the conduct of the receiver it has appointed and shall require regular and detailed reports. The receivership shall be reviewed at least every sixty days.

(F) A receivership established pursuant to this section shall be terminated, following notification of the appropriate parties and a hearing, if the court determines either of the following:

(1) The residential facility has been closed and the former residents have been relocated to an appropriate facility.

(2) Circumstances no longer exist at the facility that present a substantial risk of physical or mental harm to residents, and there is no deficiency in the facility that is likely to create a future risk of harm.

Notwithstanding division (F)(2) of this section, the court shall not terminate a receivership for a residential facility that has previously operated under another receivership unless the responsibility for the operation of the facility is transferred to an operator approved by the court and the department of developmental disabilities.

(G) The department of developmental disabilities may, upon its own initiative or at the request of an owner, operator, or resident of a residential facility, or at the request of a resident's guardian or relative, a county board of developmental disabilities, or the legal rights service, petition the court to appoint a receiver to take possession of and operate a residential facility. When the department has been requested to file a petition by any of the parties listed above, it shall, within forty-eight hours of such request, either file such a petition or notify the requesting party of its decision not to file. If the department refuses to file, the requesting party may file a petition with the court requesting the appointment of a receiver to take possession of and

operate a residential facility.

Petitions filed pursuant to this division shall include the following:

(1) A description of the specific conditions existing at the facility which present a substantial risk of physical or mental harm to residents;

(2) A statement of the absence of other adequate remedies at law;

(3) The number of individuals residing at the facility;

(4) A statement that the facts have been brought to the attention of the owner or licensee and that conditions have not been remedied within a reasonable period of time or that the conditions, though remedied periodically, habitually exist at the facility as a pattern or practice;

(5) The name and address of the person holding the license for the facility and the address of the department of developmental disabilities.

The court may award to an operator appropriate costs and expenses, including reasonable attorney's fees, if it determines that a petitioner has initiated a proceeding in bad faith or merely for the purpose of harassing or embarrassing the operator.

(H) Except for the department of developmental disabilities or a county board of developmental disabilities, no party or person interested in an action shall be appointed a receiver pursuant to this section.

To assist the court in identifying persons qualified to be named as receivers, the director of developmental disabilities or the director's designee shall maintain a list of the names of such persons. The director shall, in accordance with Chapter 119. of the Revised Code, establish standards for evaluating persons desiring to be included on such a list.

(I) Before a receiver enters upon the duties of that person, the receiver must be sworn to perform the duties of receiver faithfully, and, with surety approved by the court, judge, or clerk, execute a bond to such person, and in such sum as the court or judge directs, to the effect that such receiver will faithfully discharge the duties of receiver in the action, and obey the orders of the court therein.

(J) Under the control of the appointing court, a receiver may bring and defend actions in the receiver's own name as receiver and take and keep possession of property.

The court shall authorize the receiver to do the following:

(1) Collect payment for all goods and services provided to the residents or others during the period of the receivership at the same rate as was charged by the licensee at the time the petition for receivership was filed, unless a different rate is set by the court;

(2) Honor all leases, mortgages, and secured transactions governing all buildings, goods, and fixtures of which the receiver has taken possession

and continues to use, subject to the following conditions:

(a) In the case of a rental agreement, only to the extent of payments that are for the use of the property during the period of the receivership;

(b) In the case of a purchase agreement only to the extent of payments that come due during the period of the receivership;

~~(c) If the court determines that the cost of the lease, mortgage, or secured transaction was increased by a transaction required to be reported under division (B)(3) of section 5123.172 of the Revised Code, only to the extent determined by the court to be the fair market value for use of the property during the period of the receivership.~~

(3) If transfer of residents is necessary, provide for the orderly transfer of residents by doing the following:

(a) Cooperating with all appropriate state and local agencies in carrying out the transfer of residents to alternative community placements;

(b) Providing for the transportation of residents' belongings and records;

(c) Helping to locate alternative placements and develop discharge plans;

(d) Preparing residents for the trauma of discharge;

(e) Permitting residents or guardians to participate in transfer or discharge planning except when an emergency exists and immediate transfer is necessary.

(4) Make periodic reports on the status of the residential program to the appropriate state agency, county board of developmental disabilities, parents, guardians, and residents;

(5) Compromise demands or claims;

(6) Generally do such acts respecting the residential facility as the court authorizes.

(K) Neither the receiver nor the department of developmental disabilities is liable for debts incurred by the owner or operator of a residential facility for which a receiver has been appointed.

(L) The department of developmental disabilities may contract for the operation of a residential facility in receivership. The department shall establish the conditions of a contract. ~~A condition may be the same as, similar to, or different from a condition established by section 5123.18 of the Revised Code and the rules adopted under that section for a contract entered into under that section.~~ Notwithstanding any other provision of law, contracts that are necessary to carry out the powers and duties of the receiver need not be competitively bid.

(M) The department of developmental disabilities, the department of job and family services, and the department of health shall provide technical

assistance to any receiver appointed pursuant to this section.

Sec. 5123.194. In the case of an individual who resides in a residential facility and is preparing to move into an independent living arrangement and the individual's liable relative, the department of developmental disabilities may waive the support collection requirements of sections 5121.04, and 5123.122, and 5123.18 of the Revised Code for the purpose of allowing income or resources to be used to acquire items necessary for independent living. The department shall adopt rules in accordance with section 111.15 of the Revised Code to implement this section, including rules that establish the method the department shall use to determine when an individual is preparing to move into an independent living arrangement.

Sec. 5123.352. There is hereby created in the state treasury the community developmental disabilities trust fund. The director of developmental disabilities, not later than sixty days after the end of each fiscal year, shall certify to the director of budget and management the amount of all the unexpended, unencumbered balances of general revenue fund appropriations made to the department of developmental disabilities for the fiscal year, excluding appropriations for rental payments to the Ohio public facilities commission, and the amount of any other funds held by the department in excess of amounts necessary to meet the department's operating costs and obligations pursuant to this chapter and Chapter 5126. of the Revised Code. On receipt of the certification, the director of budget and management shall transfer cash to the trust fund in an amount up to, but not exceeding, the total of the amounts certified by the director of developmental disabilities, except in cases in which the transfer will involve more than twenty million dollars. In such cases, the director of budget and management shall notify the controlling board and must receive the board's approval of the transfer prior to making the transfer.

All moneys in the trust fund shall be ~~distributed~~ used for purposes specified in accordance with section 5126.19 5123.0418 of the Revised Code.

Sec. 5123.42. (A) Beginning nine months after March 31, 2003, MR/DD personnel who are not specifically authorized by other provisions of the Revised Code to administer prescribed medications, perform health-related activities, or perform tube feedings may do so pursuant to this section as part of the specialized services the MR/DD personnel provide to individuals with mental retardation and developmental disabilities in the following categories:

(1) Recipients of early intervention, preschool, and school-age services offered or provided pursuant to this chapter or Chapter 5126. of the Revised

Code;

(2) Recipients of adult services offered or provided pursuant to this chapter or Chapter 5126. of the Revised Code;

(3) Recipients of family support services offered or provided pursuant to this chapter or Chapter 5126. of the Revised Code;

(4) Recipients of services from certified supported living providers, if the services are offered or provided pursuant to this chapter or Chapter 5126. of the Revised Code;

(5) Recipients of residential support services from certified home and community-based services providers, if the services are received in a community living arrangement that includes not more than four individuals with mental retardation and developmental disabilities and the services are offered or provided pursuant to this chapter or Chapter 5126. of the Revised Code;

(6) Recipients of services not included in divisions (A)(1) to (5) of this section that are offered or provided pursuant to this chapter or Chapter 5126. of the Revised Code;

(7) Residents of a residential facility with five or fewer resident beds;

(8) Residents of a residential facility with at least six but not more than sixteen resident beds;

(9) Residents of a residential facility with seventeen or more resident beds who are on a field trip from the facility, if all of the following are the case:

(a) The field trip is sponsored by the facility for purposes of complying with federal medicaid statutes and regulations, state medicaid statutes and rules, or other federal or state statutes, regulations, or rules that require the facility to provide habilitation, community integration, or normalization services to its residents.

(b) Not more than ~~five~~ ten field trip participants are residents who have health needs requiring the administration of prescribed medications, excluding participants who self-administer prescribed medications or receive assistance with self-administration of prescribed medications.

(c) The facility staffs the field trip with MR/DD personnel in such a manner that one person will administer prescribed medications, perform health-related activities, or perform tube feedings for not more than ~~two~~ four participants if one or ~~both~~ more of those participants have health needs requiring the person to administer prescribed medications through a gastrostomy or jejunostomy tube.

(d) According to the instructions of a health care professional acting within the scope of the professional's practice, the health needs of the

participants who require administration of prescribed medications by MR/DD personnel are such that the participants must receive the medications during the field trip to avoid jeopardizing their health and safety.

(B)(1) In the case of recipients of early intervention, preschool, and school-age services, as specified in division (A)(1) of this section, all of the following apply:

(a) With nursing delegation, MR/DD personnel may perform health-related activities.

(b) With nursing delegation, MR/DD personnel may administer oral and topical prescribed medications.

(c) With nursing delegation, MR/DD personnel may administer prescribed medications through gastrostomy and jejunostomy tubes, if the tubes being used are stable and labeled.

(d) With nursing delegation, MR/DD personnel may perform routine tube feedings, if the gastrostomy and jejunostomy tubes being used are stable and labeled.

(2) In the case of recipients of adult services, as specified in division (A)(2) of this section, all of the following apply:

(a) With nursing delegation, MR/DD personnel may perform health-related activities.

(b) With nursing delegation, MR/DD personnel may administer oral and topical prescribed medications.

(c) With nursing delegation, MR/DD personnel may administer prescribed medications through gastrostomy and jejunostomy tubes, if the tubes being used are stable and labeled.

(d) With nursing delegation, MR/DD personnel may perform routine tube feedings, if the gastrostomy and jejunostomy tubes being used are stable and labeled.

(3) In the case of recipients of family support services, as specified in division (A)(3) of this section, all of the following apply:

(a) Without nursing delegation, MR/DD personnel may perform health-related activities.

(b) Without nursing delegation, MR/DD personnel may administer oral and topical prescribed medications.

(c) With nursing delegation, MR/DD personnel may administer prescribed medications through gastrostomy and jejunostomy tubes, if the tubes being used are stable and labeled.

(d) With nursing delegation, MR/DD personnel may perform routine tube feedings, if the gastrostomy and jejunostomy tubes being used are

stable and labeled.

(e) With nursing delegation, MR/DD personnel may administer routine doses of insulin through subcutaneous injections and insulin pumps.

(4) In the case of recipients of services from certified supported living providers, as specified in division (A)(4) of this section, all of the following apply:

(a) Without nursing delegation, MR/DD personnel may perform health-related activities.

(b) Without nursing delegation, MR/DD personnel may administer oral and topical prescribed medications.

(c) With nursing delegation, MR/DD personnel may administer prescribed medications through gastrostomy and jejunostomy tubes, if the tubes being used are stable and labeled.

(d) With nursing delegation, MR/DD personnel may perform routine tube feedings, if the gastrostomy and jejunostomy tubes being used are stable and labeled.

(e) With nursing delegation, MR/DD personnel may administer routine doses of insulin through subcutaneous injections and insulin pumps.

(5) In the case of recipients of residential support services from certified home and community-based services providers, as specified in division (A)(5) of this section, all of the following apply:

(a) Without nursing delegation, MR/DD personnel may perform health-related activities.

(b) Without nursing delegation, MR/DD personnel may administer oral and topical prescribed medications.

(c) With nursing delegation, MR/DD personnel may administer prescribed medications through gastrostomy and jejunostomy tubes, if the tubes being used are stable and labeled.

(d) With nursing delegation, MR/DD personnel may perform routine tube feedings, if the gastrostomy and jejunostomy tubes being used are stable and labeled.

(e) With nursing delegation, MR/DD personnel may administer routine doses of insulin through subcutaneous injections and insulin pumps.

(6) In the case of recipients of services not included in divisions (A)(1) to (5) of this section, as specified in division (A)(6) of this section, all of the following apply:

(a) With nursing delegation, MR/DD personnel may perform health-related activities.

(b) With nursing delegation, MR/DD personnel may administer oral and topical prescribed medications.

(c) With nursing delegation, MR/DD personnel may administer prescribed medications through gastrostomy and jejunostomy tubes, if the tubes being used are stable and labeled.

(d) With nursing delegation, MR/DD personnel may perform routine tube feedings, if the gastrostomy and jejunostomy tubes being used are stable and labeled.

(7) In the case of residents of a residential facility with five or fewer beds, as specified in division (A)(7) of this section, all of the following apply:

(a) Without nursing delegation, MR/DD personnel may perform health-related activities.

(b) Without nursing delegation, MR/DD personnel may administer oral and topical prescribed medications.

(c) With nursing delegation, MR/DD personnel may administer prescribed medications through gastrostomy and jejunostomy tubes, if the tubes being used are stable and labeled.

(d) With nursing delegation, MR/DD personnel may perform routine tube feedings, if the gastrostomy and jejunostomy tubes being used are stable and labeled.

(e) With nursing delegation, MR/DD personnel may administer routine doses of insulin through subcutaneous injections and insulin pumps.

(8) In the case of residents of a residential facility with at least six but not more than sixteen resident beds, as specified in division (A)(8) of this section, all of the following apply:

(a) With nursing delegation, MR/DD personnel may perform health-related activities.

(b) With nursing delegation, MR/DD personnel may administer oral and topical prescribed medications.

(c) With nursing delegation, MR/DD personnel may administer prescribed medications through gastrostomy and jejunostomy tubes, if the tubes being used are stable and labeled.

(d) With nursing delegation, MR/DD personnel may perform routine tube feedings, if the gastrostomy and jejunostomy tubes being used are stable and labeled.

(9) In the case of residents of a residential facility with seventeen or more resident beds who are on a field trip from the facility, all of the following apply during the field trip, subject to the limitations specified in division (A)(9) of this section:

(a) With nursing delegation, MR/DD personnel may perform health-related activities.

(b) With nursing delegation, MR/DD personnel may administer oral and topical prescribed medications.

(c) With nursing delegation, MR/DD personnel may administer prescribed medications through gastrostomy and jejunostomy tubes, if the tubes being used are stable and labeled.

(d) With nursing delegation, MR/DD personnel may perform routine tube feedings, if the gastrostomy and jejunostomy tubes being used are stable and labeled.

(C) The authority of MR/DD personnel to administer prescribed medications, perform health-related activities, and perform tube feedings pursuant to this section is subject to all of the following:

(1) To administer prescribed medications, perform health-related activities, or perform tube feedings for individuals in the categories specified under divisions (A)(1) to (8) of this section, MR/DD personnel shall obtain the certificate or certificates required by the department of developmental disabilities and issued under section 5123.45 of the Revised Code. MR/DD personnel shall administer prescribed medication, perform health-related activities, and perform tube feedings only as authorized by the certificate or certificates held.

(2) To administer prescribed medications, perform health-related activities, or perform tube feedings for individuals in the category specified under division (A)(9) of this section, MR/DD personnel shall successfully complete the training course or courses developed under section 5123.43 of the Revised Code for the MR/DD personnel. MR/DD personnel shall administer prescribed medication, perform health-related activities, and perform tube feedings only as authorized by the training completed.

(3) If nursing delegation is required under division (B) of this section, MR/DD personnel shall not act without nursing delegation or in a manner that is inconsistent with the delegation.

(4) The employer of MR/DD personnel shall ensure that MR/DD personnel have been trained specifically with respect to each individual for whom they administer prescribed medications, perform health-related activities, or perform tube feedings. MR/DD personnel shall not administer prescribed medications, perform health-related activities, or perform tube feedings for any individual for whom they have not been specifically trained.

(5) If the employer of MR/DD personnel believes that MR/DD personnel have not or will not safely administer prescribed medications, perform health-related activities, or perform tube feedings, the employer shall prohibit the action from continuing or commencing. MR/DD personnel

shall not engage in the action or actions subject to an employer's prohibition.

(D) In accordance with section 5123.46 of the Revised Code, the department of developmental disabilities shall adopt rules governing its implementation of this section. The rules shall include the following:

(1) Requirements for documentation of the administration of prescribed medications, performance of health-related activities, and performance of tube feedings by MR/DD personnel pursuant to the authority granted under this section;

(2) Procedures for reporting errors that occur in the administration of prescribed medications, performance of health-related activities, and performance of tube feedings by MR/DD personnel pursuant to the authority granted under this section;

(3) Other standards and procedures the department considers necessary for implementation of this section.

Sec. 5123.45. (A) The department of developmental disabilities shall establish a program under which the department issues certificates to the following:

(1) MR/DD personnel, for purposes of meeting the requirement of division (C)(1) of section 5123.42 of the Revised Code to obtain a certificate or certificates to administer prescribed medications, perform health-related activities, and perform tube feedings;

(2) Registered nurses, for purposes of meeting the requirement of division (B)(1) of section 5123.441 of the Revised Code to obtain a certificate or certificates to provide the MR/DD personnel training courses developed under section 5123.43 of the Revised Code.

(B)(1) Except as provided in division (B)(2) of this section, to receive a certificate issued under this section, MR/DD personnel and registered nurses shall successfully complete the applicable training course or courses and meet all other applicable requirements established in rules adopted pursuant to this section. The department shall issue the appropriate certificate or certificates to MR/DD personnel and registered nurses who meet the requirements for the certificate or certificates.

(2) The department shall include provisions in the program for issuing certificates to the following:

~~(a) MR/DD personnel and registered nurses who, on March 31, 2003, are authorized to provide care to individuals with mental retardation and developmental disabilities pursuant to section 5123.193 or sections 5126.351 to 5126.354 of the Revised Code were required to be included in the certificate program pursuant to division (B)(2) of this section as that division existed immediately before the effective date of this amendment. A~~

~~person~~ MR/DD personnel who ~~receives~~ receive a certificate under division (B)(2)(a) of this section shall not administer insulin until ~~the person has~~ they have been trained by a registered nurse who has received a certificate under this section that allows the registered nurse to provide training courses to MR/DD personnel in the administration of insulin:

~~(b) Registered nurses who, on March 31, 2003, are authorized to train MR/DD personnel to provide care to individuals with mental retardation and developmental disabilities pursuant to section 5123.193 or sections 5126.351 to 5126.354 of the Revised Code.~~ A registered nurse who receives a certificate under division (B)(2)(b) of this section shall not provide training courses to MR/DD personnel in the administration of insulin unless the registered nurse completes a course developed under section 5123.44 of the Revised Code that enables the registered nurse to receive a certificate to provide training courses to MR/DD personnel in the administration of insulin.

(C) Certificates issued to MR/DD personnel are valid for one year and may be renewed. Certificates issued to registered nurses are valid for two years and may be renewed.

To be eligible for renewal, MR/DD personnel and registered nurses shall meet the applicable continued competency requirements and continuing education requirements specified in rules adopted under division (D) of this section. In the case of registered nurses, continuing nursing education completed in compliance with the license renewal requirements established under Chapter 4723. of the Revised Code may be counted toward meeting the continuing education requirements established in the rules adopted under division (D) of this section.

(D) In accordance with section 5123.46 of the Revised Code, the department shall adopt rules that establish all of the following:

(1) Requirements that MR/DD personnel and registered nurses must meet to be eligible to take a training course;

(2) Standards that must be met to receive a certificate, including requirements pertaining to an applicant's criminal background;

(3) Procedures to be followed in applying for a certificate and issuing a certificate;

(4) Standards and procedures for renewing a certificate, including requirements for continuing education and, in the case of MR/DD personnel who administer prescribed medications, standards that require successful demonstration of proficiency in administering prescribed medications;

(5) Standards and procedures for suspending or revoking a certificate;

(6) Standards and procedures for suspending a certificate without a

hearing pending the outcome of an investigation;

(7) Any other standards or procedures the department considers necessary to administer the certification program.

Sec. 5123.60. (A) A legal rights service is hereby created and established to protect and advocate the rights of mentally ill persons, mentally retarded persons, developmentally disabled persons, and other disabled persons who may be represented by the service pursuant to division (L) of this section; to receive and act upon complaints concerning institutional and hospital practices and conditions of institutions for mentally retarded or developmentally disabled persons and hospitals for the mentally ill; and to assure that all persons detained, hospitalized, discharged, or institutionalized, and all persons whose detention, hospitalization, discharge, or institutionalization is sought or has been sought under this chapter or Chapter 5122. of the Revised Code are fully informed of their rights and adequately represented by counsel in proceedings under this chapter or Chapter 5122. of the Revised Code and in any proceedings to secure the rights of those persons. Notwithstanding the definitions of "mentally retarded person" and "developmentally disabled person" in section 5123.01 of the Revised Code, the legal rights service shall determine who is a mentally retarded or developmentally disabled person for purposes of this section and sections 5123.601 to 5123.604 of the Revised Code.

(B)(1) In regard to those persons detained, hospitalized, or institutionalized under Chapter 5122. of the Revised Code, the legal rights service shall undertake formal representation only of those persons who are involuntarily detained, hospitalized, or institutionalized pursuant to sections 5122.10 to 5122.15 of the Revised Code, and those voluntarily detained, hospitalized, or institutionalized who are minors, who have been adjudicated incompetent, who have been detained, hospitalized, or institutionalized in a public hospital, or who have requested representation by the legal rights service.

(2) If a person referred to in division (A) of this section voluntarily requests in writing that the legal rights service terminate participation in the person's case, such involvement shall cease.

(3) Persons described in divisions (A) and (B)(1) of this section who are represented by the legal rights service are clients of the legal rights service.

(C) Any person voluntarily hospitalized or institutionalized in a public hospital under division (A) of section 5122.02 of the Revised Code, after being fully informed of the person's rights under division (A) of this section, may, by written request, waive assistance by the legal rights service if the waiver is knowingly and intelligently made, without duress or coercion.

The waiver may be rescinded at any time by the voluntary patient or resident, or by the voluntary patient's or resident's legal guardian.

(D)(1) The legal rights service commission is hereby created for the purposes of appointing an administrator of the legal rights service, advising the administrator, assisting the administrator in developing a budget, advising the administrator in establishing and annually reviewing a strategic plan, creating a procedure for filing and determination of grievances against the legal rights service, and establishing general policy guidelines, including guidelines for the commencement of litigation, for the legal rights service. The commission may adopt rules to carry these purposes into effect and may receive and act upon appeals of personnel decisions by the administrator.

(2) The commission shall consist of seven members. One member, who shall serve as chairperson, shall be appointed by the chief justice of the supreme court, three members shall be appointed by the speaker of the house of representatives, and three members shall be appointed by the president of the senate. At least two members shall have experience in the field of developmental disabilities, and at least two members shall have experience in the field of mental health. No member shall be a provider or related to a provider of services to mentally retarded, developmentally disabled, or mentally ill persons.

(3) Terms of office of the members of the commission shall be for three years, each term ending on the same day of the month of the year as did the term which it succeeds. Each member shall serve subsequent to the expiration of the member's term until a successor is appointed and qualifies, or until sixty days has elapsed, whichever occurs first. No member shall serve more than two consecutive terms.

All vacancies in the membership of the commission shall be filled in the manner prescribed for regular appointments to the commission and shall be limited to the unexpired terms.

(4) The commission shall meet at least four times each year. Members shall be reimbursed for their necessary and actual expenses incurred in the performance of their official duties.

(5) The administrator of the legal rights service shall serve at the pleasure of the commission.

The administrator shall be an attorney admitted to practice law in this state. The salary of the administrator shall be established in accordance with section 124.14 of the Revised Code.

(E) The legal rights service shall be completely independent of the department of mental health and the department of developmental disabilities and, notwithstanding section 109.02 of the Revised Code, shall

also be independent of the office of the attorney general. The administrator of the legal rights service, staff, and attorneys designated by the administrator to represent persons detained, hospitalized, or institutionalized under this chapter or Chapter 5122. of the Revised Code shall have ready access to the following:

(1) During normal business hours and at other reasonable times, all records, except records of community residential facilities and records of contract agencies of county boards of developmental disabilities and boards of alcohol, drug addiction, and mental health services, relating to expenditures of state and federal funds or to the commitment, care, treatment, and habilitation of all persons represented by the legal rights service, including those who may be represented pursuant to division (L) of this section, or persons detained, hospitalized, institutionalized, or receiving services under this chapter or Chapter 340., 5119., 5122., or 5126. of the Revised Code that are records maintained by the following entities providing services for those persons: departments; institutions; hospitals; boards of alcohol, drug addiction, and mental health services; county boards of developmental disabilities; and any other entity providing services to persons who may be represented by the service pursuant to division (L) of this section;

(2) Any records maintained in computerized data banks of the departments or boards or, in the case of persons who may be represented by the service pursuant to division (L) of this section, any other entity that provides services to those persons;

(3) During their normal working hours, personnel of the departments, facilities, boards, agencies, institutions, hospitals, and other service-providing entities;

(4) At any time, all persons detained, hospitalized, or institutionalized; persons receiving services under this chapter or Chapter 340., 5119., 5122., or 5126. of the Revised Code; and persons who may be represented by the service pursuant to division (L) of this section.

(5) Records of a community residential facility, a contract agency of a board of alcohol, drug addiction, and mental health services, or a contract agency of a county board of developmental disabilities with one of the following consents:

(a) The consent of the person, including when the person is a minor or has been adjudicated incompetent;

(b) The consent of the person's guardian of the person, if any, or the parent if the person is a minor;

(c) No consent, if the person is unable to consent for any reason, and the

guardian of the person, if any, or the parent of the minor, has refused to consent or has not responded to a request for consent and either of the following has occurred:

(i) A complaint regarding the person has been received by the legal rights service;

(ii) The legal rights service has determined that there is probable cause to believe that such person has been subjected to abuse or neglect.

(F) The administrator of the legal rights service shall do the following:

(1) Administer and organize the work of the legal rights service and establish administrative or geographic divisions as the administrator considers necessary, proper, and expedient;

(2) Adopt and promulgate rules that are not in conflict with rules adopted by the commission and prescribe duties for the efficient conduct of the business and general administration of the legal rights service;

(3) Appoint and discharge employees, and hire experts, consultants, advisors, or other professionally qualified persons as the administrator considers necessary to carry out the duties of the legal rights service;

(4) Apply for and accept grants of funds, and accept charitable gifts and bequests;

(5) Prepare and submit a budget to the general assembly for the operation of the legal rights service. At least thirty days prior to submitting the budget to the general assembly, the administrator shall provide a copy of the budget to the commission for review and comment. When submitting the budget to the general assembly, the administrator shall include a copy of any written comments returned by the commission to the administrator.

(6) Enter into contracts and make expenditures necessary for the efficient operation of the legal rights service;

(7) Annually prepare a report of activities and submit copies of the report to the governor, the chief justice of the supreme court, the president of the senate, the speaker of the house of representatives, the director of mental health, and the director of developmental disabilities, and make the report available to the public;

(8) Upon request of the commission or of the chairperson of the commission, report to the commission on specific litigation issues or activities.

(G)(1) The legal rights service may act directly or contract with other organizations or individuals for the provision of the services envisioned under this section.

(2) Whenever possible, the administrator shall attempt to facilitate the resolution of complaints through administrative channels. Subject to

division (G)(3) of this section, if attempts at administrative resolution prove unsatisfactory, the administrator may pursue any legal, administrative, and other appropriate remedies or approaches that may be necessary to accomplish the purposes of this section.

(3) The administrator may not pursue a class action lawsuit under division (G)(2) of this section when attempts at administrative resolution of a complaint prove unsatisfactory under that division unless both of the following have first occurred:

(a) At least four members of the commission, by their affirmative vote, have consented to the pursuit of the class action lawsuit;

(b) At least five members of the commission are present at the meeting of the commission at which that consent is obtained.

(4) If compensation for the work of attorneys employed by the legal rights service or another agency or political subdivision of the state is awarded to the service in a class action lawsuit pursued by the service, the compensation shall be limited to the actual hourly rate of pay for that legal work.

(5) All records received or maintained by the legal rights service in connection with any investigation, representation, or other activity under this section shall be confidential and shall not be disclosed except as authorized by the person represented by the legal rights service or, subject to any privilege, a guardian of the person or parent of the minor. Subject to division (G)(~~5~~)(7) of this section, relationships between personnel and the agents of the legal rights service and its clients shall be fiduciary relationships, and all communications shall be privileged as if between attorney and client.

(~~5~~)(6) Any person who has been represented by the legal rights service or who has applied for and been denied representation and who files a grievance with the service concerning the representation or application may appeal the decision of the service on the grievance to the commission. The person may appeal notwithstanding any objections of the person's legal guardian. The commission may examine any records relevant to the appeal and shall maintain the confidentiality of any records that are required to be kept confidential.

(H) The legal rights service, on the order of the administrator, with the approval by an affirmative vote of at least four members of the commission, may compel by subpoena the appearance and sworn testimony of any person the administrator reasonably believes may be able to provide information or to produce any documents, books, records, papers, or other information necessary to carry out its duties. On the refusal of any person to produce or

authenticate any requested documents, the legal rights service may apply to the Franklin county court of common pleas to compel the production or authentication of requested documents. If the court finds that failure to produce or authenticate any requested documents was improper, the court may hold the person in contempt as in the case of disobedience of the requirements of a subpoena issued from the court, or a refusal to testify in the court.

(I) The legal rights service may conduct public hearings.

(J) The legal rights service may request from any governmental agency any cooperation, assistance, services, or data that will enable it to perform its duties.

(K) In any malpractice action filed against the administrator of the legal rights service, a member of the staff of the legal rights service, or an attorney designated by the administrator to perform legal services under division (E) of this section, the state shall, when the administrator, member, or attorney has acted in good faith and in the scope of employment, indemnify the administrator, member, or attorney for any judgment awarded or amount negotiated in settlement, and for any court costs or legal fees incurred in defense of the claim.

This division does not limit or waive, and shall not be construed to limit or waive, any defense that is available to the legal rights service, its administrator or employees, persons under a personal services contract with it, or persons designated under division (E) of this section, including, but not limited to, any defense available under section 9.86 of the Revised Code.

(L) In addition to providing services to mentally ill, mentally retarded, or developmentally disabled persons, when a grant authorizing the provision of services to other individuals is accepted pursuant to division (F)(4) of this section, the legal rights service and its ombudsperson section may provide advocacy or ombudsperson services to those other individuals and exercise any other authority granted by this section or sections 5123.601 to 5123.604 of the Revised Code on behalf of those individuals. Determinations of whether an individual is eligible for services under this division shall be made by the legal rights service.

Sec. 5126.01. As used in this chapter:

(A) As used in this division, "adult" means an individual who is eighteen years of age or over and not enrolled in a program or service under Chapter 3323. of the Revised Code and an individual sixteen or seventeen years of age who is eligible for adult services under rules adopted by the director of developmental disabilities pursuant to Chapter 119. of the Revised Code.

(1) "Adult services" means services provided to an adult outside the home, except when they are provided within the home according to an individual's assessed needs and identified in an individual service plan, that support learning and assistance in the area of self-care, sensory and motor development, socialization, daily living skills, communication, community living, social skills, or vocational skills.

(2) "Adult services" includes all of the following:

(a) Adult day habilitation services;

(b) Adult day care;

(c) Prevocational services;

(d) Sheltered employment;

(e) Educational experiences and training obtained through entities and activities that are not expressly intended for individuals with mental retardation and developmental disabilities, including trade schools, vocational or technical schools, adult education, job exploration and sampling, unpaid work experience in the community, volunteer activities, and spectator sports;

(f) Community employment services and supported employment services.

(B)(1) "Adult day habilitation services" means adult services that do the following:

(a) Provide access to and participation in typical activities and functions of community life that are desired and chosen by the general population, including such activities and functions as opportunities to experience and participate in community exploration, companionship with friends and peers, leisure activities, hobbies, maintaining family contacts, community events, and activities where individuals without disabilities are involved;

(b) Provide supports or a combination of training and supports that afford an individual a wide variety of opportunities to facilitate and build relationships and social supports in the community.

(2) "Adult day habilitation services" includes all of the following:

(a) Personal care services needed to ensure an individual's ability to experience and participate in vocational services, educational services, community activities, and any other adult day habilitation services;

(b) Skilled services provided while receiving adult day habilitation services, including such skilled services as behavior management intervention, occupational therapy, speech and language therapy, physical therapy, and nursing services;

(c) Training and education in self-determination designed to help the individual do one or more of the following: develop self-advocacy skills,

exercise the individual's civil rights, acquire skills that enable the individual to exercise control and responsibility over the services received, and acquire skills that enable the individual to become more independent, integrated, or productive in the community;

(d) Recreational and leisure activities identified in the individual's service plan as therapeutic in nature or assistive in developing or maintaining social supports;

(e) Counseling and assistance provided to obtain housing, including such counseling as identifying options for either rental or purchase, identifying financial resources, assessing needs for environmental modifications, locating housing, and planning for ongoing management and maintenance of the housing selected;

(f) Transportation necessary to access adult day habilitation services;

(g) Habilitation management, as described in section 5126.14 of the Revised Code.

(3) "Adult day habilitation services" does not include activities that are components of the provision of residential services, family support services, or supported living services.

(C) "Appointing authority" means the following:

(1) In the case of a member of a county board of developmental disabilities appointed by, or to be appointed by, a board of county commissioners, the board of county commissioners;

(2) In the case of a member of a county board appointed by, or to be appointed by, a senior probate judge, the senior probate judge.

(D) "Community employment services" or "supported employment services" means job training and other services related to employment outside a sheltered workshop. "Community employment services" or "supported employment services" include all of the following:

(1) Job training resulting in the attainment of competitive work, supported work in a typical work environment, or self-employment;

(2) Supervised work experience through an employer paid to provide the supervised work experience;

(3) Ongoing work in a competitive work environment at a wage commensurate with workers without disabilities;

(4) Ongoing supervision by an employer paid to provide the supervision.

(E) As used in this division, "substantial functional limitation," "developmental delay," and "established risk" have the meanings established pursuant to section 5123.011 of the Revised Code.

"Developmental disability" means a severe, chronic disability that is

characterized by all of the following:

(1) It is attributable to a mental or physical impairment or a combination of mental and physical impairments, other than a mental or physical impairment solely caused by mental illness as defined in division (A) of section 5122.01 of the Revised Code;

(2) It is manifested before age twenty-two;

(3) It is likely to continue indefinitely;

(4) It results in one of the following:

(a) In the case of a person under age three, at least one developmental delay or an established risk;

(b) In the case of a person at least age three but under age six, at least two developmental delays or an established risk;

(c) In the case of a person age six or older, a substantial functional limitation in at least three of the following areas of major life activity, as appropriate for the person's age: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and, if the person is at least age sixteen, capacity for economic self-sufficiency.

(5) It causes the person to need a combination and sequence of special, interdisciplinary, or other type of care, treatment, or provision of services for an extended period of time that is individually planned and coordinated for the person.

(F) "Early childhood services" means a planned program of habilitation designed to meet the needs of individuals with mental retardation or other developmental disabilities who have not attained compulsory school age.

(G)(1) "Environmental modifications" means the physical adaptations to an individual's home, specified in the individual's service plan, that are necessary to ensure the individual's health, safety, and welfare or that enable the individual to function with greater independence in the home, and without which the individual would require institutionalization.

(2) "Environmental modifications" includes such adaptations as installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, and installation of specialized electric and plumbing systems necessary to accommodate the individual's medical equipment and supplies.

(3) "Environmental modifications" does not include physical adaptations or improvements to the home that are of general utility or not of direct medical or remedial benefit to the individual, including such adaptations or improvements as carpeting, roof repair, and central air conditioning.

(H) "Family support services" means the services provided under a family support services program operated under section 5126.11 of the Revised Code.

(I) "Habilitation" means the process by which the staff of the facility or agency assists an individual with mental retardation or other developmental disability in acquiring and maintaining those life skills that enable the individual to cope more effectively with the demands of the individual's own person and environment, and in raising the level of the individual's personal, physical, mental, social, and vocational efficiency. Habilitation includes, but is not limited to, programs of formal, structured education and training.

(J) "Home and community-based services" means medicaid-funded home and community-based services specified in division (B)(1) of section 5111.87 of the Revised Code and provided under the medicaid waiver components the department of developmental disabilities administers pursuant to section 5111.871 of the Revised Code. However, home and community-based services provided under the medicaid waiver component known as the transitions developmental disabilities waiver are to be considered to be home and community-based services for the purposes of this chapter only to the extent, if any, provided by the contract required by section 5111.871 of the Revised Code regarding the waiver.

(K) "Immediate family" means parents, grandparents, brothers, sisters, spouses, sons, daughters, aunts, uncles, mothers-in-law, fathers-in-law, brothers-in-law, sisters-in-law, sons-in-law, and daughters-in-law.

(L) "Medicaid" has the same meaning as in section 5111.01 of the Revised Code.

(M) "Medicaid case management services" means case management services provided to an individual with mental retardation or other developmental disability that the state medicaid plan requires.

(N) "Mental retardation" means a mental impairment manifested during the developmental period characterized by significantly subaverage general intellectual functioning existing concurrently with deficiencies in the effectiveness or degree with which an individual meets the standards of personal independence and social responsibility expected of the individual's age and cultural group.

(O) "Residential services" means services to individuals with mental retardation or other developmental disabilities to provide housing, food, clothing, habilitation, staff support, and related support services necessary for the health, safety, and welfare of the individuals and the advancement of their quality of life. "Residential services" includes program management, as

described in section 5126.14 of the Revised Code.

(P) "Resources" means available capital and other assets, including moneys received from the federal, state, and local governments, private grants, and donations; appropriately qualified personnel; and appropriate capital facilities and equipment.

(Q) "Senior probate judge" means the current probate judge of a county who has served as probate judge of that county longer than any of the other current probate judges of that county. If a county has only one probate judge, "senior probate judge" means that probate judge.

(R) "Service and support administration" means the duties performed by a service and support administrator pursuant to section 5126.15 of the Revised Code.

(S)(1) "Specialized medical, adaptive, and assistive equipment, supplies, and supports" means equipment, supplies, and supports that enable an individual to increase the ability to perform activities of daily living or to perceive, control, or communicate within the environment.

(2) "Specialized medical, adaptive, and assistive equipment, supplies, and supports" includes the following:

(a) Eating utensils, adaptive feeding dishes, plate guards, mylatex straps, hand splints, reaches, feeder seats, adjustable pointer sticks, interpreter services, telecommunication devices for the deaf, computerized communications boards, other communication devices, support animals, veterinary care for support animals, adaptive beds, supine boards, prone boards, wedges, sand bags, sidelayers, bolsters, adaptive electrical switches, hand-held shower heads, air conditioners, humidifiers, emergency response systems, folding shopping carts, vehicle lifts, vehicle hand controls, other adaptations of vehicles for accessibility, and repair of the equipment received.

(b) Nondisposable items not covered by medicaid that are intended to assist an individual in activities of daily living or instrumental activities of daily living.

(T) "Supportive home services" means a range of services to families of individuals with mental retardation or other developmental disabilities to develop and maintain increased acceptance and understanding of such persons, increased ability of family members to teach the person, better coordination between school and home, skills in performing specific therapeutic and management techniques, and ability to cope with specific situations.

(U)(1) "Supported living" means services provided for as long as twenty-four hours a day to an individual with mental retardation or other

developmental disability through any public or private resources, including moneys from the individual, that enhance the individual's reputation in community life and advance the individual's quality of life by doing the following:

(a) Providing the support necessary to enable an individual to live in a residence of the individual's choice, with any number of individuals who are not disabled, or with not more than three individuals with mental retardation and developmental disabilities unless the individuals are related by blood or marriage;

(b) Encouraging the individual's participation in the community;

(c) Promoting the individual's rights and autonomy;

(d) Assisting the individual in acquiring, retaining, and improving the skills and competence necessary to live successfully in the individual's residence.

(2) "Supported living" includes the provision of all of the following:

(a) Housing, food, clothing, habilitation, staff support, professional services, and any related support services necessary to ensure the health, safety, and welfare of the individual receiving the services;

(b) A combination of lifelong or extended-duration supervision, training, and other services essential to daily living, including assessment and evaluation and assistance with the cost of training materials, transportation, fees, and supplies;

(c) Personal care services and homemaker services;

(d) Household maintenance that does not include modifications to the physical structure of the residence;

(e) Respite care services;

(f) Program management, as described in section 5126.14 of the Revised Code.

Sec. 5126.029. (A) Each county board of developmental disabilities shall hold an organizational meeting no later than the thirty-first day of January of each year and shall elect its officers, which shall include a president, vice-president, and recording secretary. After its annual organizational meeting, the board shall meet in such manner and at such times as prescribed by rules adopted by the board, but the board shall meet at least ~~ten~~ the following number of times annually in regularly scheduled sessions in accordance with section 121.22 of the Revised Code, not including in-service training sessions;

(1) Unless division (A)(2) of this section applies to the board, ten;

(2) If the board shares a superintendent or other administrative staff with one or more other boards of developmental disabilities, eight. A

(B) A majority of the board constitutes a quorum. The board shall adopt rules for the conduct of its business and a record shall be kept of board proceedings, which shall be open for public inspection.

Sec. 5126.04. (A) Each county board of developmental disabilities shall plan and set priorities based on available resources for the provision of facilities, programs, and other services to meet the needs of county residents who are individuals with mental retardation and other developmental disabilities, former residents of the county residing in state institutions or, before the effective date of this amendment, placed under purchase of service agreements under section 5123.18 of the Revised Code, and children subject to a determination made pursuant to section 121.38 of the Revised Code.

Each county board shall assess the facility and service needs of the individuals with mental retardation and other developmental disabilities who are residents of the county or former residents of the county residing in state institutions or, before the effective date of this amendment, placed under purchase of service agreements under section 5123.18 of the Revised Code.

Each county board shall require individual habilitation or service plans for individuals with mental retardation and other developmental disabilities who are being served or who have been determined eligible for services and are awaiting the provision of services. Each board shall ensure that methods of having their service needs evaluated are available.

(B)(1) If a foster child is in need of assessment for eligible services or is receiving services from a county board of developmental disabilities and that child is placed in a different county, the agency that placed the child, immediately upon placement, shall inform the county board in the new county all of the following:

- (a) That a foster child has been placed in that county;
- (b) The name and other identifying information of the foster child;
- (c) The name of the foster child's previous county of residence;
- (d) That the foster child was in need of assessment for eligible services or was receiving services from the county board of developmental disabilities in the previous county.

(2) Upon receiving the notice described in division (B)(1) of this section or otherwise learning that the child was in need of assessment for eligible services or was receiving services from a county board of developmental disabilities in the previous county, the county board in the new county shall communicate with the county board of the previous county to determine how services for the foster child shall be provided in accordance with each board's plan and priorities as described in division (A) of this section.

If the two county boards are unable to reach an agreement within ten days of the child's placement, the county board in the new county shall send notice to the Ohio department of developmental disabilities of the failure to agree. The department shall decide how services shall be provided for the foster child within ten days of receiving notice that the county boards could not reach an agreement. The department may decide that one, or both, of the county boards shall provide services. The services shall be provided in accordance with the board's plan and priorities as described in division (A) of this section.

(C) The department of developmental disabilities may adopt rules in accordance with Chapter 119. of the Revised Code as necessary to implement this section. To the extent that rules adopted under this section apply to the identification and placement of children with disabilities under Chapter 3323. of the Revised Code, the rules shall be consistent with the standards and procedures established under sections 3323.03 to 3323.05 of the Revised Code.

(D) The responsibility or authority of a county board to provide services under this chapter does not affect the responsibility of any other entity of state or local government to provide services to individuals with mental retardation and developmental disabilities.

(E) On or before the first day of February prior to a school year, a county board of developmental disabilities may elect not to participate during that school year in the provision of or contracting for educational services for children ages six through twenty-one years of age, provided that on or before that date the board gives notice of this election to the superintendent of public instruction, each school district in the county, and the educational service center serving the county. If a board makes this election, it shall not have any responsibility for or authority to provide educational services that school year for children ages six through twenty-one years of age. If a board does not make an election for a school year in accordance with this division, the board shall be deemed to have elected to participate during that school year in the provision of or contracting for educational services for children ages six through twenty-one years of age.

(F) If a county board of developmental disabilities elects to provide educational services during a school year to individuals six through twenty-one years of age who have multiple disabilities, the board may provide these services to individuals who are appropriately identified and determined eligible pursuant to Chapter 3323. of the Revised Code, and in accordance with applicable rules of the state board of education. The county

board may also provide related services to individuals six through twenty-one years of age who have one or more disabling conditions, in accordance with section 3317.20 and Chapter 3323. of the Revised Code and applicable rules of the state board of education.

Sec. 5126.042. (A) As used in this section:

(1) ~~"Emergency, emergency status"~~ "emergency status" means ~~any situation a status that creates for~~ an individual with mental retardation or developmental disabilities ~~a has when the individual is at~~ risk of substantial self-harm or substantial harm to others if action is not taken within thirty days. An "emergency status" may include a status resulting from one or more of the following situations:

- (a)(1) Loss of present residence for any reason, including legal action;
- (b)(2) Loss of present caretaker for any reason, including serious illness of the caretaker, change in the caretaker's status, or inability of the caretaker to perform effectively for the individual;
- (c)(3) Abuse, neglect, or exploitation of the individual;
- (d)(4) Health and safety conditions that pose a serious risk to the individual or others of immediate harm or death;
- (e)(5) Change in the emotional or physical condition of the individual that necessitates substantial accommodation that cannot be reasonably provided by the individual's existing caretaker.

(2) ~~"Service substitution list" means a service substitution list established by a county board of developmental disabilities before September 1, 2008, pursuant to division (B) of this section as this section existed on the day immediately before September 1, 2008.~~

(B) If a county board of developmental disabilities determines that available resources are not sufficient to meet the needs of all individuals who request non-medicaid programs and or services and may be offered the programs and services, it shall establish one or more waiting lists for the non-medicaid programs or services in accordance with its plan developed under section 5126.04 of the Revised Code. The board may establish priorities for making placements on its waiting lists according to an individual's emergency status and shall establish priorities in accordance with divisions (D) and (E) of established under this section division. Any such priorities shall be consistent with the board's plan and applicable law.

~~The individuals who may be placed on a waiting list include individuals with a need for services on an emergency basis and individuals who have requested services for which resources are not available.~~

~~An individual placed on a county board's service substitution list before September 1, 2008, for the purpose of obtaining home and~~

~~community-based services shall be deemed to have been placed on the county board's waiting list for home and community-based services on the date the individual made a request to the county board that the individual receive home and community-based services instead of the services the individual received at the time the request for home and community-based services was made to the county board.~~

~~(C) A~~ If a county board shall establish a separate waiting list for each of the following categories of services, and may establish separate waiting lists within the waiting lists:

- ~~(1) Early childhood services;~~
- ~~(2) Educational programs for preschool and school age children;~~
- ~~(3) Adult services;~~
- ~~(4) Service and support administration;~~
- ~~(5) Residential services and supported living;~~
- ~~(6) Transportation services;~~
- ~~(7) Other services determined necessary and appropriate for persons with mental retardation or a developmental disability according to their individual habilitation or service plans;~~
- (8) Family support services provided under section 5126.11 of the Revised Code determines that available resources are insufficient to meet the needs of all individuals who request home and community-based services, it shall establish a waiting list for the services. An individual's date of placement on the waiting list shall be the date a request is made to the board for the individual to receive the home and community-based services. The board shall provide for an individual who has an emergency status to receive priority status on the waiting list. The board shall also provide for an individual to whom any of the following apply to receive priority status on the waiting list in accordance with rules adopted under division (E) of this section:

(1) The individual is receiving supported living, family support services, or adult services for which no federal financial participation is received under the medicaid program;

(2) The individual's primary caregiver is at least sixty years of age;

(3) The individual has intensive needs as determined in accordance with rules adopted under division (E) of this section.

~~(D) Except as provided in division (G) of this section, a county board shall do, as priorities, all of the following in accordance with the assessment component, approved under section 5123.046 of the Revised Code, of the county board's plan developed under section 5126.054 of the Revised Code:~~

~~(1) For the purpose of obtaining additional federal medicaid funds for~~

~~home and community based services and medicaid case management services, do both of the following:~~

~~(a) Give an individual who is eligible for home and community-based services and meets both of the following requirements priority over any other individual on a waiting list established under division (C) of this section for home and community-based services that include supported living, residential services, or family support services:~~

~~(i) Is twenty-two years of age or older;~~

~~(ii) Receives supported living or family support services.~~

~~(b) Give an individual who is eligible for home and community-based services and meets both of the following requirements priority over any other individual on a waiting list established under division (C) of this section for home and community-based services that include adult services:~~

~~(i) Resides in the individual's own home or the home of the individual's family and will continue to reside in that home after enrollment in home and community-based services;~~

~~(ii) Receives adult services from the county board.~~

~~(2) As federal medicaid funds become available pursuant to division (D)(1) of this section, give an individual who is eligible for home and community-based services and meets any of the following requirements priority for such services over any other individual on a waiting list established under division (C) of this section:~~

~~(a) Does not receive residential services or supported living, either needs services in the individual's current living arrangement or will need services in a new living arrangement, and has a primary caregiver who is sixty years of age or older;~~

~~(b) Is less than twenty-two years of age and has at least one of the following service needs that are unusual in scope or intensity:~~

~~(i) Severe behavior problems for which a behavior support plan is needed;~~

~~(ii) An emotional disorder for which anti-psychotic medication is needed;~~

~~(iii) A medical condition that leaves the individual dependent on life-support medical technology;~~

~~(iv) A condition affecting multiple body systems for which a combination of specialized medical, psychological, educational, or habilitation services are needed;~~

~~(v) A condition the county board determines to be comparable in severity to any condition described in divisions (D)(2)(b)(i) to (iv) of this section and places the individual at significant risk of institutionalization.~~

~~(c) Is twenty two years of age or older, does not receive residential services or supported living, and is determined by the county board to have intensive needs for home and community based services on an in-home or out-of-home basis.~~

~~(E) Except as provided in division (G) of this section and for a number of years and beginning on a date specified in rules adopted under division (K) of this section, a county board shall give an individual who is eligible for home and community based services, resides in a nursing facility, and chooses to move to another setting with the help of home and community based services, priority over any other individual on a waiting list established under division (C) of this section for home and community based services who does not meet these criteria.~~

~~(F) If two or more individuals on a waiting list established under division (C) of this section for home and community-based services have priority for the services pursuant to division ~~(D)~~(C)(1) or (2), or ~~(E)~~(3) of this section, a county board may shall use criteria specified in rules adopted under division ~~(K)~~(2)(E) of this section in determining the order in which the individuals with priority will be offered the services. Otherwise, the county board shall offer the home and community-based services to such individuals in the order they are placed on the waiting list.~~

~~(G) No individual may receive priority for services pursuant to division (D) or (E) of this section over an individual placed on a waiting list established under division (C) of this section on an emergency status services. An individual who has priority for home and community-based services because the individual has an emergency status has priority for the services over all other individuals on the waiting list who do not have emergency status.~~

~~(H) Prior to establishing any waiting list under this section, a county board shall develop and implement a policy for waiting lists that complies with this section and rules adopted under division (K) of this section.~~

~~Prior to placing an individual on a waiting list, the county board shall assess the service needs of the individual in accordance with all applicable state and federal laws. The county board shall place the individual on the appropriate waiting list and may place the individual on more than one waiting list. The county board shall notify the individual of the individual's placement and position on each waiting list on which the individual is placed.~~

~~At least annually, the county board shall reassess the service needs of each individual on a waiting list. If it determines that an individual no longer needs a program or service, the county board shall remove the individual~~

from the waiting list. If it determines that an individual needs a program or service other than the one for which the individual is on the waiting list, the county board shall provide the program or service to the individual or place the individual on a waiting list for the program or service in accordance with the board's policy for waiting lists.

When a program or service for which there is a waiting list becomes available, the county board shall reassess the service needs of the individual next scheduled on the waiting list to receive that program or service. If the reassessment demonstrates that the individual continues to need the program or service, the board shall offer the program or service to the individual. If it determines that an individual no longer needs a program or service, the county board shall remove the individual from the waiting list. If it determines that an individual needs a program or service other than the one for which the individual is on the waiting list, the county board shall provide the program or service to the individual or place the individual on a waiting list for the program or service in accordance with the board's policy for waiting lists. The county board shall notify the individual of the individual's placement and position on the waiting list on which the individual is placed.

(I) A child subject to a determination made pursuant to section 121.38 of the Revised Code who requires the home and community-based services provided through a medicaid component that the department of developmental disabilities administers under section 5111.871 of the Revised Code shall receive services through that medicaid component. For all other services, a child subject to a determination made pursuant to section 121.38 of the Revised Code shall be treated as an emergency by the county boards and shall not be subject to a waiting list.

(J) Not later than the fifteenth day of March of each even-numbered year, each county board shall prepare and submit to the director of developmental disabilities its recommendations for the funding of services for individuals with mental retardation and developmental disabilities and its proposals for reducing the waiting lists for services.

(K)(1)(E) The department of developmental disabilities shall adopt rules in accordance with Chapter 119. of the Revised Code governing waiting lists established under division (C) of this section. The rules shall include procedures to be followed to ensure that the due process rights of individuals placed on waiting lists are not violated. As

(2) As part of the rules adopted under this division, the department shall adopt rules establishing criteria a county board ~~may~~ shall use under division (F)(D) of this section in determining the order in which individuals with priority for home and community-based services pursuant to division (C)(1).

~~(2), or (3) of this section will be offered the services. The rules shall also specify conditions under which a county board, when there is no individual with priority for home and community-based services pursuant to division (D)(1) or (2) or (E) of this section available and appropriate for the services, may offer the services to an individual on a waiting list for the services but not given such priority for the services.~~

~~(3) As part of the rules adopted under this division, the department shall adopt rules specifying both of the following for the priority category established under division (E) of this section:~~

~~(a) The number of years, which shall not exceed five, that the priority category will be in effect;~~

~~(b) The date that the priority category is to go into effect.~~

~~(L)(E) The following shall take precedence over the applicable provisions of this section:~~

~~(1) Medicaid rules and regulations;~~

~~(2) Any specific requirements that may be contained within a medicaid state plan amendment or waiver program that a county board has authority to administer or with respect to which it has authority to provide services, programs, or supports.~~

Sec. 5126.05. (A) Subject to the rules established by the director of developmental disabilities pursuant to Chapter 119. of the Revised Code for programs and services offered pursuant to this chapter, and subject to the rules established by the state board of education pursuant to Chapter 119. of the Revised Code for programs and services offered pursuant to Chapter 3323. of the Revised Code, the county board of developmental disabilities shall:

(1) Administer and operate facilities, programs, and services as provided by this chapter and Chapter 3323. of the Revised Code and establish policies for their administration and operation;

(2) Coordinate, monitor, and evaluate existing services and facilities available to individuals with mental retardation and developmental disabilities;

(3) Provide early childhood services, supportive home services, and adult services, according to the plan and priorities developed under section 5126.04 of the Revised Code;

(4) Provide or contract for special education services pursuant to Chapters ~~3306.~~, 3317. and 3323. of the Revised Code and ensure that related services, as defined in section 3323.01 of the Revised Code, are available according to the plan and priorities developed under section 5126.04 of the Revised Code;

(5) Adopt a budget, authorize expenditures for the purposes specified in this chapter and do so in accordance with section 319.16 of the Revised Code, approve attendance of board members and employees at professional meetings and approve expenditures for attendance, and exercise such powers and duties as are prescribed by the director;

(6) Submit annual reports of its work and expenditures, pursuant to sections 3323.09 and 5126.12 of the Revised Code, to the director, the superintendent of public instruction, and the board of county commissioners at the close of the fiscal year and at such other times as may reasonably be requested;

(7) Authorize all positions of employment, establish compensation, including but not limited to salary schedules and fringe benefits for all board employees, approve contracts of employment for management employees that are for a term of more than one year, employ legal counsel under section 309.10 of the Revised Code, and contract for employee benefits;

(8) Provide service and support administration in accordance with section 5126.15 of the Revised Code;

(9) Certify respite care homes pursuant to rules adopted under section 5123.171 of the Revised Code by the director of developmental disabilities.

(B) To the extent that rules adopted under this section apply to the identification and placement of children with disabilities under Chapter 3323. of the Revised Code, they shall be consistent with the standards and procedures established under sections 3323.03 to 3323.05 of the Revised Code.

(C) Any county board may enter into contracts with other such boards and with public or private, nonprofit, or profit-making agencies or organizations of the same or another county, to provide the facilities, programs, and services authorized or required, upon such terms as may be agreeable, and in accordance with this chapter and Chapter 3323. of the Revised Code and rules adopted thereunder and in accordance with sections 307.86 and 5126.071 of the Revised Code.

(D) A county board may combine transportation for children and adults enrolled in programs and services offered under ~~section 5126.12~~ Chapter 5126. of the Revised Code with transportation for children enrolled in classes funded under section 3317.20 or units approved under section 3317.05 of the Revised Code.

(E) A county board may purchase all necessary insurance policies, may purchase equipment and supplies through the department of administrative services or from other sources, and may enter into agreements with public agencies or nonprofit organizations for cooperative purchasing

arrangements.

(F) A county board may receive by gift, grant, devise, or bequest any moneys, lands, or property for the benefit of the purposes for which the board is established and hold, apply, and dispose of the moneys, lands, and property according to the terms of the gift, grant, devise, or bequest. All money received by gift, grant, bequest, or disposition of lands or property received by gift, grant, devise, or bequest shall be deposited in the county treasury to the credit of such board and shall be available for use by the board for purposes determined or stated by the donor or grantor, but may not be used for personal expenses of the board members. Any interest or earnings accruing from such gift, grant, devise, or bequest shall be treated in the same manner and subject to the same provisions as such gift, grant, devise, or bequest.

(G) The board of county commissioners shall levy taxes and make appropriations sufficient to enable the county board of developmental disabilities to perform its functions and duties, and may utilize any available local, state, and federal funds for such purpose.

Sec. 5126.054. (A) Each county board of developmental disabilities shall, by resolution, develop a three-calendar year plan that includes the following three components:

(1) An assessment component that includes all of the following:

(a) The number of individuals with mental retardation or other developmental disability residing in the county who need the level of care provided by an intermediate care facility for the mentally retarded, may seek home and community-based services, and are given priority on a waiting list established for the services pursuant to ~~division (D)~~ of section 5126.042 of the Revised Code; the service needs of those individuals; and the projected annualized cost for services;

(b) The source of funds available to the county board to pay the nonfederal share of medicaid expenditures that the county board is required by sections 5126.059 and 5126.0510 of the Revised Code to pay;

(c) Any other applicable information or conditions that the department of developmental disabilities requires as a condition of approving the component under section 5123.046 of the Revised Code.

(2) A preliminary implementation component that specifies the number of individuals to be provided, during the first year that the plan is in effect, home and community-based services pursuant to the waiting list priority given to them under ~~divisions (D)(1) and (2)~~ of section 5126.042 of the Revised Code and the types of home and community-based services the individuals are to receive;

(3) A component that provides for the implementation of medicaid case management services and home and community-based services for individuals who begin to receive the services on or after the date the plan is approved under section 5123.046 of the Revised Code. A county board shall include all of the following in the component:

(a) If the department of developmental disabilities or department of job and family services requires, an agreement to pay the nonfederal share of medicaid expenditures that the county board is required by sections 5126.059 and 5126.0510 of the Revised Code to pay;

(b) How the services are to be phased in over the period the plan covers, including how the county board will serve individuals who have priority on a waiting list established under ~~division (C) of section 5126.042 who are given priority status under division (D)(1) of that section~~ of the Revised Code;

(c) Any agreement or commitment regarding the county board's funding of home and community-based services that the county board has with the department at the time the county board develops the component;

(d) Assurances adequate to the department that the county board will comply with all of the following requirements:

(i) To provide the types of home and community-based services specified in the preliminary implementation component required by division (A)(2) of this section to at least the number of individuals specified in that component;

(ii) To use any additional funds the county board receives for the services to improve the county board's resource capabilities for supporting such services available in the county at the time the component is developed and to expand the services to accommodate the unmet need for those services in the county;

(iii) To employ or contract with a business manager or enter into an agreement with another county board of developmental disabilities that employs or contracts with a business manager to have the business manager serve both county boards. No superintendent of a county board may serve as the county board's business manager.

(iv) To employ or contract with a medicaid services manager or enter into an agreement with another county board of developmental disabilities that employs or contracts with a medicaid services manager to have the medicaid services manager serve both county boards. No superintendent of a county board may serve as the county board's medicaid services manager.

(e) Programmatic and financial accountability measures and projected outcomes expected from the implementation of the plan;

(f) Any other applicable information or conditions that the department requires as a condition of approving the component under section 5123.046 of the Revised Code.

(B) A county board whose plan developed under division (A) of this section is approved by the department under section 5123.046 of the Revised Code shall update and renew the plan in accordance with a schedule the department shall develop.

Sec. 5126.0510. (A) Except as otherwise provided in an agreement entered into under section 5123.048 of the Revised Code and subject to divisions (B), (C), and (D) of this section, a county board of developmental disabilities shall pay the nonfederal share of medicaid expenditures for the following home and community-based services provided to an individual with mental retardation or other developmental disability who the county board determines under section 5126.041 of the Revised Code is eligible for county board services:

(1) Home and community-based services provided by the county board to such an individual;

(2) Home and community-based services provided by a provider other than the county board to such an individual who is enrolled as of June 30, 2007, in the medicaid waiver component under which the services are provided;

(3) Home and community-based services provided by a provider other than the county board to such an individual who, pursuant to a request the county board makes, enrolls in the medicaid waiver component under which the services are provided after June 30, 2007;

(4) Home and community-based services provided by a provider other than the county board to such an individual for whom there is in effect an agreement entered into under division (E) of this section between the county board and director of developmental disabilities.

(B) In the case of medicaid expenditures for home and community-based services for which division (A)(2) of this section requires a county board to pay the nonfederal share, the following shall apply to such services provided during fiscal year 2008 under the individual options medicaid waiver component:

(1) The county board shall pay no less than the total amount the county board paid as the nonfederal share for home and community-based services provided in fiscal year 2007 under the individual options medicaid waiver component;

(2) The county board shall pay no more than the sum of the following:

(a) The total amount the county board paid as the nonfederal share for

home and community-based services provided in fiscal year 2007 under the individual options medicaid waiver component;

(b) An amount equal to one per cent of the total amount the department of developmental disabilities and county board paid as the nonfederal share for home and community-based services provided in fiscal year 2007 under the individual options medicaid waiver component to individuals the county board determined under section 5126.041 of the Revised Code are eligible for county board services.

(C) A county board is not required to pay the nonfederal share of home and community-based services provided after June 30, 2008, that the county board is otherwise required by division (A)(2) of this section to pay if the department of developmental disabilities fails to comply with division (A) of section 5123.0416 of the Revised Code.

(D) A county board is not required to pay the nonfederal share of home and community-based services that the county board is otherwise required by division (A)(3) of this section to pay if both of the following apply:

(1) The services are provided to an individual who enrolls in the medicaid waiver component under which the services are provided as the result of an order issued following a state hearing, administrative appeal, or appeal to a court of common pleas made under section 5101.35 of the Revised Code;

(2) There are more individuals who are eligible for services from the county board enrolled in ~~the medicaid waiver component~~ home and community-based services than is required by section 5126.0512 of the Revised Code.

(E) A county board may enter into an agreement with the director of developmental disabilities under which the county board agrees to pay the nonfederal share of medicaid expenditures for one or more home and community-based services that the county board is not otherwise required by division (A)(1), (2), or (3) of this section to pay and that are provided to an individual the county board determines under section 5126.041 of the Revised Code is eligible for county board services. The agreement shall specify which home and community-based services the agreement covers. The county board shall pay the nonfederal share of medicaid expenditures for the home and community-based services that the agreement covers as long as the agreement is in effect.

Sec. 5126.0511. (A) A county board of developmental disabilities may use the following funds to pay the nonfederal share of the medicaid expenditures that the county board is required by sections 5126.059 and 5126.0510 of the Revised Code to pay:

(1) To the extent consistent with the levy that generated the taxes, the following taxes:

(a) Taxes levied pursuant to division (L) of section 5705.19 of the Revised Code and section 5705.222 of the Revised Code;

(b) Taxes levied under section 5705.191 of the Revised Code that the board of county commissioners allocates to the county board.

(2) Funds that the department of developmental disabilities distributes to the county board under ~~sections 5126.11 and~~ section 5126.18 of the Revised Code and for purposes of the family support services program established under section 5126.11 of the Revised Code;

(3) Earned federal revenue funds the county board receives for medicaid services the county board provides pursuant to the county board's valid medicaid provider agreement;

(4) Funds that the department of developmental disabilities distributes to the county board as subsidy payments;

(5) In the case of medicaid expenditures for home and community-based services, funds allocated to or otherwise made available for the county board under section 5123.0416 of the Revised Code to pay the nonfederal share of such medicaid expenditures.

(B) Each year, each county board shall adopt a resolution specifying the amount of funds it will use in the next year to pay the nonfederal share of the medicaid expenditures that the county board is required by sections 5126.059 and 5126.0510 of the Revised Code to pay. The amount specified shall be adequate to assure that the services for which the medicaid expenditures are made will be available in the county in a manner that conforms to all applicable state and federal laws. A county board shall state in its resolution that the payment of the nonfederal share represents an ongoing financial commitment of the county board. A county board shall adopt the resolution in time for the county auditor to make the determination required by division (C) of this section.

(C) Each year, a county auditor shall determine whether the amount of funds a county board specifies in the resolution it adopts under division (B) of this section will be available in the following year for the county board to pay the nonfederal share of the medicaid expenditures that the county board is required by sections 5126.059 and 5126.0510 of the Revised Code to pay. The county auditor shall make the determination not later than the last day of the year before the year in which the funds are to be used.

Sec. 5126.0512. (A) ~~As used in this section, "medicaid waiver component" means a medicaid waiver component as defined in section 5111.85 of the Revised Code under which home and community-based~~

services are provided:

~~(B)~~ Effective July 1, 2007, and ~~except~~ Except as provided in rules adopted under section 5123.0413 of the Revised Code, each county board of developmental disabilities shall ensure, ~~for each medicaid waiver component,~~ that the number of individuals eligible under section 5126.041 of the Revised Code for services from the county board who are enrolled in ~~a medicaid waiver component~~ home and community-based services is no less than the sum of the following:

(1) The number of individuals eligible for services from the county board who are enrolled in ~~the medicaid waiver component~~ home and community-based services on June 30, 2007;

(2) The number of ~~medicaid waiver component~~ home and community-based services slots the county board requested before July 1, 2007, that were assigned to the county board before that date but in which no individual was enrolled before that date.

~~(C)~~(B) An individual enrolled in ~~a medicaid waiver component~~ home and community-based services after March 1, 2007, due to an emergency reserve capacity waiver assignment shall not be counted in determining the number of individuals a county board must ensure under division ~~(B)~~(A) of this section are enrolled in ~~a medicaid waiver component~~ home and community-based services.

~~(D)~~(C) An individual who is enrolled in ~~a medicaid waiver component~~ home and community-based services to comply with the terms of the consent order filed March 5, 2007, in *Martin v. Strickland*, Case No. 89-CV-00362, in the United States district court for the southern district of Ohio, eastern division, shall be excluded in determining whether a county board has complied with division ~~(B)~~(A) of this section.

~~(E)~~(D) A county board shall make as many requests for individuals to be enrolled in ~~a medicaid waiver component~~ home and community-based services as necessary for the county board to comply with division ~~(B)~~(A) of this section.

Sec. 5126.08. (A) The director of developmental disabilities shall adopt rules in accordance with Chapter 119. of the Revised Code for all programs and services offered by a county board of developmental disabilities. Such rules shall include, but are not limited to, the following:

- (1) Determination of what constitutes a program or service;
- (2) Standards to be followed by a board in administering, providing, arranging, or operating programs and services;
- (3) Standards for determining the nature and degree of mental retardation, including mild mental retardation, or developmental disability;