

(4) "Disqualifying offense" means any of the offenses listed or described in divisions (A)(3) (a) to (e) of section 109.572 of the Revised Code.

(5)(a) "Employee" means either of the following:

(i) A person appointed to or employed by the department of developmental disabilities or a county board of developmental disabilities;

(ii) A person employed in a direct services position by a provider or subcontractor.

(b) "Employee" does not mean a person who provides only respite care under a family support services program established under section 5126.11 of the Revised Code if a family member of the individual with a developmental disability who receives the respite care selected the person.

(6) "Minor drug possession offense" has the same meaning as in section 2925.01 of the Revised Code.

(7) "Provider" means a person that provides specialized services to individuals with developmental disabilities and employs one or more persons in direct services positions.

(8) "Responsible entity" means the following:

(a) The department of developmental disabilities in the case of either of the following:

(i) A person who is an applicant because the person is under final consideration for appointment to or employment with the department, being transferred to the department, or being recalled to or reemployed by the department after a layoff;

(ii) A person who is an employee because the person is appointed to or employed by the department.

(b) A county board of developmental disabilities in the case of either of the following:

(i) A person who is an applicant because the person is under final consideration for appointment to or employment with the county board, being transferred to the county board, or being recalled to or reemployed by the county board after a layoff;

(ii) A person who is an employee because the person is appointed to or employed by the county board.

(c) A provider in the case of either of the following:

(i) A person who is an applicant because the person is under final consideration for a direct services position with the provider;

(ii) A person who is an employee because the person is employed in a direct services position by the provider.

(d) A subcontractor in the case of either of the following:

(i) A person who is an applicant because the person is under final consideration for a direct services position with the subcontractor;

(ii) A person who is an employee because the person is employed in a direct services position by the subcontractor.

(9) "Specialized services" means any program or service designed and operated to serve primarily individuals with developmental disabilities, including a program or service provided by an

entity licensed or certified by the department of developmental disabilities. If there is a question as to whether a provider or subcontractor is providing specialized services, the provider or subcontractor may request that the director of developmental disabilities make a determination. The director's determination is final.

(10) "Subcontractor" means a person to which both of the following apply:

(a) The person has either of the following:

(i) A subcontract with a provider to provide specialized services included in the contract between the provider and the department of developmental disabilities or a county board of developmental disabilities;

(ii) A subcontract with another subcontractor to provide specialized services included in a subcontract between the other subcontractor and a provider or other subcontractor.

(b) The person employs one or more persons in direct services positions.

(B) A responsible entity shall not employ an applicant or continue to employ an employee if either of the following applies:

(1) The applicant or employee fails to comply with division (D)(3) of this section.

(2) Except as provided in rules adopted under this section, the applicant or employee is found by a criminal records check required by this section to have been convicted of, pleaded guilty to, or been found eligible for intervention in lieu of conviction for a disqualifying offense.

(C) Before employing an applicant in a position for which a criminal records check is required by this section, a responsible entity shall require the applicant to submit a statement with the applicant's signature attesting that the applicant has not been convicted of, pleaded guilty to, or been found eligible for intervention in lieu of conviction for a disqualifying offense. The responsible entity also shall require the applicant to sign an agreement under which the applicant agrees to notify the responsible entity within fourteen calendar days if, while employed by the responsible entity, the applicant is formally charged with, is convicted of, pleads guilty to, or is found eligible for intervention in lieu of conviction for a disqualifying offense. The agreement shall provide that the applicant's failure to provide the notification may result in termination of the applicant's employment.

(D)(1) As a condition of employing any applicant in a position for which a criminal records check is required by this section, a responsible entity shall request the superintendent of the bureau of criminal identification and investigation to conduct a criminal records check of the applicant. If rules adopted under this section require an employee to undergo a criminal records check, a responsible entity shall request the superintendent to conduct a criminal records check of the employee at times specified in the rules as a condition of the responsible entity's continuing to employ the employee in a position for which a criminal records check is required by this section. If an applicant or employee does not present proof that the applicant or employee has been a resident of this state for the five-year period immediately prior to the date upon which the criminal records check is requested, the responsible entity shall request that the superintendent obtain information

from the federal bureau of investigation as a part of the criminal records check. If the applicant or employee presents proof that the applicant or employee has been a resident of this state for that five-year period, the responsible entity may request that the superintendent include information from the federal bureau of investigation in the criminal records check. For purposes of this division, an applicant or employee may provide proof of residency in this state by presenting, with a ~~notarized~~ statement asserting that the applicant or employee has been a resident of this state for that five-year period, a valid driver's license, notification of registration as an elector, a copy of an officially filed federal or state tax form identifying the applicant's or employee's permanent residence, or any other document the responsible entity considers acceptable.

(2) A responsible entity shall do all of the following:

(a) Provide to each applicant and employee for whom a criminal records check is required by this section a copy of the form prescribed pursuant to division (C)(1) of section 109.572 of the Revised Code and a standard impression sheet to obtain fingerprint impressions prescribed pursuant to division (C)(2) of section 109.572 of the Revised Code;

(b) Obtain the completed form and standard impression sheet from the applicant or employee;

(c) Forward the completed form and standard impression sheet to the superintendent at the time the criminal records check is requested.

(3) Any applicant or employee who receives pursuant to this division a copy of the form prescribed pursuant to division (C)(1) of section 109.572 of the Revised Code and a copy of the standard impression sheet prescribed pursuant to division (C)(2) of that section and who is requested to complete the form and provide a set of the applicant's or employee's fingerprint impressions shall complete the form or provide all the information necessary to complete the form and shall provide the standard impression sheet with the impressions of the applicant's or employee's fingerprints.

(4) A responsible entity 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 requested and conducted pursuant to this section.

(E) A responsible entity may request any other state or federal agency to supply the responsible entity with a written report regarding the criminal record of an applicant or employee. If an employee holds an occupational or professional license or other credentials, the responsible entity may request that the state or federal agency that regulates the employee's occupation or profession supply the responsible entity with a written report of any information pertaining to the employee's criminal record that the agency obtains in the course of conducting an investigation or in the process of renewing the employee's license or other credentials. The responsible entity may consider the reports when determining whether to employ the applicant or to continue to employ the employee.

(F) As a condition of employing an applicant in a position for which a criminal records check is required by this section and that involves transporting individuals with developmental disabilities or operating a responsible entity's vehicles for any purpose, the responsible entity shall

obtain the applicant's driving record from the bureau of motor vehicles. If rules adopted under this section require a responsible entity to obtain an employee's driving record, the responsible entity shall obtain the employee's driving record from the bureau at times specified in the rules as a condition of continuing to employ the employee. The responsible entity may consider the applicant's or employee's driving record when determining whether to employ the applicant or to continue to employ the employee.

(G) A responsible entity may employ an applicant conditionally pending receipt of a report regarding the applicant requested under this section. The responsible entity shall request the report before employing the applicant conditionally. The responsible entity shall terminate the applicant's employment if it is determined from a report that the applicant failed to inform the responsible entity that the applicant had been convicted of, pleaded guilty to, or been found eligible for intervention in lieu of conviction for a disqualifying offense.

(H) A responsible entity may charge an applicant a fee for costs the responsible entity incurs in obtaining a report regarding the applicant under this section if the responsible entity notifies the applicant of the amount of the fee at the time of the applicant's initial application for employment and that, unless the fee is paid, the responsible entity will not consider the applicant for employment. The fee shall not exceed the amount of the fee, if any, the responsible entity pays for the report.

(I)(1) Any report obtained pursuant to this section is not a public record for purposes of section 149.43 of the Revised Code and shall not be made available to any person, other than the following:

(a) The applicant or employee who is the subject of the report or the applicant's or employee's representative;

(b) The responsible entity that requested the report or its representative;

(c) The department if a county board, provider, or subcontractor is the responsible entity that requested the report and the department requests the responsible entity to provide a copy of the report to the department;

(d) A county board if a provider or subcontractor is the responsible entity that requested the report and the county board requests the responsible entity to provide a copy of the report to the county board;

(e) Any court, hearing officer, or other necessary individual involved in a case dealing with any of the following:

(i) The denial of employment to the applicant or employee;

(ii) The denial, suspension, or revocation of a certificate under section 5123.166 or 5123.45 of the Revised Code;

(iii) A civil or criminal action regarding the medicaid program or a program the department administers.

(2) An applicant or employee for whom the responsible entity has obtained reports under this section may submit a written request to the responsible entity to have copies of the reports sent to

any state agency, entity of local government, or private entity. The applicant or employee shall specify in the request the agencies or entities to which the copies are to be sent. On receiving the request, the responsible entity shall send copies of the reports to the agencies or entities specified.

(3) A responsible entity may request that a state agency, entity of local government, or private entity send copies to the responsible entity of any report regarding a records check or criminal records check that the agency or entity possesses, if the responsible entity obtains the written consent of the individual who is the subject of the report.

(4) A responsible entity shall provide each applicant and employee with a copy of any report obtained about the applicant or employee under this section.

(J) The director of developmental disabilities shall adopt rules in accordance with Chapter 119. of the Revised Code to implement this section.

(1) The rules may do the following:

- (a) Require employees to undergo criminal records checks under this section;
- (b) Require responsible entities to obtain the driving records of employees under this section;
- (c) If the rules require employees to undergo criminal records checks, require responsible entities to obtain the driving records of employees, or both, exempt one or more classes of employees from the requirements.

(2) The rules shall do all of the following:

(a) If the rules require employees to undergo criminal records checks, require responsible entities to obtain the driving records of employees, or both, specify the times at which the criminal records checks are to be conducted and the driving records are to be obtained;

(b) Specify circumstances under which a responsible entity may employ an applicant or employee who is found by a criminal records check required by this section to have been convicted of, pleaded guilty to, or been found eligible for intervention in lieu of conviction for a disqualifying offense but meets standards in regard to rehabilitation set by the director;

(c) Require a responsible entity to request a criminal records check under this section before employing an applicant conditionally as permitted under division (G) of this section.

Sec. 5123.16. (A) As used in sections 5123.16 to ~~5123.1611~~ 5123.1613 of the Revised Code:

(1) "Applicant" means any of the following:

(a) The chief executive officer of a business that applies under section 5123.161 of the Revised Code for a certificate to provide supported living;

(b) The chief executive officer of a business that seeks renewal of the business's supported living certificate under section 5123.164 of the Revised Code;

(c) An individual who applies under section 5123.161 of the Revised Code for a certificate to provide supported living as an independent provider;

(d) An independent provider who seeks renewal of the independent provider's supported living certificate under section 5123.164 of the Revised Code.

(2) "Business" means an association, corporation, nonprofit organization, partnership, trust,

or other group of persons. "Business" does not mean an independent provider.

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

(4) "Disqualifying offense" means any of the offenses listed or described in divisions (A)(3)(a) to (e) of section 109.572 of the Revised Code.

(5) "Independent provider" means a provider who provides supported living on a self-employed basis and does not employ, directly or through contract, another person to provide the supported living.

(6) "Provider" means a person or government entity certified by the director of developmental disabilities to provide supported living. For the purpose of division (A)(8) of this section, "provider" includes a person or government entity that seeks or previously held a certificate to provide supported living.

(7) "Minor drug possession offense" has the same meaning as in section 2925.01 of the Revised Code.

(8) "Related party" means any of the following:

(a) In the case of a provider who is an individual, any of the following:

(i) The spouse of the provider;

(ii) A parent or stepparent of the provider or provider's spouse;

(iii) A child of the provider or provider's spouse;

(iv) A sibling, half sibling, or stepsibling of the provider or provider's spouse;

(v) A grandparent of the provider or provider's spouse;

(vi) A grandchild of the provider or provider's spouse.

(b) In the case of a provider that is a person other than an individual, any of the following:

(i) Any person or government entity that directly or indirectly controls the provider's day-to-day operations (including as a general manager, business manager, financial manager, administrator, or director), regardless of whether the person or government entity exercises the control pursuant to a contract or other arrangement and regardless of whether the person or government entity is required to file an Internal Revenue Code form W-2 for the provider;

(ii) An officer of the provider, including the chief executive officer, president, vice-president, secretary, and treasurer;

(iii) A member of the provider's board of directors or trustees;

(iv) A person owning a financial interest of five per cent or more in the provider, including a direct, indirect, security, or mortgage financial interest;

(v) The spouse, parent, stepparent, child, sibling, half sibling, stepsibling, grandparent, or grandchild of any of the persons specified in divisions (A)(8)(b)(i) to (iv) of this section;

(vi) A person over which the provider has control of the day-to-day operation;

(vii) A corporation that has a subsidiary relationship with the provider.

(c) In the case of a provider that is a government entity, any of the following:

(i) Any person or government entity that directly or indirectly controls the provider's day-to-day operations (including as a general manager, financial manager, administrator, or director), regardless of whether the person or government entity exercises the control pursuant to a contract or other arrangement;

(ii) An officer of the provider;

(iii) A member of the provider's governing board;

(iv) A person or government entity over which the provider has control of the day-to-day operation.

(B) No person or government entity may provide supported living without a valid supported living certificate issued by the director of developmental disabilities.

(C) A county board of developmental disabilities may provide supported living only to the extent permitted by rules adopted under section 5123.1611 of the Revised Code.

Sec. 5123.168. The director of developmental disabilities ~~may issue an adjudication order in accordance with Chapter 119. of the Revised Code to shall~~ terminate a supported living certificate if the certificate holder has not billed for supported living for ~~twelve~~ twenty-four consecutive months. To terminate a supported living certificate under this section, the director shall send a notice by certified mail to the certificate holder at the address on file with the department of developmental disabilities explaining why the certificate is terminated.

Sec. 5123.169. (A) The director of developmental disabilities shall not issue a supported living certificate to an applicant or renew an applicant's supported living certificate if either of the following applies:

(1) The applicant fails to comply with division (C)(2) of this section;

(2) Except as provided in rules adopted under section 5123.1611 of the Revised Code, the applicant is found by a criminal records check required by this section to have been convicted of, pleaded guilty to, or been found eligible for intervention in lieu of conviction for a disqualifying offense.

(B) Before issuing a supported living certificate to an applicant or renewing an applicant's supported living certificate, the director shall require the applicant to submit a statement with the applicant's signature attesting that the applicant has not been convicted of, pleaded guilty to, or been found eligible for intervention in lieu of conviction for a disqualifying offense. The director also shall require the applicant to sign an agreement under which the applicant agrees to notify the director within fourteen calendar days if, while holding a supported living certificate, the applicant is formally charged with, is convicted of, pleads guilty to, or is found eligible for intervention in lieu of conviction for a disqualifying offense. The agreement shall provide that the applicant's failure to provide the notification may result in action being taken by the director against the applicant under section 5123.166 of the Revised Code.

(C)(1) As a condition of receiving a supported living certificate or having a supported living certificate renewed, an applicant shall request the superintendent of the bureau of criminal

identification and investigation to conduct a criminal records check of the applicant. If an applicant does not present proof to the director that the applicant has been a resident of this state for the five-year period immediately prior to the date that the applicant applies for issuance or renewal of the supported living certificate, the director shall require the applicant to request that the superintendent obtain information from the federal bureau of investigation as a part of the criminal records check. If the applicant presents proof to the director that the applicant has been a resident of this state for that five-year period, the director may require the applicant to request that the superintendent include information from the federal bureau of investigation in the criminal records check. For purposes of this division, an applicant may provide proof of residency in this state by presenting, with a ~~notarized~~ statement asserting that the applicant has been a resident of this state for that five-year period, a valid driver's license, notification of registration as an elector, a copy of an officially filed federal or state tax form identifying the applicant's permanent residence, or any other document the director considers acceptable.

(2) Each applicant shall do all of the following:

(a) Obtain a copy of the form prescribed pursuant to division (C)(1) of section 109.572 of the Revised Code and a standard impression sheet prescribed pursuant to division (C)(2) of section 109.572 of the Revised Code;

(b) Complete the form and provide the applicant's fingerprint impressions on the standard impression sheet;

(c) Forward the completed form and standard impression sheet to the superintendent at the time the criminal records check is requested;

(d) Instruct the superintendent to submit the completed report of the criminal records check directly to the director;

(e) 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 of the applicant requested and conducted pursuant to this section.

(D) The director may request any other state or federal agency to supply the director with a written report regarding the criminal record of an applicant. The director may consider the reports when determining whether to issue a supported living certificate to the applicant or to renew an applicant's supported living certificate.

(E) An applicant who seeks to be an independent provider or is an independent provider seeking renewal of the applicant's supported living certificate shall obtain the applicant's driving record from the bureau of motor vehicles and provide a copy of the record to the director if the supported living that the applicant will provide involves transporting individuals with developmental disabilities. The director may consider the applicant's driving record when determining whether to issue the applicant a supported living certificate or to renew the applicant's supported living certificate.

(F)(1) A report obtained pursuant to this section is not a public record for purposes of section

149.43 of the Revised Code and shall not be made available to any person, other than the following:

- (a) The applicant who is the subject of the report or the applicant's representative;
- (b) The director or the director's representative;
- (c) Any court, hearing officer, or other necessary individual involved in a case dealing with

any of the following:

- (i) The denial of a supported living certificate or refusal to renew a supported living certificate;
- (ii) The denial, suspension, or revocation of a certificate under section 5123.45 of the Revised Code;
- (iii) A civil or criminal action regarding the medicaid program.

(2) An applicant for whom the director has obtained reports under this section may submit a written request to the director to have copies of the reports sent to any person or state or local government entity. The applicant shall specify in the request the person or entities to which the copies are to be sent. On receiving the request, the director shall send copies of the reports to the persons or entities specified.

(3) The director may request that a person or state or local government entity send copies to the director of any report regarding a records check or criminal records check that the person or entity possesses, if the director obtains the written consent of the individual who is the subject of the report.

(4) The director shall provide each applicant with a copy of any report obtained about the applicant under this section.

Sec. 5123.1613. (A) A person who has been granted guardianship of an individual with a developmental disability shall not provide supported living to that individual either as an independent provider or as an employee or contractor of a supported living certificate holder unless there is a relationship by blood, adoption, or marriage between the guardian and the individual.

(B) A supported living certificate holder owned or operated by a guardian of an individual with a developmental disability shall not provide supported living to that individual unless there is a relationship by blood, adoption, or marriage between the guardian and the individual.

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 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 or a county board of developmental disabilities, 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 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.

(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. 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~~ children and youth, and the department of health shall provide technical assistance to any receiver appointed pursuant to this section.

Sec. 5123.41. As used in this section and sections 5123.42 to 5123.47 of the Revised Code:

(A) "Adult services" has the same meaning as in section 5126.01 of the Revised Code.

(B) "Certified supported living provider" means a person or government entity certified under section 5123.161 of the Revised Code.

(C) "Drug" has the same meaning as in section 4729.01 of the Revised Code.

(D) "Family member" means a parent, sibling, spouse, son, daughter, grandparent, aunt, uncle, cousin, or guardian of an individual with a developmental disability if the individual with a developmental disability lives with the person and is dependent on the person to the extent that, if the supports were withdrawn, another living arrangement would have to be found.

(E) "Family support services" has the same meaning as in section 5126.01 of the Revised Code.

~~(E)~~(F) "Health-related activities" means the following:

- (1) Taking vital signs;
- (2) Application of clean dressings that do not require health assessment;
- (3) Basic measurement of bodily intake and output;
- (4) Oral suctioning;
- (5) Use of glucometers;
- (6) External urinary catheter cleaning;
- (7) Emptying and replacing ostomy bags;
- (8) Collection of specimens by noninvasive means;
- (9) Pulse oximetry reading;
- (10) Use of continuous positive airway pressure machines;
- (11) Application of percussion vests;
- (12) Use of cough assist devices and insufflators;
- (13) Application of prescribed compression hosiery.

~~(F)~~(G) "Licensed health professional authorized to prescribe drugs" has the same meaning as in section 4729.01 of the Revised Code.

~~(G)~~(H) "Metered dose inhaled medication" means a premeasured medication administered by inhalation using a hand-held dispenser or aerosol nebulizer.

~~(H)~~(I) "Developmental disabilities personnel" means the employees and the workers under contract who provide specialized services to individuals with developmental disabilities. "Developmental disabilities personnel" includes those who provide the services as follows:

- (1) Through direct employment with the department of developmental disabilities or a county board of developmental disabilities;
- (2) Through an entity under contract with the department of developmental disabilities or a county board of developmental disabilities;
- (3) Through direct employment or by being under contract with private entities, including private entities that operate residential facilities.

~~(I)~~(J) "Nursing delegation" means the process established in rules adopted by the board of nursing pursuant to Chapter 4723. of the Revised Code under which a registered nurse or licensed practical nurse acting at the direction of a registered nurse transfers the performance of a particular nursing activity or task to another person who is not otherwise authorized to perform the activity or

task.

~~(D)~~(K) "Over-the-counter medication" means a drug that may be sold and purchased without a prescription.

~~(K)~~(L) "Prescribed medication" means a drug that is to be administered according to the instructions of a licensed health professional authorized to prescribe drugs.

~~(L)~~(M) "Residential facility" means a facility licensed under section 5123.19 of the Revised Code.

~~(M)~~(N) "Specialized services" has the same meaning as in section 5123.50 of the Revised Code.

~~(N)~~(O) "Topical over-the-counter musculoskeletal medication" means an over-the-counter medication that is applied topically or passes through the skin to provide relief from discomfort in the muscles, joints, or bones.

Sec. 5123.42. (A) Developmental disabilities personnel who are not specifically authorized by other provisions of the Revised Code to administer medications or perform health-related activities may do so pursuant to this section as part of the specialized services the developmental disabilities personnel provide to individuals with 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, if the services are received in a setting where seventeen or more individuals receive the services and the services are offered or provided pursuant to this chapter or Chapter 5126. of the Revised Code;

(3) Recipients of adult services, if the services are received in a setting where not more than sixteen individuals receive the services and the services are offered or provided pursuant to this chapter or Chapter 5126. of the Revised Code;

(4) Recipients of family support services offered or provided pursuant to this chapter or Chapter 5126. of the Revised Code;

(5) 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;

(6) 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 developmental disabilities and the services are offered or provided pursuant to this chapter or Chapter 5126. of the Revised Code;

(7) Recipients of services not included in divisions (A)(1) to (6) of this section that are offered or provided pursuant to this chapter or Chapter 5126. of the Revised Code;

(8) Residents of a residential facility with not more than five resident beds;

(9) Residents of a residential facility with at least six resident beds.

(B)(1) In the case of individuals described in divisions (A)(1) to (9) of this section,

developmental disabilities personnel may do all of the following without nursing delegation and without a certificate issued under section 5123.45 of the Revised Code:

(a) Activate a ~~vagal-vagus~~ nerve stimulator;

(b) ~~Use an epinephrine autoinjector to~~ To treat anaphylaxis, administer prescribed epinephrine either by autoinjector or intranasally;

(c) Administer topical over-the-counter medications for the purpose of cleaning, protecting, or comforting the skin, hair, nails, teeth, or oral surfaces, but not for the purpose of treating an open wound or a condition that requires a medical diagnosis, including a fungal infection.

(2) The authority of developmental disabilities personnel to ~~activate a vagal nerve stimulator, use an epinephrine autoinjector, and perform the health-related activity or administer topical over-the-counter~~ the medications described in division (B)(1) of this section is subject to all of the following:

(a) ~~To activate a vagal nerve stimulator or use an epinephrine autoinjector,~~ developmental Developmental disabilities personnel shall successfully complete the training course or courses developed under section 5123.43 of the Revised Code for developmental disabilities personnel. Developmental disabilities personnel shall ~~activate a vagal nerve stimulator or use an epinephrine autoinjector~~ perform the health-related activity or administer the medications described in division (B)(1) of this section only as authorized by the training completed.

(b) The employer of developmental disabilities personnel shall ensure that the personnel have been trained specifically with respect to each individual for whom they ~~activate a vagal nerve stimulator or use an epinephrine autoinjector~~ perform the health-related activity or administer the medications described in division (B)(1) of this section. Developmental disabilities personnel shall not ~~activate a vagal nerve stimulator or use an epinephrine autoinjector~~ perform such an activity or administer such medications for any individual for whom they have not been specifically trained.

(c) If the employer of developmental disabilities personnel believes that the personnel have not or will not safely ~~activate a vagal nerve stimulator or use an epinephrine autoinjector~~ perform the health-related activity or administer the medications described in division (B)(1) of this section, the employer shall prohibit the developmental disabilities personnel from continuing or commencing to do so. Developmental disabilities personnel shall not engage in the action or actions subject to an employer's prohibition.

(d) Developmental disabilities personnel shall activate a ~~vagal-vagus~~ nerve stimulator, ~~use an~~ administer prescribed epinephrine either by autoinjector or intranasally, or administer topical over-the-counter medications in accordance with the manufacturer's instructions.

(C)(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, developmental disabilities personnel may perform health-related activities.

(b) With nursing delegation, developmental disabilities personnel may administer oral and

topical prescribed medications and topical over-the-counter musculoskeletal medications.

(c) With nursing delegation, developmental disabilities personnel may administer oxygen and metered dose inhaled medications.

(d) With nursing delegation, developmental disabilities personnel may administer prescribed medications through gastrostomy and jejunostomy tubes, if the tubes being used are stable and labeled.

(e) With nursing delegation, developmental disabilities personnel may administer routine doses of insulin through subcutaneous injections, inhalation, and insulin pumps.

(f) With nursing delegation, developmental disabilities personnel may administer prescribed medications for the treatment of metabolic glycemic disorders through subcutaneous injections.

(2) In the case of individuals described in divisions (A)(2), (7), and (9) of this section, all of the following apply:

(a) With nursing delegation, developmental disabilities personnel may perform health-related activities.

(b) With nursing delegation, developmental disabilities personnel may administer oral and topical prescribed medications and topical over-the-counter musculoskeletal medications.

(c) With nursing delegation, developmental disabilities personnel may administer oxygen and metered dose inhaled medications.

(d) With nursing delegation, developmental disabilities personnel may administer prescribed medications through gastrostomy and jejunostomy tubes, if the tubes being used are stable and labeled.

(e) With nursing delegation, developmental disabilities personnel may administer routine doses of insulin through subcutaneous injections, inhalation, and insulin pumps.

(f) With nursing delegation, developmental disabilities personnel may administer prescribed medications for the treatment of metabolic glycemic disorders through subcutaneous injections.

(3) In the case of individuals described in divisions (A)(3), (4), (5), (6), and (8) of this section, all of the following apply:

(a) Without nursing delegation, developmental disabilities personnel may perform health-related activities.

(b) Without nursing delegation, developmental disabilities personnel may administer oral and topical prescribed medications and topical over-the-counter musculoskeletal medications.

(c) Without nursing delegation, developmental disabilities personnel may administer oxygen and metered dose inhaled medications.

(d) With nursing delegation, developmental disabilities personnel may administer prescribed medications through gastrostomy and jejunostomy tubes, if the tubes being used are stable and labeled.

(e) With nursing delegation, developmental disabilities personnel may administer routine doses of insulin through subcutaneous injections, inhalation, and insulin pumps.

(f) With nursing delegation, developmental disabilities personnel may administer prescribed medications for the treatment of metabolic glycemic disorders through subcutaneous injections.

(D) The authority of developmental disabilities personnel to administer medications and perform health-related activities pursuant to division (C) of this section is subject to all of the following:

(1) To administer medications or perform health-related activities for individuals in the categories specified under divisions (A)(1) to (9) of this section, developmental disabilities personnel shall obtain the certificate or certificates required by the department of developmental disabilities and issued under section 5123.45 of the Revised Code. Developmental disabilities personnel shall administer medications and perform health-related activities only as authorized by the certificate or certificates held.

(2) If nursing delegation is required under division (C) of this section, developmental disabilities personnel shall not act without nursing delegation or in a manner that is inconsistent with the delegation.

(3) The employer of developmental disabilities personnel shall ensure that the personnel have been trained specifically with respect to each individual for whom they administer medications or perform health-related activities. Developmental disabilities personnel shall not administer medications or perform health-related activities for any individual for whom they have not been specifically trained.

(4) If the employer of developmental disabilities personnel believes that the developmental disabilities personnel have not or will not safely administer medications or perform health-related activities, the employer shall prohibit the ~~the~~ personnel from continuing or commencing to do so. Developmental disabilities personnel shall not engage in the action or actions subject to an employer's prohibition.

(E) 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 medications and performance of health-related activities by developmental disabilities personnel pursuant to the authority granted under this section;

(2) Procedures for reporting errors that occur in the administration of medications and performance of health-related activities by developmental disabilities personnel pursuant to the authority granted under this section;

(3) Other standards and procedures the department considers necessary for implementation of this section.

Sec. 5123.423. A family member may administer medications or perform health-related activities as described in section 5123.42 of the Revised Code without either of the following: nursing delegation or a certificate issued under section 5123.45 of the Revised Code.

Sec. 5123.47. (A) As used in this section:

(1) "In-home care" means the supportive services provided within the home of an individual with a developmental disability who receives funding for the services through a county board of developmental disabilities, including any recipient of residential services funded as home and community-based services, family support services provided under section 5126.11 of the Revised Code, or supported living provided in accordance with sections 5126.41 to 5126.47 of the Revised Code. "In-home care" includes care that is provided outside an individual's home in places incidental to the home, and while traveling to places incidental to the home, except that "in-home care" does not include care provided in the facilities of a county board of developmental disabilities or care provided in schools.

(2) "Parent" means either parent of a child, including an adoptive parent but not a foster parent.

(3) "Unlicensed in-home care worker" means an individual who provides in-home care on a self-employed basis and does not employ, either directly or through contract, another person to provide the in-home care, but who is not a health care professional.

~~(4) "Family member" means a parent, sibling, spouse, son, daughter, grandparent, aunt, uncle, cousin, or guardian of the individual with a developmental disability if the individual with a developmental disability lives with the person and is dependent on the person to the extent that, if the supports were withdrawn, another living arrangement would have to be found.~~

~~(5)~~ "Health care professional" means any of the following:

(a) A dentist who holds a valid license issued under Chapter 4715. of the Revised Code;

(b) A registered or licensed practical nurse who holds a valid license issued under Chapter 4723. of the Revised Code;

(c) An optometrist who holds a valid license issued under Chapter 4725. of the Revised Code;

(d) A pharmacist who holds a valid license issued under Chapter 4729. of the Revised Code;

(e) A person who holds a valid license or certificate issued under Chapter 4731. of the Revised Code to practice medicine and surgery, osteopathic medicine and surgery, podiatric medicine and surgery, or a limited brand of medicine;

(f) A physician assistant who holds a valid license issued under Chapter 4730. of the Revised Code;

(g) An occupational therapist or occupational therapy assistant or a physical therapist or physical therapist assistant who holds a valid license issued under Chapter 4755. of the Revised Code;

(h) A respiratory care professional who holds a valid license issued under Chapter 4761. of the Revised Code;

(i) A certified mental health assistant who holds a valid license issued under Chapter 4772. of the Revised Code.

~~(6)~~(5) "Health care task" means a task that is prescribed, ordered, ~~delegated,~~ or otherwise directed by a health care professional acting within the scope of the professional's practice. "Health care task" includes the administration of ~~oral and topical prescribed medications; administration of nutrition and medications through gastrostomy and jejunostomy tubes that are stable and labeled; administration of oxygen and metered dose inhaled medications; administration of insulin through subcutaneous injections, inhalation, and insulin pumps; and administration of prescribed medications for the treatment of metabolic glycemie disorders through subcutaneous injections.~~

(B) Except as provided in division ~~(E)~~(F) of this section, a family member of an individual with a developmental disability may authorize an unlicensed in-home care worker to perform health care tasks as part of the in-home care the worker provides to the individual, if all of the following apply:

(1) The family member is the primary supervisor of the care.

(2) At the time the family member both authorizes the unlicensed in-home care worker to perform health care tasks and supervises the care provided to the individual, the family member is not acting as a paid provider for the individual.

(3) The unlicensed in-home care worker has been selected by the family member or the individual receiving care and is under the direct supervision of the family member.

~~(3) The unlicensed in-home care worker is providing the care through an employment or other arrangement entered into directly with the family member and is not otherwise employed by or under contract with a person or government entity to provide services to individuals with developmental disabilities.~~

(4) The health care task is completed in accordance with standard, written instructions.

(5) Performance of the health care task requires no judgment based on specialized health care knowledge or expertise.

(6) The outcome of the health care task is reasonably predictable.

(7) Performance of the health care task requires no complex observation of the individual receiving the care.

(8) Improper performance of the health care task will result in only minimal complications that are not life-threatening.

(C) A family member who authorizes an unlicensed in-home care worker to perform health care tasks under this section shall obtain ~~do~~ all of the following:

(1) Obtain a prescription, if applicable, and written instructions from a health care professional for the care to be provided to the individual. ~~The family member shall authorize;~~

(2) Authorize the unlicensed in-home care worker to provide the care by preparing a written document granting the authority. ~~The family member shall provide;~~

(3) Provide the unlicensed in-home care worker with appropriate training and written instructions in accordance with the instructions obtained from the health care professional. ~~The family member or a health care professional shall be;~~

(4) Be available to communicate with the unlicensed in-home care worker either in person or by telecommunication while the in-home care worker performs a health care task.

(D) Before an unlicensed in-home care worker may perform the health care tasks authorized by a family member under this section, the worker shall accept the written document described in division (C)(2) of this section granting the worker that authority.

(E) A family member who authorizes an unlicensed in-home care worker to ~~administer oral and topical prescribed medications or perform other~~ health care tasks retains full responsibility for the health and safety of the individual receiving the care and for ensuring that the worker provides the care appropriately and safely. No entity that funds or monitors the provision of in-home care may be held liable for the results of the care provided under this section by an unlicensed in-home care worker, including such entities as the county board of developmental disabilities and the department of developmental disabilities.

An unlicensed in-home care worker who is authorized under this section by a family member to provide care to an individual may not be held liable for any injury caused in providing the care, unless the worker provides the care in a manner that is not in accordance with the training and instructions received or the worker acts in a manner that constitutes willful or wanton misconduct.

~~(E)~~(F) A county board of developmental disabilities may evaluate the authority granted by a family member under this section to an unlicensed in-home care worker at any time it considers necessary and shall evaluate the authority on receipt of a complaint. If in evaluating the authority, the board shall use appropriately licensed health care professionals.

If, after its evaluation, the board determines that a family member has acted in a manner that is inappropriate for the health and safety of the individual receiving the care, then all of the following apply:

(1) The authorization granted by the family member to an unlicensed in-home care worker is void, ~~and the,~~

(2) The family member may not authorize other unlicensed in-home care workers to provide the care. ~~In making such a determination, the~~

(3) The board shall use authorize appropriately licensed health care professionals and or certified providers to instead perform the health care tasks.

(4) The board shall provide the family member an opportunity to file a complaint under section 5126.06 of the Revised Code.

Sec. 5124.15. (A) Except as otherwise provided by section 5124.101 of the Revised Code, sections 5124.151 to 5124.154 of the Revised Code, and division (B) of this section, the total per medicaid day payment rate that the department of developmental disabilities shall pay to an ICF/IID provider for ICF/IID services the provider's ICF/IID provides during a fiscal year shall equal the sum of all of the following:

(1) The per medicaid day capital component rate determined for the ICF/IID under section

5124.17 of the Revised Code;

(2) The per medicaid day direct care costs component rate determined for the ICF/IID under section 5124.19 of the Revised Code;

(3) The per medicaid day indirect care costs component rate determined for the ICF/IID under section 5124.21 of the Revised Code;

(4) The per medicaid day other protected costs component rate determined for the ICF/IID under section 5124.23 of the Revised Code;

(5) The sum of the following:

(a) The per medicaid day quality incentive payment determined for the ICF/IID under section 5124.24 of the Revised Code;

(b) A direct support personnel payment equal to two and four-hundredths per cent of the ICF/IID's desk-reviewed, actual, allowable, per medicaid day direct care costs from the applicable cost report year;

(c) ~~A~~ For state fiscal year 2026, a professional workforce development payment equal to ~~thirteen and fifty five hundredths for state fiscal year 2024 and twenty and eighty one hundredths during fiscal year 2025~~ ten and four hundred five thousandths per cent of the ICF/IID's desk-reviewed, actual, allowable, per medicaid day direct care costs from the applicable cost report year.

(B) The department shall adjust the total per medicaid day payment rate otherwise determined for an ICF/IID under this section as directed by the general assembly through the enactment of law governing medicaid payments to ICF/IID providers.

(C)(1) In addition to paying an ICF/IID provider the total per medicaid day payment rate determined for the provider's ICF/IID under divisions (A) and (B) of this section for a fiscal year, the department may do either or both of the following:

(a) In accordance with section 5124.25 of the Revised Code, pay the provider a rate add-on for ventilator-dependent outlier ICF/IID services if the rate add-on is to be paid under that section and the department approves the provider's application for the rate add-on;

(b) In accordance with section 5124.26 of the Revised Code, pay the provider for outlier ICF/IID services the ICF/IID provides to residents identified as needing intensive behavioral health support services if the rate add-on is to be paid under that section and the department approves the provider's application for the rate add-on.

(2) The rate add-ons are not to be part of the ICF/IID's total per medicaid day payment rate.

Sec. 5126.222. (A) A superintendent of a county board of developmental disabilities shall ensure that a service and support administrator, a conditional status service and support administrator, and a service and support administration supervisor successfully completes a web-based training program established by the department of developmental disabilities not later than thirty days after being hired. The training shall include all of the following topics:

(1) Empowering individuals serviced through the development of person-centered individual service plans;

(2) Coordinating services;

(3) Enhancing team effectiveness;

(4) Understanding medicaid;

(5) An overview of ICFs/IID;

(6) An overview of medicaid home and community-based services waivers administered by the department of developmental disabilities and county boards of developmental disabilities, including self-directed services, budget authority, and employer authority;

(7) Targeted case management;

(8) Employment navigation.

(B) Before a superintendent of a county board of developmental disabilities renews the certification of a service and support administrator or service and support administration supervisor, the superintendent shall ensure that the renewal applicant has successfully completed the training program described in division (A) of this section.

Sec. 5139.05. (A) The juvenile court may commit any child to the department of youth services as authorized in Chapter 2152. of the Revised Code, provided that any child so committed shall be at least ten years of age at the time of the child's delinquent act, and, if the child is ten or eleven years of age, the delinquent act is a violation of section 2909.03 of the Revised Code or would be aggravated murder, murder, or a first or second degree felony offense of violence if committed by an adult. Any order to commit a child to an institution under the control and management of the department shall have the effect of ordering that the child be committed to the department and assigned to an institution or placed in a community corrections facility in accordance with division (E) of section 5139.36 of the Revised Code as follows:

(1) For an indefinite term consisting of the prescribed minimum period specified by the court under division (A)(1) of section 2152.16 of the Revised Code and a maximum period not to exceed the child's attainment of twenty-one years of age, if the child was committed pursuant to section 2152.16 of the Revised Code;

(2) Until the child's attainment of twenty-one years of age, if the child was committed for aggravated murder or murder pursuant to section 2152.16 of the Revised Code;

(3) For a period of commitment that shall be in addition to, and shall be served consecutively with and prior to, a period of commitment described in division (A)(1) or (2) of this section, if the child was committed pursuant to section 2152.17 of the Revised Code;

(4) If the child is ten or eleven years of age, to an institution, a residential care facility, a residential facility, or a facility licensed by the department of ~~job and family services~~ children and youth that the department of youth services considers best designated for the training and rehabilitation of the child and protection of the public. The child shall be housed separately from children who are twelve years of age or older until the child is released or discharged or until the child attains twelve years of age, whichever occurs first. Upon the child's attainment of twelve years of age, if the child has not been released or discharged, the department is not required to house the

child separately.

(B)(1) Except as otherwise provided in section 5139.54 of the Revised Code, the release authority of the department of youth services, in accordance with section 5139.51 of the Revised Code and at any time after the end of the minimum period specified under division (A)(1) of section 2152.16 of the Revised Code, may grant the release from custody of any child committed to the department.

The order committing a child to the department of youth services shall state that the child has been adjudicated a delinquent child and state the minimum period. The jurisdiction of the court terminates at the end of the minimum period except as follows:

- (a) In relation to judicial release procedures, supervision, and violations;
- (b) With respect to functions of the court related to the revocation of supervised release that are specified in sections 5139.51 and 5139.52 of the Revised Code;
- (c) In relation to its duties relating to serious youthful offender dispositional sentences under sections 2152.13 and 2152.14 of the Revised Code.

(2) When a child has been committed to the department under section 2152.16 of the Revised Code, the department shall retain legal custody of the child until one of the following:

- (a) The department discharges the child to the exclusive management, control, and custody of the child's parent or the guardian of the child's person or, if the child is eighteen years of age or older, discharges the child.
- (b) The committing court, upon its own motion, upon petition of the parent, guardian of the person, or next friend of a child, or upon petition of the department, terminates the department's legal custody of the child.
- (c) The committing court grants the child a judicial release to court supervision under section 2152.22 of the Revised Code.
- (d) The department's legal custody of the child is terminated automatically by the child attaining twenty-one years of age.
- (e) If the child is subject to a serious youthful offender dispositional sentence, the adult portion of that dispositional sentence is imposed under section 2152.14 of the Revised Code.

(C) When a child is committed to the department of youth services, the department may assign the child to a hospital for mental, physical, and other examination, inquiry, or treatment for the period of time that is necessary. The department may remove any child in its custody to a hospital for observation, and a complete report of every observation at the hospital shall be made in writing and shall include a record of observation, treatment, and medical history and a recommendation for future treatment, custody, and maintenance. The department shall thereupon order the placement and treatment that it determines to be most conducive to the purposes of Chapters 2151. and 5139. of the Revised Code. The committing court and all public authorities shall make available to the department all pertinent data in their possession with respect to the case.

(D) Records maintained by the department of youth services pertaining to the children in its

custody shall be accessible only to department employees, except by consent of the department, upon the order of the judge of a court of record, or as provided in divisions (D)(1) and (2) of this section. These records shall not be considered "public records," as defined in section 149.43 of the Revised Code.

(1) Except as otherwise provided by a law of this state or the United States, the department of youth services may release records that are maintained by the department of youth services and that pertain to children in its custody to the department of rehabilitation and correction regarding persons who are under the jurisdiction of the department of rehabilitation and correction and who have previously been committed to the department of youth services. The department of rehabilitation and correction may use those records for the limited purpose of carrying out the duties of the department of rehabilitation and correction. Records released by the department of youth services to the department of rehabilitation and correction shall remain confidential and shall not be considered public records as defined in section 149.43 of the Revised Code.

(2) The department of youth services shall provide to the superintendent of the school district in which a child discharged or released from the custody of the department is entitled to attend school under section 3313.64 or 3313.65 of the Revised Code the records described in divisions (D)(4)(a) to (d) of section 2152.18 of the Revised Code. Subject to the provisions of section 3319.321 of the Revised Code and the Family Educational Rights and Privacy Act, 20 U.S.C. 1232g, as amended, the records released to the superintendent shall remain confidential and shall not be considered public records as defined in section 149.43 of the Revised Code.

(E)(1) When a child is committed to the department of youth services, the department, orally or in writing, shall notify the parent, guardian, or custodian of a child that the parent, guardian, or custodian may request at any time from the superintendent of the institution in which the child is located any of the information described in divisions (E)(1)(a), (b), (c), and (d) of this section. The parent, guardian, or custodian may provide the department with the name, address, and telephone number of the parent, guardian, or custodian, and, until the department is notified of a change of name, address, or telephone number, the department shall use the name, address, and telephone number provided by the parent, guardian, or custodian to provide notices or answer inquiries concerning the following information:

(a) When the department of youth services makes a permanent assignment of the child to a facility, the department, orally or in writing and on or before the third business day after the day the permanent assignment is made, shall notify the parent, guardian, or custodian of the child of the name of the facility to which the child has been permanently assigned.

If a parent, guardian, or custodian of a child who is committed to the department of youth services requests, orally or in writing, the department to provide the parent, guardian, or custodian with the name of the facility in which the child is currently located, the department, orally or in writing and on or before the next business day after the day on which the request is made, shall provide the name of that facility to the parent, guardian, or custodian.

(b) If a parent, guardian, or custodian of a child who is committed to the department of youth services, orally or in writing, asks the superintendent of the institution in which the child is located whether the child is being disciplined by the personnel of the institution, what disciplinary measure the personnel of the institution are using for the child, or why the child is being disciplined, the superintendent or the superintendent's designee, on or before the next business day after the day on which the request is made, shall provide the parent, guardian, or custodian with written or oral responses to the questions.

(c) If a parent, guardian, or custodian of a child who is committed to the department of youth services, orally or in writing, asks the superintendent of the institution in which the child is held whether the child is receiving any medication from personnel of the institution, what type of medication the child is receiving, or what condition of the child the medication is intended to treat, the superintendent or the superintendent's designee, on or before the next business day after the day on which the request is made, shall provide the parent, guardian, or custodian with oral or written responses to the questions.

(d) When a major incident occurs with respect to a child who is committed to the department of youth services, the department, as soon as reasonably possible after the major incident occurs, shall notify the parent, guardian, or custodian of the child that a major incident has occurred with respect to the child and of all the details of that incident that the department has ascertained.

(2) The failure of the department of youth services to provide any notification required by or answer any requests made pursuant to division (E) of this section does not create a cause of action against the state.

(F) The department of youth services, as a means of punishment while the child is in its custody, shall not prohibit a child who is committed to the department from seeing that child's parent, guardian, or custodian during standard visitation periods allowed by the department of youth services unless the superintendent of the institution in which the child is held determines that permitting that child to visit with the child's parent, guardian, or custodian would create a safety risk to that child, that child's parents, guardian, or custodian, the personnel of the institution, or other children held in that institution.

(G) As used in this section:

(1) "Permanent assignment" means the assignment or transfer for an extended period of time of a child who is committed to the department of youth services to a facility in which the child will receive training or participate in activities that are directed toward the child's successful rehabilitation. "Permanent assignment" does not include the transfer of a child to a facility for judicial release hearings pursuant to section 2152.22 of the Revised Code or for any other temporary assignment or transfer to a facility.

(2) "Major incident" means the escape or attempted escape of a child who has been committed to the department of youth services from the facility to which the child is assigned; the return to the custody of the department of a child who has escaped or otherwise fled the custody and

control of the department without authorization; the allegation of any sexual activity with a child committed to the department; physical injury to a child committed to the department as a result of alleged abuse by department staff; an accident resulting in injury to a child committed to the department that requires medical care or treatment outside the institution in which the child is located; the discovery of a controlled substance upon the person or in the property of a child committed to the department; a suicide attempt by a child committed to the department; a suicide attempt by a child committed to the department that results in injury to the child requiring emergency medical services outside the institution in which the child is located; the death of a child committed to the department; an injury to a visitor at an institution under the control of the department that is caused by a child committed to the department; and the commission or suspected commission of an act by a child committed to the department that would be an offense if committed by an adult.

(3) "Sexual activity" has the same meaning as in section 2907.01 of the Revised Code.

(4) "Controlled substance" has the same meaning as in section 3719.01 of the Revised Code.

(5) "Residential care facility" and "residential facility" have the same meanings as in section 2151.011 of the Revised Code.

Sec. 5139.08. The department of youth services may enter into an agreement with the director of rehabilitation and correction pursuant to which the department of youth services, in accordance with division (C)(2) of section 5139.06 and section 5120.162 of the Revised Code, may transfer to a correctional medical center established by the department of rehabilitation and correction, children who are within its custody for diagnosis or treatment of an illness, physical condition, or other medical problem. The department of youth services may enter into any other agreements with the director of children and youth, the director of job and family services, the director of mental health and addiction services, the director of developmental disabilities, the director of rehabilitation and correction, with the courts having probation officers or other public officials, and with private agencies or institutions for separate care or special treatment of children subject to the control of the department of youth services. The department of youth services may, upon the request of a juvenile court not having a regular probation officer, provide probation services for such court.

Upon request by the department of youth services, any public agency or group care facility established or administered by the state for the care and treatment of children and youth shall, consistent with its functions, accept and care for any child whose custody is vested in the department in the same manner as it would be required to do if custody had been vested by a court in such agency or group care facility. If the department has reasonable grounds to believe that any child or youth whose custody is vested in it is mentally ill or has an intellectual disability, the department may file an affidavit under section 5122.11 or 5123.76 of the Revised Code. The department's affidavit for admission of a child or youth to such institution shall be filed with the probate court of the county from which the child was committed to the department. Such court may request the

probate court of the county in which the child is held to conduct the hearing on the application, in which case the court making such request shall bear the expenses of the proceeding. If the department files such an affidavit, the child or youth may be kept in such institution until a final decision on the affidavit is made by the appropriate court.

Sec. 5139.12. Any person who is required, pursuant to division (A) of section 2151.421 of the Revised Code, to report the person's knowledge of or reasonable cause to suspect abuse or neglect or threat of abuse or neglect of a child under eighteen years of age or a person with a developmental disability or physical impairment under twenty-one years of age, or any person who is permitted, pursuant to division (B) of that section, to report or cause such a report to be made and who makes or causes the report to be made, shall direct that report to the state highway patrol if the child is a delinquent child in the custody of an institution. If the state highway patrol determines after receipt of the report that there is probable cause that abuse or neglect or threat of abuse or neglect of the delinquent child occurred, the highway patrol shall report its findings to the department of youth services, to the court that ordered the disposition of the delinquent child for the act that would have been an offense if committed by an adult and for which the delinquent child is in the custody of the department, to the public children services agency in the county in which the child resides or in which the abuse or neglect or threat of abuse or neglect occurred, and to the ~~chairperson and vice chairperson of the correctional institution inspection committee established by section 103.71 of the Revised Code~~ attorney general.

Sec. 5139.14. (A)(1) The department of youth services shall permit representatives of all nonprofit faith-based, business, professional, civic, educational, and community organizations that are registered with the department to enter institutions that are under the department's control and management for the purpose of providing reentry services to delinquent children in the department's custody. Reentry services may include, but are not limited to, counseling, housing, job-placement, and money-management assistance.

(2) The department shall adopt rules pursuant to Chapter 119. of the Revised Code for the screening and registration of nonprofit faith-based, business, professional, civic, educational, and community organizations that apply to provide reentry services to delinquent children in institutions under the department's control and management.

(B)(1) The department shall post a department telephone number on the department's official internet web site that nonprofit faith-based, business, professional, civic, educational, and community organizations that wish to provide reentry services to delinquent children may call to obtain information. The internet web site also shall list all of the faith-based, business, professional, civic, educational, and community organizations that are registered with the department under this section.

(2) The department shall actively recruit nonprofit faith-based, business, professional, civic, educational, and community organizations to provide reentry services in institutions under the department's control and management. The department shall recruit nonprofit organizations from all

faiths and beliefs.

(C) Annually, the department shall issue a written report on the department's progress in implementing the recommendations of the correctional faith-based initiatives task force. The department shall provide a copy of the written report to ~~each member of the correctional institution inspection committee created under section 103.71 of the Revised Code~~ the general assembly in accordance with section 101.68 of the Revised Code.

(D) The department shall not endorse or sponsor any faith-based reentry program or endorse any specific religious message. The department may not require any child in its custody to participate in a faith-based program.

Sec. 5139.34. (A) Funds may be appropriated to the department of youth services for the purpose of granting state subsidies to counties. A county or the juvenile court that serves a county shall use state subsidies granted to the county pursuant to this section only in accordance with divisions (B)(2)(a) and (3)(a) of section 5139.43 of the Revised Code and the rules pertaining to the state subsidy funds that the department adopts pursuant to division (D) of section 5139.04 of the Revised Code. The department shall not grant financial assistance pursuant to this section for the provision of care and services for children in a placement facility unless the facility has been certified, licensed, or approved by a state or national agency with certification, licensure, or approval authority, including, but not limited to, the department of ~~job and family services~~ children and youth, department of education and workforce, department of mental health and addiction services, department of developmental disabilities, or American correctional association. For the purposes of this section, placement facilities do not include a state institution or a county or district children's home.

The department of youth services also shall not grant financial assistance pursuant to this section for the provision of care and services for children, including, but not limited to, care and services in a detention facility, in another facility, or in out-of-home placement, unless the minimum standards applicable to the care and services that the department prescribes in rules adopted pursuant to division (D) of section 5139.04 of the Revised Code have been satisfied.

(B) The department of youth services shall apply the following formula to determine the amount of the annual grant that each county is to receive pursuant to division (A) of this section, subject to the appropriation for this purpose to the department made by the general assembly:

(1) Each county shall receive a basic annual grant of fifty thousand dollars.

(2) The sum of the basic annual grants provided under division (B)(1) of this section shall be subtracted from the total amount of funds appropriated to the department of youth services for the purpose of making grants pursuant to division (A) of this section to determine the remaining portion of the funds appropriated. The remaining portion of the funds appropriated shall be distributed on a per capita basis to each county that has a population of more than twenty-five thousand for that portion of the population of the county that exceeds twenty-five thousand.

(C)(1) Prior to a county's receipt of an annual grant pursuant to this section, the juvenile

court that serves the county shall prepare, submit, and file in accordance with division (B)(3)(a) of section 5139.43 of the Revised Code an annual grant agreement and application for funding that is for the combined purposes of, and that satisfies the requirements of, this section and section 5139.43 of the Revised Code. In addition to the subject matters described in division (B)(3)(a) of section 5139.43 of the Revised Code or in the rules that the department adopts to implement that division, the annual grant agreement and application for funding shall address fiscal accountability and performance matters pertaining to the programs, care, and services that are specified in the agreement and application and for which state subsidy funds granted pursuant to this section will be used.

(2) The county treasurer of each county that receives an annual grant pursuant to this section shall deposit the state subsidy funds so received into the county's felony delinquent care and custody fund created pursuant to division (B)(1) of section 5139.43 of the Revised Code. Subject to exceptions prescribed in section 5139.43 of the Revised Code that may apply to the disbursement, the department shall disburse the state subsidy funds to which a county is entitled in a lump sum payment that shall be made in July of each calendar year.

(3) Upon an order of the juvenile court that serves a county and subject to appropriation by the board of county commissioners of that county, a county treasurer shall disburse from the county's felony delinquent care and custody fund the state subsidy funds granted to the county pursuant to this section for use only in accordance with this section, the applicable provisions of section 5139.43 of the Revised Code, and the county's approved annual grant agreement and application for funding.

(4) The moneys in a county's felony delinquent care and custody fund that represent state subsidy funds granted pursuant to this section are subject to appropriation by the board of county commissioners of the county; shall be disbursed by the county treasurer as required by division (C)(3) of this section; shall be used in the manners referred to in division (C)(3) of this section; shall not revert to the county general fund at the end of any fiscal year; shall carry over in the felony delinquent care and custody fund from the end of any fiscal year to the next fiscal year; shall be in addition to, and shall not be used to reduce, any usual annual increase in county funding that the juvenile court is eligible to receive or the current level of county funding of the juvenile court and of any programs, care, or services for alleged or adjudicated delinquent children, unruly children, or juvenile traffic offenders or for children who are at risk of becoming delinquent children, unruly children, or juvenile traffic offenders; and shall not be used to pay for the care and custody of felony delinquents who are in the care and custody of an institution pursuant to a commitment, recommitment, or revocation of a release on parole by the juvenile court of that county or who are in the care and custody of a community corrections facility pursuant to a placement by the department as described in division (E) of section 5139.36 of the Revised Code.

(5) As a condition of the continued receipt of state subsidy funds pursuant to this section, each county and the juvenile court that serves each county that receives an annual grant pursuant to

this section shall comply with divisions (B)(3)(b), (c), and (d) of section 5139.43 of the Revised Code.

Sec. 5145.162. (A) There is hereby created the office of enterprise development advisory board to advise and assist the department of rehabilitation and correction with the creation of training programs and jobs for inmates and releasees through partnerships with private sector businesses. The board shall consist of at least five appointed members ~~and the staff representative assigned by the correctional institution inspection committee, who shall serve as an ex-officio member.~~ Each member shall have experience in labor relations, marketing, business management, or business. The members and chairperson shall be appointed by the director of the department of rehabilitation and correction.

(B) Each member of the advisory board shall receive no compensation but may be reimbursed for expenses actually and necessarily incurred in the performance of official duties of the board. Members of the board who are state employees shall be reimbursed for expenses pursuant to travel rules promulgated by the office of budget and management.

(C) The advisory board shall adopt procedures for the conduct of the board's meetings. The board shall meet at least once every quarter, and otherwise shall meet at the call of the chairperson or the director of the department of rehabilitation and correction. Sixty per cent of the members shall constitute a quorum. No transaction of the board's business shall be taken without the concurrence of a quorum of the members. The board may have committees with persons who are not members of the board but whose experience and expertise is relevant and useful to the work of the committee.

(D) The advisory board shall have the following duties:

(1) Solicit business proposals offering job training, apprenticeship, education programs, and employment opportunities for inmates, releasees, and Ohio penal industries;

(2) Provide information and input to the office of enterprise development to support the job training and employment program of inmates and releasees and any additional, related duties as requested by the director of the department of rehabilitation and correction;

(3) Recommend to the office of enterprise development any legislation, administrative rule, or department policy change that the board believes is necessary to implement the department's program;

(4) Promote public awareness of the office of enterprise development and the office's employment program;

(5) Familiarize itself and the public with avenues to access the office of enterprise development on employment program concerns;

(6) Advocate for the needs and concerns of the office of enterprise development in local communities, counties, and the state;

(7) Play an active role in the office of enterprise development's efforts to reduce recidivism in the state by doing all of the following:

(a) Providing input and making recommendations for the office's consideration in monitoring

employment program compliance and effectiveness;

(b) Making suggestions on the appropriate priorities for the office's grant award criteria;

(c) Being a liaison between the office and constituents of the board's members;

(d) Working to develop constituent groups interested in employment program issues;

(8) Aid in the employment program development process by playing a leadership role in professional associations by discussing employment program issues.

(E) The department of rehabilitation and correction shall initially screen each proposal obtained under division (D)(1) of this section to ensure that the proposal is a viable venture to pursue. If the department determines that a proposal is a viable venture to pursue, the department shall submit the proposal to the board for objective review against established guidelines. The board shall determine whether to recommend the implementation of the program to the department.

Sec. 5145.32. Every officer or employee of a correctional institution under the control or supervision of the department of rehabilitation and correction, and every contractor, or employee of such contractor, upon entering the grounds of a state correctional institution, shall be subject to screening to prevent the conveyance of drugs of abuse into the institution.

Sec. 5153.10. Each public children services agency shall designate an executive officer known as the "executive director," who shall not be in the classified civil service. The superintendent of the children's home, the county director of job and family services, or other individual may serve as the executive director.

The agency shall, from time to time, inquire into community conditions affecting the welfare of children and study the work of the agency and its relation to the work of other organizations whose functions are related to child welfare. The agency may, after consultation with the executive director, adopt rules of general application, not inconsistent with law or with the rules adopted by the director of ~~job and family services~~ children and youth.

Sec. 5153.122. Each PCSA caseworker hired after January 1, 2007, shall complete in-service training during the first year of the caseworker's continuous employment as a PCSA caseworker, except that the executive director of the public children services agency may waive the training requirement for a school of social work graduate who participated in the university partnership program described in division (E) of section ~~5101.141-5180.42~~ of the Revised Code and as provided in section 5153.124 of the Revised Code. The training shall consist of courses in all of the following:

(A) Recognizing, accepting reports of, and preventing child abuse, neglect, and dependency;

(B) Assessing child safety;

(C) Assessing risks;

(D) Interviewing persons;

(E) Investigating cases;

(F) Intervening;

(G) Providing services to children and their families;

(H) The importance of and need for accurate data;

(I) Preparation for court;

(J) Maintenance of case record information;

(K) The legal duties of PCSA caseworkers to protect the constitutional and statutory rights of children and families from the initial time of contact during investigation through treatment, including instruction regarding parents' rights and the limitations that the Fourth Amendment to the United States Constitution places upon caseworkers and their investigations;

(L) Content on other topics relevant to child abuse, neglect, and dependency, including permanency strategies, concurrent planning, and adoption as an option for unintended pregnancies.

After a PCSA caseworker's first year of continuous employment as a PCSA caseworker, the caseworker annually shall complete thirty-six hours of training in areas relevant to the caseworker's assigned duties.

During the first two years of continuous employment as a PCSA caseworker, each PCSA caseworker shall complete training in recognizing the signs of domestic violence and its relationship to child abuse as established in rules the director of children and youth shall adopt pursuant to Chapter 119. of the Revised Code.

Sec. 5153.16. (A) Except as provided in section 2151.422 of the Revised Code, in accordance with rules adopted under section 5153.166 of the Revised Code, and on behalf of children in the county whom the public children services agency considers to be in need of public care or protective services, the public children services agency shall do all of the following:

(1) Make an investigation concerning any child alleged to be an abused, neglected, or dependent child;

(2) Enter into agreements with the parent, guardian, or other person having legal custody of any child, or with the department of children and youth, department of mental health and addiction services, department of developmental disabilities, other department, any certified organization within or outside the county, or any agency or institution outside the state, having legal custody of any child, with respect to the custody, care, or placement of any child, or with respect to any matter, in the interests of the child, provided the permanent custody of a child shall not be transferred by a parent to the public children services agency without the consent of the juvenile court;

(3) Enter into a contract with an agency providing prevention services in an effort to prevent neglect or abuse, to enhance a child's welfare, and to preserve the family unit intact when referring a family for prevention services under division (J) of section 2151.421 of the Revised Code.

(4) Accept custody of children committed to the public children services agency by a court exercising juvenile jurisdiction;

(5) Provide such care as the public children services agency considers to be in the best interests of any child adjudicated to be an abused, neglected, or dependent child the agency finds to be in need of public care or service;

(6) Provide social services to any unmarried girl adjudicated to be an abused, neglected, or dependent child who is pregnant with or has been delivered of a child;

(7) Make available to the children with medical handicaps program of the department of health at its request any information concerning a child with a disability found to be in need of treatment under sections 3701.021 to 3701.028 of the Revised Code who is receiving services from the public children services agency;

(8) Provide temporary emergency care for any child considered by the public children services agency to be in need of such care, without agreement or commitment;

(9) Find certified foster homes, within or outside the county, for the care of children, including children with disabilities from other counties attending special schools in the county;

(10) Subject to the approval of the board of county commissioners and the department of children and youth, establish and operate a training school or enter into an agreement with any municipal corporation or other political subdivision of the county respecting the operation, acquisition, or maintenance of any children's home, training school, or other institution for the care of children maintained by such municipal corporation or political subdivision;

(11) Acquire and operate a county children's home, establish, maintain, and operate a receiving home for the temporary care of children, or procure certified foster homes for this purpose;

(12) Enter into an agreement with the trustees of any district children's home, respecting the operation of the district children's home in cooperation with the other county boards in the district;

(13) Cooperate with, make its services available to, and act as the agent of persons, courts, the department of children and youth, the department of health, and other organizations within and outside the state, in matters relating to the welfare of children, except that the public children services agency shall not be required to provide supervision of or other services related to the exercise of parenting time rights granted pursuant to section 3109.051 or 3109.12 of the Revised Code or companionship or visitation rights granted pursuant to section 3109.051, 3109.11, or 3109.12 of the Revised Code unless a juvenile court, pursuant to Chapter 2151. of the Revised Code, or a common pleas court, pursuant to division (E)(6) of section 3113.31 of the Revised Code, requires the provision of supervision or other services related to the exercise of the parenting time rights or companionship or visitation rights;

(14) Make investigations at the request of any superintendent of schools in the county or the principal of any school concerning the application of any child adjudicated to be an abused, neglected, or dependent child for release from school, where such service is not provided through a school attendance department;

(15) Administer funds provided under Title IV-E of the "Social Security Act," 94 Stat. 501 (1980), 42 U.S.C.A. 671, as amended, in accordance with rules adopted under section ~~5101.141~~ 5180.42 of the Revised Code;

(16) In addition to administering Title IV-E adoption assistance funds, enter into agreements to make adoption assistance payments under section 5153.163 of the Revised Code;

(17) Implement a system of safety and risk assessment, in accordance with rules adopted by the director of children and youth, to assist the public children services agency in determining the

risk of abuse or neglect to a child;

(18) Enter into a plan of cooperation with the board of county commissioners under section 307.983 of the Revised Code and comply with each fiscal agreement the board enters into under section 307.98 of the Revised Code that include family services duties of public children services agencies and contracts the board enters into under sections 307.981 and 307.982 of the Revised Code that affect the public children services agency;

(19) Make reasonable efforts to prevent the removal of an alleged or adjudicated abused, neglected, or dependent child from the child's home, eliminate the continued removal of the child from the child's home, or make it possible for the child to return home safely, except that reasonable efforts of that nature are not required when a court has made a determination under division (A)(2) of section 2151.419 of the Revised Code;

(20) Make reasonable efforts to place the child in a timely manner in accordance with the permanency plan approved under division (E) of section 2151.417 of the Revised Code and to complete whatever steps are necessary to finalize the permanent placement of the child;

(21) Administer a Title IV-A program identified under division (A)(4)(c) or (h) of section 5101.80 of the Revised Code that the department of children and youth provides for the public children services agency to administer under the department's supervision pursuant to section 5101.801 of the Revised Code;

(22) Administer the kinship permanency incentive program created under section ~~5101.802~~ 5180.52 of the Revised Code under the supervision of the director of children and youth;

(23) Provide independent living services pursuant to sections 2151.81 to 2151.84 of the Revised Code;

(24) File a missing child report with a local law enforcement agency upon becoming aware that a child in the custody of the public children services agency is or may be missing.

(B) The public children services agency shall use the system implemented pursuant to division (A)(17) of this section in connection with an investigation undertaken pursuant to division (G)(1) of section 2151.421 of the Revised Code to assess both of the following:

(1) The ongoing safety of the child;

(2) The appropriateness of the intensity and duration of the services provided to meet child and family needs throughout the duration of a case.

(C) Except as provided in section 2151.422 of the Revised Code, in accordance with rules of the director of children and youth, and on behalf of children in the county whom the public children services agency considers to be in need of public care or protective services, the public children services agency may do the following:

(1) Provide or find, with other child serving systems, specialized foster care for the care of children in a specialized foster home, as defined in section 5103.02 of the Revised Code, certified under section 5103.03 of the Revised Code;

(2)(a) Except as limited by divisions (C)(2)(b) and (c) of this section, contract with the

following for the purpose of assisting the agency with its duties:

- (i) County departments of job and family services;
- (ii) Boards of alcohol, drug addiction, and mental health services;
- (iii) County boards of developmental disabilities;
- (iv) Regional councils of political subdivisions established under Chapter 167. of the Revised Code;

- (v) Private and government providers of services;
- (vi) Managed care organizations and prepaid health plans.

(b) A public children services agency contract under division (C)(2)(a) of this section regarding the agency's duties under section 2151.421 of the Revised Code may not provide for the entity under contract with the agency to perform any service not authorized by the department's rules.

(c) Only a county children services board appointed under section 5153.03 of the Revised Code that is a public children services agency may contract under division (C)(2)(a) of this section. If an entity specified in division (B) or (C) of section 5153.02 of the Revised Code is the public children services agency for a county, the board of county commissioners may enter into contracts pursuant to section 307.982 of the Revised Code regarding the agency's duties.

Sec. 5153.163. (A) As used in this section:

(1) "Adoptive parent" means, as the context requires, a prospective adoptive parent or an adoptive parent.

(2) "Relative" has the same meaning as in section ~~5101.141~~ 5180.42 of the Revised Code.

(B)(1) Before a child's adoption is finalized, a public children services agency may enter into an agreement with the child's adoptive parent under which the agency, to the extent state funds are available, may make state adoption maintenance subsidy payments as needed on behalf of the child when all of the following apply:

(a) The child is a child with special needs.

(b) The child was placed in the adoptive home by a public children services agency or a private child placing agency and may legally be adopted.

(c) The adoptive parent has the capability of providing the permanent family relationships needed by the child.

(d) The needs of the child are beyond the economic resources of the adoptive parent.

(e) Acceptance of the child as a member of the adoptive parent's family would not be in the child's best interest without payments on the child's behalf under this section.

(f) The gross income of the adoptive parent's family does not exceed one hundred twenty per cent of the median income of a family of the same size, including the child, as most recently determined for this state by the secretary of health and human services under Title XX of the "Social Security Act," 88 Stat. 2337, 42 U.S.C.A. 1397, as amended.

(g) The child is not eligible for adoption assistance payments under Title IV-E of the "Social

Security Act," 94 Stat. 501 (1980), 42 U.S.C.A. 671, as amended.

(2) State adoption maintenance subsidy payment agreements must be made by either the public children services agency that has permanent custody of the child or the public children services agency of the county in which the private child placing agency that has permanent custody of the child is located.

(3) State adoption maintenance subsidy payments shall be made in accordance with the agreement between the public children services agency and the adoptive parent and are subject to an annual redetermination of need.

(4) Payments under this division may begin either before or after issuance of the final adoption decree, except that payments made before issuance of the final adoption decree may be made only while the child is living in the adoptive parent's home. Preadoption payments may be made for not more than twelve months, unless the final adoption decree is not issued within that time because of a delay in court proceedings. Payments that begin before issuance of the final adoption decree may continue after its issuance.

(C)(1) A public children services agency may enter into an agreement with a child's relative under which the agency, to the extent state funds are available, may provide state kinship guardianship assistance as needed on behalf of the child when all of the following apply:

(a) The relative has cared for the eligible child as a foster caregiver as defined by section 5103.02 of the Revised Code for at least six consecutive months.

(b) Both of the following apply:

(i) A juvenile court issued an order granting legal custody of the child to the relative, or a probate court issued an order granting guardianship of the child to the relative, and the order is not a temporary court order.

(ii) The relative has committed to care for the child on a permanent basis.

(c) The relative signed a state kinship guardianship assistance agreement prior to assuming legal guardianship or legal custody of the child.

(d) The child had been removed from home pursuant to a voluntary placement agreement or as a result of a judicial determination to the effect that continuation in the home would be contrary to the welfare of the child.

(e) Returning the child home or adoption are not appropriate permanency options for the child.

(f) The child demonstrates a strong attachment to the relative and the relative has a strong commitment to caring permanently for the child.

(g) With respect to a child who has attained fourteen years of age, the child has been consulted regarding the state kinship guardianship assistance arrangement.

(h) The child is not eligible for kinship guardianship assistance payments under Title IV-E of the "Social Security Act," 42 U.S.C. 673(d), as amended.

(2) The public children services agency that had custody of a child immediately prior to a

court granting legal custody or guardianship of the child to a relative of the child described in division (C)(1) of this section is authorized to enter into a state kinship guardianship assistance agreement with that relative.

(3) State kinship guardianship assistance for a child shall be provided in accordance with a state kinship guardianship assistance agreement entered into between the public children services agency and relative of the child described in division (C)(1) of this section and is subject to an annual redetermination of need.

~~(4) Not later than fifteen months after September 30, 2021, if the amended state plan submitted under Title IV-E to implement 42 U.S.C. 673(d) as described in section 5101.1416 of the Revised Code is approved, division (C) of this section shall be implemented.~~

(D) No payment shall be made under division (B) or (C) of this section on behalf of any person eighteen years of age or older beyond the end of the school year during which the person attains the age of eighteen or on behalf of a person with a mental or physical disability twenty-one years of age or older.

(E) The director of children and youth shall adopt rules in accordance with Chapter 119. of the Revised Code that are needed to implement this section. The rules shall establish all of the following:

- (1) The application process for all forms of assistance provided under this section;
- (2) The method to determine the amount of assistance payable under division (B) of this section;
- (3) The definition of "child with special needs" for this section;
- (4) The process whereby a child's continuing need for services provided under division (B) or (C) of this section is annually redetermined;
- (5) Any other rule, requirement, or procedure the department considers appropriate for the implementation of this section.

(F) The state adoption special services subsidy program ceases to exist on July 1, 2004, except that, subject to the findings of the annual redetermination process established under division (E) of this section and the child's individual need for services, a public children services agency may continue to provide state adoption special services subsidy payments on behalf of a child for whom payments were being made prior to July 1, 2004.

(G) Benefits and services provided under this section are inalienable whether by way of assignment, charge, or otherwise and exempt from execution, attachment, garnishment, and other like processes.

Sec. 5160.37. (A) A medical assistance recipient's enrollment in a medical assistance program gives an automatic right of recovery to the department of medicaid and a county department of job and family services against the liability of a third party for the cost of medical assistance paid on behalf of the recipient. When an action or claim is brought against a third party by a medical assistance recipient, any payment, settlement or compromise of the action or claim, or any

court award or judgment, is subject to the recovery right of the department of medicaid or county department. Except in the case of a medical assistance recipient who receives medical assistance through a medicaid managed care organization, the department's or county department's claim shall not exceed the amount of medical assistance paid by the department or county department on behalf of the recipient. A payment, settlement, compromise, judgment, or award that excludes the cost of medical assistance paid for by the department or county department shall not preclude a department from enforcing its rights under this section.

(B)(1) In the case of a medical assistance recipient who receives medical assistance through a medicaid managed care organization that has a capitation agreement with a provider, the amount of the department's or county department's claim shall be the amount the medicaid managed care organization would have paid in the absence of a capitation agreement.

(2) In the case of a medical assistance recipient who receives medical assistance through a medicaid managed care organization that does not have a capitation agreement with a provider, the amount of the department's or county department's claim shall be the amount the medicaid managed care organization pays for medical assistance rendered to the recipient, even if that amount is more than the amount the department or county department pays to the medicaid managed care organization for the recipient's medical assistance.

(C) A medical assistance recipient, and the recipient's attorney, if any, shall cooperate with the departments. In furtherance of this requirement, the medical assistance recipient, or the recipient's attorney, if any, shall, not later than thirty days after initiating informal recovery activity or filing a legal recovery action against a third party, provide written notice of the activity or action to the department of medicaid or county department if it has paid for medical assistance under a medical assistance program.

(D) The written notice that must be given under division (C) of this section shall disclose the identity and address of any third party against whom the medical assistance recipient has or may have a right of recovery.

(E) No settlement, compromise, judgment, or award or any recovery in any action or claim by a medical assistance recipient where the department or county department has a right of recovery shall be made final without first giving the department or county department written notice as described in division (C) of this section and a reasonable opportunity to perfect its rights of recovery. If the department or county department is not given the appropriate written notice, the medical assistance recipient and, if there is one, the recipient's attorney, are liable to reimburse the department or county department for the recovery received to the extent of medical assistance payments made by the department or county department.

(F) The department or county department shall be permitted to enforce its recovery rights against the third party even though it accepted prior payments in discharge of its rights under this section if, at the time the department or county department received such payments, it was not aware that additional medical expenses had been incurred but had not yet been paid by the department or

county department. The third party becomes liable to the department or county department as soon as the third party is notified in writing of the valid claims for recovery under this section.

(G)(1) Subject to division (G)(2) of this section, the right of recovery of the department or county department does not apply to that portion of any judgment, award, settlement, or compromise of a claim, to the extent of attorneys' fees, costs, or other expenses incurred by a medical assistance recipient in securing the judgment, award, settlement, or compromise, or to the extent of medical, surgical, and hospital expenses paid by such recipient from the recipient's own resources.

(2) Reasonable attorneys' fees, not to exceed one-third of the total judgment, award, settlement, or compromise, plus costs and other expenses incurred by the medical assistance recipient in securing the judgment, award, settlement, or compromise, shall first be deducted from the total judgment, award, settlement, or compromise. After fees, costs, and other expenses are deducted from the total judgment, award, settlement, or compromise, there shall be a rebuttable presumption that the department of medicaid or county department shall receive no less than one-half of the remaining amount, or the actual amount of medical assistance paid, whichever is less. A party may rebut the presumption in accordance with division (L)(1)-~~or (2)~~, or (3) of this section, as applicable.

(H) A right of recovery created by this section may be enforced separately or jointly by the department of medicaid or county department. To enforce its recovery rights, the department or county department may do any of the following:

(1) Intervene or join in any action or proceeding brought by the medical assistance recipient or on the recipient's behalf against any third party who may be liable for the cost of medical assistance paid;

(2) Institute and pursue legal proceedings against any third party who may be liable for the cost of medical assistance paid;

(3) Initiate legal proceedings in conjunction with any injured, diseased, or disabled medical assistance recipient or the recipient's attorney or representative.

(I) A medical assistance recipient shall not assess attorney fees, costs, or other expenses against the department of medicaid or a county department when the department or county department enforces its right of recovery created by this section.

(J) The right of recovery given to the department under this section includes payments made by a third party under contract with a person having a duty to support.

(K) The department of medicaid may assign to a medical assistance provider the right of recovery given to the department under this section with respect to any claim for which the department has notified the provider that the department intends to recoup the department's prior payment for the claim.

(L)(1) Prior to any payment to the department or a county department pursuant to the department's or county department's right of recovery under this section, a party that desires to rebut the presumption in division (G) of this section shall submit to the department or county department a

request for a hearing in accordance with the procedure the department establishes in rules required by division (O) of this section. The amount sought by the department or county department shall be held in escrow or in an interest on lawyers' trust account until the hearing examiner renders a decision or the case is otherwise concluded. A party successfully rebuts the presumption by a showing of clear and convincing evidence that a different allocation is warranted.

(2) A medical assistance recipient who has repaid money, on or after September 29, 2007, to the department or a county department pursuant to the department's or county department's right of recovery under this section, section 5160.38 of the Revised Code, or former section 5101.58 or 5101.59 of the Revised Code may request a hearing to rebut the presumption in division (G) of this section. The request shall be made in accordance with the procedure the department establishes for this purpose in rules required by division (O) of this section. It must be made not later than one hundred eighty days after September 29, 2015, or ninety days after the payment is made, whichever is later. A party successfully rebuts the presumption by a showing of clear and convincing evidence that a different allocation is warranted.

(3) A medical assistance recipient who has repaid money, between April 6, 2007 and September 28, 2007, to the department or a county department pursuant to the department's or county department's right of recovery under this section, section 5160.38 of the Revised Code, or former section 5101.58 or 5101.59 of the Revised Code may request a hearing to rebut the presumption in division (G) of this section. The request shall be made not later than one hundred eighty days after the effective date of this amendment in accordance with the procedure the department establishes for this purpose in rules required by division (O) of this section. The presumption is successfully rebutted if the requestor demonstrates by clear and convincing evidence that a different allocation is warranted.

(4) With respect to a hearing requested under division (L)(1)-~~or~~, (2), or (3) of this section, all of the following are the case:

(a) The hearing examiner may consider, but is not bound by the allocation of, medical expenses specified in a settlement agreement between the medical assistance recipient and the relevant third party;

(b) The department or county department may raise affirmative defenses during the hearing, including the existence of a prior settlement with the medical assistance recipient, the doctrine of accord and satisfaction, or the common law principle of res judicata;

(c) If the parties agree, live testimony shall not be presented at the hearing;

(d) The hearing may be governed by rules adopted under section 5160.02 of the Revised Code. If such rules are adopted, Chapter 119. of the Revised Code applies to the hearing only to the extent specified in those rules;

(e) The hearing examiner's decision is binding on the department or county department and the medical assistance recipient unless the decision is reversed or modified on appeal to the medicaid director as described in division (M) of this section;

(f) A request for a hearing may be submitted by any of the following:

(i) The medical assistance recipient;

(ii) The medical assistance recipient's authorized representative;

(iii) The executor or administrator of a medical assistance recipient's estate authorized to make or pursue a request;

(iv) A court-appointed guardian;

(v) An attorney who has been directly retained by the medical assistance recipient, or the recipient's parent, legal guardian, or court-appointed guardian.

(M)(1) A medical assistance recipient who disagrees with a hearing examiner's decision under division (L) of this section may file an administrative appeal with the medicaid director in accordance with the procedure the department establishes for this purpose in rules required by division (O) of this section. A hearing is not required during the administrative appeal, but the director or the director's designee shall review the hearing examiner's decision and any prior relevant administrative action. After the review, the director or the director's designee shall affirm, modify, remand, or reverse the hearing decision. A decision made under this division is final and binding on the department or county department and the medical assistance recipient unless it is reversed or modified on appeal to a court of common pleas as described in division (N) of this section.

(2) An administrative appeal may be governed by rules adopted under section 5160.02 of the Revised Code. If such rules are adopted, Chapter 119. of the Revised Code applies to an administrative appeal only to the extent specified in those rules.

(N) A party to an administrative appeal described in division (M) of this section may file an appeal with a court of common pleas in accordance with section 119.12 of the Revised Code.

(O) The medicaid director shall adopt rules under section 5160.02 of the Revised Code as necessary to implement this section, including rules establishing procedures a party may use to request a hearing under division (L)(1)~~or~~, (2), or (3) of this section or an administrative appeal under division (M)(1) of this section. The rules shall be adopted in accordance with Chapter 119. of the Revised Code.

(P) Divisions (L) to (N) of this section are remedial in nature and shall be liberally construed by the courts of this state in accordance with section 1.11 of the Revised Code. Those divisions specify the sole remedy available to a party who claims the department or a county department has received or is to receive more money than entitled to receive under this section, section 5160.38 of the Revised Code, or former section 5101.58 or 5101.59 of the Revised Code.

Sec. 5162.08. (A) Notwithstanding any provision of law to the contrary, and in accordance with section 5166.03 of the Revised Code, the department of medicaid shall not seek or implement an amendment to the medicaid state plan or a medicaid waiver under section 1115 or 1915 of the "Social Security Act," 42 U.S.C. 1315 and 42 U.S.C. 1396n, that would expand medicaid coverage to any additional individuals or class of individuals or increase any net costs to the state, without first providing notice to the legislative service commission and the standing committees in the house

of representatives and the senate with jurisdiction over medicaid.

(B) The department shall provide regular updates to those committees, on a schedule determined by the chairpersons of each committee, regarding the status of any amendment to the medicaid state plan or medicaid waiver described in division (A) of this section.

Sec. 5162.13. (A) On or before the first day of January of each year, the department of medicaid shall complete a report on the effectiveness of the medicaid program in meeting the health care needs of low-income pregnant women, infants, and children. The report shall include all of the following, delineated by race and ethnic group:

- (1) The estimated number of pregnant women, infants, and children eligible for the program;
- (2) The actual number of eligible persons enrolled in the program;
- (3) The actual number of enrolled pregnant women categorized by estimated gestational age at time of enrollment;
- (4) The average number of days between the following events:
 - (a) A pregnant woman's application for medicaid and enrollment in the fee-for-service component of medicaid;
 - (b) A pregnant woman's application for enrollment in a medicaid managed care organization and enrollment in the managed care organization.

The information described in divisions (A)(4)(a) and (b) of this section shall also be delineated by county and the urban and rural communities specified in rules adopted under section 3701.142 of the Revised Code.

- (5) The number of prenatal, postpartum, and child health visits;
- (6) The estimated number of enrolled women of child-bearing age who use a tobacco product;
- (7) The estimated number of enrolled women of child-bearing age who participate in a tobacco cessation program or who use a tobacco cessation product;
- (8) The rates at which enrolled pregnant women receive addiction or mental health services, progesterone therapy, and any other service specified by the department;
- (9) A report on birth outcomes, including a comparison of low-birthweight births and infant mortality rates of medicaid recipients with the general female child-bearing and infant population in this state;
- (10) A comparison of the prenatal, delivery, and child health costs of the program with such costs of similar programs in other states, where available;
- (11) A report on performance data generated by the component of the state innovation model (SIM) grant pertaining to episode-based payments for perinatal care that was awarded to this state by the center for medicare and medicaid innovation in the United States centers for medicare and medicaid services;
- (12) A report on funds allocated for infant mortality reduction initiatives in the urban and rural communities specified in rules adopted under section 3701.142 of the Revised Code;

(13) A report on the results of client responses to questions related to pregnancy services and healthcheck that are asked by the personnel of county departments of job and family services;

(14) A comparison of the performance of the fee-for-service component of medicaid with the performance of each medicaid managed care organization on perinatal health metrics;

(15) A report demonstrating cost savings resulting from program investments;

(16) Beginning two years after ~~the effective date of this amendment~~ April 30, 2024, a report on the medicaid coverage of doula services required by section 5164.071 of the Revised Code, including:

(a) Outcomes related to maternal health and maternal morbidity;

(b) Infant health outcomes;

(c) The average costs of providing doula services to mothers and infants;

(d) Estimated cost increases or savings as a result of providing doula coverage.

(B) The department shall submit the report to the general assembly in accordance with section 101.68 of the Revised Code ~~and to the joint medicaid oversight committee~~. The department also shall make the report available to the public.

(C) The department shall provide to the ~~joint medicaid oversight committee~~ legislative service commission a copy of the data used to calculate the information required in the report under division (A)(16) of this section.

Sec. 5162.132. ~~Annually~~ (A) Not later than the thirty-first day of December of each year, the department of medicaid shall prepare a report on the department's efforts to minimize fraud, waste, and abuse in the medicaid program. The report shall include all of the following for the most recently concluded state fiscal year:

(1) Improper medicaid payments and expenditures, including the individual and total dollar amounts for claims that were determined to be the result of fraud, waste, or abuse;

(2) Federal and state recovered funds, including the dollar amounts per claim and the total dollar amounts concerning fraud, waste, and abuse in the medicaid program;

(3) Aggregate data concerning improper payments and ineligible medicaid recipients who received medicaid services as a percentage of the claims investigated or reviewed;

(4) The number of payments made in error, the dollar amount of those payments within the medicaid program, and the number of confirmed cases of intentional program violation and fraud.

(B) Each report shall be made available on the department's web site. The department shall submit a copy of each report to the ~~governor, general assembly, and joint medicaid oversight committee~~ chairpersons and ranking members of the committees of the house of representatives and senate with jurisdiction over medicaid and the legislative service commission. ~~The copy to the general assembly shall be submitted in accordance with section 101.68 of the Revised Code. Copies of the report also shall be made available to the public on request.~~

Sec. 5162.133. Not less than once each year, the medicaid director shall submit a report on the medicaid buy-in for workers with disabilities program to the governor, ~~and the~~ general assembly;

~~and joint medicaid oversight committee.~~ The copy to the general assembly shall be submitted in accordance with section 101.68 of the Revised Code. The report shall include all of the following information:

(A) The number of individuals who participated in the medicaid buy-in for workers with disabilities program;

(B) The cost of the program;

(C) ~~The amount of revenue generated by premiums that participants pay under section 5163.094 of the Revised Code;~~

~~(D)~~ The average amount of earned income of participants' families;

~~(E)~~(D) The average amount of time participants have participated in the program;

~~(F)~~(E) The types of other health insurance participants have been able to obtain.

Sec. 5162.134. Not later than the first day of each July, the medicaid director shall complete a report of the evaluation conducted under section 5164.911 of the Revised Code regarding the integrated care delivery system. The director shall provide a copy of the report to the general assembly ~~and joint medicaid oversight committee. The copy to the general assembly shall be provided~~ in accordance with section 101.68 of the Revised Code. The director also shall make the report available to the public.

Sec. 5162.136. (A) The department of medicaid shall conduct periodic reviews to determine the barriers that medicaid recipients face in gaining full access to interventions intended to reduce tobacco use, prevent prematurity, and promote optimal birth spacing. The first review shall occur not later than sixty days after ~~the effective date of this section~~ April 6, 2017. Thereafter, reviews shall be conducted every six months. The department shall prepare a report that summarizes the results of each review, which must contain the information specified in division (C)(1) or (2) of this section, as applicable. Each report shall be submitted to the commission on infant mortality, ~~the joint medicaid oversight committee,~~ and the general assembly. Submissions to the general assembly shall be made in accordance with section 101.68 of the Revised Code.

(B) The department shall make a presentation on each report at the first meeting of the commission on infant mortality that follows the report's submission to the commission.

(C)(1) All of the following shall be in the first report submitted in accordance with division (A) of this section:

(a) Identification of the access barriers described in division (A) of this section, the individuals affected by the barriers, and whether the barriers result from policies implemented by the department, medicaid managed care organizations, providers, or others;

(b) Recommendations for the expedient removal of the access barriers;

(c) An analysis of the performance of the fee-for-service component of medicaid and the performance of each medicaid managed care organization on health metrics pertaining to tobacco cessation, prematurity prevention, and birth spacing;

(d) Any other information the department considers pertinent to the report's topic.

(2) All of the following shall be in each subsequent report submitted in accordance with division (A) of this section:

(a) The progress that has been made on removing the access barriers described in division (A) of this section and the impact such progress has had on reducing the infant mortality rate in this state;

(b) A performance analysis of the fee-for-service component of medicaid and each medicaid managed care organization on health metrics pertaining to tobacco cessation, prematurity prevention, and birth spacing;

(c) Any other information the department considers pertinent.

Sec. 5162.1310. (A) The department of medicaid shall periodically evaluate the success that members of the expansion eligibility group have with the following:

(1) Obtaining employer-sponsored health insurance coverage;

(2) Improving health conditions that would otherwise prevent or inhibit stable employment;

(3) Improving the conditions of their employment, including duration and hours of employment.

(B) For the purpose of aiding the department's evaluations under this section, medicaid managed care organizations shall collect and submit to the department relevant data about members of the expansion eligibility group who are enrolled in the organizations' medicaid MCO plans. The department may request that a medicaid managed care organization collect and submit to the department additional data the department needs for the evaluation.

(C) The department shall complete a report for each evaluation conducted under this section. The director shall provide a copy of the report to the general assembly ~~and joint medicaid oversight committee. The copy to the general assembly shall be provided~~ in accordance with section 101.68 of the Revised Code.

Sec. 5162.14. (A) The medicaid director shall immediately provide notice in accordance with this section if the United States centers for medicare and medicaid services does any of the following related to a quarterly medicaid statement of expenditures for medical assistance programs form that is submitted by the department of medicaid:

(1) Determines that the form has a variance of expenditures of eight per cent or greater;

(2) Asks any questions related to the form;

(3) Refuses to certify the information provided on the form;

(4) Refuses to release any funds to the state.

(B) When providing notice under this section, the director shall include any letter or information that is provided by the United States centers for medicare and medicaid services in its questioning or deciding not to certify the form, as well as any correspondences from the department in response.

(C) The notice required under this section shall be provided to all of the following:

(1) The speaker of the house of representatives and president of the senate;

(2) The director of the legislative service commission;

(3) The chairpersons of the relevant standing committees in both the house of representatives and the senate.

Sec. 5162.25. (A) As used in this section:

(1) "State directed payment program" means a payment program authorized by the United States centers for medicare and medicaid services under 42 C.F.R. 438.6(c).

(2) "Preprint" means a form created by the United States centers for medicare and medicaid services to request approval of a state directed payment program, as required under 42 C.F.R. 438.6(c).

(B)(1) Except as provided in division (B)(2) or (3) of this section, the medicaid director shall comply with this section for all new and existing state directed payment programs.

(2) The medicaid director shall not establish more than fifty state directed payment programs during a fiscal biennium.

(3) This section does not apply to a state directed payment program that is funded by the department of medicaid or the hospital franchise permit fee program.

(C) All of the following apply to a state directed payment program that is subject to this section:

(1) The program shall comply with the requirements of 42 C.F.R. 438.6(c), including all of the following:

(a) The program shall be approved by the United States centers for medicare and medicaid services, and the director shall seek approval for the program in accordance with section 5162.07 of the Revised Code.

(b) Directed payments under the program shall not exceed the average commercial rate for all providers participating under a preprint unless exempted by a value-based purchasing agreement approved by the United States centers for medicare and medicaid services.

(c) The program shall be subject to an evaluation plan, in accordance with 42 C.F.R. 438.6(c)(2)(ii)(D).

(2) The program shall be for hospital providers and services or professional services provided by hospitals.

(3) Unless otherwise determined by the medicaid director, only one state directed payment preprint may be approved for each of the following provider classes:

(a) Inpatient and outpatient hospital services;

(b) Physician services;

(c) Children's hospitals participating in the outcomes acceleration for kids quality initiative.

(D) A hospital provider participating in a state directed payment program shall do all of the following:

(1) Enter into one or more contracts related to the state directed payment program as necessary, as determined by the department;

(2) Comply with all average commercial rate reporting requirements established by the department, related to the requirements set forth in 42 C.F.R. 438.6(c)(2)(iii);

(3) Comply with the department's state directed payment quality measure set, including the metrics and targets set by the department for the state directed payment program to advance the goals and objectives specified in the department's quality strategy, as specified in 42 C.F.R. 438.6(c)(2)(ii)(C) and 42 C.F.R. 438.340;

(4) Cooperate with any evaluation or reporting requirements established by the department related to the requirements set forth in 42 C.F.R. 438.6(c)(2)(ii)(D) and (F).

(E) For any preprint effective for a rating period beginning on or after January 1, 2027, a hospital provider contract required under division (D)(1) of this section shall be executed not later than the first day of October preceding the first fiscal year of a biennium. A contract required under this section may be entered into in accordance with section 5162.32 of the Revised Code.

(F) The department shall enter into an agreement with the authorized representative of each entity participating in a state directed payment program established under this section. No agreement entered into under this section shall be valid and enforceable unless the director of budget and management first certifies that there is a balance in the appropriation used to support state directed payment programs that is not already obligated under existing directed payment programs, in an amount at least equal to the cost in the current fiscal year of the state directed payment program that is the subject of the agreement.

(G)(1) All funds supporting a state directed payment program shall comply with the requirements specified in 42 C.F.R. 433.51. No hospital provider may participate in a state directed payment program unless sufficient funds are obligated and appropriated.

(2) The department shall not at any time provide general revenue funds or other state funds for a state directed payment program that is subject to this section. The director shall terminate or decline to establish any state directed payment program if either of the following is the case:

(a) Local funding is not available or sufficient to sustain the program.

(b) The federal government restricts or limits the availability of federal funds to support state directed payment programs or otherwise requires the state to utilize general revenue funds or other state funds as a condition of establishing or maintaining a state directed payment program.

(H) The department shall not utilize more than two per cent of funds received to support a state directed payment program established under this section, including federal financial participation, for the administration of state directed payment programs. Additionally, the department shall not utilize more than two per cent of funds received to support a state directed payment program established under this section, including federal financial participation, for the administration of the department and the medicaid program.

Sec. 5162.251. The department of medicaid shall prepare and submit quarterly reports to the legislative service commission and the chairpersons of the standing committees in the house of representatives and the senate with jurisdiction over medicaid regarding any new state directed

payment programs established under section 5162.25 of the Revised Code.

Sec. 5162.70. (A) As used in this section:

(1) "CPI" means the consumer price index for all urban consumers as published by the United States bureau of labor statistics.

(2) "CPI medical inflation rate" means the inflation rate for medical care, or the successor term for medical care, for the midwest region as specified in the CPI.

~~(3) "JMOC projected medical inflation rate" means the following:-~~

~~(a) The projected medical inflation rate for a fiscal biennium determined by the actuary with which the joint medicaid oversight committee contracts under section 103.414 of the Revised Code if the committee agrees with the actuary's projected medical inflation rate for that fiscal biennium;~~

~~(b) The different projected medical inflation rate for a fiscal biennium determined by the joint medicaid oversight committee under section 103.414 of the Revised Code if the committee disagrees with the projected medical inflation rate determined for that fiscal biennium by the actuary with which the committee contracts under that section.-~~

(4) "Successor term" means a term that the United States bureau of labor statistics uses in place of another term in revisions to the CPI.

(B) The medicaid director shall implement reforms to the medicaid program that do all of the following:

(1) Limit the growth in the per member per month cost of the medicaid program, as determined on an aggregate basis for all eligibility groups, for a fiscal biennium to not more than the lesser of the following:

(a) The average annual increase in the CPI medical inflation rate for the most recent three-year period for which the necessary data is available as of the first day of the fiscal biennium, weighted by the most recent year of the three years;

(b) The ~~JMOC~~ projected medical inflation rate for the fiscal biennium, as determined under section 103.412 of the Revised Code.

(2) Achieve the limit in the growth of the per member per month cost of the medicaid program under division (B)(1) of this section by doing all of the following:

(a) Improving the physical and mental health of medicaid recipients;

(b) Providing for medicaid recipients to receive medicaid services in the most cost-effective and sustainable manner;

(c) Removing barriers that impede medicaid recipients' ability to transfer to lower cost, and more appropriate, medicaid services, including home and community-based services;

(d) Establishing medicaid payment rates that encourage value over volume and result in medicaid services being provided in the most efficient and effective manner possible;

(e) Implementing fraud and abuse prevention and cost avoidance mechanisms to the fullest extent possible.

(3) Reduce the prevalence of comorbid health conditions among, and the mortality rates of,

medicaid recipients;

(4) Reduce infant mortality rates among medicaid recipients.

(C) When determining the growth in the per member per month cost of the medicaid program for purposes of the reforms required by this section, the medicaid director shall not exclude any medicaid eligibility group, provider wages, or service. The director may exclude one-time expenses or expenses that are not directly related to enrollees.

(D) The medicaid director shall implement the reforms under this section in accordance with evidence-based strategies that include measurable goals.

(E) By October first of each calendar year, the medicaid director shall submit to the ~~joint medicaid oversight committee~~ legislative service commission a report detailing the reforms implemented under this section. In even-numbered years, the report shall include the department's historical and projected medicaid program expenditure and utilization trend rates by medicaid program and service category for each year of the upcoming fiscal biennium and an explanation of how the trend rates were calculated.

(F) The reforms implemented under this section shall, without making the medicaid program's eligibility requirements more restrictive, reduce the relative number of individuals enrolled in the medicaid program who have the greatest potential to obtain the income and resources that would enable them to cease enrollment in medicaid and instead obtain health care coverage through employer-sponsored health insurance or an exchange.

Sec. 5162.82. Before making any payment rate increases greater than ten per cent under the medicaid program, the medicaid director shall notify the ~~joint medicaid oversight committee~~ standing committees with oversight of the medicaid program as provided in section 103.41 of the Revised Code of the increase ~~and be available to testify before the joint medicaid oversight committee regarding the increase.~~

Sec. 5163.03. (A) ~~Subject to section 5163.05 of the Revised Code, the~~ The medicaid program shall cover all mandatory eligibility groups.

(B) The medicaid program shall cover all of the optional eligibility groups that state statutes require the medicaid program to cover.

(C) The medicaid program may cover any of the optional eligibility groups to which either of the following applies:

(1) State statutes expressly permit the medicaid program to cover the optional eligibility group.

(2) The medicaid program covers the optional eligibility group ~~on the effective date of this amendment~~ November 22, 2017.

(D) The medicaid program shall not cover an optional eligibility group to which either of the following applies:

(1) State statutes prohibit the medicaid program from covering the optional eligibility group.

(2) Except as provided in divisions (B) and (C)(1) of this section, the medicaid program does

not cover the optional eligibility group on ~~the effective date of this amendment~~ November 22, 2017.

Sec. 5163.04. (A) If the federal medical assistance percentage for medical assistance provided to members of the expansion eligibility group is set below ninety per cent, the department of medicaid shall do both of the following:

(1) Immediately discontinue all medical assistance for members of the group.

(2) Not later than fifteen business days after the change to the federal medical assistance percentage, certify to the director of budget and management, legislative service commission, the president of the senate, and the speaker of the house of representatives the state and federal shares of total actual expenditure for the expansion eligibility group for the most recently completed month prior to the change.

(B)(1) Except as provided in division (B)(2) of this section, the state share amount certified under division (A)(2) of this section shall be multiplied by the number of months remaining in the fiscal year. The amount calculated under this division shall remain in the general revenue fund until the end of the fiscal year, at which time the funds shall be transferred in accordance with section 131.44 of the Revised Code.

(2) If the change to the federal medical assistance percentage described in division (A) of this section occurs during the first year of a fiscal biennium, the state share amount certified under division (A)(2) of this section shall be multiplied by twelve for the second year of the fiscal biennium. The amount calculated under this division shall remain in the general revenue fund until the end of the fiscal biennium, at which time the funds shall be transferred in accordance with section 131.44 of the Revised Code.

Sec. 5163.091. Under the medicaid buy-in for workers with disabilities program, an individual who does ~~all~~ both of the following in accordance with rules authorized by section 5163.098 of the Revised Code qualifies for the medicaid program:

(A) Applies for the medicaid buy-in for workers with disabilities program;

(B) Provides satisfactory evidence of all of the following:

(1) That the individual is at least sixteen years of age and under sixty-five years of age;

(2) Except as provided in section 5163.096 of the Revised Code, that one of the following applies to the individual:

(a) The individual is considered disabled for the purpose of the supplemental security income program, regardless of whether the individual receives supplemental security income benefits, and the individual has earnings from employment.

(b) The individual is an employed individual with a medically improved disability.

(3) That the value of the individual's resources, less amounts disregarded pursuant to rules authorized by section 5163.098 of the Revised Code, does not exceed the amount provided for by section 5163.092 of the Revised Code;

(4) That the individual's income, less amounts disregarded pursuant to section 5163.093 of the Revised Code, does not exceed two hundred fifty per cent of the federal poverty line;

(5) That the individual meets the additional eligibility requirements for the medicaid buy-in for workers with disabilities program established in rules authorized by section 5163.098 of the Revised Code.

~~(C) To the extent required by section 5163.094 of the Revised Code, pays the premium established under that section.~~

Sec. 5163.093. For the purpose of determining whether an individual is within the income eligibility limit for the medicaid buy-in for workers with disabilities program, all of the following apply:

(A) Twenty thousand dollars of the individual's earned income shall be disregarded.

(B) No amount that the individual's employer pays to obtain health insurance for one or more members of the individual's family, ~~including any amount of a premium established under section 5163.094 of the Revised Code that the employer pays,~~ shall be treated as the individual's income.

(C) Any other amounts, if any, specified in rules authorized by section 5163.098 of the Revised Code shall be disregarded from the individual's earned income, unearned income, or both.

Sec. 5163.094. An individual ~~whose income exceeds one hundred fifty per cent of the federal poverty line shall~~ not be required to pay an annual premium as a condition of qualifying for the medicaid buy-in for workers with disabilities program. ~~The amount of the premium shall be determined as follows:-~~

~~(A) Subtract one hundred fifty per cent of the federal poverty line, as applicable for a family size equal to the size of the individual's family, from the amount of the income of the individual's family;~~

~~(B) Subtract an amount specified in rules authorized by section 5163.098 of the Revised Code from the difference determined under division (A) of this section;~~

~~(C) Multiply the difference determined under division (B) of this section by one tenth.~~

Sec. 5163.098. (A) The medicaid director shall adopt rules under section 5163.02 of the Revised Code as necessary to implement the medicaid buy-in for workers with disabilities program. The rules shall do all of the following:

(1) Specify assets, asset values, and amounts to be disregarded in determining asset and income eligibility limits for the program;

(2) Establish meanings for the terms "earned income," "health insurance," "resources," "spouse," and "unearned income";

(3) Establish additional eligibility requirements for the program that must be established for the United States secretary of health and human services to approve the program;

~~(4) For the purpose of division (B) of section 5163.094 of the Revised Code, specify an amount to be subtracted from the difference determined under division (A) of that section.~~

(B) The director may adopt rules under section 5163.02 of the Revised Code to specify amounts to be disregarded from an individual's earned income, unearned income, or both under division (C) of section 5163.093 of the Revised Code for the purpose of determining whether the

individual is within the income eligibility limit for the medicaid buy-in for workers with disabilities program.

Sec. 5163.104. As used in this section, "presumptive eligibility error rate" has the same meaning as in section 5163.103 of the Revised Code.

Quarterly, the department of medicaid shall report to the general assembly the presumptive eligibility error rate for presumptive eligibility determinations made during the previous quarter. Reports made under this section shall be submitted to the general assembly in accordance with section 101.68 of the Revised Code.

Sec. 5163.11. To the extent permissible under federal law, the department of medicaid shall redetermine the eligibility of members of the expansion eligibility group for medicaid benefits every six months.

Sec. 5163.30. (A) As used in this section:

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

- (a) The individual or spouse;
- (b) A person or government entity, including a court or administrative agency, with legal authority to act in place of or on behalf of the individual or spouse;
- (c) A person or government entity, including a court or administrative agency, acting at the direction or on the request of the individual or spouse.

(2) "Home and community-based services" means home and community-based services furnished under a medicaid waiver granted by the United States secretary of health and human services under the "Social Security Act," section 1915(c) or (d), 42 U.S.C. 1396n(c) or (d).

(3) "Institutionalized individual" means a resident of a nursing facility, an inpatient in a medical institution for whom a payment is made based on a level of care provided in a nursing facility, or an individual described in the "Social Security Act," section 1902(a)(10)(A)(ii)(VI), 42 U.S.C. 1396a(a)(10)(A)(ii)(VI).

(4) "Look-back date" means the date that is a number of months specified in rules adopted under section 5163.02 of the Revised Code immediately before either of the following:

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

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

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

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

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

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

(B) Except as provided in division (C) of this section and rules adopted under section 5163.02 of the Revised Code, an institutionalized individual is ineligible for nursing facility services, nursing facility equivalent services, and home and community-based services if the individual or individual's spouse disposes of assets for less than fair market value on or after the look-back date. The institutionalized individual's ineligibility shall begin on a date determined in accordance with rules adopted under section 5163.02 of the Revised Code and shall continue for a number of months determined in accordance with such rules.

(C)(1) An institutionalized individual may be granted a waiver of all or a portion of the period of ineligibility to which the individual would otherwise be subjected under division (B) of this section if the ineligibility would cause an undue hardship for the individual.

(2) An institutionalized individual ~~shall~~may be granted a waiver of all or a portion of the period of ineligibility if the administrator of the nursing facility in which the individual resides has notified the individual of a proposed transfer or discharge under section 3721.16 of the Revised Code due to failure to pay for the care the nursing facility has provided to the individual, the individual or the individual's sponsor requests a hearing on the proposed transfer or discharge in accordance with section 3721.161 of the Revised Code, and the transfer or discharge is upheld by a final determination that is not subject to further appeal.

(3) An institutionalized individual may be granted a waiver of all of the period of ineligibility if all of the assets that were disposed of for less than fair market value are returned to the individual or individual's spouse or if the individual or individual's spouse receives cash or other personal or real property that equals the difference between what the individual or individual's spouse received for the assets and the fair market value of the assets. Except as provided in division (C)(1) or (2) of this section, no waiver of any part of the period of ineligibility shall be granted if the amount the individual or individual's spouse receives is less than the difference between what the individual or individual's spouse received for the assets and the fair market value of the assets.

(4) Waivers shall be granted in accordance with rules adopted under section 5163.02 of the Revised Code.

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

RMD Sec. 5163.33. (A) In determining the amount of income that a medicaid recipient must apply monthly toward payment of the cost of care in a nursing facility or ICF/IID, a county department of job and family services shall deduct from the recipient's monthly income a monthly personal needs allowance in accordance with the "Social Security Act," section 1902(q), 42 U.S.C. 1396a(q).

The above boxed and initialed text was disapproved.

Date: 6/3/25

Mike DeWine

RMG
 (B) In the case of a resident of a nursing facility, the monthly personal needs allowance shall be not less than ~~fifty-seventy-five~~ fifty dollars for an individual resident and not less than one hundred fifty dollars for a married couple if both spouses are residents of a nursing facility and their incomes are considered available to each other in determining eligibility.

(C) In the case of a resident of an ICF/IID, the monthly personal needs allowance shall be as follows:

(1) Prior to January 1, 2016, forty dollars unless the resident has earned income, in which case the monthly personal needs allowance shall be determined by the department of medicaid, or the department's designee, but shall not exceed one hundred five dollars;

(2) For calendar year 2016 and each calendar year thereafter, not less than ~~fifty-seventy-five~~ fifty dollars for an individual resident and not less than one hundred fifty dollars for a married couple if both spouses are residents of an ICF/IID and their incomes are considered available to each other in determining eligibility.

Sec. 5163.50. (A) The department of medicaid shall issue one or more requests for information relating to medicaid eligibility data and operations to identify and assess systems and solutions that may be available to improve or augment the management, efficiency, frequency, and accuracy of medicaid eligibility determinations and processing. The requests for information shall include systems and data relating to all of the following:

(1) Medicaid enrollee or applicant identity verification;

(2) Medicaid enrollee death verification;

(3) Employment and wages;

(4) Lottery winnings;

(5) Residency verification including residency relating to concurrent enrollment in medicaid programs in other states;

(6) Household composition;

(7) Medicaid enrollee incarceration status;

(8) Third-party liability verification;

(9) Asset verification;

(10) Any other records or systems the department considers appropriate in order to strengthen program integrity, reduce costs, and reduce fraud, waste, and abuse in the medicaid program.

(B) As part of the considerations under division (A) of this section, the department shall consider augmenting existing vendor arrangements relating to processing and managing medicaid eligibility cases.

(C) The department may procure one or more vendors to implement any solutions identified as cost effective and feasible. Any vendor compensation under this section shall be performance-based.

(D) The department shall prepare and submit a report to the chairpersons of the standing

The above boxed and initialed text was disapproved.

Date: 6/30/25

Mike DeWine

committees in the house of representatives and senate with jurisdiction over medicaid detailing its findings from the requests for information and considerations conducted under this section.

Sec. 5164.093. (A) As used in this section, "rapid whole genome sequencing" means an investigation of the entire human genome, including coding and non-coding regions and mitochondrial deoxyribonucleic acid, to identify disease-causing genetic changes, and includes patient-only whole genome sequencing and duo and trio whole genome sequencing of the patient and biological parent or parents.

(B) Beginning one year after the effective date of this section, and subject to approval from the centers for medicare and medicaid services, the medicaid program shall reimburse medicaid providers for rapid whole genome sequencing for patients who are Medicaid recipients and meet all of the following criteria:

(1) The patient is under one year of age.

(2) The patient has a complex or acute illness of unknown etiology that is not confirmed to be caused by an environmental exposure, toxic ingestion, infection with normal response to therapy, or trauma.

(3) The patient is receiving hospital services in an intensive care unit or other high acuity care unit within a hospital.

(C) A laboratory performing the rapid whole genome sequencing provided pursuant to this section shall return the preliminary positive results within seven days and final results within fifteen days from the date of receipt of the sample.

(D) Payment provided pursuant to this section may be subject to any of the following evidence-based medical necessity criteria:

(1) The patient has symptoms that suggest a broad differential diagnosis that would require an evaluation by multiple genetic tests if rapid whole genome sequencing is not performed.

(2) The patient's treating health care provider has determined that timely identification of a molecular diagnosis is necessary to guide clinical decision-making and testing results may guide the treatment or management of the patient's condition.

(3) The patient has a family genetic history related to the patient's condition.

(4) The patient has a complex or acute illness of unknown etiology including at least one of the following conditions:

(a) Congenital anomalies involving at least two organ systems or complex or multiple congenital anomalies in one organ system;

(b) Specific organ malformations highly suggestive of a genetic etiology;

(c) Abnormal laboratory tests or abnormal chemistry profiles suggesting the presence of a genetic disease, complex metabolic disorder, or inborn error of metabolism;

(d) Refractory or severe hypoglycemia or hyperglycemia;

(e) Abnormal response to therapy related to an underlying medical condition affecting vital organs or bodily systems;

(f) Severe muscle weakness, rigidity, or spasticity;
(g) A high-risk stratification for a brief, resolved, unexplained, and recurrent event that is any of the following:

- (i) An event without respiratory infection;
- (ii) A witnessed seizure-like event;
- (iii) A cardiopulmonary resuscitation event.

(h) Refractory seizures;
(i) Abnormal cardiac diagnostic testing results suggestive of possible channelopathies, arrhythmias, cardiomyopathies, myocarditis, or structural heart disease;

- (j) Abnormal diagnostic imaging studies suggestive of an underlying genetic condition;
- (k) Abnormal physiologic function studies suggestive of an underlying genetic etiology.

(E) The director may add conditions to those specified in division (D)(4) of this section based on new medical evidence and may provide coverage for rapid whole genome sequencing or other next-generation sequencing and genetic testing in addition to the reimbursement required under this section.

(F)(1) Except as provided in division (F)(2) of this section, genetic data generated as a result of performing rapid whole genome sequencing pursuant to this section shall have a primary use of assisting the ordering health care professional and treating care team to diagnose and treat the patient, and as protected health information it shall be subject to the requirements applicable to protected health information set forth in the "Health Insurance Portability and Accountability Act of 1996," 42 U.S.C. 1320d et seq., the "Health Information Technology for Economic and Clinical Health Act of 2009," 42 U.S.C. 17921 et seq., and any other applicable law regarding protected health information.

(2) Genetic data generated from rapid whole genome sequencing reimbursed under this section can be used in scientific research if consent for such use of the data has been expressly given by the patient's legal guardian. The patient, the patient's legal guardian, or the patient's health care provider with the patient or the patient's guardian's consent, may request access to the results of the testing for use in other clinical settings. A health care provider may only charge a fee to the patient based on the direct costs of producing the results in a format usable in other clinical settings. A patient or a patient's legal guardian shall have the right to rescind the original consent to the use of the data in scientific research at any time, and upon receipt of a written revocation of the consent the health care provider or other entity using the data shall cease use and expunge the data from any data repository where it is held.

(G) The director shall take any actions necessary to implement the provisions of this section, including:

- (1) Adopting rules authorized by section 5166.02 of the Revised Code;

(2) Any other administrative action determined to be necessary to implement the requirements of this section.

Sec. 5165.19. (A)(1) Semiannually, except as provided in division (A)(2) of this section, the department of medicaid shall determine each nursing facility's per medicaid day payment rate for direct care costs by multiplying the facility's semiannual case-mix score determined under section 5165.192 of the Revised Code by the cost per case-mix unit determined under division (C) of this section for the facility's peer group.

(2) Beginning January 1, 2024, during state fiscal years 2024 and 2025, the department shall determine each nursing facility's per medicaid day payment rate for direct care costs by multiplying the cost per case-mix unit determined under division (C) of this section for the facility's peer group by the case-mix score specified in division (A)(2)(a) or (b) of this section, as selected by the nursing facility not later than October 1, 2023. If the nursing facility does not make a selection by October 1, 2023, the case-mix score specified in division (A)(2)(a) of this section shall apply. The case-mix score may be either of the following:

(a) The semiannual case-mix score determined for the facility under division (A)(1) of this section;

(b) The facility's quarterly case-mix score from March 31, 2023, which shall apply to the facility's direct care rate from January 1, 2024, to June 30, 2025.

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

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

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

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

(C)(1) ~~The~~ Except as provided in division (C)(4) of this section, the department shall determine a cost per case-mix unit for each peer group established under division (B) of 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 conducts a rebasing. To determine a peer group's cost per case-mix unit, the department shall do both 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 5165.192 of the Revised Code for the applicable calendar year;

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

(2) In making the identification under division (C)(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 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.

(4) The department shall multiply each cost per case-mix unit determined under division (C)(1) of this section by the peer group average case-mix score in effect on December 31, 2025, divided by the peer group average case-mix score determined under section 5165.192 of the Revised Code for the semiannual period beginning January 1, 2026. The product determined under this division for each nursing facility's peer group shall be the cost per case-mix unit used to determine the nursing facility's per medicaid day payment rate for direct care costs under division (A)(1) of this section for the period beginning January 1, 2026, and ending on the day before the department's next rebasing conducted after that date takes effect.

Sec. 5165.192. (A)(1) Except as provided in division (B) of this section and in accordance with the process specified in rules authorized by this section, the department of medicaid shall do all of the following:

(a) Every quarter, determine the following two case-mix scores for each nursing facility:

(i) A quarterly case-mix score that includes each resident who is a medicaid recipient and is not a low case-mix resident;

(ii) A quarterly case-mix score that includes each resident regardless of payment source.

(b) Every six months, determine a semiannual average case-mix score for each nursing facility by using the quarterly case-mix scores determined for the nursing facility pursuant to division (A)(1)(a)(i) of this section;

(c) After the end of each calendar year, determine an annual average case-mix score for each nursing facility by using the quarterly case-mix scores determined for the nursing facility pursuant to division (A)(1)(a)(ii) of this section.

(2) When determining case-mix scores under division (A)(1) of this section, the department shall use all of the following:

(a) Data from a resident assessment instrument specified in rules authorized by section 5165.191 of the Revised Code;

(b) Except as provided in rules authorized by 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 this section, the grouper methodology used on ~~June 30, 1999~~ October 1, 2019, for the patient driven payment model nursing index, by the United States department of health and human services for prospective payment of skilled nursing facilities under the medicare program.

(B)(1) Subject to division (B)(2) of this section, the department, for one or more months of a calendar quarter, may assign to a nursing facility a case-mix score that is five per cent less than the nursing facility's case-mix score for the immediately preceding calendar quarter if any of the following apply:

(a) The provider does not timely submit complete and accurate resident assessment data necessary to determine the nursing facility's case-mix score for the calendar quarter;

(b) The nursing facility was subject to an exception review under section 5165.193 of the Revised Code for the immediately preceding calendar quarter;

(c) The nursing facility was assigned a case-mix score for the immediately preceding calendar quarter.

(2) Before assigning a case-mix score to a nursing facility due to the submission of incorrect resident assessment data, the department shall permit the provider to correct the data. The department may assign the case-mix score if the provider fails to submit the corrected resident assessment data not later than the earlier of the forty-fifth day after the end of the calendar quarter to which the data pertains or the deadline for submission of such corrections established by regulations adopted by the United States department of health and human services under Title XVIII and Title XIX.

(3) If, for more than six months in a calendar year, a provider is paid a rate determined for a nursing facility using a case-mix score assigned to the nursing facility under division (B)(1) of this section, the department may assign the nursing facility a cost per case-mix unit that is five per cent less than the nursing facility's actual or assigned cost per case-mix unit for the immediately preceding calendar year. The department may use the assigned cost per case-mix unit, instead of determining the nursing facility's actual cost per case-mix unit in accordance with section 5165.19 of the Revised Code, to establish the nursing facility's rate for direct care costs for the fiscal year immediately following the calendar year for which the cost per case-mix unit is assigned.

(4) The department shall take action under division (B)(1), (2), or (3) of this section only in accordance with rules authorized by this section. The department shall not take an action that affects rates for prior payment periods except in accordance with sections 5165.41 and 5165.42 of the

Revised Code.

(C) The medicaid director shall adopt rules under section 5165.02 of the Revised Code as necessary to implement this section.

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

(a) Specify the process for determining the semiannual and annual average case-mix scores for nursing facilities;

~~(b) Adjust the case mix values specified in division (A)(2)(b) of this section to reflect changes in relative wage differentials that are specific to this state;~~

~~(c) 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;~~

(d) Modify the grouper methodology specified in division (A)(2)(c) of this section as follows:

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

~~(ii) Allow the use of the index maximizer element of the methodology;~~

(iii) Incorporate changes to the grouper methodology for the patient driven payment model nursing index used by the United States department of health and human services makes after June 30, 1999 on October 1, 2019, for prospective payment of skilled nursing facilities under the medicare program;

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

~~(e)~~(c) Establish procedures under which resident assessment data shall be reviewed for accuracy and providers shall be notified of any data that requires correction;

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

~~(g)~~(e) Specify when and how the department will assign case-mix scores or costs per case-mix unit to a nursing facility under division (B) of this section if information necessary to calculate the nursing facility's case-mix score is not provided or corrected in accordance with the procedures established by the rules.

(2) Notwithstanding any other provision of this chapter, the rules may provide for the exclusion of case-mix scores assigned to a nursing facility under division (B) of this section from the determination of the nursing facility's semiannual or annual average case-mix score and the cost per case-mix unit for the nursing facility's peer group.

Sec. 5165.26. (A) As used in this section:

(1) "Base rate" means the portion of a nursing facility's total per medicaid day payment rate determined under divisions (A) and (B) of section 5165.15 of the Revised Code.

(2) "CMS" means the United States centers for medicare and medicaid services.

(3) "Long-stay resident" means an individual who has resided in a nursing facility for at least one hundred one days.

(4) "Nursing facilities for which a quality score was determined" includes nursing facilities that are determined to have a quality score of zero.

(5) "SFF list" means the list of nursing facilities that the United States department of health and human services creates under the special focus facility program.

(6) "Special focus facility program" means the program conducted by the United States secretary of health and human services pursuant to section 1919(f)(10) of the "Social Security Act," 42 U.S.C. 1396r(f)(10).

(B) Subject to divisions (D) and (E) and except as provided in division (F) of this section, the department of medicaid shall determine each nursing facility's per medicaid day quality incentive payment rate as follows:

(1) Determine the sum of the quality scores determined under division (C) of this section for all nursing facilities.

(2) Determine the average quality score by dividing the sum determined under division (B) (1) of this section by the number of nursing facilities for which a quality score was determined.

(3) Determine the sum of the total number of medicaid days for all of the calendar year preceding the fiscal year for which the rate is determined for all nursing facilities for which a quality score was determined.

(4) Multiply the average quality score determined under division (B)(2) of this section by the sum determined under division (B)(3) of this section.

(5) Determine the value per quality point by determining the quotient of the following:

(a) The sum determined under division (E)(2) of this section.

(b) The product determined under division (B)(4) of this section.

(6) Multiply the value per quality point determined under division (B)(5) of this section by the nursing facility's quality score determined under division (C) of this section.

(C)(1) Except as provided in divisions (C)(2) and (3) of this section, a nursing facility's quality score for a state fiscal year shall be the sum of the following:

(a) The total number of points that CMS assigned to the nursing facility under CMS's nursing facility five-star quality rating system for the following quality metrics, or CMS's successor metrics as described below, based on the most recent four-quarter average data, or the average data for fewer quarters in the case of successor metrics, available in the database maintained by CMS and known as nursing home compare in the most recent month of the calendar year during which the fiscal year for which the rate is determined begins:

(i) The percentage of the nursing facility's long-stay residents at high risk for pressure ulcers who had pressure ulcers;

(ii) The percentage of the nursing facility's long-stay residents who had a urinary tract

infection;

(iii) The percentage of the nursing facility's long-stay residents whose ability to move independently worsened;

(iv) The percentage of the nursing facility's long-stay residents who had a catheter inserted and left in their bladder.

If CMS ceases to publish any of the metrics specified in division (C)(1)(a) of this section, the department shall use the nursing facility quality metrics on the same topics that CMS subsequently publishes.

(b) Seven and five-tenths points for fiscal year 2024 and three points for fiscal year 2025 and subsequent fiscal years if the nursing facility's occupancy rate is greater than seventy-five per cent. For purposes of this division, the department shall utilize the facility's occupancy rate for licensed beds reported on its cost report for the calendar year preceding the fiscal year for which the rate is determined or, if the facility is not required to be licensed, the facility's occupancy rate for certified beds. If the facility surrenders licensed or certified beds before the first day of July of the calendar year in which the fiscal year begins, the department shall calculate a nursing facility's occupancy rate by dividing the inpatient days reported on the facility's cost report for the calendar year preceding the fiscal year for which the rate is determined by the product of the number of days in the calendar year and the facility's number of licensed, or if applicable, certified beds on the first day of July of the calendar year in which the fiscal year begins.

(c) Beginning with state fiscal year 2025, the total number of points that CMS assigned to the nursing facility under CMS's nursing facility five-star quality rating system for the following quality metrics, or successor metrics designated by CMS, based on the most recent four-quarter average data available in the database maintained by CMS and known as nursing home compare in the most recent month of the calendar year during which the fiscal year for which the rate is determined begins:

(i) The percentage of the nursing facility's long-stay residents whose need for help with daily activities has increased;

(ii) The percentage of the nursing facility's long-stay residents experiencing one or more falls with major injury;

(iii) The percentage of the nursing facility's long-stay residents who were administered an antipsychotic medication;

(iv) Adjusted total nurse staffing hours per resident per day using quintiles instead of deciles by using the points assigned to the higher of the two deciles that constitute the quintile.

If CMS ceases to publish any of the metrics specified in division (C)(1)(c) of this section, the department shall use the nursing facility quality metrics on the same topics CMS subsequently publishes.

(2) In determining a nursing facility's quality score for a state fiscal year, the department shall make the following adjustment to the number of points that CMS assigned to the nursing

facility for each of the quality metrics specified in divisions (C)(1)(a) and (c) of this section:

(a) Unless division (C)(2)(b) or (c) of this section applies, divide the number of the nursing facility's points for the quality metric by twenty.

(b) If CMS assigned the nursing facility to the lowest percentile for the quality metric, reduce the number of the nursing facility's points for the quality metric to zero.

(c) If the nursing facility's total number of points calculated for or during a state fiscal year for all of the quality metrics specified in divisions (C)(1)(a), and if applicable, division (C)(1)(c) of this section is less than a number of points that is equal to the twenty-fifth percentile of all nursing facilities, calculated using the points for the July 1 rate setting of that fiscal year reduce the nursing facility's points to zero until the next point calculation. If a facility's recalculated points under division (C)(3) of this section are below the number of points determined to be the twenty-fifth percentile for that fiscal year, the facility shall receive zero points for the remainder of that fiscal year.

(3) A nursing facility's quality score shall be recalculated for the second half of the state fiscal year based on the most recent four quarter average data, or the average data for fewer quarters in the case of successor metrics, available in the database maintained by CMS and known as the care compare, in the most recent month of the calendar year during which the fiscal year for which the rate is determined begins. The metrics specified by division (C)(1)(b) of this section shall not be recalculated. In redetermining the quality payment for each facility based on the recalculated points, the department shall use the same per point value determined for the quality payment at the start of the fiscal year.

(D) A nursing facility shall not receive a quality incentive payment if the Department of Health assigned the nursing facility to the SFF list under the special focus facility program and the nursing facility is listed in table A, on the first day of May of the calendar year for which the rate is being determined.

(E) The total amount to be spent on quality incentive payments under division (B) of this section for a fiscal year shall be determined as follows:

(1) Determine the following amount for each nursing facility:

(a) The amount that is five and two-tenths per cent of the nursing facility's base rate for nursing facility services provided on the first day of the state fiscal year plus one dollar and seventy-nine cents plus sixty per cent of the per diem amount by which the nursing facility's rate for direct care costs determined for the fiscal year under section 5165.19 of the Revised Code changed as a result of the rebasing conducted under section 5165.36 of the Revised Code.

(b) Multiply the amount determined under division (E)(1)(a) of this section by the number of the nursing facility's medicaid days for the calendar year preceding the fiscal year for which the rate is determined.

(2) Determine the sum of the products determined under division (E)(1)(b) of this section for all nursing facilities for which the product was determined for the state fiscal year.

(3) To the sum determined under division (E)(2) of this section, add one hundred twenty-five million dollars.

(F)(1) Beginning July 1, 2023, a new nursing facility shall receive a quality incentive payment for the fiscal year in which the new facility obtains an initial provider agreement and the immediately following fiscal year equal to the median quality incentive payment determined for nursing facilities for the fiscal year. For the state fiscal year after the immediately following fiscal year and subsequent fiscal years, the quality incentive payment shall be determined under division (C) of this section.

(2) A nursing facility that undergoes a change of operator with an effective date of July 1, ~~2023~~2025, or later shall not receive a quality incentive payment until the earlier of the first day of January or the first day of July that is at least six months after the effective date of the change of operator. Thereafter any quality incentive payment shall be determined under division (C) of this section.

~~(3) A nursing facility that undergoes a change of owner with an effective date of July 1, 2023, or later shall not receive a quality incentive payment until the earlier of the first day of January or the first day of July that is at least six months after the effective date of the change of owner if, within one year after the change of owner, there is an increase in the lease payments or other financial obligations of the operator to the owner above the payments or obligations specified by the agreement between the previous owner and the operator. Thereafter, any quality incentive payments for the facility shall be determined under division (C) of this section.~~

Sec. 5166.03. The medicaid director may not submit a request to the United States secretary of health and human services for a medicaid waiver under the "Social Security Act," section 1115, 42 U.S.C. 1315, unless the director provides the speaker of the house of representatives and president of the senate written notice of the director's intent to submit the request at least ten days before the date the director submits the request to the United States secretary. The notice shall include a detailed explanation of the medicaid waiver the director proposes to seek and confirmation that the department of medicaid has complied with the requirements of section 5162.08 of the Revised Code.

Sec. 5166.50. (A) Within one year of the effective date of this section, the department of medicaid shall apply for a medicaid waiver component to provide reentry services to medicaid-eligible imprisoned individuals for ninety days before an imprisoned individual's expected release date. The benefits provided shall include:

(1) Mental health services;

(2) Behavioral health services;

(3) Substance use disorder treatment and related services;

(4) A thirty-day supply of prescription medication at the time of release, including medication administered by injection.

(B) The department shall implement the medicaid waiver component within one year after

approval from the United States centers for medicare and medicaid services.

(C)(1) If the department is unable to apply for the medicaid waiver component within the time frame specified in division (A) of this section, the department shall request an extension of up to thirty days from the speaker of the house of representatives and the president of the senate.

(2) If the department is unable to implement the medicaid waiver component within the time frame specified in division (B) of this section, the department shall request an extension for the amount of time needed to implement the waiver component from the speaker of the house of representatives and the president of the senate.

(D) If the medicaid waiver component is not approved by the United States centers for medicare and medicaid services, the department shall reapply for the waiver within four years after the effective date of this section.

Sec. 5167.01. As used in this chapter:

(A) "~~340B covered entity grantee~~" means an entity described in section 340B(a)(4)(A)-(K) of the "Public Health Service Act," 42 U.S.C. 256b(a)(4)(A)-(K) that is designated as an active (A)-(K) entity under the health resources and services administration covered entity daily report, and includes any pharmacy under contract with the entity to dispense drugs on behalf of the entity.

(B) "Affiliated company" means an entity, including a third-party payer or specialty pharmacy, with common ownership, members of a board of directors, or managers, or that is a parent company, subsidiary company, jointly held company, or holding company with respect to the other entity.

(C) "Care management system" means the system established under section 5167.03 of the Revised Code.

(D) "Controlled substance" has the same meaning as in section 3719.01 of the Revised Code.

(E) "Dual eligible individual" has the same meaning as in section 5160.01 of the Revised Code.

(F) "Emergency services" has the same meaning as in the "Social Security Act," section 1932(b)(2), 42 U.S.C. 1396u-2(b)(2).

(G) "Enrollee" means a medicaid recipient who participates in the care management system and enrolls in a medicaid MCO plan.

(H) "ICDS participant" ~~has and~~ "integrated care delivery system" have the same ~~meaning~~ meanings as in section 5164.01 of the Revised Code.

(I) "ICDS successor program" means a fully integrated dual eligible special needs plan established in accordance with 42 C.F.R. 422.107, that the department of medicaid utilizes as a replacement for the integrated care delivery system.

(J) "Medicaid managed care organization" means a managed care organization under contract with the department of medicaid pursuant to section 5167.10 of the Revised Code.

~~(K)~~ "Medicaid MCO plan" means a plan that a medicaid managed care organization, pursuant to its contract with the department of medicaid under section 5167.10 of the Revised Code,

makes available to medicaid recipients participating in the care management system.

~~(K)~~(L) "Medicaid waiver component" has the same meaning as in section 5166.01 of the Revised Code.

~~(L)~~(M) "Network provider" has the same meaning as in 42 C.F.R. 438.2.

~~(M)~~(N) "Nursing facility services" has the same meaning as in section 5165.01 of the Revised Code.

~~(N)~~(O) "Part B drug" means a drug or biological described in section 1842(o)(1)(C) of the "Social Security Act," 42 U.S.C. 1395u(o)(1)(C).

~~(O)~~(P) "Pharmacy benefit manager" has the same meaning as in section 3959.01 of the Revised Code.

~~(P)~~(Q) "Practice of pharmacy" has the same meaning as in section 4729.01 of the Revised Code.

~~(Q)~~(R) "Prescribed drug" has the same meaning as in section 5164.01 of the Revised Code.

~~(R)~~(S) "Prior authorization requirement" has the same meaning as in section 5160.34 of the Revised Code.

~~(S)~~(T) "Provider" means any person or government entity that furnishes services to a medicaid recipient enrolled in a medicaid MCO plan, regardless of whether the person or entity has a provider agreement.

~~(T)~~(U) "Provider agreement" has the same meaning as in section 5164.01 of the Revised Code.

~~(U)~~(V) "State pharmacy benefit manager" means the pharmacy benefit manager selected by and under contract with the medicaid director under section 5167.24 of the Revised Code.

~~(V)~~(W) "Third-party administrator" means any person who adjusts or settles claims on behalf of an insuring entity in connection with life, dental, health, prescription drugs, or disability insurance or self-insurance programs and includes a pharmacy benefit manager.

Sec. 5167.03. (A) As part of the medicaid program, the department of medicaid shall establish a care management system. The department shall implement the system in some or all counties.

(B) The department shall designate the medicaid recipients who are required or permitted to participate in the care management system. Those who shall be required to participate in the system include medicaid recipients who receive cognitive behavioral therapy as described in division (A)(2) of section 5167.16 of the Revised Code. Except as provided in section 5166.406 of the Revised Code, no medicaid recipient participating in the healthy Ohio program established under section 5166.40 of the Revised Code shall participate in the system.

~~The~~ (C) ~~Except as otherwise provided in this section, the general assembly's authorization through the enactment of legislation is needed before home and community-based services available under a medicaid waiver component or nursing facility services are included in the care management system, except that, ICDS participants, or participants in the ICDS successor program, may be~~

required or permitted to obtain such services under the system. Medicaid recipients who receive such services may be designated for voluntary or mandatory participation in the system in order to receive other health care services included in the system. *RM*

The ~~(D)~~ Subject to division (E) of this section, the department may require or permit participants in the care management system to do either or both of the following:

~~(A)~~ (1) Obtain health care services from providers designated by the department;

~~(B)~~ (2) Enroll in a medicaid MCO plan.

RM (E)(1) The department shall allow individuals participating in the care management system to enroll in the medicaid MCO plan of the individual's choosing. If an individual does not elect a medicaid MCO plan in which to enroll during the time period specified by the department, the department shall randomly assign the individual to a medicaid MCO plan. When assigning individuals to a medicaid MCO plan under this division, the department shall not give preference to any specific medicaid MCO plan or group of plans.

(2) If the department is unable to satisfy the requirements established under division (E)(1) of this section, it shall notify the general assembly, the legislative service commission, and the auditor of state not later than thirty days after making such a determination. As part of the notice required under this division, the department shall provide an explanation as to why it is unable to satisfy the requirements.

Sec. 5167.09. The department of medicaid shall include all of the following on the department's managed care financial dashboard:

(A) Actuarial metrics for annual and quarterly cost reports, delineated by the following categories:

(1) Adults for whom financial eligibility for the medicaid program is determined by utilizing the modified adjusted gross income standard and who are not members of the expansion eligibility group;

(2) Children for whom financial eligibility for the medicaid program is determined by utilizing the modified adjusted gross income standard;

(3) Individuals in the aged, blind, and disabled eligibility group who are twenty-one years of age or older;

(4) Individuals in the aged, blind, and disabled eligibility group who are twenty years of age or younger;

(5) Individuals who are members of the expansion eligibility group;

(6) Individuals who are members of the adoption and foster kids eligibility group;

(7) All other individuals eligible for medicaid benefits who are not included in another category described in division (A) of this section.

(B) Quarterly and annual composite per member per month category of service reports for each managed care organization providing services under the care management system, delineated into the following categories:

The above boxed and initialed text was disapproved.

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Mike DeWine

- (1) Inpatient services;
- (2) Outpatient facility services;
- (3) Professional services;
- (4) Radiology, pathology, and laboratory services;
- (5) Pharmacy services;
- (6) Behavioral health services;
- (7) All other services.

(C) As used in this section, "expansion eligibility group" has the same meaning as in section 5163.01 of the Revised Code.

Sec. 5167.123. (A) No contract between a medicaid managed care organization, including a third-party administrator, and a 340B ~~covered entity grantee~~ shall contain any of the following provisions:

(1) A payment rate for a prescribed drug provided by a 340B grantee to an individual as a result of health care services provided by the grantee directly to the individual, that is less than the national average drug acquisition cost rate for that drug as determined by the United States centers for medicare and medicaid services, measured at the time the drug is administered or dispensed, or, if no such rate is available at that time, a reimbursement rate that is less than the wholesale acquisition cost of the drug, as defined in 42 U.S.C. 1395w-3a(c)(6)(B) payment rate applied to health care providers that are not 340B grantees;

(2) A fee that is not imposed on a health care provider that is not a 340B ~~covered entity grantee~~;

(3) A fee amount that exceeds the amount for a health care provider that is not a 340B ~~covered entity grantee~~.

(B) The organization, or its contracted third-party administrators, shall not discriminate against a 340B ~~covered entity grantee~~ in a manner that prevents or interferes with a medicaid recipient's choice to receive a prescription drug from a 340B ~~covered entity or its contracted pharmacies grantee~~.

(C) Any provision of a contract entered into between the organization and a 340B ~~covered entity grantee~~ that is contrary to division (A) of this section is unenforceable and shall be replaced with the dispensing fee or payment rate that applies for health care providers that are not 340B ~~covered entities grantees~~.

(D) A medicaid managed care organization or a third-party administrator shall provide a payment rate for all prescribed drugs obtained through the federal 340B drug pricing program by providers that are not 340B grantees that is equal to the payment rate for those prescribed drugs that is specified in the medicaid state plan.

(E) Any payment made pursuant to a payment rate described in this section is subject to audit by the department of medicaid under section 5160.20 of the Revised Code.

Sec. 5167.24. (A) If the department of medicaid includes prescribed drugs in the care

management system as authorized under section 5167.05 of the Revised Code, the medicaid director, through a procurement process, shall select a third-party administrator to serve as the single pharmacy benefit manager used by medicaid managed care organizations under the care management system. The state pharmacy benefit manager shall be responsible for processing all pharmacy claims under the care management system. The department of medicaid is responsible for enforcing the contract after the procurement process.

(B) As part of the procurement process, the director shall do all of the following:

- (1) Accept applications from entities seeking to become the state pharmacy benefit manager;
- (2) Establish eligibility criteria an entity must meet in order to become the state pharmacy benefit manager;
- (3) Select and contract with a single state pharmacy benefit manager;
- (4) Develop a master contract to be used by the director when contracting with the state pharmacy benefit manager, which shall prohibit the state pharmacy benefit manager from requiring a medicaid recipient to obtain a specialty drug from a specialty pharmacy owned or otherwise associated with the state pharmacy benefit manager.

(C) A prospective state pharmacy benefit manager shall disclose to the director all of the following during the procurement process:

(1) Any activity, policy, practice, contract, or arrangement of the state pharmacy benefit manager that may directly or indirectly present any conflict of interest with the pharmacy benefit manager's relationship with or obligation to the department or a medicaid managed care organization;

(2) All common ownership, members of a board of directors, managers, or other control of the pharmacy benefit manager (or any of the pharmacy benefit manager's affiliated companies) with any of the following:

- (a) A medicaid managed care organization and its affiliated companies;
- (b) An entity that contracts on behalf of a pharmacy or any pharmacy services administration organization and its affiliated companies;
- (c) A drug wholesaler or distributor and its affiliated companies;
- (d) A third-party payer and its affiliated companies;
- (e) A pharmacy and its affiliated companies.

(3) Any direct or indirect fees, charges, or any kind of assessments imposed by the pharmacy benefit manager on pharmacies licensed in this state with which the pharmacy benefit manager shares common ownership, management, or control; or that are owned, managed, or controlled by any of the pharmacy benefit manager's affiliated companies;

(4) Any direct or indirect fees, charges, or any kind of assessments imposed by the pharmacy benefit manager on pharmacies licensed in this state;

~~(6)~~(5) Any financial terms and arrangements between the pharmacy benefit manager and a prescription drug manufacturer or labeler, including formulary management, drug substitution

programs, educational support claims processing, or data sales fees.

~~(D) The director shall select a provisional state pharmacy benefit manager not later than July 1, 2020.~~

~~(1) Once a provisional state pharmacy benefit manager has been selected, full implementation of the entity as the state pharmacy benefit manager shall be subject to that entity's demonstrated ability to fulfill the duties and obligations of the state pharmacy benefit manager as illustrated through a readiness review process established by the director. Any entity failing to complete the readiness review process shall be deemed as having not met the criteria of the review process. The selected entity shall not enter into contracts with the department or medicaid managed care organizations as the state pharmacy benefit manager before the date on which the entity has satisfactorily completed the readiness review process.~~

~~(2) If the director determines that, for reasons beyond the director's control, selection of a provisional state pharmacy benefit manager cannot occur before July 1, 2020, the director shall notify the joint medicaid oversight committee of the reasons for the delay and identify the steps the director is taking to complete the selection as expeditiously as possible.~~

Sec. 5168.08. (A) Before or during each program year, the department of medicaid shall issue to each hospital the preliminary determination of the amount that the hospital is assessed under section 5168.06 of the Revised Code during the program year. The preliminary determination of a hospital's assessment shall be calculated for a cost-reporting period that is specified in rules adopted under section 5168.02 of the Revised Code.

The department shall consult with hospitals each year when determining the date on which it will issue the preliminary determinations in order to minimize hospitals' cash flow difficulties.

If no hospital submits a request for reconsideration under division (B) of this section, the preliminary determination constitutes the final reconciliation of each hospital's assessment under section 5168.06 of the Revised Code. The final reconciliation is constitutes an interim final order and may be subject to adjustments under made by the United States centers for medicare and medicaid services pursuant to division (D) of this section.

(B) Not later than fourteen days after the preliminary determinations are issued, any hospital may submit to the department a written request to reconsider the preliminary determinations. The request shall be accompanied by written materials setting forth the basis for the reconsideration, which may be delivered to the department by regular mail, electronic mail, or in-person delivery. ~~If one or more hospitals submit a request, the department shall hold a public hearing not later than thirty days after the preliminary determinations are issued to reconsider the preliminary determinations. The department shall issue to each hospital a written notice of the date, time, and place of the hearing at least ten days prior to the hearing.~~ On the basis of the evidence submitted to the department ~~or presented at the public hearing~~, the department shall reconsider and may adjust the preliminary determinations. The result of the reconsideration is the final reconciliation of the hospital's assessment under section 5168.06 of the Revised Code. The final reconciliation is

constitutes an interim final order and may be subject to adjustments under-by the United States centers for medicare and medicaid services pursuant to division (D) of this section.

(C) The department shall issue to each hospital a written notice of its assessment for the program year under the final reconciliation. A hospital may appeal the final reconciliation of its assessment to the court of common pleas of Franklin county, pursuant to Chapter 2505. of the Revised Code. The complete record of the proceedings shall include all documentation considered by the department in issuing the final reconciliation. While a judicial appeal is pending, the hospital shall pay, in accordance with the schedules required by division (B) of section 5168.06 of the Revised Code, any amount of its assessment that is not in dispute into the hospital care assurance program fund created in section 5168.11 of the Revised Code.

(D) In the course of any program year, the department may adjust the assessment rate or rates established in rules pursuant to section 5168.06 of the Revised Code or adjust the amounts of intergovernmental transfers required under section 5168.07 of the Revised Code and, as a result of the adjustment, adjust each hospital's assessment and intergovernmental transfer, to reflect refinements made by the United States centers for medicare and medicaid services during that program year to the limits it prescribed under the "Social Security Act," section 1923(f), 42 U.S.C. 1396r-4(f). When adjusted, the assessment rate or rates must comply with division (A) of section 5168.06 of the Revised Code. An adjusted intergovernmental transfer must comply with division (A) of section 5168.07 of the Revised Code. The department shall notify hospitals of adjustments made under this division and adjust for the remainder of the program year the installments paid by hospitals under sections 5168.06 and 5168.07 of the Revised Code in accordance with rules adopted under section 5168.02 of the Revised Code.

Sec. 5168.11. (A) Except as provided in section 5162.52 of the Revised Code, all payments of assessments by hospitals under section 5168.06 of the Revised Code and all intergovernmental transfers under section 5168.07 of the Revised Code shall be deposited in the state treasury to the credit of the hospital care assurance program fund, hereby created. All investment earnings of the hospital care assurance program fund shall be credited to the fund. The department of medicaid shall maintain records that show the amount of money in the hospital care assurance program fund at any time that has been paid by each hospital and the amount of any investment earnings on that amount. All moneys credited to the hospital care assurance program fund shall be used solely to make payments to hospitals under division (D) of this section and section 5168.09 of the Revised Code.

(B) All federal matching funds received as a result of the department distributing funds from the hospital care assurance program fund to hospitals under section 5168.09 of the Revised Code shall be credited to the health care - federal fund created under section 5162.50 of the Revised Code.

(C) All distributions of funds to hospitals under section 5168.09 of the Revised Code are conditional on:

(1) Expiration of the time for appeals under section 5168.08 of the Revised Code without the filing of an appeal, or on court determinations, in the event of appeals, that the hospital is entitled to

the funds;

(2) The sum of the following being sufficient to distribute the funds after the final determination of any appeals:

(a) The available money in the hospital care assurance program fund;

(b) The available portion of the money in the health care - federal fund that is credited to that fund pursuant to division (B) of this section.

(3) The hospital's compliance with section 5168.14 of the Revised Code.

(D) If an audit conducted by the department, pursuant to 42 C.F.R. 455.304, of the amounts of payments made and funds received by hospitals under sections 5168.06, 5168.07, and 5168.09 of the Revised Code identifies amounts that, due to errors by the department, a hospital should not have been required to pay but did pay, should have been required to pay but did not pay, should not have received but did receive, or should have received but did not receive, the department shall:

(1) Make payments to any hospital that the audit reveals paid amounts it should not have been required to pay or did not receive amounts it should have received;

(2) Take action to recover from a hospital any amounts that the audit reveals it should have been required to pay but did not pay or that it should not have received but did receive.

Payments made under division (D)(1) of this section shall be made from the hospital care assurance program fund. Amounts recovered under division (D)(2) of this section shall be deposited to the credit of that fund. ~~Any hospital may appeal the amount.~~ An action authorized under Chapter 2721. of the Revised Code and filed in Franklin county shall be the exclusive remedy for any hospital that disagrees with the amount that the hospital is to be paid under division (D)(1) or the amount that is to be recovered from the hospital under division (D)(2) of this section to the court of common pleas of Franklin county. While any judicial proceeding is pending under division (D) of this section, a hospital shall pay to the hospital care assurance program fund any amount identified pursuant to division (D)(2) of this section that is not in dispute.

Sec. 5168.22. (A) Before or during each assessment program year, the department of medicaid shall issue to each hospital the preliminary determination of the amount that the hospital is assessed under section 5168.21 of the Revised Code for the assessment program year. Except as provided in division (B) of this section, the preliminary determination becomes the final determination for the assessment program year fifteen days after the preliminary determination is issued to the hospital.

(B) A hospital may request that the department reconsider the preliminary determination issued to the hospital under division (A) of this section by submitting to the department a written request for a reconsideration not later than fourteen days after the hospital's preliminary determination is issued to the hospital. The request must be accompanied by written materials setting forth the basis for the reconsideration, which may be delivered to the department by regular mail, electronic mail, or in-person delivery. On receipt of the timely request, the department shall reconsider the preliminary determination and may adjust the preliminary determination on the basis

of the written materials accompanying the request. The result of the reconsideration is the final determination of the hospital's assessment under section 5168.21 of the Revised Code for the assessment program year.

(C) The department shall issue to each hospital a written notice of the final determination of its assessment for the assessment program year. A hospital may appeal the final determination to the court of common pleas of Franklin county, pursuant to Chapter 2505. of the Revised Code. The complete record of the proceedings shall include all documentation considered by the department in issuing the final determination. While a judicial appeal is pending, the hospital shall pay, in accordance with section 5168.23 of the Revised Code, any amount of its assessment that is not in dispute.

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Sec. 5168.25. There is hereby created in the state treasury the hospital assessment fund. All installment payments made by hospitals under section 5168.23 of the Revised Code and all recoveries the department of medicaid makes under section 5168.24 of the Revised Code shall be deposited into the fund. ~~All investment earnings of the fund shall be credited to the fund.~~ The department shall use money in the fund to pay for the costs of the medicaid program, including the program's administrative costs.

Sec. 5168.90. (A) At least quarterly, the medicaid director shall report to the ~~members of the joint medicaid oversight committee and the executive director of the joint medicaid oversight committee~~ legislative service commission both of the following:

- (1) The fee rates and the aggregate total of the fees assessed for each of the following:
 - (a) The hospital assessment established under section 5168.21 of the Revised Code;
 - (b) The nursing home and hospital long-term care unit franchise permit fee under section 5168.41 of the Revised Code;
 - (c) The ICF/IID franchise permit fee under section 5168.61 of the Revised Code;
 - (d) The health insuring corporation franchise fee under section 5168.76 of the Revised Code.
- (2) If there is a rate increase for any of the fee rates listed under division (A)(1) of this section pending before the centers for medicare and medicaid services.

(B) The director may adopt rules under section 5162.02 of the Revised Code to compile and submit the reports required under this section, including rules, as authorized under section 5162.021 of the Revised Code, that specify the information that must be submitted to the director by the department of developmental disabilities regarding the ICF/IID franchise permit fee.

~~Sec. 5104.50~~ 5180.04. (A) The governor shall create the ~~early childhood children and youth~~ advisory council in accordance with 42 U.S.C. 9837b(b)(1) and 20 U.S.C. 1441 and shall appoint one of its members to serve as chairperson of the council with the director of children and youth serving as co-chairperson. ~~The~~

(B)(1) The council shall serve as both the state advisory council on early childhood education and care, as described in 42 U.S.C. 9837b(b)(1), and the state interagency coordinating council, as described in 20 U.S.C. 1441. ~~In addition to the duties specified in 42 U.S.C. 9837b(b)(1).~~

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Date: _____

Mike DeWine

Mike DeWine, Governor

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(2) The council shall ~~promote~~ advise the governor on the availability, accessibility, affordability, and quality of services provided through the prenatal and child-serving systems. This includes fostering a continuum of care that promotes family-centered programs and services that acknowledge and support the social, emotional, cognitive, intellectual, and physical development of children and the vital role of families in ensuring the well-being and success of children.

(3) The ~~early childhood advisory~~ council shall advise the director of children and youth on matters affecting the licensing of centers, type A homes, and type B homes and the certification of in-home aides. The council shall make an annual report to the director that addresses the availability, affordability, accessibility, and quality of child care and that summarizes the recommendations and plans of action that the council has proposed to the director during the preceding fiscal year. The director shall provide copies of the report to the governor, speaker and minority leader of the house of representatives, and the president and minority leader of the senate and, on request, shall make copies available to the public.

(C)(1) The advisory council shall include up to twenty-five members appointed by the governor, including the following:

- (a) At least one representative of the department of children and youth;
- (b) At least one representative of the department of medicaid;
- (c) At least one representative of the department of job and family services;
- (d) At least one representative of the department of behavioral health ;
- (e) At least one representative of the department of education and workforce;
- (f) At least one representative of the department of health;
- (g) At least one representative of the department of developmental disabilities;
- (h) At least one representative of the department of youth services;
- (i) At least one representative from each of the following stakeholder groups, selected from multi-sized municipal corporations and geographically diverse areas of the state, including rural, urban, and suburban areas:

- (i) Maternal and infant vitality;
- (ii) Early intervention;
- (iii) Home visiting;
- (iv) Early childhood education;
- (v) Child care centers providing publicly funded child care;
- (vi) Family child care homes providing publicly funded child care;
- (vii) School child programs;
- (viii) Preschool programs;
- (ix) Children's services.

(2) In making appointments to the advisory council, the governor shall ensure that the membership of the council reasonably represents the population of the state.

(D)(1) The advisory council shall create topic-specific advisory groups that address a continuum of services including the following:

- (a) Early childhood education and care;
- (b) Children services;
- (c) Maternal and infant vitality;
- (d) Early childhood mental health services and supports;
- (e) Early intervention services.

(2) No representative of the department of children and youth shall serve as a chairperson for a topic-specific advisory group.

(3) The governor shall appoint additional members as necessary to the early childhood education and care advisory group and the early intervention services advisory group to satisfy the requirements of 42 U.S.C. 9837b(b)(1) and 20 U.S.C. 1441.

(4) The director of children and youth shall appoint each representative appointed pursuant to division (C)(1)(i) of this section to at least one topic-specific advisory group.

Sec. 5180.14. (A) As used in this section and sections 5180.15, 5180.16, and 5180.17 of the Revised Code:

(1) "Child care center," "type A family child care home," and "licensed type B family child care home" have the same meanings as in section 5104.01 of the Revised Code.

(2) "Child care facility" means a child care center, a type A family child care home, or a licensed type B family child care home.

(3) "Foster caregiver" has the same meaning as in section 5103.02 of the Revised Code.

(4) "Freestanding birthing center" has the same meaning as in section 3701.503 of the Revised Code.

(5) "Hospital" has the same meaning as in section 3722.01 of the Revised Code to which either of the following applies:

(a) The hospital has a maternity unit.

(b) The hospital receives for care infants who have been transferred to it from other facilities and who have never been discharged to their residences following birth.

(6) "Infant" means a child who is less than one year of age.

(7) "Maternity unit" means the distinct portion of a hospital in which maternity services are provided.

(8) "Other person responsible for the infant" includes a foster caregiver.

(9) "Parent" means either parent, unless the parents are separated or divorced or their marriage has been dissolved or annulled, in which case "parent" means the parent who is the residential parent and legal custodian of the child. "Parent" also means a prospective adoptive parent with whom a child is placed.

(10) "Shaken baby syndrome" means signs and symptoms, including, but not limited to, retinal hemorrhages in one or both eyes, subdural hematoma, or brain swelling, resulting from the

violent shaking or the shaking and impacting of the head of an infant or small child.

(B) The director of children and youth shall establish the shaken baby syndrome education program by doing all of the following:

(1) Developing educational materials that present readily comprehensible information on shaken baby syndrome;

(2) Making available on the department of children and youth web site in an easily accessible format the educational materials developed under division (B)(1) of this section;

(3) Annually assessing the effectiveness of the shaken baby syndrome education program by doing all of the following:

(a) Evaluating the reports received pursuant to section ~~5101.135~~ 5180.405 of the Revised Code;

(b) Reviewing the content of the educational materials to determine if updates or improvements should be made;

(c) Reviewing the manner in which the educational materials are distributed, as described in section 5180.15 of the Revised Code, to determine if modifications to that manner should be made.

(C) In meeting the requirements under division (B) of this section, the director shall develop educational materials that, to the extent possible, minimize administrative or financial burdens on any of the entities or persons listed in section 5180.15 of the Revised Code.

Sec. 5180.17. (A) As used in this section:

(1) "Contractor" means a person who provides personal services pursuant to a contract.

(2) "Critical access hospital" means a facility designated as a critical access hospital by the director of health under section 3701.073 of the Revised Code.

(3) "Crib" includes a portable play yard or other suitable sleeping place.

(B) Each hospital and freestanding birthing center shall implement an infant safe sleep screening procedure. The purpose of the procedure is to determine whether there will be a safe crib for an infant to sleep in once the infant is discharged from the facility to the infant's residence following birth. The procedure shall consist of questions that facility staff or volunteers must ask the infant's parent, guardian, or other person responsible for the infant regarding the infant's intended sleeping place and environment.

The director of children and youth shall develop questions that facilities may use when implementing the infant safe sleep screening procedure required by this division. The director may consult with persons and government entities that have expertise in infant safe sleep practices when developing the questions.

(C) If, prior to an infant's discharge from a facility to the infant's residence following birth, a facility other than a critical access hospital or a facility identified under division (D) of this section determines through the procedure implemented under division (B) of this section that the infant is unlikely to have a safe crib at the infant's residence, the facility shall make a good faith effort to arrange for the parent, guardian, or other person responsible for the infant to obtain a safe crib at no

charge to that individual. In meeting this requirement, the facility may do any of the following:

- (1) Obtain a safe crib with its own resources;
- (2) Collaborate with or obtain assistance from persons or government entities that are able to procure a safe crib or provide money to purchase a safe crib;
- (3) Refer the parent, guardian, or other person responsible for the infant to a person or government entity described in division (C)(2) of this section to obtain a safe crib free of charge from that source;
- (4) If funds are available for the cribs for kids program or a successor program administered by the department of children and youth, refer the parent, guardian, or other person responsible for the infant to a site, designated by the department for purposes of the program, at which a safe crib may be obtained at no charge.

If a safe crib is procured as described in division (C)(1), (2), or (3) of this section, the facility shall ensure that the crib recipient receives safe sleep education and crib assembly instructions from the facility or another source. If a safe crib is procured as described in division (C)(4) of this section, the department of children and youth shall ensure that the cribs for kids program or a successor program administered by the department provides safe sleep education and crib assembly instructions to the recipient.

(D) The director of children and youth shall identify the facilities in this state that are not critical access hospitals and are not served by a site described in division (C)(4) of this section. The director shall identify not less than annually the facilities that meet both criteria and notify those that do so.

(E) When a facility that is a hospital registers with the department of health under section 3701.07 of the Revised Code or a facility that is a freestanding birthing center renews its license in accordance with rules adopted under section 3702.30 of the Revised Code, the facility shall report the following information to the department of children and youth in a manner the department prescribes:

- (1) The number of safe cribs that the facility obtained and distributed by using its own resources as described in division (C)(1) of this section since the last time the facility reported this information to the department;
- (2) The number of safe cribs that the facility obtained and distributed by collaborating with or obtaining assistance from another person or government entity as described in division (C)(2) of this section since the last time the facility reported this information to the department;
- (3) The number of referrals that the facility made to a person or government entity as described in division (C)(3) of this section since the last time the facility reported this information to the department;
- (4) The number of referrals that the facility made to a site designated by the department as described in division (C)(4) of this section since the last time the facility reported this information to the department;

(5) Demographic information specified by the director of children and youth regarding the individuals to whom safe cribs were distributed as described in division (E)(1) or (2) of this section or for whom a referral described in division (E)(3) or (4) of this section was made;

(6) In the case of a critical access hospital or a facility identified under division (D) of this section, demographic information specified by the director of children and youth regarding each parent, guardian, or other person responsible for the infant determined to be unlikely to have a safe crib at the infant's residence pursuant to the procedure implemented under division (B) of this section;

(7) Any other information collected by the facility regarding infant sleep environments and intended infant sleep environments that the director determines to be appropriate.

(F) The director of children and youth shall prepare a written report that summarizes the information collected under division (E) of this section for the preceding twelve months, assesses whether at-risk families are sufficiently being served by the crib distribution and referral system established by this section, makes suggestions for system improvements, and provides any other information the director considers appropriate for inclusion in the report. On completion, the report shall be submitted to the general assembly with, and in the same manner as, the report that the department of medicaid submits to the general assembly ~~and joint medicaid oversight committee~~ pursuant to section 5162.13 of the Revised Code. A copy of the report also shall be submitted to the governor.

(G) A facility, and any employee, contractor, or volunteer of a facility, that implements an infant safe sleep procedure in accordance with division (B) of this section is not liable for damages in a civil action for injury, death, or loss to person or property that allegedly arises from an act or omission associated with implementation of the procedure, unless the act or omission constitutes willful or wanton misconduct.

A facility, and any employee, contractor, or volunteer of a facility, that implements an infant safe sleep screening procedure in accordance with division (B) of this section is not subject to criminal prosecution or, to the extent that a person is regulated under Title XLVII of the Revised Code, professional disciplinary action under that title, for an act or omission associated with implementation of the procedure.

This division does not eliminate, limit, or reduce any other immunity or defense that a facility, or an employee, contractor, or volunteer of a facility, may be entitled to under Chapter 2744. of the Revised Code, or any other provision of the Revised Code, or the common law of this state.

(H) A facility, and any employee, contractor, or volunteer of a facility, is neither liable for damages in a civil action, nor subject to criminal prosecution, for injury, death, or loss to person or property that allegedly arises from a crib obtained by a parent, guardian, or other person responsible for the infant as a result of any action the facility, employee, contractor, or volunteer takes to comply with division (C) of this section.

The immunity provided by this division does not require compliance with division (D) of

section 2305.37 of the Revised Code.

Sec. 5180.20. (A) The director of children and youth shall identify each government program providing benefits, other than the help me grow program established by the department of children and youth pursuant to section 5180.21 of the Revised Code, that has the goal of reducing infant mortality and negative birth outcomes or the goal of reducing disparities among women who are pregnant or capable of becoming pregnant and who belong to a racial or ethnic minority. A program shall be identified only if it provides education, training, and support services related to those goals to program participants in their homes. The director may consult with the Ohio partnership to build stronger families for assistance with identifying the programs.

(B) An administrator of a program identified under division (A) of this section shall report to the director data on program performance indicators that are used to assess progress toward achieving program goals. The administrator shall report the data in the format and within the time frames specified in rules adopted under division (C) of this section. Using the data reported under this division, the director shall prepare an annual report assessing the performance of each government program identified pursuant to division (A) of this section during the immediately preceding twelve-month period. In addition, the report shall summarize and provide an analysis of the information contained in the "information for medical and health use only" section of the birth records for individuals born during the prior twelve-month period.

The director shall provide a copy of the report to the general assembly ~~and the joint medicare oversight committee. The copy to the general assembly shall be provided~~ in accordance with section 101.68 of the Revised Code.

(C) The director shall adopt rules specifying program performance indicators on which data must be reported by the administrators described in division (B) of this section as well as the format and time frames in which the data must be reported. To the extent possible, the program performance indicators specified in the rules shall be consistent with federal reporting requirements for federally funded home visiting services. The rules shall be adopted in accordance with Chapter 119. of the Revised Code.

Sec. 5180.21. (A) The department of children and youth shall establish the help me grow program as the state's evidence-based parent support program that encourages early prenatal and well-baby care, as well as provides parenting education to promote the comprehensive health and development of children. The program shall provide home visiting services to families with a pregnant woman or child under five years of age that meet the eligibility requirements established in rules adopted under this section. Home visiting services shall be provided through evidence-based home visiting models or innovative, promising home visiting models recommended by the ~~Ohio home visiting consortium~~ children and youth advisory council created under section ~~5180.23~~ 5180.04 of the Revised Code.

(B) Families shall be referred to the appropriate home visiting services through the central intake and referral system created under section 5180.22 of the Revised Code.

(C) To the extent possible, the goals of the help me grow program shall be consistent with the goals of the federal home visiting program, as specified by the maternal and child health bureau of the health resources and services administration in the United States department of health and human services or its successor.

(D) The director of children and youth shall enter into an interagency agreement with one or more state agencies, including the department of developmental disabilities, department of job and family services, department of medicaid, commission on minority health, Ohio fatherhood commission, and children's trust fund board, to implement the help me grow program, to ensure coordination of early childhood programs, and to maximize reimbursement for the help me grow program from any federal source.

In addition to creating the central intake and referral system as described in section 5180.22 of the Revised Code, the department of children and youth shall ensure there is a consistent comprehensive screening and connection program to support the coordination of home visiting services across the state, including through the department of health, department of developmental disabilities, department of job and family services, department of medicaid, and commission on minority health. Following the program's establishment, the department of children and youth shall evaluate the program's effectiveness in coordinating home visiting services at least once annually.

(E) The director may distribute help me grow program funds through contracts, grants, or subsidies to entities providing services under the program.

(F) As a condition of receiving payments for home visiting services, providers shall report to the director data on the program performance indicators, specified in rules adopted under division (G) of this section, that are used to assess progress toward achieving all of the following:

(1) The benchmark domains established for the federal home visiting program, including improvement in maternal and newborn health; reduction in child injuries, abuse, and neglect; improved school readiness and achievement; reduction in crime and domestic violence; and improved family economic self-sufficiency;

(2) Improvement in birth outcomes and reduction in stillbirths, as that term is defined in section 5180.12 of the Revised Code;

(3) Reduction in tobacco use by pregnant women, new parents, and others living in households with children.

The providers shall report the data in the format and within the time frames specified in the rules.

The director shall prepare an annual report on the data received from the providers. Each report shall include an evaluation addressing the number of families and children served, the number and type of services provided, health and developmental outcomes for participating families and children, and variation in outcomes between the types of home visiting programs specified in division (B)(3) of section 5180.22 of the Revised Code. The director shall submit the report to the general assembly in accordance with section 101.68 of the Revised Code and make the report

available on the internet web site maintained by the department of children and youth.

(G) Pursuant to Chapter 119. of the Revised Code, the director shall adopt rules that are necessary and proper to implement this section. The rules shall specify all of the following:

- (1) Subject to division (H) of this section, eligibility requirements for home visiting services;
- (2) Eligibility requirements for providers of home visiting services;
- (3) Standards and procedures for the provision of program services, including data collection, program monitoring, and program evaluation;
- (4) Procedures for appealing the denial of an application for program services or the termination of services;
- (5) Procedures for appealing the denial of an application to become a provider of program services or the termination of the department's approval of a provider;
- (6) Procedures for addressing complaints;
- (7) The program performance indicators on which data must be reported by providers of home visiting services under division (F) of this section, which, to the extent possible, shall be consistent with federal reporting requirements for federally funded home visiting services;
- (8) The format in which reports must be submitted under division (F) of this section and the time frames within which the reports must be submitted;
- (9) Criteria for payment of approved providers of program services;
- (10) Any other rules necessary to implement the program.

(H) When adopting rules required by division (G)(1) of this section, the director shall specify that families residing in the urban and rural communities specified in rules adopted under section 3701.142 of the Revised Code and families in the child welfare system are to receive priority over other families for home visiting services.

(I) The department, in collaboration with the departments of job and family services and medicaid, shall propose strategies to increase the workforce capacity of home visiting service providers and parenting support professionals, including efforts to incentivize and retain such providers and professionals in this state.

Sec. 5180.22. (A) The department of children and youth shall create a central intake and referral system for all home visiting programs operating in this state. Through a competitive bidding process, the department of children and youth may select one or more persons or government entities to operate the system. In its oversight of the one or more system operators, the department shall streamline the system to ensure families and children receive services from home visiting programs as described in division (B)(3) of this section.

(B) If the department of children and youth chooses to select one or more system operators as described in division (A) of this section, a contract with any system operator shall require that the system do all of the following:

- (1) Serve as a single point of entry for access, assessment, and referral of families and children to appropriate home visiting services based on each family's location of residence;

(2) Use a standardized form or other mechanism to assess each family member's risk factors and social determinants of health;

(3) Ensure that families and children are referred to and receive services from home visiting programs that are appropriate to their level of needs, including the following:

(a) Programs using home visiting contractors that provide services within a pathways community HUB certified by the pathways community HUB institute;

(b) Programs that provide services using the early head start home-based option.

(C) The standardized form or other mechanism described in division (B)(2) of this section shall be agreed to by the ~~home-visiting-consortium-children and youth advisory council~~ created under section ~~5180.23-5180.04~~ of the Revised Code.

(D) A contract entered into under division (B) of this section shall require a system operator to issue an annual report to the department of children and youth that includes data regarding referrals made by the central intake and referral system, costs associated with the referrals, and the quality of services received by families and children who were referred to services through the system. The report shall be distributed to the ~~home-visiting-consortium-children and youth advisory council~~ created under section ~~5180.23-5180.04~~ of the Revised Code.

(E) Nothing in this section is intended to do any of the following:

(1) Prohibit the department of children and youth from using alternative promotional materials or names for the central intake and referral system;

(2) Require the use of help me grow program promotional materials or names;

(3) Prohibit providers, central coordinators, the department of children and youth, or stakeholders from using the help me grow name for promotional materials for home visiting.

Sec. ~~5101.76~~ 5180.26. (A) A residential camp, as defined in section 2151.011 of the Revised Code, a child day camp, as defined in section 5104.01 of the Revised Code, or a child day camp operated by any county, township, municipal corporation, township park district created under section 511.18 of the Revised Code, park district created under section 1545.04 of the Revised Code, or joint recreation district established under section 755.14 of the Revised Code may procure epinephrine autoinjectors for use in emergency situations identified under division (C)(5) of this section by doing one of the following:

(1) Having a licensed health professional authorized to prescribe drugs, acting in accordance with section 4723.483, 4730.433, or 4731.96 of the Revised Code, personally furnish the epinephrine autoinjectors to the camp or issue a prescription for them in the name of the camp;

(2) Obtaining a prescriber-issued protocol that includes definitive orders for epinephrine autoinjectors and the dosages of epinephrine to be administered through them.

A camp that elects to procure epinephrine autoinjectors under this section is encouraged to maintain at least two epinephrine autoinjectors at all times.

(B) A camp that elects to procure epinephrine autoinjectors under this section shall adopt a policy governing their maintenance and use. Before adopting the policy, the camp shall consult with

a licensed health professional authorized to prescribe drugs.

(C) The policy adopted under division (B) of this section shall do all of the following:

(1) Identify the one or more locations in which an epinephrine autoinjector must be stored;

(2) Specify the conditions under which an epinephrine autoinjector must be stored, replaced, and disposed;

(3) Specify the individuals employed by or under contract with the camp who may access and use an epinephrine autoinjector to provide a dosage of epinephrine to an individual in an emergency situation identified under division (C)(5) of this section;

(4) Specify any training that employees or contractors specified under division (C)(3) of this section must complete before being authorized to access and use an epinephrine autoinjector;

(5) Identify the emergency situations, including when an individual exhibits signs and symptoms of anaphylaxis, in which employees or contractors specified under division (C)(3) of this section may access and use an epinephrine autoinjector;

(6) Specify that assistance from an emergency medical service provider must be requested immediately after an epinephrine autoinjector is used;

(7) Specify the individuals to whom a dosage of epinephrine may be administered through an epinephrine autoinjector in an emergency situation specified under division (C)(5) of this section.

(D)(1) The following are not liable in damages in a civil action for injury, death, or loss to person or property that allegedly arises from an act or omission associated with procuring, maintaining, accessing, or using an epinephrine autoinjector under this section, unless the act or omission constitutes willful or wanton misconduct:

(a) A camp;

(b) A camp employee or contractor;

(c) A licensed health professional authorized to prescribe drugs who personally furnishes or prescribes epinephrine autoinjectors, provides a consultation, or issues a protocol pursuant to this section.

(2) This section does not eliminate, limit, or reduce any other immunity or defense that a camp or camp employee or contractor or licensed health professional may be entitled to under Chapter 2744. or any other provision of the Revised Code or under the common law of this state.

(E) A camp may accept donations of epinephrine autoinjectors from a wholesale distributor of dangerous drugs, as defined in section 4729.01 of the Revised Code, and may accept donations of money from any person to purchase epinephrine autoinjectors.

(F) A camp that elects to procure epinephrine autoinjectors under this section shall report to the department of children and youth each procurement and occurrence in which an epinephrine autoinjector is used from a camp's supply of epinephrine autoinjectors.

(G) As used in this section, "licensed health professional authorized to prescribe drugs" and "prescriber" have the same meanings as in section 4729.01 of the Revised Code.

Sec. ~~5401.77~~ 5180.261. (A) As used in this section, "inhaler" means a device that delivers

medication to alleviate asthmatic symptoms, is manufactured in the form of a metered dose inhaler or dry powdered inhaler, and may include a spacer, holding chamber, or other device that attaches to the inhaler and is used to improve the delivery of the medication.

(B) A residential camp, as defined in section 2151.011 of the Revised Code, a child day camp, as defined in section 5104.01 of the Revised Code, or a child day camp operated by any county, township, municipal corporation, township park district created under section 511.18 of the Revised Code, park district created under section 1545.04 of the Revised Code, or joint recreation district established under section 755.14 of the Revised Code may procure inhalers for use in emergency situations identified under division (D)(5) of this section. A camp that elects to procure inhalers under this section is encouraged to maintain at least two inhalers at all times.

(C) A camp that elects to procure inhalers under this section shall adopt a policy governing their maintenance and use. Before adopting the policy, the camp shall consult with a licensed health professional authorized to prescribe drugs, as defined in section 4729.01 of the Revised Code.

(D) A component of a policy adopted by a camp under division (C) of this section shall be a prescriber-issued protocol specifying definitive orders for inhalers, including the dosages of medication to be administered through them, the number of times that each inhaler may be used before disposal, and the methods of disposal. The policy also shall do all of the following:

- (1) Identify the one or more locations in which an inhaler must be stored;
- (2) Specify the conditions under which an inhaler must be stored, replaced, and disposed;
- (3) Specify the individuals employed by or under contract with the camp who may access and use an inhaler to provide a dosage of medication to an individual in an emergency situation identified under division (D)(5) of this section;
- (4) Specify any training that employees or contractors specified under division (D)(3) of this section must complete before being authorized to access and use an inhaler;
- (5) Identify the emergency situations, including when an individual exhibits signs and symptoms of asthma, in which employees or contractors specified under division (D)(3) of this section may access and use an inhaler;
- (6) Specify that assistance from an emergency medical service provider must be requested immediately after an employee or contractor, other than a licensed health professional, uses an inhaler;
- (7) Specify the individuals to whom a dosage of medication may be administered through an inhaler in an emergency situation specified under division (D)(5) of this section.

(E) A camp or camp employee or contractor is not liable in damages in a civil action for injury, death, or loss to person or property that allegedly arises from an act or omission associated with procuring, maintaining, accessing, or using an inhaler under this section, unless the act or omission constitutes willful or wanton misconduct.

This section does not eliminate, limit, or reduce any other immunity or defense that a camp or camp employee or contractor may be entitled to under Chapter 2744. or any other provision of the

Revised Code or under the common law of this state.

(F) A camp may accept donations of inhalers from a wholesale distributor of dangerous drugs, as defined in section 4729.01 of the Revised Code, and may accept donations of money from any person to purchase inhalers.

(G) A camp that elects to procure inhalers under this section shall report to the department of children and youth each procurement and occurrence in which an inhaler is used from a camp's supply of inhalers.

Sec. ~~5101.78~~ 5180.262. (A) As used in this section, "licensed health professional authorized to prescribe drugs" and "prescriber" have the same meanings as in section 4729.01 of the Revised Code.

(B) A residential camp, as defined in section 2151.011 of the Revised Code; a child day camp, as defined in section 5104.01 of the Revised Code; or a child day camp operated by any county, township, municipal corporation, township park district created under section 511.18 of the Revised Code, park district created under section 1545.04 of the Revised Code, or joint recreation district established under section 755.14 of the Revised Code may procure injectable or nasally administered glucagon for use in emergency situations identified under division (D)(5) of this section by doing one of the following:

(1) Having a licensed health professional authorized to prescribe drugs, acting in accordance with section 4723.4811, 4730.437, or 4731.92 of the Revised Code, personally furnish the injectable or nasally administered glucagon to the camp or issue a prescription for the drug in the name of the camp;

(2) Obtaining a prescriber-issued protocol that includes definitive orders for injectable or nasally administered glucagon and the dosages to be administered;

A camp that elects to procure injectable or nasally administered glucagon under this section is encouraged to maintain at least two doses of the drug at all times.

(C) A camp that elects to procure injectable or nasally administered glucagon under this section shall adopt a policy governing maintenance and use of the drug. Before adopting the policy, the camp shall consult with a licensed health professional authorized to prescribe drugs.

(D) The policy adopted under division (C) of this section shall do all of the following:

(1) Identify the one or more locations at the camp in which injectable or nasally administered glucagon must be stored;

(2) Specify the conditions under which injectable or nasally administered glucagon must be stored, replaced, or disposed;

(3) Specify the individuals employed by or under contract with the camp, or who volunteer at the camp, who may access and use injectable or nasally administered glucagon in an emergency situation identified under division (D)(5) of this section;

(4) Specify any training that employees, contractors, or volunteers specified under division (D)(3) of this section must complete before being authorized to access and use injectable or nasally

administered glucagon;

(5) Identify the emergency situations, including when an individual exhibits signs and symptoms of severe hypoglycemia, in which employees, contractors, or volunteers specified under division (D)(3) of this section may access and use injectable or nasally administered glucagon;

(6) Specify that assistance from an emergency medical service provider must be requested immediately after a dose of glucagon is administered;

(7) Specify the individuals to whom a dose of glucagon may be administered in an emergency situation specified under division (D)(5) of this section.

(E)(1) The following are not liable in damages in a civil action for injury, death, or loss to person or property that allegedly arises from an act or omission associated with procuring, maintaining, accessing, or using injectable or nasally administered glucagon under this section, unless the act or omission constitutes willful or wanton misconduct:

(a) A camp;

(b) A camp employee, contractor, or volunteer;

(c) A licensed health professional authorized to prescribe drugs who personally furnishes or prescribes injectable or nasally administered glucagon, provides a consultation, or issues a protocol pursuant to this section;

(2) This section does not eliminate, limit, or reduce any other immunity or defense that a camp; camp employee, contractor, or volunteer; or licensed health professional may be entitled to under Chapter 2744. or any other provision of the Revised Code or under the common law of this state.

(F) A camp may accept donations of injectable or nasally administered glucagon from a wholesale distributor of dangerous drugs or manufacturer of dangerous drugs, as defined in section 4729.01 of the Revised Code, and may accept donations of money from any person to purchase the drug.

(G) A camp that elects to procure injectable or nasally administered glucagon under this section shall report to the department of children and youth each procurement and each occurrence in which a dose of the drug is used from the camp's supply.

Sec. ~~3738.04~~ 5180.27. (A) As used in this section and sections ~~3738.02-5180.271~~ to ~~3738.09~~ 5180.278 of the Revised Code, "pregnancy-associated death" means the death of a woman while pregnant or anytime within one year of pregnancy regardless of cause.

(B) There is hereby established in the department of ~~health-children and youth~~ a pregnancy-associated mortality review (PAMR) board to identify and review all pregnancy-associated deaths statewide for the purpose of reducing the incidence of those deaths.

Sec. ~~3738.02~~ 5180.271. The PAMR board may not conduct a review of a pregnancy-associated death while an investigation of the death or prosecution of a person for causing the death is pending unless the prosecuting attorney agrees to allow the review. The law enforcement agency conducting the criminal investigation, on the conclusion of the investigation, and the prosecuting

attorney prosecuting the case, on the conclusion of the prosecution, shall notify the chairperson of the PAMR board of the conclusion.

Sec. ~~3738.03~~ 5180.272. All of the following apply with respect to the PAMR board:

(A) The director of ~~health-children and youth~~ shall appoint the board's members. In doing so, the director shall make a good faith effort to select members who represent all regions of the state and multiple areas of expertise and constituencies concerned with the care of pregnant and postpartum women.

(B) The board, by a majority vote of a quorum of its members, shall select an individual to serve as its chairperson. The board may replace a chairperson in the same manner.

(C) An appointed member shall hold office until a successor is appointed. The director of ~~health-children and youth~~ shall fill a vacancy as soon as practicable.

(D) A member shall not receive any compensation for, and shall not be paid for any expenses incurred pursuant to, fulfilling the member's duties on the board.

(E) The board shall meet at the call of the board's chairperson as often as the chairperson determines necessary for timely completion of pregnancy-associated death reviews. The reviews shall be conducted in accordance with rules adopted under section ~~3738.09~~ 5180.278 of the Revised Code.

(F) The department of ~~health-children and youth~~ shall provide meeting space, staff services, and other technical assistance required by the board in carrying out its duties.

Sec. ~~3738.04~~ 5180.273. The PAMR board shall seek to reduce the incidence of pregnancy-associated deaths in this state by doing all of the following:

(A) Promoting cooperation, collaboration, and communication between all groups, professions, agencies, and entities that serve pregnant and postpartum women and families;

(B) Recommending and developing plans for implementing service and program changes, as well as changes to the groups, professions, agencies, and entities that serve pregnant and postpartum women and families;

(C) Providing the department of ~~health-children and youth~~ with aggregate data, trends, and patterns regarding pregnancy-associated deaths using data and other relevant information specified in rules adopted under section ~~3738.09~~ 5180.278 of the Revised Code;

(D) Developing effective interventions to reduce the mortality of pregnant and postpartum women.

Sec. ~~3738.05~~ 5180.274. (A) Notwithstanding section 3701.243 and any other section of the Revised Code pertaining to confidentiality, and except as provided in division (B) of this section, an individual, government entity, agency that provides services specifically to individuals or families, law enforcement agency, health care provider, or other public or private entity that provided services to a woman whose death is being reviewed by the PAMR board shall submit to the board a copy of any record it possesses that the board requests. In addition, such an individual or entity may make available to the board additional information, documents, or reports that could be useful to the

board's investigation.

(B) No person, government entity, law enforcement agency, or prosecuting attorney shall provide any information regarding a pregnancy-associated death while an investigation of the death or prosecution of a person for causing the death is pending unless the prosecuting attorney agrees to allow the review.

(C) A family member of the deceased may decline to participate in an interview as part of the review process. In that case, the review shall continue without the family member's participation.

Sec. ~~3738.06~~ 5180.275. (A) Any record, document, report, or other information presented to the PAMR board, as well as all statements made by board members during board meetings, all work products of the board, and data submitted to the department of ~~health~~ children and youth by the board, other than the biennial reports described in section ~~3738.08~~ 5180.277 of the Revised Code, are confidential and not a public record under section 149.43 of the Revised Code. Such materials shall be used by the board and department only in the exercise of the proper functions of the board and department.

(B) No person shall permit or encourage the unauthorized dissemination of confidential information described in division (A) of this section.

~~(C) Whoever violates division (B) of this section is guilty of a misdemeanor of the second degree.~~

Sec. ~~3738.07~~ 5180.276. (A) An individual or public or private entity providing records, documents, reports, or other information to the PAMR board is immune from any civil liability for injury, death, or loss to person or property that otherwise might be incurred or imposed as a result of providing the records, documents, reports, or information to the board.

(B) Each board member is immune from any civil liability for injury, death, or loss to person or property that might otherwise be incurred or imposed as a result of the member's participation on the board.

Sec. ~~3738.08~~ 5180.277. (A) The PAMR board shall prepare a biennial report that does all of the following:

(1) Summarizes the board's findings from the reviews completed in the immediately preceding two calendar years, including any trends or patterns identified by the board;

(2) Makes recommendations on how pregnancy-associated deaths may be prevented, including changes that should be made to policies and laws;

(3) Includes any other information related to pregnancy-associated mortality the board considers useful.

(B) A report shall not contain individually identifiable information regarding any woman whose death was reviewed by the board.

(C) The board shall submit a copy of each report to the director of ~~health~~ children and youth, the general assembly, and the governor. The copy to the general assembly shall be submitted in accordance with section 101.68 of the Revised Code. The initial report shall be submitted not later

than March 1, 2020, with subsequent reports submitted not later than March 1 every two years thereafter.

The director shall make a copy of each report available on the department of ~~health's~~ children and youth's web site.

(D) Reports prepared under this section are public records under section 149.43 of the Revised Code.

Sec. ~~3738.09~~ 5180.278. The director of ~~health-children and youth~~ shall adopt rules that are necessary for the implementation of sections ~~3738.01-5180.27~~ to ~~3738.08-5180.277~~ of the Revised Code, including rules that do all of the following:

(A) Establish a procedure for the PAMR board to follow in conducting pregnancy-associated death reviews;

(B) Specify the data and other relevant information the board must use when conducting pregnancy-associated death reviews;

(C) Establish guidelines for the board to follow to prevent an unauthorized dissemination of confidential information in violation of division (B) of section ~~3738.06-5180.275~~ of the Revised Code.

The rules shall be adopted in accordance with Chapter 119. of the Revised Code.

Sec. ~~5101.13~~ 5180.40. (A) The department of children and youth shall establish and maintain a uniform statewide automated child welfare information system in accordance with the requirements of 42 ~~U.S.C.A.~~ U.S.C. 674(a)(3)(C) and related federal regulations and guidelines. The information system shall contain records regarding any of the following:

(1) Investigations of children and families, and children's care in out-of-home care, in accordance with sections 2151.421 and 5153.16 of the Revised Code;

(2) Care and treatment provided to children and families;

(3) Any other information related to children and families that state or federal law, regulation, or rule requires the department or a public children services agency to maintain.

(B) ~~The department shall plan implementation of the information system on a county-by-county basis and shall finalize statewide implementation by all public children services agencies as described in section 5153.02 of the Revised Code not later than January 1, 2008.~~

(C) ~~The department shall promptly notify all public children services agencies of the initiation and completion of statewide implementation of the statewide information system established under division (A) of this section.~~

(~~D~~) "Out-of-home care" has the same meaning as in section 2151.011 of the Revised Code.

Sec. ~~5101.131~~ 5180.401. Except as provided in section ~~5101.132-5180.402~~ of the Revised Code, information contained in or obtained from the information system established and maintained under section ~~5101.13-5180.40~~ of the Revised Code is confidential and is not subject to disclosure pursuant to section 149.43 or 1347.08 of the Revised Code.

Sec. ~~5101.132~~ 5180.402. (A) Information contained in the information system established

and maintained under section ~~5101.13~~5180.40 of the Revised Code may be accessed or entered only as follows:

(1) The department of job and family services, the department of children and youth, a public children services agency, a title IV-E agency, a prosecuting attorney, a private child placing agency, and a private noncustodial agency may access or enter the information when either of the following is the case:

(a) The access or entry is directly connected with assessment, investigation, or services regarding a child or family;

(b) The access or entry is permitted by state or federal law, rule, or regulation.

(2) A person may access or enter the information in a manner, to the extent, and for the purposes authorized by rules adopted by the department.

(B) As used in this section, "title IV-E agency" means a public children services agency or a public entity with which the department of job and family services or department of children and youth has a title IV-E subgrant agreement in effect.

Sec. ~~5101.133~~ 5180.403. No person shall access or use information contained in the information system established and maintained under section ~~5101.13~~5180.40 of the Revised Code other than in accordance with section ~~5101.132~~5180.402 of the Revised Code or rules authorized by that section.

No person shall disclose information obtained from the information system established and maintained under section ~~5101.13~~5180.40 of the Revised Code in a manner not specified by rules authorized by section ~~5101.134~~5180.404 of the Revised Code.

Sec. ~~5101.134~~ 5180.404. (A) Notwithstanding any provision of the Revised Code that requires confidentiality of information that is contained in the uniform statewide automated child welfare information system established in section ~~5101.13~~5180.40 of the Revised Code, the department of children and youth shall adopt rules in accordance with Chapter 119. of the Revised Code regarding a private child placing agency's or private noncustodial agency's access, data entry, and use of information in the uniform statewide automated child welfare information system.

(B)(1) The department of children and youth may adopt rules in accordance with section 111.15 of the Revised Code, as if they were internal management rules, as necessary to carry out the purposes of sections ~~5101.13~~5180.40 to ~~5101.133~~5180.403 of the Revised Code.

(2) The department may adopt rules in accordance with Chapter 119. of the Revised Code as necessary to carry out the purposes of division (A)(2) of section ~~5101.132~~5180.402 of the Revised Code.

(C) Public children services agencies shall implement and use the information system established pursuant to section ~~5101.13~~5180.40 of the Revised Code in accordance with rules adopted by the department.

Sec. ~~5101.135~~ 5180.405. (A) A public children services employee who is entering a report of an investigation of child abuse in the statewide automated child welfare information system, as

required by section ~~5101.13-5180.40~~ of the Revised Code, shall make a notation on each case of child abuse that indicates whether the child abuse arose from an act that caused the child to suffer from, or resulted in the child suffering from, shaken baby syndrome.

(B) On the first day of March of each year, the department of children and youth shall report to the director of health the number of reports of child abuse that arose from an act that caused the child to suffer from, or resulted in the child suffering from, shaken baby syndrome and that arose during the calendar year immediately preceding the calendar year in which the report is made, as determined by an examination of the statewide automated child welfare information system established and maintained under section ~~5101.13-5180.40~~ of the Revised Code.

(C) As used in this section, "shaken baby syndrome" has the same meaning as in section 5180.14 of the Revised Code.

Sec. ~~5101.136~~ 5180.406. If a person requests the department of ~~job and family services~~ children and youth to conduct a search of whether that person's name has been placed or remains in the statewide automated child welfare information system as an alleged perpetrator of child abuse or neglect and a search reveals that a "substantiated" disposition exists, the department shall send a letter to the person who requested the search indicating a "match."

Sec. ~~5101.137~~ 5180.407. The department of ~~job and family services~~ children and youth shall work with stakeholders to establish an expungement policy regarding dispositions of child abuse or neglect in Ohio's central registry on child abuse and neglect by March 1, 2024.

Sec. ~~5101.14~~ 5180.41. (A) As used in this section and section ~~5101.144-5180.411~~ of the Revised Code, "children services" means services provided to children pursuant to Chapter 5153. of the Revised Code.

(B) Within available funds, the department of children and youth shall distribute funds to the counties within thirty days after the beginning of each calendar quarter for a part of the counties' costs for children services.

Funds provided to the county under this section shall be deposited into the children services fund created pursuant to section ~~5101.144-5180.411~~ of the Revised Code.

(C) In each fiscal year, the amount of funds available for distribution under this section shall be allocated to counties as follows:

(1) If the amount is less than the amount initially appropriated for the immediately preceding fiscal year, each county shall receive an amount equal to the percentage of the funding it received in the immediately preceding fiscal year, exclusive of any releases from or additions to the allocation or any sanctions imposed under this section;

(2) If the amount is equal to the amount initially appropriated for the immediately preceding fiscal year, each county shall receive an amount equal to the amount it received in the preceding fiscal year, exclusive of any releases from or additions to the allocation or any sanctions imposed under this section;

(3) If the amount is greater than the amount initially appropriated for the immediately

preceding fiscal year, each county shall receive the amount determined under division (C)(2) of this section as a base allocation, plus a percentage of the amount that exceeds the amount initially appropriated for the immediately preceding fiscal year. The amount exceeding the amount initially appropriated in the immediately preceding fiscal year shall be allocated to the counties as follows:

- (a) Twelve per cent divided equally among all counties;
- (b) Forty-eight per cent in the ratio that the number of residents of the county under the age of eighteen bears to the total number of such persons residing in this state;
- (c) Forty per cent in the ratio that the number of residents of the county with incomes under the federal poverty guideline bears to the total number of such persons in this state.

As used in division (C)(3)(c) of this section, "federal poverty guideline" means the poverty guideline as defined by the United States office of management and budget and revised by the United States secretary of health and human services in accordance with section 673 of the "Community Services Block Grant Act," 95 Stat. 511 (1981), 42 U.S.C.A. 9902, as amended.

(D) Within ninety days after the end of each state fiscal biennium, each county shall return any unspent funds to the department.

(E) The director of children and youth may adopt the following rules in accordance with section 111.15 of the Revised Code:

- (1) Rules that are necessary for the allocation of funds under this section;
- (2) Rules prescribing reports on expenditures to be submitted by the counties as necessary for the implementation of this section.

Sec. ~~5101.144~~ 5180.411. Each county shall deposit all funds its public children services agency receives from appropriations made by the board of county commissioners or any other source for the purpose of providing children services into a special fund in the county treasury known as the children services fund. A county shall use money in the fund only for the purposes of meeting the expenses of providing children services.

Sec. ~~5101.141~~ 5180.42. (A) As used in sections ~~5101.141~~ 5180.42 to ~~5101.1417~~ 5180.4214 of the Revised Code:

- (1) "Adopted young adult" means a person:
 - (a) Who was in the temporary or permanent custody of a public children services agency;
 - (b) Who was adopted at the age of sixteen or seventeen and attained the age of sixteen before a Title IV-E adoption assistance agreement became effective;
 - (c) Who has attained the age of eighteen; and
 - (d) Who has not yet attained the age of twenty-one.
- (2) "Child" means any of the following:
 - (a) A person who meets the requirements of division (B)(3) of section 5153.01 of the Revised Code;
 - (b) An adopted young adult;
 - (c) An emancipated young adult.

(3) "Emancipated young adult" means a person:

(a) Who was in the temporary or permanent custody of a public children services agency, a planned permanent living arrangement, or in the Title-IV-E-eligible care and placement responsibility of a juvenile court or other governmental agency that provides Title IV-E reimbursable placement services;

(b) Whose custody, arrangement, or care and placement was terminated on or after the person's eighteenth birthday; and

(c) Who has not yet attained the age of twenty-one.

(4) "Kinship guardianship young adult" means an individual that meets the following criteria:

(a) Was in the temporary or permanent custody of a public children services agency or a planned permanent living arrangement prior to the commitment described in division (A)(4)(b) of this section;

(b) Was committed to the legal custody or legal guardianship of a kinship caregiver at the age of sixteen or seventeen and attained the age of sixteen before a Title IV-E kinship guardianship assistance agreement became effective;

(c) Has attained the age of eighteen;

(d) Has not yet attained the age of twenty-one.

(5) "Relative" means, with respect to a child, any of the following who is eighteen years of age or older:

(a) The following individuals related by blood or adoption to the child:

(i) Grandparents, including grandparents with the prefix "great," "great-great," or "great-great-great";

(ii) Siblings;

(iii) Aunts, uncles, nephews, and nieces, including such relatives with the prefix "great," "great-great," "grand," or "great-grand";

(iv) First cousins and first cousins once removed.

(b) Stepparents and stepsiblings of the child;

(c) Spouses and former spouses of individuals named in divisions (A)(5)(a) and (b) of this section;

(d) A legal guardian of the child;

(e) A legal custodian of the child;

(f) Any nonrelative adult that has a familiar and long-standing relationship or bond with the child or the family, which relationship or bond will ensure the child's social ties.

(6) "Representative" means a person with whom the department of children and youth has entered into a contract, pursuant to division (B)(2)(b) of this section.

(7) "Title IV-E" means Title IV-E of the "Social Security Act," 94 Stat. 501, 42 U.S.C. 670 (1980), as amended.

(B)(1) Except as provided in divisions (B)(2), and (3), and (4) of this section, the department of children and youth shall act as the single state agency to administer federal payments for foster care, kinship guardianship assistance, and adoption assistance made pursuant to Title IV-E. The director of children and youth shall adopt rules to implement this authority. Rules governing financial and administrative requirements applicable to public children services agencies and government entities that provide Title IV-E reimbursable placement services to children shall be adopted in accordance with section 111.15 of the Revised Code, as if they were internal management rules. Rules governing requirements applicable to private child placing agencies and private noncustodial agencies and rules establishing eligibility, program participation, and other requirements concerning Title IV-E shall be adopted in accordance with Chapter 119. of the Revised Code. A public children services agency to which the department distributes Title IV-E funds shall administer the funds in accordance with those rules.

~~(2) If the (2)(a) The department shall implement the state plan is as amended under divisions (A) and (B) of section 5101.1411-5180.428 of the Revised Code, both of the following shall apply:~~

~~(a) Implementation of the amendments to the plan shall begin fifteen months after September 13, 2016, the effective date of H.B. 50 of the 131st general assembly, if both of the following apply:~~

~~(i) The plan as amended is approved by the secretary of health and human services;~~

~~(ii) The if the general assembly has appropriated sufficient funds to operate the program required under the plan as amended.~~

(b) The department shall have, exercise, and perform all new duties required under the plan as amended. In doing so, the department may contract with another person to carry out those new duties, to the extent permitted under Title IV-E.

~~(3) If the state plan is amended under division (C) of section 5101.1411 of the Revised Code, both of the following apply:-~~

~~(a) Implementation of the amendments to the plan shall begin fifteen months after September 30, 2021, if both of the following apply:-~~

~~(i) The plan as amended is approved by the secretary of health and human services.~~

~~(ii) The general assembly has appropriated sufficient funds to operate the program required under the plan as amended.~~

~~(b) The department shall perform all new duties required under the amended plan. In doing so, the department may contract with another person to carry out those new duties, to the extent permitted under Title IV E.~~

~~(4) If The department shall implement the state plan is as amended under section 5101.1416 5180.4213 of the Revised Code, and is approved by the secretary of health and human services, implementation of the amendments to the plan shall begin fifteen months after September 30, 2021.~~

(C)(1) Except with regard to the new duties imposed on the department or its contractor under divisions division (B)(2)(b) and (B)(3)(b) of this section that are not imposed on the county, the county, on behalf of each child eligible for foster care maintenance payments under Title IV-E,

shall make payments to cover the cost of providing all of the following:

- (a) The child's food, clothing, shelter, daily supervision, and school supplies;
- (b) The child's personal incidentals;
- (c) Reasonable travel to the child's home for visitation.

(2) In addition to payments made under division (C)(1) of this section, the county may, on behalf of each child eligible for foster care maintenance payments under Title IV-E, make payments to cover the cost of providing the following:

- (a) Liability insurance with respect to the child;
- (b) If the county is participating in the demonstration project established under division (A) of section ~~5101.142~~5180.421 of the Revised Code, services provided under the project.

(3) With respect to a child who is in a child-care institution, including any type of group home designed for the care of children or any privately operated program consisting of two or more certified foster homes operated by a common administrative unit, the foster care maintenance payments made by the county on behalf of the child shall include the reasonable cost of the administration and operation of the institution, group home, or program, as necessary to provide the items described in divisions (C)(1) and (2) of this section.

(D) To the extent that either foster care maintenance payments under division (C) of this section, Title IV-E kinship guardianship assistance, or Title IV-E adoption assistance payments for maintenance costs require the expenditure of county funds, the board of county commissioners shall report the nature and amount of each expenditure of county funds to the department.

(E) The department shall distribute to public children services agencies that incur and report expenditures of the type described in division (D) of this section federal financial participation received for administrative and training costs incurred in the operation of foster care maintenance, kinship guardianship assistance, and adoption assistance programs. The department may withhold not more than three per cent of the federal financial participation received. The funds withheld may be used only to fund the following:

- (1) The Ohio child welfare training program established under section 5103.30 of the Revised Code;
- (2) The university partnership program for college and university students majoring in social work who have committed to work for a public children services agency upon graduation;
- (3) Efforts supporting organizational excellence, including voluntary activities to be accredited by a nationally recognized accreditation organization.

The funds withheld shall be in addition to any administration and training cost for which the department is reimbursed through its own cost allocation plan.

(F) All federal financial participation funds received by a county pursuant to this section shall be deposited into the county's children services fund created pursuant to section ~~5101.144~~5180.411 of the Revised Code.

~~(G)~~(G)(1) The department shall periodically publish and distribute the maximum amounts

that the department will reimburse public children services agencies for making payments on behalf of children eligible for foster care maintenance payments.

(2) The department may issue a request for proposals to establish statewide rate cards for placement and care of children eligible for foster care maintenance payments. If a request for proposals is issued, the department shall review and accept the reasonable cost of providing the items described in division (C) of this section. Foster homes, as defined in section 5103.02 of the Revised Code, and kinship caregivers, as defined in section 5101.85 of the Revised Code, shall be exempt from the established statewide rates.

(H) The department, by and through its director, is hereby authorized to develop, participate in the development of, negotiate, and enter into one or more interstate compacts on behalf of this state with agencies of any other states, for the provision of social services to children in relation to whom all of the following apply:

(1) They have special needs.

(2) This state or another state that is a party to the interstate compact is providing kinship guardianship assistance or adoption assistance on their behalf.

(3) They move into this state from another state or move out of this state to another state.

~~Sec. 5101.142~~ 5180.421. (A) The department of children and youth may apply to the United States secretary of health and human services for a waiver of requirements established under Title IV-E, or regulations adopted thereunder, to conduct a demonstration project expanding eligibility for and services provided under Title IV-E. The department may enter into agreements with the secretary necessary to implement the demonstration project, including agreements establishing the terms and conditions of the waiver authorizing the project. If a demonstration project is to be established, the department shall do all of the following:

(1) Have the director of children and youth adopt rules in accordance with Chapter 119. of the Revised Code governing the project. The rules shall be consistent with the agreements the department enters into with the secretary.

(2) Enter into agreements with public children services agencies that the department selects for participation in the project. The department shall not select an agency that objects to participation or refuses to be bound by the terms and conditions of the project.

(3) Contract with persons or governmental agencies providing services under the project;

(4) Amend the state plan required by section 471 of the "Social Security Act," 42 ~~U.S.C.A.~~U.S.C. 671, as amended, as needed to implement the project;

(5) Conduct ongoing evaluations of the project;

(6) Perform other administrative and operational activities required by the agreement with the secretary.

(B) The department may apply to the United States secretary of health and human services for a waiver of the requirements established under Title IV-B of the "Social Security Act of 1967," ~~81 Stat. 821, 42 U.S.C.A.~~U.S.C. 620 or regulations adopted thereunder and established under any

other federal law or regulations that affect the children services functions prescribed by Chapter 5153. of the Revised Code, to conduct demonstration projects or otherwise improve the effectiveness and efficiency of the children services function.

Sec. ~~5101.145~~ 5180.422. (A) In adopting rules under section ~~5101.141~~ 5180.42 of the Revised Code regarding financial requirements applicable to public children services agencies, private child placing agencies, private noncustodial agencies, and government entities that provide Title IV-E reimbursable placement services to children, the department of children and youth ~~shall~~ may establish both of the following:

(1) A single form for the agencies or entities to report costs reimbursable under Title IV-E and costs reimbursable under medicaid;

(2) Procedures to monitor cost reports submitted by the agencies or entities.

(B) The procedures established under division (A)(2) of this section shall ~~be implemented not later than October 1, 2003. The procedures shall be~~ used to do both of the following:

(1) Determine which of the costs are reimbursable under Title IV-E;

(2) Ensure that costs reimbursable under medicaid are excluded from determinations made under division (B)(1) of this section.

Sec. ~~5101.146~~ 5180.423. The department of children and youth shall establish the following penalties, which shall be enforced at the discretion of the department, for the failure of a public children services agency, private child placing agency, private noncustodial agency, or government entity that provides Title IV-E reimbursable placement services to children to comply with procedures the department establishes to ensure fiscal accountability:

(A) For initial failure, the department and the agency or entity involved shall jointly develop and implement a corrective action plan according to a specific schedule. If requested by the agency or entity involved, the department shall provide technical assistance to the agency or entity to ensure the fiscal accountability procedures and goals of the plan are met.

(B) For subsequent failures or failure to achieve the goals of the plan described in division (A) of this section, one of the following:

(1) For public children services agencies, the department may take any action permitted under division (C)(2), (4), (5), or (6) of section 5101.24 of the Revised Code.

(2) For private child placing agencies or private noncustodial agencies, cancellation of any Title IV-E allowability rates for the agency involved pursuant to section ~~5101.141~~ 5180.42 of the Revised Code or revocation pursuant to Chapter 119. of the Revised Code of that agency's certificate issued under section 5103.03 of the Revised Code;

(3) For government entities, other than public children services agencies, that provide Title IV-E reimbursable placement services to children, cancellation of any Title IV-E allowability rates for the entity involved pursuant to section ~~5101.141~~ 5180.42 of the Revised Code.

Sec. ~~5101.147~~ 5180.424. If a public children services agency fails to comply with the fiscal accountability procedures established by the department of children and youth, the department shall

notify the board of county commissioners of the county served by the agency. If a private child placing agency or private noncustodial agency fails to comply with the fiscal accountability procedures, the department shall notify the executive director of each public children services agency that has entered into a contract for services with the private child placing agency or private noncustodial agency.

Sec. ~~5101.148~~ 5180.425. If the department of children and youth sanctions a public children services agency, private child placing agency, or private noncustodial agency, it shall take every possible precaution to ensure that any foster children that have been placed by the agency under sanction are not unnecessarily removed from the certified foster homes in which they reside.

Sec. ~~5101.149~~ 5180.426. Money from the children services fund shall not be used to provide a personal loan to any individual.

Sec. ~~5101.1410~~ 5180.427. In addition to the remedies available under sections ~~5101.146 and 5101.24~~ and 5180.423 of the Revised Code, the department of children and youth may certify a claim to the attorney general under section 131.02 of the Revised Code for the attorney general to take action under that section against a public children services agency, private child placing agency, private noncustodial agency, or government entity that provides Title IV-E reimbursable placement services to children if all of the following are the case:

(A) The agency or entity files a cost report with the department pursuant to rules adopted under division (B) of section ~~5101.141~~ 5180.42 of the Revised Code.

(B) The department receives and distributes federal Title IV-E reimbursement funds based on the cost report.

(C) The agency's or entity's misstatement, misclassification, overstatement, understatement, or other inclusion or omission of any cost included in the cost report causes the United States department of health and human services to disallow all or part of the federal Title IV-E reimbursement funds the department received and distributed.

(D) The agency's or entity's misstatement, misclassification, overstatement, understatement, or other inclusion or omission of any cost included in the cost report is not the direct result of a written directive concerning the agency or entity's cost report that the department issued to the agency or entity.

Sec. ~~5101.1411~~ 5180.428. (A)(1) The director of ~~job and family services-children and youth~~ shall, ~~not later than nine months after September 13, 2016, the effective date of H.B. 50 of the 131st general assembly, submit an amendment to the state plan required by 42 U.S.C. 671 to the United States secretary of health and human services to~~ implement 42 U.S.C. 675(8) to make federal payments for foster care under Title IV-E directly to, or on behalf of, any emancipated young adult who meets the following requirements:

(a) The emancipated young adult signs a voluntary participation agreement.

(b) The emancipated young adult satisfies division (D) of this section.

(2) Any emancipated young adult who meets the requirements of division (A)(1) of this