Large Filing Separator Sheet

CASE NUMBER: 10-166-TR-ORD

FILE DATE: APR 06 2010

SECTION: 3

NUMBER OF PAGES: 201

DESCRIPTION OF DOCUMENT:

REQUEST- CONTINUED

(2) To provide payment for more than one free passing emissions inspection or a total of three emissions inspections for a motor vehicle in any 365-day period. The owner or lessee of a motor vehicle is responsible for inspection fees that are related to emissions inspections beyond one free passing emissions inspection or three total emissions inspections in any 365-day period. Inspection fees that are charged by a contractor conducting emissions inspections under a motor vehicle inspection and maintenance program must be approved by the Director of Environmental Protection.

The act declares that the motor vehicle inspection and maintenance program established under the act expires upon the termination of all contracts entered into under the act and must not be implemented beyond the final date on which termination occurs.

Finally, the act repeals a statute governing earlier programs that is no longer operative.

Clean Diesel School Bus Fund

(R.C. 3704.144)

Continuing law creates the Clean Diesel School Bus Fund consisting of gifts, grants, and contributions made for the purpose of adding pollution control equipment to diesel-powered school buses. The Fund is administered by the Director of Environmental Protection who must use money in the Fund for the above purpose and to pay the EPA's costs incurred in administering the grant program. The act requires the Director to make grants from the Fund to county boards of mental retardation and developmental disabilities as well as to school districts.

Extension of various air and water fees and related provisions

Synthetic minor facility emissions fees

(R.C. 3745.11(D))

Under continuing law, each person who owns or operates a synthetic minor facility must pay an annual fee based on the sum of the actual annual emissions from the facility of particulate matter, sulfur dioxide, nitrogen dioxide, organic compounds, and lead in accordance with a fee schedule. "Synthetic minor facility" means a facility for which one or more permits to install or permits to operate have been issued for the air contaminant sources at the facility that include terms and conditions that lower the facility's potential to emit air contaminants below the major source thresholds established in rules adopted under continuing law. Prior law required the fee to be paid through June 30, 2010. The act extends the fee through June 30, 2012.

Water pollution control fees and safe drinking water fees

(R.C. 3745.11(L), (M), and (N) and 6109.21)

Under law revised in part by the act, a person applying for a plan approval for a wastewater treatment works is required to pay a fee of $100 plus 0.65 of 1% of the estimated project cost, up to a maximum of $15,000, when submitting an application through June 30, 2010, and a fee of $100 plus 0.2 of 1% of the estimated project cost, up to a maximum of $5,000, on and after July 1, 2010. Under the act, the first tier fee is extended through June 30, 2012, and the second tier applies to applications submitted on or after July 1, 2012.

Continuing law establishes two schedules for annual discharge fees to be paid by holders of national pollutant discharge elimination system (NPDES) permits with an average daily discharge flow of 5,000 or more gallons per day. Under each of the schedules, one of which is for public dischargers and one of which is for industrial dischargers, the fees are based on the average daily discharge flow and increase as the flow increases. Under prior law, the fees were due by January 30, 2008, and January 30, 2009. The act extends payment of the fees and the fee schedules to January 30, 2010, and January 30, 2011.

In addition to the fee schedules described above, continuing law imposes a $7,500 surcharge to the annual discharge fee applicable to major industrial dischargers. Under prior law, the surcharge was required to be paid by January 30, 2008, and January 30, 2009. The act continues the surcharge and requires it to be paid annually by January 30, 2010, and January 30, 2011.

Under continuing law, one category of public discharger and eight categories of industrial dischargers that are NPDES permit holders are exempt from the annual discharge fees that are based on average daily discharge flow. Instead, they are required to pay an annual discharge fee of $180. Under prior law, the fee was due annually not later than January 30, 2008, and January 30, 2009. The act continues the fee and requires it to be paid annually by January 30, 2009, and January 30, 2010.

The Safe Drinking Water Law prohibits anyone from operating or maintaining a public water system without an annual license from the Director of Environmental Protection. Applications for initial licenses or license renewals must be accompanied by a fee, which is calculated using schedules for the three basic categories of public water systems established in continuing law. Under prior law, the fee for initial licenses and license renewals was required in statute through June 30, 2010, and had to be paid annually prior to January 31, 2010. The act extends the initial license and license

renewal fee through June 30, 2012, and requires the fee to be paid annually prior to January 31, 2012.

The Safe Drinking Water Law also requires anyone who intends to construct, install, or modify a public water supply system to obtain approval of the plans from the Director. Ongoing law establishes a fee for such plan approval of $150 plus 0.35 of 1% of the estimated project cost. Under law retained in part by the act, the fee cannot exceed $20,000 through June 30, 2010, and $15,000 on and after July 1, 2010. The act instead specifies that the $20,000 limit applies to persons applying for plan approval through June 30, 2012, and the $15,000 limit applies to persons applying for plan approval on and after July 1, 2012.

Continuing law establishes two schedules of fees that the Environmental Protection Agency charges for evaluating laboratories and laboratory personnel for compliance with accepted analytical techniques and procedures established under the Safe Drinking Water Law. Under law retained in part by the act, a schedule with higher fees is applicable through June 30, 2010, and a schedule with lower fees is applicable on and after July 1, 2010. The act continues the higher fee schedule through June 30, 2012, and applies the lower fee schedule to evaluations conducted on or after July 1, 2012. The act also continues through June 30, 2012, a provision stating that an individual laboratory cannot be assessed a fee more than once in a three-year period unless the person requests the addition of analytical methods or analysts, in which case the person must pay $1,800 for each additional survey requested.

Certification of operators of water supply systems or wastewater systems

(R.C. 3745.11(O))

Law retained in part by the act establishes a $45 application fee to take the examination for certification as an operator of a water supply system or a wastewater system through November 30, 2010, and a $25 application fee on and after December 1, 2010. The act continues the higher application fee through November 30, 2012, and applies the lower fee on and after December 1, 2012. Under continuing law, upon approval from the Director that an applicant is eligible to take the examination, the applicant must pay a fee in accordance with a statutory schedule. Under law retained in part by the act, a higher schedule is established through November 30, 2010, and a lower schedule applies on and after December 1, 2010. The act extends the higher fee schedule through November 30, 2012, and applies the lower fee schedule beginning December 1, 2012.

Application fees under Water Pollution Control Law and Safe Drinking Water Law

(R.C. 3745.11(S))

Law retained in part by the act requires any person applying for a permit, other than a NPDES permit, a variance, or plan approval under the Safe Drinking Water Law or the Water Pollution Control Law to pay a nonrefundable fee of $100 at the time the application is submitted through June 30, 2010, and a nonrefundable fee of $15 if the application is submitted on or after July 1, 2010. The act extends the $100 fee through June 30, 2012, and applies the $15 fee on and after July 1, 2012.

Similarly, under law retained in part by the act, a person applying for a NPDES permit through June 30, 2010, must pay a nonrefundable fee of $200 at the time of application. On and after July 1, 2010, the nonrefundable application fee is $15. The act extends the $200 fee through June 30, 2012, and applies the $15 fee on and after July 1, 2012.

Hazardous waste facility permit modifications

(R.C. 3734.01 (not in the act) and 3734.05)

Continuing law establishes requirements governing the modification of a hazardous waste facility or its operations. "Modification" is defined to mean a change or alteration to a hazardous waste facility or its operations that is inconsistent with or not authorized by its existing permit or authorization to operate. The Director of Environmental Protection is required to adopt rules classifying modifications as either Class 1, Class 2, or Class 3 modifications. Class 1 modifications generally involve the most minor changes to a facility or its operations while Class 3 modifications represent the most significant changes.

Prior law provided that any modification that involved the transfer of a hazardous waste facility installation and operation permit to a new owner or operator was required to be classified as a Class 3 modification. The act instead specifies that any modification that involves the transfer of a hazardous waste facility installation and operation permit to a new owner or operator *for an off-site facility* must be classified as a Class 3 modification. The transfer of a hazardous waste facility installation and operation permit to a new owner or operator for a facility that is not an off-site facility must be classified as a Class 1 modification requiring prior approval of the Director. "Off-site facility" is generally defined under continuing law to mean a facility that is located off the premises where hazardous waste is generated or any such facility that is owned and operated by the generator of the waste and that exclusively disposes of hazardous waste generated at one or more premises owned by the generator.

With respect to permit modification applications for a transfer of a permit to a new owner or operator of a hazardous waste facility, prior law required the Director to make a determination regarding the transferee's compliance with specified federal law related to hazardous waste management, Ohio laws related to hazardous waste management, air pollution control, and water pollution control, and similar laws of other states. The Director was required to determine if the transferee demonstrated sufficient reliability, expertise, and competency to operate a hazardous waste facility in accordance with Ohio law. The act repeals those provisions but retains the continuing definitions of "owner" and "operator" and applies them to the entire statute governing modifications of hazardous waste facilities.

Natural Resources Damages Fund; Hazardous Waste Clean-up Fund; Environmental Protection Remediation Fund

(R.C. 3734.28, 3734.281, and 3734.282)

The act creates in the state treasury the Natural Resource Damages Fund consisting of money collected by the state for natural resources damages under the federal Comprehensive Environmental Response, Compensation, and Liability Act of 1980, the federal Oil Pollution Act, the federal Clean Water Act, or any other applicable federal or state law. Money in the Fund is required to be used only in accordance with the purposes of and the limitations on natural resources damages set forth in those acts or laws.

Correspondingly, the act repeals a provision in prior law that required natural resource damages collected under the federal Comprehensive Environmental Response, Compensation, and Liability Act of 1980 to be credited to the Hazardous Waste Clean-up Fund. Continuing law requires the Director of Environmental Protection to use that Fund for hazardous waste remediation activities.

Under law revised by the act, money in the Hazardous Waste Clean-up Fund may be used through October 15, 2005, to fund certain emergency and remedial actions as well as the Voluntary Action Program. The act eliminates the date restriction, thus authorizing money in the Fund to be used for those purposes permanently.

Law unchanged in part by the act creates the Environmental Protection Remediation Fund consisting of any money set aside for the cleanup of the Ashtabula River; money collected from certain settlements made by the Director of Environmental Protection related to enforcement actions under the Construction and Demolition Debris Law, the Solid, Hazardous, and Infectious Waste Law, and the Water Pollution Control Law; and money received under the federal Comprehensive Environmental Response, Compensation, and Liability Act of 1980. Money in the Fund is required to

be used by the Environmental Protection Agency for the purposes of conducting environmental remediation at hazardous waste facilities, solid waste facilities, and construction and demolition debris facilities and other sites in the state. The act repeals the provision that required money set aside for the cleanup of the Ashtabula River to be credited to the Fund. In addition, the act clarifies that, except for money credited to the Natural Resource Damages Fund (see above), the Fund must consist of money collected from judgments for the state or settlements with the Director related to enforcement actions under the Construction and Demolition Debris Law, the Solid, Hazardous, and Infectious Waste Law, and the Water Pollution Control Law.

The act authorizes the Director of Environmental Protection to enter into contracts and grant agreements with federal, state, or local government agencies, nonprofit organizations, and colleges and universities for the purpose of carrying out the EPA's and the Director's responsibilities for which money may be expended from the Hazardous Waste Clean-up Fund, the Environmental Protection Remediation Fund, and the Natural Resource Damages Fund.

Air contaminant source installation permits

(R.C. 3704.03)

Continuing law prohibits the location, installation, construction, or modification of any air contaminant source or any machine, equipment, device, apparatus, or physical facility intended primarily to prevent or control the emission of air contaminants unless an installation permit has been obtained from the Director of Environmental Protection. Continuing law establishes requirements governing the application for and the issuance of an installation permit. The act requires an air contaminant source that is the subject of an installation permit to be installed or modified in accordance with the permit not later than 18 months after the permit's effective date at which point the permit must terminate unless one of the following applies:

(1) The owner or operator has undertaken a continuing program of installation or modification during the 18-month period;

(2) The owner or operator has entered into a binding contractual obligation to undertake and complete within a reasonable period of time a continuing program of installation or modification of the air contaminant source during the 18-month period;

(3) The Director has extended the date by which the air contaminant source that is the subject of the installation permit must be installed or modified;

(4) The installation permit is the subject of an appeal by a party other than the owner or operator of the air contaminant source that is the subject of the installation permit, in which case the date of termination of the permit is not later than 18 months after the effective date of the permit plus the number of days between the date on which the permit was appealed and the date on which all appeals concerning the permit have been resolved; or

(5) The installation permit has been superseded by a subsequent installation permit, in which case the original installation permit terminates on the effective date of the superseding installation permit.

The act declares that the above provisions apply to an installation permit that has not terminated as of the effective date of the act. Further, the act authorizes the Director to adopt rules in accordance with the Administrative Procedure Act for the purpose of establishing additional requirements that are necessary for the implementation of those provisions.

Environmental Review Appeals Commission: deadlines for the issuance of orders

(R.C. 3745.05)

The Environmental Review Appeals Commission is an appellate review board whose primary statutory duty is to hear and resolve appeals from certain legal actions taken under environmental laws by state and local governmental entities, including the Environmental Protection Agency (EPA), the State Fire Marshal, the State Emergency Response Commission, the Department of Agriculture, and boards of health. The majority of cases heard by the Commission relate to final actions of the EPA. Continuing law establishes requirements governing appeals to the Commission.

The act establishes additional requirements governing the time within which orders concerning appeals to the Commission must be issued. Under the act, the Commission must issue a written order affirming, vacating, or modifying an action pursuant to the following schedule:

(1) For an appeal that was filed with the Commission before April 15, 2008, the Commission must issue a written order not later than December 15, 2009.

(2) For all other appeals that have been filed with the Commission as of October 15, 2009, the Commission must issue a written order not later than July 15, 2010.

(3) For an appeal that is filed with the Commission after October 15, 2009, the Commission must issue a written order not later than 12 months after the filing of the appeal with the Commission.

eTECH COMMISSION (ETC)

- Transfers responsibility for developing a state education technology plan from the State Board of Education to the eTech Ohio Commission and requires the Commission to "implement" the plan and to consult with the State Board in the development and modification of the plan.

- Requires the eTech Ohio Commission, with assistance from the Department of Education and the Chancellor of the Board of Regents, to develop and implement a pilot project to provide at least two Advanced Placement and one foreign language interactive distance learning courses.

- Requires the Superintendent of Public Instruction, the Chancellor, and the Commission, by December 31, 2010, to submit a formative evaluation and legislative recommendations regarding the pilot project to the Governor and the General Assembly.

Background

The eTech Ohio Commission is a state agency that provides financial and technical assistance to school districts, other educational entities, public television and radio stations, and radio reading services for the acquisition and use of educational technology and for the development of educational materials. The Commission consists of 13 members, nine of whom are voting members and four of whom are nonvoting legislative members. The voting members include the Superintendent of Public Instruction (or a designee), the Chancellor of the Board of Regents (or a designee), and the state chief information officer (or a designee).

State education technology plan

(R.C. 3301.07 and 3353.09)

Under prior law, the State Board of Education was responsible for developing "a state plan to encourage and promote the use of technological advancements in educational settings." The act transfers that responsibility to the eTech Ohio Commission. Further, the act changes the purpose of the plan to "creating an aligned

education technology system that spans preschool to postsecondary education and that complies with federal mandates." Moreover, the act requires the Commission to "implement" the plan.

The Commission must consult with the State Board in the development and modification of the plan.

Interactive distance learning pilot project

The act requires the eTech Ohio Commission, with assistance from the Department of Education and the Chancellor of the Board of Regents, to establish an interactive distance learning pilot project to provide at least three courses free of charge to high schools. It first creates, in permanent codified law, a program that must serve, free of charge, all high schools operated by school districts. It then narrows eligibility for fiscal years 2010 and 2011 by structuring the program as a limited competitive grant program that complies with restrictions on the federal funds it uses to finance the pilot program during those years. The pilot project must begin offering courses for the 2009-2010 school year. Presumably, unless other provisions are enacted in the meantime, the pilot project will be administered under the broader permanent provision after fiscal year 2011.

Permanent provision

(R.C. 3353.20(A) to (F))

Under the permanent provision, the Commission must contract for the development of courses to be offered. The Department of Education, in consultation with the Chancellor of the Board of Regents, must select the courses to be offered by the pilot project and develop the standards for the curriculum of each course. Then, the Commission and the Department, jointly, and again in consultation with the Chancellor, must select the teachers who will be paid by the Commission.

The Commission is solely responsible to:

(1) Produce and broadcast the courses;

(2) Except as limited by the temporary provision, provide funds for schools to purchase necessary video conferencing telecommunications equipment and connectivity devices;

(3) Except as limited by the temporary provision, assist schools in arranging for the purchase and installation of telecommunications equipment and connectivity devices;

(4) Except as limited by the temporary provision, pay for up to one school year, the cost of upgrading Internet service for schools that currently have a connection that is capable of transmitting data at only 1.544 Mbits per second or slower;

(5) Offer training in the use of the telecommunications equipment necessary to participate in the pilot project; and

(6) Administer and oversee the operation of the pilot project.

Finally, the Commission, the Department, and the Chancellor, jointly, must notify schools about the pilot project and promote their participation in it.

The act specifies that each school will determine how and where its students will participate in the courses, consistent with specifications for technology and connectivity required by the Commission. The grade for a student enrolled in a course will be assigned by the course teacher and transmitted to the student's high school.[199]

Temporary provision

(Section 265.30.83)

Grants for EETT-eligible entities

Under the temporary provision for fiscal years 2010 and 2011, the Department of Education and the Commission must enter into a memorandum of understanding to use for the pilot project some of the federal education technology funds ("EETT" funds) allocated to Ohio. For the pilot project, the act allocates the lesser of $4.5 million or one-half of the state's regular EETT funds each year.[200] Under federal law, roughly one-half of a state's EETT funds must be paid to Title I schools[201] according to the Title I formula. The other half may be paid for special projects, like the distance learning pilot project, but only to eligible entities and only as competitive grants. EETT-eligible entities are (1) school districts that qualify for Title I funds and have one or more schools in

[199] The act does not specify the manner of transmitting a student's grade or whether the student's school must record that grade and award credit for the completed course.

[200] This amount does not include education technology funds allocated to Ohio under the American Recovery and Reinvestment Act of 2009. "EETT" is an acronym for "Enhancing Education Through Technology." (20 U.S.C. 6751 *et seq.*)

[201] "Title I" refers to a long-standing federal education program providing targeted funds to schools with relatively high concentrations of economically disadvantaged students. The funds generally are paid through the state Department of Education according to a federal formula.

"improvement status," under the federal No Child Left Behind Act,[202] (2) school districts that have substantial need for assistance in acquiring and using technology, and (3) entities in a collaborative partnership with a school district described in (1) or (2).[203]

Thus, the act specifies that the Commission and the Department must operate the distance learning pilot project for fiscal years 2010 and 2011 as a competitive grant program, instead of the entitlement program as otherwise provided under the permanent provision. In doing so, the Department and the Commission must specify in their memorandum of understanding how they will divide administrative duties. But the Commission must have the authority to set the grant criteria and to select the grant recipients, and the Department must have all federal monitoring and compliance responsibilities. Among other things, the memorandum also must specify that the Department and Commission may not use more than 5% of appropriated federal funds for administrative purposes (as permitted under federal law).

Furthermore, the Commission must: (1) issue a request for proposals before or during the 2009-2010 school year, (2) limit the number of grants so that each grant recipient receives an amount sufficient to ensure full participation in the program, (3) solicit all eligible entities to participate in the program, (4) require 25% of any grant award be used for professional development, (5) require that eligible entities use a percentage of their grant awards to contract with a vendor selected by the Commission for the development and offering of interactive distance learning courses, (6) require eligible entities submitting proposals to specify the amount, if any, needed to purchase video conferencing telecommunications equipment and upgraded Internet services, and (7) assist eligible entities in arranging for the purchase and installation of telecommunications equipment.

Priority for grants

The act establishes guidelines the Commission must use in awarding grants to eligible entities. Under these guidelines, the Commission must give priority to:

(1) School districts for which Advanced Placement or foreign language course offerings make up less than 1% of the district's total course offerings;

(2) Schools and school districts that without additional assistance lack the necessary connectivity or equipment to offer interactive distance learning courses;

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[202] A school is in "improvement status" under federal law if it has failed to make "adequate yearly progress" for two or more consecutive years. Adequate yearly progress (or "AYP") is an academic performance target set for each school and school district.

[203] 20 U.S.C. 6753 and 6762.

(3) School districts that demonstrate that the course offerings will take place during the regular school day; and

(4) Schools and school districts "that demonstrate commitment to appropriately supporting distance learning offerings," including but not limited to:

(a) Enrolling a minimum number of students to participate in the distance learning classes;

(b) Committing the necessary personnel to facilitate and assist students with distance learning classes; and

(c) Committing the necessary personnel capable of operating distance learning equipment.

Limited obligation and participation by non-eligible entities

The act specifies that in the development, administration, and oversight of the program, the Commission is not obligated for more than the amount appropriated. Also, the act states that, in fiscal years 2010 and 2011, no school that is not an EETT-eligible entity is entitled to the goods and services prescribed in the permanent pilot project provision. Nevertheless, it also states that any student, teacher, or other school employee of a public or nonpublic school that is not awarded a grant may participate in the interactive distance learning pilot project, as long as the participation does not impose an additional cost to the state, does not diminish the quality of project outcomes for those entities that are awarded grants, and aligns with federal regulations and guidelines.

Evaluation of the Pilot Project

(R.C. 3353.20(G); Section 265.30.83(F))

Finally, the act requires the Superintendent of Public Instruction, the Chancellor, and the Commission, by December 31, 2010, to submit to the Governor and General Assembly a formative evaluation of the implementation and results of the interactive distance learning pilot project. They also must include in their report legislative recommendations for changes in the pilot project.

- Creates the Service Coordination Workgroup to develop procedures for coordinating services that certain state agencies provide to individuals under age 21 and their families.

- Requires the Workgroup, not later than July 31, 2009, to submit a report to the Governor with recommendations for implementing the procedures.

- Prohibits the Governor from issuing executive orders that have been previously issued and declared as anti-competitive.

- Would have prohibited the Governor's Residence Advisory Commission from using prison labor in exercising its responsibility (1) to provide for the care, provision, repair, and placement of furnishings and other objects and accessories on the grounds and public areas of the first floor of the Governor's Residence and (2) for the care and placement of plants on the grounds (VETOED).

- Would have prohibited the Department of Administrative Services from using prison labor in providing for the general maintenance of the Governor's Residence (VETOED).

Service Coordination Workgroup

(Section 751.20)

The act creates the Service Coordination Workgroup. The Workgroup is to consist of a representative of each of the following:

(1) The Office of the Governor, appointed by the Governor;

(2) The Department of Alcohol and Drug Addiction Services, appointed by the Director of Alcohol and Drug Addiction Services;

(3) The Department of Education, appointed by the Superintendent of Public Instruction;

(4) The Department of Health, appointed by the Director of Health;

(5) The Department of Job and Family Services, appointed by the Director of Job and Family Services;

(6) The Department of Mental Health, appointed by the Director of Mental Health;

(7) The Department of Developmental Disabilities, appointed by the Director of Developmental Disabilities;

(8) The Department of Youth Services, appointed by the Director of Youth Services;

(9) The Office of Budget and Management, appointed by the Director of Budget and Management;

(10) The Family and Children First Cabinet Council, appointed by the chairperson of the Council.

The representative of the Governor's office is to serve as the Workgroup's chairperson. Members of the Workgroup are to serve without compensation, except to the extent that serving on the Workgroup is considered part of their regular employment duties.

The Workgroup is required to develop procedures for coordinating services that the entities represented on the Workgroup provide to individuals under age 21 and families of those individuals. In developing the procedures, the Workgroup is required to focus on maximizing resources, reducing unnecessary costs, removing barriers to effective and efficient service coordination, eliminating duplicate services, prioritizing high risk populations, and any other matters the Workgroup considers relevant to service coordination. Not later than July 31, 2009, the Workgroup must submit a report to the Governor with recommendations for implementing the procedures. The Workgroup is to cease to exist June 30, 2011.

Executive orders of the Governor

(R.C. 107.19)

Article III, Section 5 of the Ohio Constitution vests the "supreme executive power" of the state in the Governor, and Article III, Section 6 requires the Governor to "see that the laws are faithfully executed." Inherent in these sections is the ability of the Governor to issue executive orders. The power to issue executive orders does not, however, appear to be absolute. For instance, the Governor cannot issue an executive order that directly conflicts with a statute (*State ex rel. S. Monroe and Son Co. v. Baker* (1925), 112 Ohio St. 356).

The act specifies that the Governor has no power to issue any executive order that has previously been issued and that the Federal Trade Commission, Office of Policy Planning, Bureau of Economics, and Bureau of Competition has opined is anti-competitive and is in violation of anti-trust laws. The act further provides that any such executive order will be considered invalid and unenforceable.

Prohibition on the use of prison labor at the Governor's Residence (VETOED)

(R.C. 107.40)

Continuing law creates the Governor's Residence Advisory Commission, which is responsible (1) for the care, provision, repair, and placement of furnishings and other objects and accessories on the grounds and public areas of the first floor of the Governor's Residence and (2) for the care and placement of plants on the grounds. The Governor vetoed a provision that would have prohibited the Commission, when exercising this responsibility, from using prison labor.

Continuing law also obliges the Department of Administrative Services to provide for and adopt policies and procedures regarding the use, general maintenance, and operating expenses of the Governor's Residence. The Governor vetoed a provision that would have prohibited the Department from using prison labor in providing for the general maintenance of the Governor's Residence.

DEPARTMENT OF HEALTH (DOH)

- Provides confidentiality protection for reports submitted to the Department of Health or a national child death review database by local child fatality review boards.

- Modifies the manner in which child fatality review boards must submit information on child fatalities to the Department.

- Expands the annual report the Department and the Children's Trust Fund Board must jointly make to the General Assembly and local child fatality review boards to also include data from the Department of Health Child Death Review Database or the National Child Death Review Database.

- Requires the Department to use certain appropriated funds to distribute subsidies to counties to implement the Help Me Grow program, and specifies how these funds may be used in conjunction with other departments, funds, and services.

- Specifies requirements for home-visiting programs selected by a county family and children first council to be eligible for funding.

- Codifies the existing Help Me Grow Advisory Council, mirroring the requirements set forth in federal law.

- Eliminates the Governor's Advisory Council on Physical Fitness, Wellness, and Sports.

- Allows any health care provider to conduct an HIV test if an individual has consented to medical or other health care treatment from the provider and the provider determines that the test is necessary for providing diagnosis and treatment.

- Eliminates from statute the express requirement that a person or government entity obtain informed consent from a person prior to conducting an HIV test on the person.

- Eliminates the requirement that a person or government entity, before conducting an HIV test on a person, provide the person with certain information.

- Requires a health care provider conducting an HIV test to provide post-test counseling only when a person's test result is HIV-positive.

- Requires a health care provider to inform an individual of the individual's continuing law right to an anonymous HIV test.

- Exempts certain entities from the requirement to obtain a license from the Department as a freestanding diagnostic imaging center.

- Establishes a limited extension of the Certificate of Need (CON) program's moratorium that expired June 30, 2009, with regard to granting CONs and accepting CON applications to increase the number of long-term care beds.

- Continues a provision of the CON statutes permitting addition of long-term care beds to a facility if the beds either replace existing beds or are relocated from a facility in the same county.

- Requires the Director of Health to accept CON applications for up to 30 nursing home beds in an existing nursing home if the beds are relocated from a contiguous county and beds will remain in the original county.

- Establishes a new CON comparative review process under which long-term care beds may be relocated from a county with excess beds to a county with a bed need, as determined by the Director.

- Requires a facility, when any of its beds are relocated to another county, to remove additional beds from service at the facility, and permits the Director to approve CONs for redistribution of these additional beds in a second phase of the applicable four-year comparative review period.

- Modifies preexisting reasons and establishes new reasons for which the Director must deny a CON application for addition of long-term care beds to an existing facility or for the development of a new facility, particularly by replacing the standard for denial that is based on a long-standing pattern of deficiencies with a standard for denial that is based on citations for deficiencies during the period encompassed by the three most recent standard surveys of the facility.

- Eliminates provisions of the CON statutes concerning health care activities for which a CON is no longer required.

- Revises the Dentist Loan Repayment Program.

- Extends the required length of service in a dental health shortage area to two years (from one).

- Increases the maximum amount of the dentist loan repayment to $25,000 for each of the first two years a dentist participates, and $35,000 for each of the third and fourth years of participation.

- Changes eligibility requirements, application contents, and parties to the Dentist Loan Repayment Program service contract.

- Increases to ten the number of members of the Dentist Loan Repayment Advisory Board.

- Increases to $12 (from $7) the minimum fee that may be charged for the following items or services provided by the State Office of Vital Statistics or a local board of health: (1) a certified copy of a vital record or certification of birth, (2) a search by the Office of Vital Statistics of its files and records pursuant to an information request, and (3) a copy of a record provided pursuant to an information request.

- Requires the Director of Health or a local board of health to transfer $4 of each minimum $12 fee collected to the State Office of Vital Statistics not later than 30 days after the end of each calendar quarter and requires that each $4 transferred be used to support public health systems.

- Would have required the State Registrar of Vital Statistics to review, each month, all death certificates received from local registrars of vital statistics and vital statistics

officials in other states in the preceding month and to report to county boards of elections and county auditors certain information from such certificates regarding adults who resided in the respective counties at the time of their deaths (VETOED).

- Required county boards of elections and county auditors to use the information received from the reports from the Registrar to cancel the voter registrations of the decedents and to verify whether a property where a decedent resided continues to qualify for a reduction in real property taxes under the senior citizen homestead exemption or the 2.5% owner-occupied rollback (VETOED).

- Provides that rules adopted by a board of health establishing fees for specified services are to be adopted, recorded, and certified as are municipal ordinances.

- Reduces to 20 (from 30) the number of days notice that must be provided to an entity affected by a proposed board of health fee, including fees for the licensing of food service operations and retail food establishments.

- Specifies that fees established as an emergency measure are not subject to advance notice and public hearing requirements.

- Establishes a penalty of 25% of the applicable fee for late payment of board of health fees.

- Establishes a quarterly schedule to be followed by boards of health when transmitting to the Director of Health any additional fee amounts imposed by the Public Health Council.

- Revises the definition of "palliative care" used in the laws governing hospice care programs and specifies that nothing in the definition is to be interpreted as meaning that palliative care can be provided only as a component of a hospice care program.

- Increases to $600 (from $300) the maximum amount that the Public Health Council may establish as a license fee or license renewal fee for a hospice care program.

- Increases the application fee and annual renewal licensing and inspection fee for nursing homes and residential care facilities.

- Provides that a statement of neglect added to the Nurse Aide Registry regarding a nurse aide or other individual may be removed, and any accompanying information expunged, by the Director of Health if, in the judgment of the Director, the neglect was a singular occurrence and the employment and personal history of the nurse aide or other individual does not evidence abuse or any other incident of neglect of residents.

- Provides that the petition to remove a statement of neglect from the registry and the Director of Health's notice that the rescission has been granted are not subject to expungement but are not public records.

- Increases to $300 (from $250) the annual fee for renewal of a certificate of registration as a nursing home administrator.

- Prohibits the owner or manager of an adult care facility whose license has been revoked or denied renewal other than for nonpayment of fees from applying for another license until two years have elapsed, and permanently prohibits such a person from applying if the revocation or refusal was based on abuse, neglect, or exploitation of a resident.

- Eliminates temporary licenses for adult care facilities.

- Authorizes the Director of Health to waive any of the adult care facility licensing requirements established by rule, in place of the Director's authority to waive only those requirements pertaining to fire and safety requirements or building standards.

- Eliminates the requirement that proof of insurance be submitted with an application for an adult care facility license.

- Clarifies that an adult care facility is an adult family home or adult group home when supervision is provided to all residents, rather than to three or more residents.

- Increases the fine for operating an adult care facility without a license to $2,000 (from $500) on a first offense and $5,000 (from $1,000) for each subsequent offense, and similarly increases the fines for violating other adult care facility licensing laws.

- Provides that if an inspection is conducted to investigate an alleged violation in an adult care facility that serves residents receiving publicly funded mental health services or Residential State Supplement Program payments, the inspection (1) must be coordinated with the appropriate mental health agency, board of alcohol, drug addiction, and mental health services (ADAMHS board), or PASSPORT administrative agency, and (2) may be conducted jointly with the appropriate entity.

- Eliminates a requirement that the Director prescribe how a violation at an adult care facility is to be corrected and instead requires the facility to submit a plan of correction.

- Requires a court that grants injunctive relief concerning unlicensed operation of an adult care facility to include an order suspending admission of new residents and requiring the facility to assist in relocating its residents.

- Permits, rather than requires, the Director to cancel a penalty for a class II or class III violation if the violation is corrected within the specified time and the facility has not been previously cited for the same violation.

- Eliminates a provision preventing the Director from imposing a penalty for a class I violation if certain requirements are met.

- Prohibits an adult care facility from admitting a resident requiring publicly funded mental health services unless the appropriate ADAMHS board is notified and the facility and the ADAMHS board have entered into a mental health resident program participation agreement.

- Requires the Director of Mental Health to approve a standardized form for mental health resident program participation agreements and, as part of approving the form, to specify the requirements that an adult care facility must meet under the agreement.

- Modifies the Public Health Council's rulemaking authority regarding procedures to be followed by an adult care facility when individuals with mental illness or severe mental disability are referred to the facility.

- Provides that in an emergency, an adult care facility is not required to provide a resident with advance notice of a proposed transfer or discharge.

- Expands the circumstances under which an employee of an ADAMHS board or mental health agency must be permitted to enter an adult care facility that has a resident who is receiving mental health services.

- Adds to the circumstances under which employees of state or local government, ADAMHS boards, mental health agencies, or PASSPORT agencies are prohibited from placing an individual in an adult care facility.

- Specifies that individuals providing skilled nursing care in adult care facilities must be appropriately licensed.

- Requires each adult care facility to post within the facility the telephone number maintained by the Department of Health for accepting complaints.

- Repeals all laws governing community alternative homes.

- Modifies the accreditation requirements for operation of a hospital by requiring the hospital (if it is not Medicare-certified) to be accredited by a national accrediting

organization approved by the Centers for Medicare and Medicaid Services, rather than the Joint Commission or the American Osteopathic Association.

- Clarifies a preexisting requirement that handlers of radioactive material, certain handlers of radiation-generating equipment, and radiation experts are to pay fees established by rule of the Public Health Council.

- Clarifies a preexisting requirement that medical-practitioner handlers of radiation-generating equipment are to pay fees specified in statute, and raises those fees by 20%.

- Requires handlers of radioactive material to pay licensure fees on receipt of an invoice rather than at the time of application for licensure.

- Requires the Director of Health to inspect records and operating procedures of facilities that service sources of radiation.

- Would have required the Department of Health to establish a Disease and Cancer Commission to study the prevalence of colorectal cancer, prostate cancer, triple negative breast cancer, and sickle cell anemia in Ohio (VETOED).

- Would have established the Hemophilia Advisory Council to advise the Director of Health on issues related to hemophilia and related bleeding disorders (VETOED).

- Would have Created the Sickle Cell Anemia Advisory Committee within the Department of Health to assist the Director of Health in fulfilling the Director's duties regarding sickle cell disease (VETOED).

- Would have required the Director of Health to apply for federal funding under the Abstinence Education Program component of the Maternal and Child Health Services Block Grant (VETOED).

- Reenacts provisions of Am. Sub. H.B. 119 of the 127th General Assembly that temporarily suspended the operation of certain provisions of the Household and Small Flow On-Site Sewage Treatment Systems Law and that enacted temporary provisions regarding that Law, and extends the termination of the suspension and the temporary law until January 1, 2010.

- Increases the licensing fees for agricultural camps.

Confidentiality of child fatality review board reports

(R.C. 149.43, 307.626, and 307.629)

Continuing law excludes from the definition of a "public record" records, certain statements, and work products of a child fatality review board, other than the annual report required to be prepared and submitted to the Department of Health. The act additionally excludes child fatality review data submitted by the child fatality review board to the Department of Health or a national child death review database from the definition of a "public record" and categorizes the data as confidential, making its unauthorized dissemination illegal.

Child fatality review board annual report

(R.C. 307.626)

Prior law modified by the act required the person convening a child fatality review board to prepare and submit to the Department of Health, by the first day of April each year, a report that included *all* of the following information with respect to *each* child death that was reviewed by the review board in the previous calendar year: (1) the cause of death, (2) factors contributing to death, (3) age, (4) sex, (5) race, (6) the geographic location of death, and (7) the year of death. The act instead requires the review board to submit a report that *summarizes* the information listed above, with respect to *all* of the child deaths that were reviewed by the board in the previous calendar year. The act also requires the board to specify the number of child deaths that were not reviewed in the previous calendar year.

The act requires the child fatality review board to submit individual data with respect to each child death review into the Department of Health Child Death Review Database or the National Child Death Review Database. The individual data must include the information specified in the list described above and any other information the board considers relevant to the review. Individual data related to a child death review that is contained in the Department of Health Child Death Review Database is not a "public record."

Annual report of the Department of Health and the Children's Trust Fund Board

(R.C. 3701.045)

Continuing law requires the Department of Health, in consultation with the Children's Trust Fund Board and any bodies acting as child fatality review boards on October 5, 2000, to adopt rules in accordance with the Administrative Procedure Act

(R.C. Chapter 119.) that establish a procedure for child fatality review boards to follow in conducting a review of the death of a child. The act requires those rules to also establish guidelines for reporting child fatality review data to the Department or a national child death review database, either of which must maintain the confidentiality of information that would permit a person's identity to be ascertained.

Help Me Grow program funding

(Section 289.20)

The act permits appropriations made to the Department of Health to distribute subsidies to counties to implement the Help Me Grow program to be used in conjunction with Early Intervention funding from the Department of Developmental Disabilities, and in conjunction with other early childhood funds and services to promote the optimal development of young children and 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.

The act also requires the Department of Health to enter into an interagency agreement with the Department of Education, the Department of Developmental Disabilities, the Department of Job and Family Services, and the Department of Mental Health to ensure that all early childhood programs and initiatives are coordinated and school linked.

Help Me Grow home-visiting programs

(Section 289.20)

Under the act, if a county family and children first council selects home-visiting programs, the home-visiting program will be eligible for funding only if it serves pregnant women or parents or other primary caregivers and the parent or other primary caregiver's child or children under three years of age, through quality programs of early childhood home visitation. The act also provides that to be eligible for funding, the home visitations must be performed by nurses, social workers, child development specialists, or other well-trained and competent staff, as demonstrated by education or training and the provision of ongoing specific training and supervision in the model of service being delivered.

The act requires eligible home-visiting programs to have outcome and research standards that demonstrate ongoing positive outcomes for children, parents, and other primary caregivers that enhance child health and development, and to conform to a clear consistent home visitation model that has been in existence for at least three years.

The home visitation model must be research-based; grounded in relevant, empirically based knowledge; linked to program-determined outcomes; associated with a national organization or institution of higher education that has comprehensive home visitation program standards that ensure high quality service delivery and continuous program improvement; and have demonstrated significant positive outcomes when evaluated using well-designed and rigorous randomized, controlled, or quasi-experimental research designs, and the evaluation results have been published in a peer-reviewed journal.

Help Me Grow Advisory Council

(R.C. 3701.611)

The act requires the Governor to create the Help Me Grow Advisory Council in accordance with federal law (20 U.S.C. 1441), which will serve as the State Interagency Coordinating Council for the purposes of that law. Council members must reasonably represent Ohio's population. The Governor must appoint as a member a representative of a board of health of a city or general health district or an authority having those duties.

The Governor may appoint one of the Council's members to serve as chairperson, or the Governor may delegate appointment of the chairperson to the Council. No member of the Council representing the Department of Health may serve as chairperson.

The Council must meet at least once in each quarter of the calendar year. The chairperson may call additional meetings if necessary. A Council member may not vote on any matter that is likely to provide a direct financial benefit to that member or otherwise be a conflict of interest.

The Governor may reimburse Council members for actual and necessary expenses incurred in the performance of their official duties, including child care for the parent representatives.[204] The Governor also may compensate members who are not employed or who must forfeit wages from other employment when performing official Council business.

The act requires the Help Me Grow Advisory Council to do all of the following:

[204] Federal law requires at least 20% of the Council members to be parents of children with disabilities, who have knowledge of, or experience with, programs for infants and toddlers with disabilities (20 U.S.C. 1441(b)(1)(A)).

(1) Advise and assist the Department of Health in the performance of the responsibilities described in federal law relating to a statewide system for the education of people with disabilities (20 U.S.C. 1435(a)(10)), including identification of the sources of fiscal and other support for services for early intervention programs, assignment of financial responsibility to the appropriate agency, promotion of formal interagency agreements that define the financial responsibility of each agency for paying for early intervention services and procedures for resolving disputes;[205]

(2) Advise and assist the Department of Health in the preparation and amendment of applications related to the Department's responsibilities;

(3) Advise and assist the Department of Education regarding the transition of toddlers with disabilities to preschool and other appropriate services;

(4) Prepare and submit an annual report to the Governor, before September 30, on the status of early intervention programs for infants and toddlers with disabilities and their families operated within Ohio during the most recent fiscal year.

The act permits the Council to advise and assist the Department of Health and the Department of Education regarding the provision of appropriate services for children age five and younger. The Council may advise appropriate agencies about the integration of services for infants and toddlers with disabilities, and at-risk infants and toddlers and their families, regardless of whether at-risk infants and toddlers are eligible for early intervention services.

The act requires the Council to promote 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.

Governor's Advisory Council on Physical Fitness, Wellness, and Sports

(R.C. 3701.77, 3701.771, and 3701.772 (repealed); Sections 630.10 and 630.11)

Under prior law, the Governor's Advisory Council on Physical Fitness, Wellness, and Sports prepared and recommended to the Director of Health guidelines, programs, and activities related to health and physical fitness and recommended information and educational materials that were prepared and distributed to the public that encouraged wide participation in the recommended programs and activities. The act eliminates the Advisory Council.

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[205] The act designates the Department of Health as the "lead agency" for the purposes of this federal law.

HIV testing

(R.C. 3701.242)

The act modifies the laws governing the procedures to be followed before and after performing a test on a person for the human immunodeficiency virus (HIV). The table below compares the provisions of former law with the provisions of the act.

TOPIC	FORMER LAW	THE ACT
CONSENT	In order to perform an HIV test, the person or agency of state or local government ordering or performing the test had to obtain informed consent from the individual to be tested prior to the test.[206]	The act generally eliminates this requirement.
	Consent to be tested was presumed to be valid and effective, and no evidence was admissible in a civil action to impeach, modify, or limit the consent.	The act eliminates this provision.
	A minor may also consent to an HIV test; the parents or guardian of the minor are not liable for payment for the test. The consent is not subject to disaffirmance because of minority.	Same as former law, but the act additionally specifies that the parents or guardian of the minor must not be charged for the test.
INFORMATION GIVEN TO PERSON TO BE TESTED	The person or agency had to provide the individual to be tested, or the individual's guardian, with an explanation of the following: (1) the test and testing procedures, including the purposes and limitations of the test and the meaning of its results, (2) that the test was voluntary, (3) if the test was performed on an outpatient basis, that consent to be tested could be withdrawn at any time before the individual leaves the premises where blood was taken for the test, or, if the test was performed on an inpatient basis, within one hour after the blood was taken for the test, (4) that the individual or guardian could elect to have an anonymous test, and (5) the	The act eliminates this requirement.

[206] Consent could have been oral or written (R.C. 3701.242(A)).

TOPIC	FORMER LAW	THE ACT
	behaviors known to pose risks for transmission of HIV infection.[207]	
COUNSELING	The person or government agency ordering or performing an HIV test was to provide counseling to the individual tested when the individual was (1) told the result of the test or (2) informed of a diagnosis of AIDS or of an AIDS-related condition. The individual was to be given an explanation of the nature of AIDS and AIDS-related conditions, the relationship between the HIV test and those diseases, and a list of resources for further counseling or support. When necessary, the individual was to be referred for further counseling to help cope with the emotional consequences of learning the test result.	The act eliminates this requirement and instead specifies that a health care provider[208] ordering an HIV test must provide post-test counseling for an individual who receives an HIV-positive test result.
ANONYMITY	Any individual seeking an HIV test has the right to an anonymous HIV test upon request. A health care facility[209] or health care provider that does not provide anonymous testing must refer the individual to a site where it is available.	The act retains this provision and requires a health care provider to inform the individual of this right when the provider orders an HIV test.
EXCEPTIONS	Generally, if the following circumstances exist, the consent, information to be given to the individual being tested, counseling, and anonymity provisions discussed above do not apply: (1) When the test is performed in a medical emergency by a nurse or physician and the test results are	The act eliminates the exemption from the informed consent requirement for these circumstances, but retains the exemptions from the minor consent, counseling, and anonymity provisions. (1) The act retains this exception but specifies that the post-test counseling must be given if the

[207] A person or government agency required to provide this information could obtain the signature of the individual to be tested on an informed consent form prepared by the Director of Health in rule as evidence of satisfying this requirement (R.C. 3701.242(A)).

[208] "Health care provider" continues to mean an individual who provides diagnostic, evaluative, or treatment services. The Public Health Council has the authority to adopt rules further defining the scope of the term "health care provider." (R.C. 3701.24(A)(11).)

[209] "Health care facility" continues to mean any facility, except a health care practitioner's office, that provides preventive, diagnostic, therapeutic, acute convalescent, rehabilitation, mental health, mental retardation, intermediate care, or skilled nursing services (R.C. 1751.01(M)).

TOPIC	FORMER LAW	THE ACT
	medically necessary to avoid or minimize an immediate danger to the health or safety of the individual to be tested *or another individual. However,* counseling was to be given to the tested person as soon as possible after the emergency is over.	individual receives an HIV-positive test result, rather than after the emergency.
	(2) When the test is performed for the purpose of research if the researcher does not know and cannot determine the identity of the tested individual.	(2) No change.
	(3) When the test is performed by a person who procures, processes, distributes, or uses a human body part from a deceased person donated as an anatomical gift, if the test is medically necessary to ensure that the body part is acceptable for its intended purpose.	(3) No change.
	(4) When the test is performed on an individual incarcerated in a correctional institution under the control of the Department of Rehabilitation and Correction if the head of the institution has determined, based on good cause, that a test is necessary.	(4) No change.
	(5) When the test was performed by or on the order of a physician who, in the exercise of his professional judgment, determined the test to be necessary for providing diagnosis and treatment to the individual to be tested, if the individual or the individual's parent or guardian consented to the medical treatment.	(5) The act instead permits any health care provider, rather than only a physician, to order or perform an HIV test. The act also specifies that the health care provider may perform or order the test if the individual, or individual's parent or guardian, consents to medical *or other health care* treatment. This provision replaces the informed consent requirement eliminated by the act.
	(6) When the test is performed on a person after the infection control committee of a health care facility, or other similar body, determines that a health care provider, emergency medical services worker, or peace officer, while rendering health or	(6) No change.

TOPIC	FORMER LAW	THE ACT
	emergency care to the individual, has sustained a significant exposure to the body fluids of that individual, and the individual has refused to give consent for testing. (7) When the test was ordered by a court in connection with a criminal investigation.	 (7) The act eliminates this provision.
PUBLIC HEALTH COUNCIL RULES	The Public Health Council was to adopt rules, pursuant to recommendations from the Director of Health and in accordance with the Administrative Procedure Act, specifying the information required to be given to an individual before the individual is given an HIV test, including specifications for an informed consent form that includes the required information and was prepared and distributed by the Director of Health. No provision.	The act eliminates the requirement to adopt these rules. (The requirement becomes obsolete under the changes made by the act.) The act permits the Public Health Council to adopt rules, pursuant to recommendations from the Director of Health and in accordance with the Administrative Procedure Act, which specify the information to be provided in the post-test counseling required by the act.

The act also makes conforming changes to the law governing the testing and treatment of sex offenders for HIV and the law permitting certain persons to bring an action in court to compel another person to undergo HIV testing (R.C. 2907.27 and 3701.247).

Licensure as a freestanding diagnostic imaging center

(R.C. 3702.30)

Continuing law partially changed by the act prohibits certain types of health care facilities from operating without a license issued by the Director of Health. This licensing requirement applies to all of the following: (1) an ambulatory surgical facility, (2) a freestanding dialysis center, (3) a freestanding inpatient rehabilitation facility, (4) a

freestanding birthing center, (5) a freestanding radiation therapy center, and (6) a freestanding or mobile diagnostic imaging center.

The act exempts the following entities from the requirement to obtain a license as a freestanding diagnostic imaging center:

(1) A registered hospital that provides diagnostic imaging;

(2) An entity that is reviewed as part of a hospital accreditation or certification program and that provides diagnostic imaging;

(3) An ambulatory surgical facility that provides diagnostic imaging in conjunction with or during any portion of a surgical procedure.

Certificate of Need program

(R.C. 3702.51, 3702.52, 3702.524, 3702.525, 3702.53, 3702.532, 3702.54, 3702.544, 3702.55, 3702.57, 3702.59, 3702.592, 3702.593, 3702.594, 3702.60, 3702.61, and 5155.38; 3702.511, 3702.523, 3702.527, 3702.528, 3702.529, and 3702.542 (repealed); Section 289.70)

Background--long-term care beds

Under continuing law's certificate of need (CON) program, a health care facility may conduct a "reviewable activity" only if a CON is approved by the Director of Health. Reviewable activities include such activities as building or renovating a facility or adding additional beds.

CON requirements for hospital construction and many other activities related to health care facilities were phased out in the late 1990s. The act eliminates provisions dealing with CONs for these activities. The CON program continues to exist for long-term care beds in nursing homes and hospitals.

Limited extension of the moratorium on new long-term care beds

Since at least 1993, former law had provided for a moratorium on the granting of CONs for new long-term care beds. The moratorium expired on June 30, 2009. The act provides for a limited extension of the moratorium until the act's provisions establishing a new CON comparative review process take effect.

Under the moratorium's extension, the Director of Health is essentially limited to granting CONs for the replacement or relocation of beds within the same county, as was the case under the preexisting moratorium. If a CON is granted, the Director cannot authorize additional beds beyond those being replaced or relocated.

If the Director received a CON application for another purpose between July 1 and July 16, 2009,[210] the Director cannot grant the CON. If the Director receives a CON application for another purpose between July 17 and October 16, 2009,[211] the Director cannot accept the application. In either case, the act requires the Director to return to the applicant both the application and the fee that accompanied the application. The act specifies that these provisions apply to all pending actions regarding applications received before the effective date of the act's provisions establishing a new CON comparative review process.

Replacement or relocation within the same county

As described above, during the preexisting moratorium, the Director was authorized to grant CONs for new long-term care beds if (1) the increase was attributable solely to a replacement or relocation of existing beds from an existing health care facility to a new or existing facility in the same county and (2) the beds were proposed to be one of the following types of beds:

(1) Beds used in a new or existing health care facility and licensed as nursing home beds;

(2) Beds used in a new or existing county home or county nursing home and certified under Medicare as skilled nursing facility beds or under Medicaid as nursing facility beds;

(3) Beds used in a hospital and registered with the Department of Health as long-term care beds or skilled nursing beds.

Formerly, the express authority to grant CONs for these beds ended when the moratorium expired. The act indefinitely extends the authority to approve CONs for replacement or relocation of long-term care beds within the same county.

Relocation from a contiguous county

The act requires the Director to accept CON applications for an increase of up to 30 beds in an existing nursing home if all of the following conditions are met:

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[210] July 1, 2009 is the first day after the expiration of the CON moratorium under prior law. July 16, 2009 is the day before the Governor signed the act.

[211] July 17, 2009 is the effective date of the act's limited extension of the CON moratorium. October 16, 2009 is the effective date of the act's provisions establishing a new CON comparative review process.

(1) The proposed increase is attributable solely to a relocation of licensed nursing home beds from an existing nursing home to another existing nursing home in a contiguous county;

(2) After the relocation, existing nursing home beds will remain in the county from which the beds are relocated;

(3) The beds are proposed to be licensed as nursing home beds.

Comparative review for relocation between counties

The act provides for establishment of a new CON comparative review process under which long-term care beds may be relocated from a county with excess beds to a county with a bed need as determined by the Director of Health. Under this process, the Director may approve relocation from one county to another if the relocated beds are proposed to be one of the following types of beds:

(1) Beds used in a new or existing health care facility and licensed by the Director as nursing home beds;

(2) Beds used in a new or existing county home or county nursing home and certified under Medicare as skilled nursing facility beds or under Medicaid as nursing facility beds;

(3) Beds used in a hospital and registered with the Department of Health as long-term care beds.

The Director is to do all of the following to implement the comparative review:

(1) Determine the long-term care bed supply for each county, which is to consist of all of the following:

--Nursing home beds licensed by the Director;

--Beds certified as skilled nursing facility beds under Medicare or nursing facility beds under Medicaid;

--Beds in a county home or county nursing home that are certified under the act as having been in operation on July 1, 1993, and are eligible for licensure as nursing home beds;[212]

[212] The act requires the operator of each county home and each county nursing home, not later than November 1, 2009, to certify to the Director the number of long-term care beds that were in operation in

--Beds held as approved long-term care beds under a CON approved by the Director.

(2) Determine the long-term care bed occupancy rate for the state at the time the determination is made.

(3) Not later than April 1, 2010, again on April 1, 2012, and every four years thereafter, determine for each county, using the formula developed in rules to be adopted under the act, and publish on the Department's web site, the county's bed need by identifying the number of long-term beds that would be needed in the county for the statewide occupancy rate to be 90% for a projected population aged 65 and older.

The Director's consideration of a CON that would increase the number of beds in a county must be consistent with the county's bed need with two exceptions:

(1) If a county's occupancy rate is less than 85%, the county is to be considered to have no need for additional beds.

(2) Even if a county is determined not to need any additional long-term care beds, if it has a long-term care bed occupancy rate greater than 90%, the Director may approve an increase in beds equal to up to 10% of the county's bed supply.

Review periods and phases

The period for each comparative review is to be four years, except that the first period is to be two years, beginning July 1, 2010, and ending June 30, 2012.

CON applications are to be accepted and reviewed from the first day of each review period through April 30 of the following year, which is to be the initial phase of the review period for all review periods except for the first, which is to have only one phase. If the Director determines that there will be acceptance and review of additional CON applications, the second phase of the review period is to begin on July 1 of the third year of the review period. The second phase is to be limited to acceptance and review of applications for redistribution of beds made available as described below.

Beds taken out of service

When a CON application is approved during the initial phase of a four-year review period, on completion of the project under which the beds are relocated, that number of beds must cease to be operated in the health care facility from which they were relocated. If the licensure or certification of those beds cannot be or is not

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the home on July 1, 1993. The certification must be accompanied by any documentation requested by the Director. (R.C. 5155.38.)

transferred to the facility to which the beds are relocated, the licensure or certification must be surrendered.

In addition to taking the transferred beds out of service, the health care facility from which the beds were relocated must (1) reduce the number of beds operated in the facility by a number of beds equal to at least 10% of the number of beds relocated and (2) surrender the licensure or certification of those beds. This reduction must occur not later than the date of completion of the project under which the beds were relocated. If, for example, a project is completed under which 20 beds are relocated, an additional two beds must be taken out of service in the facility from which the 20 beds were relocated. These additional beds will be available for redistribution in the second phase of the review period.

Redistribution of beds

Once approval of CON applications in the first phase of a four-year review period is complete, the Director must make a new determination of the bed need for each county by reducing the county's bed need by the number of beds approved in that phase for relocation to the county. The new bed-need determination must be made not later than April 1 of the third year of the review period.

If the Director decides to redistribute the additional beds that were taken out of service, the Director may publish on the Department's web site the remaining bed need for counties that will be considered for redistribution of the additional beds. The Director must base the determination of whether to include a county on the web site on all of the following:

(1) The statewide number of additional beds that have ceased or will cease to be operated;

(2) The county's remaining bed need;

(3) The county's bed occupancy rate.

If the Director publishes the remaining bed need for a county, the Director may, beginning on the first day of the second phase of the review period, accept CON applications for redistribution of the additional beds. Any beds not approved for redistribution during the second phase are not available for redistribution at any future time.

Considerations

The Director is to consider CON applications in both the first and second phase of the review process in accordance with all of the following:

(1) The number of beds approved for a county may include only beds available for relocation from another county and must not exceed the bed need of the receiving county;

(2) The Director must consider the existence of community resources serving persons who are age 65 or older or disabled that are demonstrably effective in providing alternatives to long-term care facility placement;

(3) The Director may approve relocation of beds from a county only if, after the relocation, the number of beds remaining in the county will exceed the county's bed need by at least 100 beds;

(4) The Director may approve relocation of beds from a health care facility only if, after the relocation, the number of beds within the census tract in which the facility is located if the facility is in a federally designated health professional shortage area, or, if the facility is not in a shortage area, the bed need for the area within a 15-mile radius of the facility, is at least equal to the state bed-need rate.

In determining which applicants should receive preference in the comparative review process, the Director must consider all of the following as weighted priorities:

(1) Whether the beds will be part of a continuing care retirement community;

(2) Whether the beds will serve an underserved population, such as low-income individuals, individuals with disabilities, or individuals who are members of racial or ethnic minority groups;

(3) Whether the project in which the beds will be included will provide alternatives to institutional care, such as adult day-care, home health care, respite or hospice care, mobile meals, residential care, independent living, or congregate living services;

(4) Whether the health care facility's owner or operator will participate in Medicaid waiver programs for alternatives to institutional care;

(5) Whether the project in which the beds will be included will reduce alternatives to institutional care by converting residential care beds or other alternative care beds to long-term care beds;

(6) Whether the facility in which the beds will be placed has positive resident and family satisfaction surveys;

(7) Whether the facility in which the beds will be placed has fewer than 50 long-term care beds;

(8) Whether the health care facility in which the beds will be placed is located within the service area of a hospital and is designed to accept patients for rehabilitation after an in-patient hospital stay;

(9) Whether the health care facility in which the beds will be placed is, or proposes to become, a nurse aide training and testing site;

(10) The rating, under the Centers for Medicare and Medicaid Services'[213] five star nursing home quality rating system, of the health care facility in which the beds will be placed.

Review procedures

Law modified by the act specifies how the CON review process is to be conducted. Continuing law provides that, except during a public hearing or as necessary to comply with a subpoena, once a notice of completeness has been received, no person may knowingly discuss in person or by telephone the merits of the application with the Director. The act further prohibits making revisions to information that was submitted to the Director before the Director mails the notice of completeness. But, the act authorizes a person to supplement an application after a notice of completeness has been received by submitting clarifying information to the Director.

The act also eliminates two conditions that previously had to be met before the Director could grant a CON. Under one of the conditions, the trustees of the health service agency of the health service area in which the project was to be located had to recommend that the CON be granted. The other condition eliminated by the act specified that the Director must not have received timely written objections to the CON application from any affected person.

Former law generally permitted the Director to grant a CON for all or part of a project, but if the conditions in continuing law listed above were met, the Director was required to approve the entire project. Under the act, the Director may approve part, rather than the entirety, of the project.

[213] CMS is part of the United State Department of Health and Human Services, the federal agency that administers Medicare and Medicaid.

Reasons for CON denial

Continuing law requires the Director to deny a CON application for addition of long-term care beds or for the development of a new health care facility under certain circumstances. For example, the Director must deny a CON application if the existing health care facility to which beds are being relocated has a waiver for life safety code deficiencies, a state fire code violation, or a state building code violation, and the project identified in the application does not propose to correct such problems.

Under law modified by the act, a CON application was to be denied if, during the 60-month period preceding the filing of the application, a notice of proposed license revocation was issued to certain individuals under the laws governing nursing homes. Previously, the CON application had to be denied if the notice was sent to the operator of the existing facility to which beds were being relocated or to any health care facility owned or operated by the applicant or any principal participant in the corporation or other business. The act requires instead that a CON application be denied if, during the 60-month period preceding the filing of the application, the notice of proposed license revocation was issued for the existing health care facility in which beds are being placed or a nursing home (rather than a health care facility)[214] owned or operated by the applicant or the corporation or other business that operates or seeks to operate the health care facility in which the beds are being placed (rather than the principal participant in the same corporation or other business).

Former law required the Director to deny a CON application if the existing health care facility to which beds were being relocated or any health care facility owned or operated by the applicant or any principal participant in the same corporation or other business had a long-standing pattern of violations of the laws governing CONs or deficiencies that caused one or more residents physical, emotional, mental, or psychosocial harm. The act eliminates this "long-standing pattern of violations or deficiencies" reason to deny a CON application and instead establishes other reasons for which a CON must be denied.

Under the act, a CON application is to be denied if, during the period that precedes the filing of the application and is encompassed by the three most recent standard surveys of the existing health care facility in which the beds are being placed, any of the following occurred:

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[214] Nursing homes are one type of facility included in the continuing definition of "health care facility" but, even though prior law used the term health care facility, this provision applied only to facilities for which a notice of proposed license revocation was issued under state law governing nursing home licensure.

(1) The facility was cited on three or more separate occasions for final, nonappealable deficiencies that, under a federal regulation, either (a) constitute a pattern of deficiencies resulting in actual harm that is not immediate jeopardy or (b) are widespread deficiencies resulting in actual harm that is not immediate jeopardy.

(2) The facility was cited on two or more separate occasions for final, nonappealable deficiencies that, under a federal regulation, either (a) constitute a pattern of deficiencies resulting in immediate jeopardy to resident health or safety or (b) are widespread deficiencies resulting in immediate jeopardy to resident health or safety.

(3) More than two nursing homes operated in Ohio by the applicant or the person who operates the facility in which the beds are being placed or, if the applicant or person operates more than 20 nursing homes in Ohio, more than 10% of those nursing homes, were each cited on three or more separate occasions for final, nonappealable deficiencies that, under a federal regulation, either (a) constitute a pattern of deficiencies resulting in actual harm that is not immediate jeopardy or (b) are widespread deficiencies resulting in actual harm that is not immediate jeopardy.

(4) More than two nursing homes operated in Ohio by the applicant or the person who operates the facility in which the beds are being placed or, if the applicant or person operates more than 20 nursing homes in Ohio, more than 10% of those nursing homes, were each cited on two more occasions for final, nonappealable deficiencies that, under a federal regulation, either (a) constitute a pattern of deficiencies resulting in immediate jeopardy to resident health or safety or (b) are widespread deficiencies resulting in immediate jeopardy to resident health or safety.

The act prohibits the Director, in applying the reasons under continuing and new law to deny a CON application due to deficiencies, from considering deficiencies cited before the current operator began to operate the health care facility at which the deficiencies were cited. The Director is permitted to disregard deficiencies cited after the health care facility was acquired by the current operator if the deficiencies are attributable to circumstances that arose under the previous operator and the current operator has implemented measures to alleviate the circumstances. In the case of an application proposing development of a new health care facility by relocation of beds, the Director is prohibited from considering deficiencies that were solely attributable to the physical plant of the existing health care facility from which the beds are being relocated.

The act also requires the Director to deny a CON application if, during the 60-month period preceding the filing of the application, the applicant has violated state law governing CONs on two or more separate occasions.

Dentist Loan Repayment Program

(R.C. 3702.87, 3702.89, 3702.90, 3702.91, 3702.92, 3702.93, and 3702.94; Section 289.20)

The Department of Health oversees the Dentist Loan Repayment Program. Under the program, the Department may, subject to available funds, repay an educational loan taken by a dentist in exchange for contractual employment in a dental health resource shortage area.

Dental health resource shortage areas

Under continuing law, the Director of Health must designate, by rule, dental health resource shortage areas in Ohio. A dental health resource shortage area is an area that experiences special dental health problems and dentist practice patterns that limit access to dental care. The designations may apply to a geographic area, one or more facilities within a particular area, or a population group within a particular area. The act requires the Director to consider for designation any area in Ohio that has been designated by the United States Secretary of Health and Human Services under federal law as a health professional shortage area.

Eligibility requirements

Under former law, an individual who was not receiving National Health Service Corps tuition or student loan repayment assistance could apply to participate in the Dentist Loan Repayment Program. The act instead specifies that the individual must not have an outstanding obligation for dental service to the federal government, a state, or other entity at the time of participation in the Program. The applicant continues to be required to meet other requirements, but the act eliminates the requirement that the applicant have been practicing dentistry for not more than three years and instead requires that the applicant hold a valid Ohio dentist license.

Application

Law requires an individual seeking to participate in the dentist loan repayment program to include certain information on the application, including whether the applicant is a dental resident, and if so, the name of the facility or institution where the applicant is a resident. The act further requires an individual who has completed a residency to include the name of the facility or institution of residency and the date of completion of the residency.

Recruitment efforts

The act eliminates a provision under which an applicant and the applicant's spouse could make one visit to a dental health resource shortage area as part of the

Director's efforts to recruit the applicant to that area and be reimbursed for travel, meals, and lodging. It also eliminates a provision under which the director could refer an applicant to the Ohio Dental Association for recruitment purposes.

Parties to the loan repayment contract

Under continuing law, once an applicant and Director agree on a placement in a dental health shortage area, they enter into a contract that outlines the conditions of service. Prior law allowed a lending institution to be party to the contract. The act removes the lending institution as a party and instead allows the dentist's employer or other funding source to be a party to the contract.

Length of service

Under prior law, a program participant was required to provide services in a shortage area for at least one year. The act extends the length of service to two years.

Repayment amount

Former law provided that the Department of Health would repay all or part of the principal and interest of a program participant's loan, up to $20,000 per year of service. The act instead provides that in the first and second years, repayment cannot exceed $25,000 each year, and in the third and fourth years, $35,000 per year.

Failure to complete service obligation

Former law specified that the individual must agree to pay the Department the following as damages for failure to complete the service obligation:

--Three times the total amount the Department agreed to repay if the failure occurred during the first two years of the service obligation;

--Three times the remaining amount the Department was obligated to repay if the failure occurred after the first two years of the service obligation.

The act removes these repayment specifications and instead specifies that any repayment for failing to complete the service obligation is an amount to be set in rules adopted by the Director.

Assignment of duty to repay loans

The act eliminates a provision under which the loan repayment contract could include an assignment to the Department of the individual's duty to pay a government or other loan for dental education expenses.[215]

Dentist Loan Repayment Advisory Board

Continuing law establishes the Dentist Loan Repayment Advisory Board. The Board includes the following members: (1) a member of the House of Representatives, appointed by the Speaker, (2) a member of the Senate, appointed by the Senate President, (3) a representative of the Board of Regents, appointed by the Chancellor, (4) the Director of Health or the Director's designee, and (5) three dental professionals nominated by the Ohio Dental Association and appointed by the Governor.

The act increases the number of Board members to ten, adding one member of the House, one member of the Senate, and one dental professional, and establishes an appointment schedule for these new members. The two members from each chamber of the General Assembly must be from different political parties.

Continuing law requires Board members to serve without compensation. However, former law allowed Board members to be reimbursed for reasonable and necessary expenses incurred in discharging their duties. The act eliminates the provision allowing members to be reimbursed for these expenses.

Continuing law requires the Board to submit an annual report to the General Assembly describing the operations of the program during the previous calendar year. The act requires the Board to also submit the report to the Governor.

Vital statistics fees

(R.C. 3705.24 and 3709.09)

Law unchanged by the act requires the Public Health Council to adopt rules prescribing the fees that the Director of Health must charge for various items and services provided by the State Office of Vital Statistics, including fees for certified copies of vital records and certifications of birth, searches by the Office of its files and records pursuant to information requests, and copies of records provided pursuant to information requests. Under prior law, the Director of Health could not charge less

[215] Under an assignment, the Department could pay the principal and interest of a loan directly instead of giving the dentist the money to pay those expenses.

than $7 for these items and services.[216] Law unchanged by the act also prohibits a board of health of a city or general health district (a "local board of health") from charging a fee for a certified copy of a vital record or a certification of birth that is less than the fee prescribed by the Public Health Council for these items; consequently the fee a local board of health had to charge for a certified copy of vital record or certification of birth under prior law also could not be less than $7. In general, money generated by these fees must be paid into the state treasury to the credit of the Department of Health's General Operations Fund.

The act increases to $12 (from $7) the minimum fee the Director of Health or a local board of health must charge for a certified copy of a vital record or certification of birth, a search by the Office of Vital Statistics of its files and records pursuant to an information request, or a copy of a record provided by the office pursuant to an information request. The act also requires the Director of Health or a local board of health to transfer $4 of each minimum $12 fee collected to the State Office of Vital Statistics not later than 30 days after the end of each calendar quarter, and requires that each $4 transferred be used to support public health systems.

Vital statistics--reports of deaths to county auditors and boards of elections (PARTIALLY VETOED)

(R.C. 319.24, 3705.03, 3705.031, 3503.18, and 3503.21)

The act eliminates provisions that (1) required the chief health officer of each political subdivision and the Director of Health to file with each county board of elections, at least once each month, the names, dates of birth, dates of death, and residences of all adults who died within the subdivision or within Ohio or another state within such month, and (2) required each county board of elections to use this information to promptly cancel the voter registrations of each deceased elector.

The Governor vetoed provisions that would have required all of the following:

(1) The State Registrar of Vital Statistics to review, in each calendar month, all death certificates received in the preceding month from local registrars of vital statistics pursuant to a requirement in continuing law (R.C. 3705.07), as well as those received from vital statistics officials in other states.

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[216] In addition to the fees that the Public Health Council is authorized to prescribe for various items and services provided by the State Office of Vital Statistics, continuing law permits the following additional fees to be charged for copies of vital records and certifications of birth: fees charged by a local registrar of vital statistics or clerk of court (under R.C. 3705.24(D) and (G)), fees to modernize and automate the vital records system (under R.C. 3705.24(B)), fees charged to benefit the Children's Trust Fund (under R.C. 3109.14), and fees charged to benefit the Family Violence Prevention Fund (under R.C. 3705.242).

(2) The Registrar to determine from each death certificate identified pursuant to the review all of the following information:

(a) The decedent's name, date of birth, date of death, and age on the date of death;

(b) The address of the decedent's residence on the date of death;

(c) The county and state in which the decedent's residence was located.

(3) The Registrar to file, not later than the end of the calendar month in which a review occurred, a report with each county auditor and each county board of elections a report that summarized the information described in (2), above, for each decedent whose residence was located in that county.

(4) Each county auditor, on receipt of a report described in (3), above, to use the information in the report to assist the auditor in verifying whether real property or a manufactured or mobile home was eligible for the senior citizen homestead exemption[217] or the 2.5% rollback in real property taxes that applies to owner-occupied residences.[218]

(5) Each county board of elections, on receipt of a report described in (3), above, to cancel the voter registration of each decedent named in the report.

Fees for board of health services

(R.C. 3709.09, 3709.092, 3701.344, 3717.07, 3717.23, 3717.25, 3717.43, 3717.45, 3718.06, 3729.07, 3733.04, 3733.25, and 3749.04)

Background

Continuing law authorizes the board of health of a city or general health district, by rule, to establish a uniform system of fees for services provided and licenses issued by the board. For certain services and licenses, the Public Health Council is required to adopt rules that establish fee categories and, under prior law modified by the act, to establish uniform methodologies for use in determining the cost of the service or

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[217] Under the homestead exemption, the property taxes charged against homes, and the manufactured home tax on manufactured or mobile homes, owned and occupied by all of the following are reduced: (1) an owner who is permanently and totally disabled, (2) an owner who is at least 65 years of age, and (3) the surviving spouse (at least 59 years of age but not age 65 or older) of a deceased owner who, at the time of death, was permanently and totally disabled or at least 65 years of age and who applied and qualified for a reduction in taxes in the year of death (R.C. 323.15(A) and 4503.065).

[218] R.C. 323.15(B).

license. Continuing law permits the Public Health Council to also adopt rules adding additional amounts to the fees to be used for administration expenses of the Department of Health. The fees for which the Council may establish methodologies and impose additional amounts are fees for enforcement of rules governing private water system installations; inspection of maternity units, newborn care nurseries, and maternity homes; installation permits for household sewage treatment systems; licenses for recreational vehicle parks, recreation camps, or combined park-camps; tattooing or body piercing licenses; manufactured home park licenses; marina licenses; and public swimming pool, public spa, and special-use pool licenses.

Prior law required the additional amounts imposed by the Public Health Council to be collected and transmitted by the board of health to the Department's, General Operations Fund, and used solely for the purposes for which the amount was collected. A board of health that established or charged a fee for services for which the Public Health Council must adopt rules was required to notify, 30 days before the fee was established, any entity affected by the fee.

Boards of health and other licensors (the Directors of Agriculture and Health) must follow a separate procedure when establishing a fee for a retail food establishment or food service operation license. Continuing law expressly requires the license fee to be based on the cost of regulating the establishment or operation as determined by the Director of Agriculture or Public Health Council. Under prior law the licensor, 30 days before establishing the license fee, was required to hold a public hearing and notify each entity holding a license of the proposed fee. Continuing law permitted additional amounts to be added to the license fee by the Director of Agriculture (for retail food establishments) or the Public Health Council (for food service operators). Prior law required the additional amounts to be transmitted by the licensor to the treasurer of state no later than 60 days after the last day of the month in which a license was issued. The additional amounts are to be used for administering and enforcing the laws governing the establishments and operations.

The act makes changes regarding the establishment of a board of health's uniform system of fees, the additional amounts imposed by the Public Health Council or Director of Agriculture, and penalties assessed on unpaid fees.

Establishment of a board of health's uniform system of fees

The act provides that all rules adopted by a board of health establishing a uniform system of fees for services provided by the board are to be adopted, recorded, and certified as are ordinances of municipal corporations.[219] The record of the rules is to

[219] R.C. 731.17 to 731.21.

be given in all courts the same effect as is given ordinances. The advertisement of the rule is to be by publication in one newspaper of general circulation in the applicable health district. The publication is to be made once a week for two consecutive weeks, and the rules are to take effect and be in force ten days from the first date of publication.

Fee categories (PARTIALLY VETOED)

For the fees for which the Public Health Council is to adopt rules, the act requires that the Public Health Council establish fee categories and "a uniform methodology" rather than "uniform methodologies" for use in calculating the costs of specified services. The Governor vetoed a provision that would have required "a uniform methodology" for license fees for food service operations or retail food establishments.

In establishing a fee for the services for which the Public Health Council is to adopt rules, the act requires the board of health to hold a public hearing and, at least 20 days (rather than 30) before the hearing, give notice of the proposed fee. The act requires the board of health to notify each entity affected by the proposed fee by providing written notice of the hearing and proposed fee and mailing the notice to the last known address of the entity. But, the act permits these fees to be established by emergency measures, in which case the board is not required to hold public hearings.

The act similarly permits licensors of retail food establishments or food service operations to establish licensing fees through emergency measures. Unless adopted as an emergency measure, the licensor is required, to hold a public hearing. Under the act, the notification of the hearing is reduced to 20 days (from 30) before the hearing. No hearing is required if the fee is established as an emergency measure. Notification of a hearing is not changed by the act.

As discussed above, the Public Health Council and Director of Agriculture may impose additional amounts on fees for certain board of health services and on licenses for a retail food establishment or food service operation. The act establishes a transmission schedule for these additional amounts and additional amounts imposed by the Public Health Council on fees for the following: enforcement of rules governing private water system installations; installation permits for a household sewage treatment system; licenses for recreational vehicle parks, recreation camps, or combined park-camps; manufactured home park licenses; marina licenses; and public swimming pool, public spa, or special-use pool licenses.[220] The act requires the additional amounts to be transmitted to the Director of Health for deposit in the state treasury, credit of the

[220] The transmission schedule for extra amounts imposed on the fees for maternity home inspections and tattooing licenses is not included in the act.

General Operations Fund, to be used solely for the purposes for which the fee was collected. The transmission schedule required under the act is:

(1) Not later than May 15th for fees and amounts received by the board of health on or after January 1st but not later than March 31st;

(2) not later than August 15th for fees and amounts received by the board of health on or after April 1st but not later than June 30th;

(3) Not later than November 15th for fees and amounts received by the board of health on or after July 1st but not later than September 30th;

(4) Not later than February 15th for fees and amounts received by the board of health on or after October 1st but not later than December 31st of the preceding year.

Late fees

The act establishes fees for late payment of fees established by a board of health. The act also modifies preexisting late fees for retail food establishment or food service operation licenses. The act provides that a fee established under the board's uniform system of fees is late if not received by the day on which payment is due. The penalty is an amount equal to 25% of the original fee.

For a retail food establishment or food service operation license the act likewise establishes a fee of 25% of the original fee. Under prior law, the maximum penalty was $50.

Definition of palliative care

(R.C. 3712.01)

Under continuing law, any person or public agency seeking to provide a hospice care program is required to be licensed by the Department of Health. One of the services that may be provided by a hospice care program is short-term inpatient care, including palliative care. Prior law defined "palliative care" as treatment directed at controlling pain, relieving other symptoms, and focusing on the special needs of a hospice patient and the hospice patient's family as they experience the stress of the dying process rather than treatment aimed at investigation and intervention for the purpose of cure or prolongation of life.

The act redefines "palliative care" as treatment for a patient with a serious or life-threatening illness directed at controlling pain, relieving other symptoms, and enhancing the quality of life of the patient and the patient's family rather than treatment for the purpose of cure. Although the act's definition no longer refers to palliative care

as care that is provided to a hospice patient, the term continues to be used in the context of hospice patients.

The act specifies that nothing in the statutory definitions established for the laws governing hospice care programs is to be interpreted to mean that palliative care can be provided only as a component of a hospice care program.[221]

Hospice licensing fees

(R.C. 3712.03)

Continuing law authorizes the Ohio Public Health Council to establish a license fee and license renewal fee for hospice care programs. Prior law specified that the fee was not to exceed $300. The act increases the maximum amount to $600.

Nursing home and residential care facility licensing fees

(R.C. 3721.02)

Under continuing law, the Director of Health is responsible for licensing nursing homes[222] and residential care facilities.[223] The Director must inspect a home or facility at least once before issuing a license and at least once every 15 months thereafter. The Director is required to charge an application fee and an annual renewal licensing and inspection fee. Prior law set the fees at $170 for each 50 persons or part thereof of a home or facility's licensed capacity. The act increases the fees as follows:

(1) For fiscal year 2010, to $220 for each 50 persons or part thereof of the home or facility's licensed capacity;

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[221] The effect of this provision is unclear, since it is not apparent how the statutory definitions established for hospice care programs limit other health care providers from engaging in palliative care if they are authorized to do so under other provisions of the Revised Code.

[222] A nursing home is a home used for the reception and care of individuals who by reason of illness or physical or mental impairment require skilled nursing care and of individuals who require personal care services but not skilled nursing care (R.C. 3721.01(A)(6)).

[223] A residential care facility is a home that provides (1) accommodations for 17 or more unrelated individuals and supervision and personal care services for three or more of those individuals who are dependent on the services of others by reason of age or physical or mental impairment or (2) accommodations for three or more unrelated individuals, supervision and personal care services for at least three of those individuals who are dependent on the services of others by reason of age or physical or mental impairment, and, to at least one of those individuals, certain skilled nursing care (R.C. 3721.01(A)(7)).

(2) For fiscal year 2011, to $270 for each 50 persons or part thereof of the home or facility's licensed capacity;

(3) For each fiscal year thereafter, to $320 for each 50 persons or part thereof of the home or facility's licensed capacity.

Nurse Aide Registry

(R.C. 1347.08 and 3721.23)

Continuing law requires the Director of Health to receive, review, and investigate allegations of abuse or neglect of a resident by a nurse aide or other individual used by a long-term care facility or residential care facility to provide services to residents. If the Director finds that a nurse aide or other individual has neglected or abused a resident, the Director is to include in the Nurse Aide Registry a statement detailing the findings pertaining to the nurse aide or other individual. The nurse aide or other individual is permitted to include a statement disputing the Director's finding and have the statement included in the Registry along with the Director's findings.

Removal of name from registry

Federal law requires that a finding of neglect be removed from a nurse aid registry if the neglect was a singular occurrence and the employment and personal history of the nurse aide or individual does not reflect a pattern of abusive behavior or neglect.[224] The act provides that a statement of neglect added to the nurse aide registry regarding a nurse aide or other individual may be removed, and any accompanying information expunged, by the Director of Health if, in the judgment of the Director, the neglect was a singular occurrence and the employment and personal history of the nurse aide or other individual does not evidence abuse or any other incident of neglect of residents.

The Director is to remove and destroy the files and records of the investigation and hearing and ensure that any examination of the files shows no record of the finding of neglect. However, the act provides that the petition to rescind the finding of neglect, and the Director's notice that the rescission has been granted, are not to be expunged. The petition and Director's notice are not public records for purposes of Ohio's law regarding access to public documents.

[224] 42 U.S.C. 1395i-3(g)(1)(D).

Nursing home administrator annual registration fee

(R.C. 4751.07)

Under continuing law, the Board of Examiners of Nursing Home Administrators licenses nursing home administrators by issuing certificates of registration. Each nursing home administrator must renew the certificate of registration annually and pay a renewal fee. The act increases the renewal fee from $250 to $300.

Adult care facilities

Background

Adult care facilities are residential facilities that provide supervision and personal care services to at least some of their residents. They are licensed by the Director of Health and classified as adult family homes (three to five unrelated adults), and adult group homes (six to sixteen unrelated adults). Personal care services that may be provided include assistance with activities of daily living, assistance with self-administration of medication, and preparation of special diets.[225]

The act specifies that a facility is an adult family home or adult group home if (1) supervision is provided to all residents (rather than three or more residents) and (2) as under prior law, three or more residents receive personal care services.

License to operate adult care facility--application process

(R.C. 3722.02)

Continuing law requires that a person seeking a license to operate an adult care facility submit certain information to the Director of Health. The act eliminates the requirement that a person submit proof of insurance. It adds a requirement that the person submit a statement specifying the facility's intended bed capacity. If the facility will admit persons referred by or receiving services from a board of alcohol, drug addiction, and mental health services (ADAMHS board) or a mental health agency under contract with an ADAMHS board, the facility must also submit a statement regarding the total number of beds anticipated to be occupied as a result of those admissions.

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[225] R.C. 3722.01(A)(6).

Restrictions on applying for license

(R.C. 3722.022)

The act prohibits a person from applying for an adult care facility license if the person is or has been the owner or manager of a facility for which a license was revoked or not renewed for any reason other than non-payment of the license renewal fee, unless at least two years have elapsed since the Director of Health issued the order revoking or refusing to renew the facility's license. A person is permanently prohibited from applying for another license if the revocation or refusal to renew was based on an act or omission that violated a resident's right to be free from abuse, neglect, or financial exploitation.

Determining number of residents for license

(R.C. 3722.021)

To determine the license that an adult care facility must obtain, law retained by the act requires the Director of Health to count individuals for whom the facility provides accommodations as one group, unless the facility is both a nursing home[226] and an adult care facility. In that case, individuals in the unit licensed as a nursing home are counted separately from individuals in the unit licensed as an adult care facility.

The act provides that if an adult care facility is also licensed as a nursing home, residential facility,[227] or both, individuals in the unit licensed as a nursing home, residential care facility, or both, are to be counted separately from individuals in the unit licensed as an adult care facility.

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[226] "Nursing home" means a home used for the reception and care of individuals who by reason of illness or physical or mental impairment require skilled nursing care and of individuals who require personal care services but not skilled nursing care (R.C. 3721.01(A)(6)).

[227] "Residential care facility" means a home that provides either of the following: (1) accommodations for 17 or more unrelated individuals and supervision and personal care services for three or more of those individuals who are dependent on the services of others by reason of age or physical or mental impairment or (2) accommodations for three or more unrelated individuals, supervision and personal care services for at least three of those individuals who are dependent on the services of others by reason of age or physical or mental impairment and skilled nursing care to at least one of those individuals (R.C. 3721.01(A)(7)).

Temporary licenses

(R.C. 3722.04)

Prior law permitted the Director of Health to issue a temporary adult care facility license, if the applicant submitted specified information and a nonrefundable license application fee. A temporary license was valid for 90 days and could be renewed for an additional 90 days. The act eliminates temporary licenses.

Waiver of licensing requirements

(R.C. 3722.04(D))

Prior law authorized the Director of Health, on written request of a facility, to waive any of the adult care facility licensing requirements established by rule pertaining to fire and safety requirements or building standards. Continuing law provides that a waiver may be granted if the Director determines that strict application of the licensing requirement would cause undue hardship to the facility and that granting the waiver would not jeopardize the health or safety of any facility resident.

The act authorizes the Director, on written request of a facility, to waive any of the adult care facility licensing requirements established by rule, in place of the Director's existing authority to waive only those requirements established by rule pertaining to fire and safety requirements or building standards.

Restrictions on facility placement

(R.C. 3722.10, 3722.16, 3722.18, and 5119.613)

Placement of residents requiring mental health services

The act prohibits an adult care facility from admitting a resident requiring publicly funded mental health services unless both of the following conditions are met: (1) the ADAMHS board serving the ADAMHS district in which the facility is located is notified and (2) the facility and the ADAMHS board have entered into a mental health resident program participation agreement, which the act creates.[228]

The act requires the Director of Mental Health to approve a standardized form to be used by adult care facilities and ADAMHS boards when entering into mental health

[228] A "mental health resident program participation agreement" means a written agreement between an adult care facility and the ADAMHS board serving the alcohol, drug addiction, and mental health service district in which the facility is located, under which the facility is authorized to admit residents who are receiving or are eligible for publicly funded mental health services (R.C. 3722.01(A)(15)).

resident program participation agreements. As part of approving the form, the Director is required to specify the requirements that facilities must meet to admit residents who are receiving or are eligible for publicly funded mental health services.

Under continuing law, before an adult care facility admits a prospective resident with mental illness or severe mental disability, the facility owner or manager is subject to both of the following: (1) if the prospective resident is referred to the facility by a mental health agency or ADAMHS board, the owner or manager must follow procedures established in rules adopted by the Public Health Council, and (2) if the prospective resident is not referred by a mental health agency or ADAMHS board, the owner or manager must offer to assist the prospective resident in obtaining appropriate mental health services and document the offer of assistance. Law retained in part by the act specifies that the Council's rules may provide for any of the following: (1) that the facility owner or manager sign written agreements with the mental health agencies and ADAMHS boards that refer prospective residents to the facility, (2) that the facility owner or manager and the mental health agencies and ADAMHS boards that refer prospective residents to the facility develop and sign a plan for services for each resident referred, and (3) any other process regarding referrals and arrangements for ongoing mental health services.

The act modifies the Public Health Council's rulemaking authority regarding the procedures described above by providing for any of the following: (1) that the facility owner or manager and the appropriate ADAMHS board sign a mental health resident program participation agreement, (2) that the facility owner or manager comply with the requirements of its mental health resident program participation agreement, (3) that the facility owner or manager and the mental health agencies and ADAMHS boards develop and sign a mental health plan for ongoing mental health services for each prospective resident, and (4) any other process established by the Council in consultation with the Director of Health and Director of Mental Health regarding referrals and arrangements for ongoing mental health services for prospective residents with mental illness.

Placement of residents by public entities and related agencies

An employee of state or local government, an ADAMHS board, a mental health agency, and a PASSPORT agency is prohibited by the act from placing or recommending placement of a person in a facility if the employee knows any of the following: (1) that the placement would cause the facility to exceed licensed capacity, (2) that an enforcement action initiated by the Director of Health is pending and may result in the revocation of or refusal to renew the facility's license, or (3) that the potential resident is receiving or is eligible for publicly funded mental health services

and the facility has not entered into a mental health resident program participation agreement with the ADAMHS board.

Inspection of adult care facilities

(R.C. 3722.04(C))

During each licensing period, continuing law requires the Director of Health to make at least one unannounced inspection of an adult care facility[229] and may make additional unannounced inspections as necessary. The act provides that if an inspection is conducted to investigate an alleged violation in an adult care facility that serves residents receiving publicly funded mental health services or Residential State Supplement Program[230] payments, the inspection (1) is to be coordinated with the appropriate mental health agency, ADAMHS board, or PASSPORT[231] administrative agency, and (2) may be conducted jointly with the mental health agency, ADAMHS board, or PASSPORT administrative agency.

Correcting violations

(R.C. 3722.06)

Continuing law provides that if the Director of Health determines that a facility has violated adult care facility laws, the Director must give the facility an opportunity to correct the violation. The Director must notify the facility of the violation and specify a reasonable time for making corrections. The Director must also state the action the Director will take if corrections are not made within the time specified. The facility's license may be revoked or not renewed if the facility fails to correct the violation within the time specified or the violation jeopardizes the health or safety of residents.

The act eliminates the preexisting requirement that the Director prescribe the steps necessary to correct a violation and instead requires the facility to submit to the Director a plan of correction stating the actions to be taken to correct the violation. The act requires the Director to conduct an inspection to determine whether the facility has corrected the violation in accordance with the plan of correction. If the Director

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[229] The required unannounced inspection during each licensing period is in addition to the inspection to determine whether a license should be issued or renewed (R.C. 3722.04(C)).

[230] The Residential State Supplement (RSS) Program provides a cash supplement to payments provided to eligible aged, blind, or disabled adults under the Supplemental Security Income (SSI) program.

[231] The Pre-Admission Screening System Providing Options and Resources Today (PASSPORT) program provides home and community-based services to certain eligible aged and disabled Medicaid recipients as an alternative to care in a nursing facility.

determines that the facility failed to correct a violation, the Director may impose a penalty.

Fines

(R.C. 3722.99)

Continuing law establishes fines for violating the adult care facility licensing laws. Under prior law, the fine for operating a facility without a license was $500 for a first offense and $1,000 for each subsequent offense. The fine for violating the other licensing laws was $100 for a first offense and $500 for each subsequent offense.

The act increases the fine for operating a facility without a license to $2,000 for a first offense and to $5,000 for each subsequent offense. The act increases the fines for violations of the other licensing laws to $500 for a first offense and to $1,000 for a subsequent offense. These fines are applied to the act's new prohibitions, as well as preexisting prohibitions that were not expressly subject to a fine.

Civil penalties

(R.C. 3722.08)

Under continuing law, the Director of Health may impose civil penalties on adult care facility owners for violating facility laws. Violations are classified a class I, class II, or class III. The Director determines the classification and penalty amount by considering specified factors.

Prior law required the Director to cancel the penalty for a class II or class III violation if the facility corrected the violation within the time specified, unless the facility has been cited previously for the same violation. Under the act, the Director is permitted, rather than required, to cancel the penalty for a class II or class III violation if these conditions are met.

The act eliminates a provision prohibiting the Director from imposing a penalty for a class I violation if all of the following apply: a resident has not suffered physical harm because of the violation, the violation has been corrected and is no longer occurring, and an inspector discovered the violation by an examination of facility records.

Injunctions

(R.C. 3722.09)

Continuing law authorizes the Director of Health to file an injunctive action against an adult care facility if the Director determines that the operation of the facility jeopardizes the health or safety of residents or the facility is operating without a license.

If a court grants injunctive relief for operating a facility without a license, the act requires the court to issue, at a minimum, an order enjoining the facility from admitting new residents and an order requiring the facility to assist residents' rights advocates to relocate facility residents. If the facility continues to operate without a license after injunctive relief is granted, the Director is to refer the case to the Attorney General.

Transfer or discharge of resident

(R.C. 3722.14)

Continuing law permits an adult care facility to transfer or discharge a resident for the following reasons:

(1) Charges for accommodations and services have not been paid within 30 days after they came due;

(2) The resident needs a level of care the facility is unable to provide;

(3) The health, safety, or welfare of the resident or another resident;

(4) The health, safety, or welfare of an individual who resides in the home but is not a resident for whom supervision or personal care services are provided;

(5) The facility's license is revoked or renewal is denied;

(6) The facility is closed by its owner.

The act adds the following reasons for such a transfer or discharge: (a) that the resident is relocated as the result of a court order concerning a facility that is operating without a license, and (b) the resident is receiving publicly funded mental health services and the facility's mental health resident program participation agreement is terminated by the facility or the ADAMHS board.

In most cases, a facility must give a resident 30 days advance notice of a proposed transfer or discharge. The act provides that in an emergency a facility is not required to provide the advance notice if the reason for the proposed transfer or

discharge is any reason other than that charges for accommodations and services have not been paid within 30 days of coming due.[232]

Continuing law establishes a process under which a resident may request, and the Director of Health must conduct, a hearing regarding transfer or discharge. The act provides that the hearing may be requested and conducted if the transfer or discharge is based on one of the reasons listed as (1) through (4) above, therefore no hearing is to be conducted if the reason for relocation or transfer is revocation or denial of renewal of the facility's license or closure of the facility by the owner.[233]

Authorization to enter facility

(R.C. 3722.15)

Under continuing law, certain individuals are authorized to enter an adult care facility at any time. This includes employees of a mental health agency that has a client residing in the facility. It also includes employees of an ADAMHS board in either of the following circumstances: (1) when acting on a complaint alleging that a resident with a mental illness or severe mental disability is suffering abuse or neglect, and (2) when an individual receiving mental health services provided by the ADAMHS board or a mental health agency under contract with the board resides in the facility.

The act expands the authority to enter an adult care facility at any time to the following:

(1) Employees of a mental health agency, when (a) the agency is acting as an agent of an ADAMHS board other than the board with which it is under contract and (b) there is a mental health resident program participation agreement between the facility and the ADAMHS board with which it is under contract;

(2) Employees of an ADAMHS board, when (a) a resident of the facility is receiving mental health services provided by another board or a mental health agency under contract with another board and (b) there is a mental health resident program participation agreement between the facility and that ADAMHS board.

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[232] Prior law contained statutory cross-reference errors that resulted in ambiguities regarding the advance notice requirements.

[233] Prior law also contained statutory cross-reference errors regarding the circumstances under which a hearing could be requested and had to be conducted.

Persons authorized to provide skilled nursing care

(R.C. 3722.011(A) and 3722.16)

Continuing law generally prohibits adult care facilities from providing skilled nursing care, unless the care is provided on a part-time, intermittent basis for not more than 120 days in any 12-month period. The care may be provided only by a home health agency, hospice care program, a nursing home on the same site, or an ADAMHS board or mental health agency.

The act specifies that individuals employed by, under contract with, or used by the entities listed above to provide skilled nursing care in adult care facilities must be appropriately licensed. The Public Health Council is to adopt rules specifying what constitutes being appropriately licensed.

Department of Health complaint number

(R.C. 3722.13)

Continuing law requires each adult care facility to post prominently within the facility a copy of residents' rights and the addresses and telephone numbers of the state long-term care ombudsperson and the regional long-term care ombudsperson program. Under prior law, the facility also had to post the addresses and telephone numbers of the Department of Health's central and district offices. The act eliminates the requirement that each adult care facility post within the facility the addresses and telephone numbers of the Department's central and district offices and instead requires each facility to post the Department's telephone number for accepting complaints.

Technical changes

The act removes obsolete provisions and makes various technical and conforming changes.

Community alternative homes

(R.C. Chapter 3724. (repealed); R.C. 173.35, 2317.422, 2903.33, 3313.65, 3701.07, 3721.01, 3722.01, 3722.02, 5101.60, and 5101.61)

Under former law, the Revised Code provided for the licensure and regulation of community alternative homes. A "community alternative home" meant a residence or facility that provided accommodations, personal assistance, and supervision for three to five unrelated individuals who have acquired immunodeficiency syndrome (AIDS) or a condition related to AIDS. The act repeals the law governing licensure and regulation of community alternative homes.

As a result of this repeal, the act eliminates other provisions relating to community alternative homes that pertain to the following:

--A community alternative home resident's eligibility for PASSPORT;

--A community alternative home resident's records being used in court in lieu of testimony;

--The abuse, neglect, or exploitation of a community alternative home resident and adult protective services for such residents;

--The school district of a child whose parent is a community alternative home resident;

--Community alternative home residents' rights advocates registering with the Department of Health;

--Community alternative homes being exempted from the nursing home, residential care facility, and adult care facility laws.

Hospital accreditation

(R.C. 3727.02; R.C. 3727.03, 3727.05, and 3727.99 (not in the act))

Prior law retained in part by the act prohibited a person or political subdivision, agency, or instrumentality of Ohio from operating a hospital unless it was certified pursuant to federal law governing the Medicare Program or was accredited by the Joint Commission[234] or the American Osteopathic Association.[235] Under continuing law, the Director of Health must adopt, and may amend or rescind, rules in accordance with the Administrative Procedure Act (R.C. Chapter 119.) establishing procedures under which hospitals must provide the Department of Health in a timely fashion with proof of the required certification or accreditation and under which the Department must institute proceedings to close a hospital that violates the prohibition. A person or political subdivision, agency, or instrumentality that violates the prohibition is guilty of a misdemeanor of the first degree and is liable for an additional penalty of $1,000 for each

[234] The Joint Commission, formerly known as the joint Commission on Accreditation of Healthcare Organizations, evaluates and accredits more than 15,000 health care organizations and programs in the United States. It is an independent, not-for-profit organization. *Facts about The Joint Commission*, available at <http://www.jointcommission.org/AboutUs/ Fact_Sheets/joint_commission_facts.htm>.

[235] The American Osteopathic Association (AOA) is a member association representing 64,000 osteopathic physicians (D.O.s). The AOA serves as the primary certifying body for doctors of osteopathic medicine, and is the accrediting agency for all osteopathic medical colleges and health care facilities. *AOA Online Press Kit*, available at <http://www.osteopathic.org/index.cfm? PageID=mc_prskit>.

day of operation that the prohibition is violated. In addition to the criminal penalty, the Director of Health is authorized to petition the common pleas court of the county in which the hospital is located for an order enjoining the entity that operates the hospital from violating this prohibition.

The act modifies only the accreditation component of the prohibition by requiring a hospital (if it is not Medicare-certified) to be accredited by a national accrediting organization approved by the Centers for Medicare and Medicaid Services,[236] rather than the Joint Commission or the American Osteopathic Association.

Handlers of radioactive material and radiation-generating equipment

(R.C. 3748.01, 3748.04, 3748.07, and 3748.13)

Law modified by the act specified licensing and inspection fees for handlers of radioactive material and registration and inspection fees for handlers of radiation-generating equipment, but provided that the fee amounts applied only until the Public Health Council adopted rules establishing fees. The Council has adopted rules establishing licensing and inspection fees for handlers of radioactive material and inspection fees for handlers of radiation-generating equipment who are not medical practitioners.

The act removes statutory licensing and inspection fee amounts to be paid by handlers of radioactive material and inspection fee amounts to be paid by handlers of radiation-generating equipment if the handlers of radiation-generating equipment are not medical practitioners. Where the act removes statutory fee amounts, it provides that handlers are to pay the appropriate fees established in Council rules.[237]

The act also requires handlers, who are not medical practitioners, of radiation-generating equipment to pay the registration fee amounts established in the Council's rules when those amounts are established. Until then, the act requires those handlers to pay a $262 biennial registration fee, which is 20% higher than the registration fee specified in prior law for handlers of radiation-generating equipment.

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[236] The Centers for Medicare and Medicaid Services is part of the U.S. Department of Health and Human Services.

[237] Prior law included a reference to a fee amount for assembler-maintainer inspections. The act eliminates this reference because assembler-maintainers are handlers of radiation-generating equipment who are not medical practitioners and therefore are required to pay fee amounts established in Council rules.

The act requires that handlers of radioactive material pay licensing fees on receipt of an invoice. Prior law required them to pay the licensing fees at the time of application.

The act eliminates a provision that prohibited the fees established in rules from revising the statutory fees to be paid by handlers of radiation-generating equipment who are medical practitioners. It instead clarifies that the Council is to adopt rules establishing fees for all handlers except handlers of radiation-generating equipment who are medical practitioners. The act increases, by approximately 20%, the statutory licensing and inspection fees to be paid by the medical-practitioner handlers of radiation-generating equipment.

Continuing law permits the Director of Health to review shielding plans or the adequacy of shielding either on request of a licensed handler of radioactive material or radiation-generating equipment or during an inspection. The act clarifies that the Council is required to establish fees for the reviews of shielding plans or the adequacy of shielding that apply to handlers of radioactive material and handlers of radiation-generating equipment who are not medical practitioners.

Under law generally unchanged by the act, the Director of Health is required to inspect all records and operating procedures of facilities that install sources of radiation. The act expands this requirement to encompass the inspection of records and operating procedures of facilities that *service* sources of radiation.

Radiation experts

(R.C. 3748.12)

Prior law specified fee amounts for the certification and certification renewal of radiation experts, but provided that these fee amounts applied only until the Public Health Council adopted rules establishing certification and certification-renewal fees. As the Council has adopted these rules, the act removes references to the statutory fee amounts.

Disease and Cancer Commission (VETOED)

(Section 289.30)

The Governor vetoed a provision that would have established in the Department of Health the Disease and Cancer Commission. The Commission was to be composed of representatives of local boards of health in areas that the Director of Health determined have a high prevalence of colorectal cancer, prostate cancer, triple negative breast cancer, or sickle cell anemia. The Commission would have been required to

study these diseases in Ohio and submit, no later than June 30, 2011, a report to the Governor, Speaker and Minority Leader of the House of Representatives, and President and Minority Leader of the Senate. The report was to include policy recommendations to combat the prevalence of the diseases. On submission of the report, the Commission would have ceased to exist.

Hemophilia Advisory Council (VETOED)

(R.C. 3701.0211)

Council responsibilities

The Governor vetoed a provision that would have established the Hemophilia Advisory Council in the Department of Health and required the Council to advise the Director of Health on all of the following:

(1) Reviewing the effect of changes to programs and policies for persons with hemophilia and related bleeding disorders;

(2) Developing standards of care and treatment for persons with hemophilia and related bleeding disorders;

(3) Developing programs of care and treatment for persons with hemophilia and related bleeding disorders, including self-administration of medication, home care, medical and dental procedures, and techniques designed to provide maximum control over bleeding episodes;

(4) Reviewing data and making recommendations regarding the ability of persons with hemophilia and related bleeding disorders to obtain appropriate health insurance coverage and access to appropriate care;

(5) Coordinating with other state agencies and private organizations to develop community-based initiatives to increase awareness of hemophilia and related bleeding disorders.

The Council would have been required to submit to the Governor and General Assembly an annual report with recommendations on increasing access to care and treatment and obtaining appropriate health insurance coverage for persons with hemophilia and related bleeding disorders.

Council membership

The Council was to consist of three nonvoting members and 11 voting members. The nonvoting members would have been (1) the Director of Health or the Director's

designee, (2) the Superintendent of Insurance or the Superintendent's designee, and (3) a representative of the Department of Job and Family Services. The voting members were to be appointed by the Governor with the advice and consent of the Senate. Not more than six were to be of the same political party and were to be appointed as follows:

(1) Two physicians treating patients with hemophilia or related bleeding disorders, one specializing in pediatrics and one specializing in the treatment of adults;

(2) A nurse treating patients with hemophilia or related bleeding disorders;

(3) A social worker treating patients with hemophilia or related bleeding disorders;

(4) A representative of a federally funded hemophilia treatment center;

(5) A representative of a health insuring corporation or sickness and accident insurer;

(6) A representative of an Ohio chapter of the National Hemophilia Foundation that serves the community of persons with hemophilia and related bleeding disorders;

(7) An adult with hemophilia or caregiver of an adult with hemophilia;

(8) A caregiver of a minor with hemophilia;

(9) A person with a bleeding disorder other than hemophilia or caregiver of a person with a bleeding disorder other than hemophilia;

(10) A person with hemophilia who is a member of the Amish sect or a health professional currently treating such persons.

Appointments were to be made not later than 90 days after the act's effective date. Except for the initial members, who were to be appointed for staggered terms of office of two, three, or four years, the terms of appointed members were two years. The Council's voting members were to select a chairperson. Members of the Council were to serve without compensation, but would have been permitted to be reimbursed for actual and necessary expenses incurred in the performance of the Council's duties.

Sickle Cell Anemia Advisory Committee (VETOED)

(R.C. 3701.136)

The Governor vetoed a provision that would have created the Sickle Cell Anemia Advisory Committee within the Department of Health to assist the Director of Health in fulfilling the Director's preexisting duties regarding sickle cell disease. The Director would have been required to appoint five members familiar with sickle cell anemia, including researchers, health care professionals, and persons personally affected by sickle cell anemia. Members were to serve without compensation, but could have been reimbursed for actual and necessary expenses incurred in the performance of their duties.

The Director was to make initial appointments to the Committee no later than 90 days after the act's effective date. After initial appointments for staggered terms of one, two, and three years, terms of office would have been three years. Members could have been reappointed and vacancies were to be filled in the same manner as original appointments.

The Committee was to annually select from among its members a chairperson. The Committee was to meet at the call of the chairperson, but not less than twice each year. A majority of the members of the Committee constituted a quorum.

Federal funds for abstinence education (VETOED)

(Section 289.60)

The Governor vetoed a provision that would have required the Director of Health to apply to the United States Secretary of Health and Human Services for funding under the Abstinence Education Program component of the Maternal and Child Health Services Block Grant (Title V of the Social Security Act).[238]

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[238] According to the United States Department of Health and Human Services Administration, Children and Families' Family and Youth Services Bureau, the purpose of the Abstinence Education Program is to "enable States to create or augment existing abstinence education programs and, at the option of the state, provide mentoring, counseling, and adult supervision to promote abstinence from sexual activity with a focus on those groups most likely to bear children out-of-wedlock." Grants are awarded to states based on a statutory formula determined by the proportion of low-income children in a state to the total number of low-income children in all states according to the latest census data. States are required to match 75% of the federal funds. (Information obtained from (www.acf.hhs.gov/programs/fysb/content/abstinence/factsheet.htm).)

Extension of moratorium regarding the sewage treatment systems program

(Sections 640.20 and 640.21)

Am. Sub. H.B. 119 of the 127th General Assembly suspended until July 1, 2009, the operation of most of the provisions of the Household and Small Flow On-Site Sewage Treatment Systems Law that was enacted by Sub. H.B. 231 of the 125th General Assembly. In addition, Am. Sub. H.B. 119 generally restored until July 1, 2009, the law related to household sewage disposal systems that existed prior to the enactment of Sub. H.B. 231. In order to effectuate the suspension of the Sub. H.B. 231 provisions and the restoration of the law that existed prior to its enactment, Am. Sub. H.B. 119 required the Director of Health, not later than July 2, 2007, to adopt rules related to household sewage disposal systems that were identical to those in effect prior to January 1, 2007, and to rescind the rules adopted pursuant to Sub. H.B. 231. Am. Sub. H.B. 119 also established additional requirements governing the duties of boards of health with respect to the approval or denial of the use of sewage treatment systems and with respect to the inspection of systems. Those requirements were required to be effective until the effective date of new rules to be adopted by the Public Health Council when the suspended provisions of the Household and Small Flow On-Site Sewage Treatment Systems Law became operational again on July 1, 2009. Am. Sub. H.B. 119 prohibited the Director of Health and the Public Health Council from adopting new rules that modify or change the requirements established by Am. Sub. H.B. 119 prior to July 1, 2009. The provisions established by Am. Sub. H.B. 119 that govern household and small flow on-site sewage treatment systems will expire on the effective date of the new rules.

Because legislation was not enacted prior to July 1, 2009, some of the provisions from Am. Sub. H.B. 119 expired and the provisions of Sub. H.B. 231 that were suspended became operational. The act essentially reenacts the provisions of Am. Sub. H.B. 119 that temporarily suspended the operation of provisions of the Household and Small Flow On-Site Sewage Treatment Systems Law and that enacted temporary provisions regarding that Law. Thus, the effect of that reenactment is to extend the termination of the suspension and the temporary law from July 1, 2009, to January 1, 2010. The act also extends the date until which the Director of Health and the Public Health Council are prohibited from adopting rules that modify or change the requirements originally established by Am. Sub. H.B. 119 until January 1, 2010.

Agricultural labor camp licensing fees

(R.C. 3733.43)

Agricultural labor camps are areas established as temporary living quarters for two or more families, or five or more people, who are engaged in agriculture or food processing. The Department of Health licenses agricultural labor camps. The act increases the following annual license fees for any license issued on or after July 1, 2009:

(1) License to operate an agricultural labor camp, $150 (from $75).

(2) License to operate an agricultural labor camp if the application for the license is made on or after April 15 in any given year, $166 (from $100).

(3) Additional fee for each housing unit, $20 (from $10).

(4) Additional fee for each housing unit if application for the license is made on or after April 15 in any given year, $42.50 per housing unit (from $15).

COMMISSION ON HISPANIC-LATINO AFFAIRS (SPA)

- Requires the Speaker of the House of Representatives and the President of the Senate to each appoint two members of their respective chamber, from different political parties, as nonvoting members of the Commission on Hispanic-Latino Affairs.

Changes in legislative membership of Commission on Hispanic-Latino Affairs

(R.C. 121.31)

Continuing law creates the Commission on Hispanic-Latino Affairs consisting of 11 voting members appointed by the Governor with the advice and consent of the Senate. Under law amended by the act, the Commission also consists of two ex officio, nonvoting members who are members of the General Assembly. Under former law, one ex officio member was to be a House of Representatives member appointed by the Speaker and one ex officio member was to be a Senate member appointed by the President. Formerly, when making their initial appointments, the Speaker was to appoint a House member who was affiliated with the minority political party in the House and the President was to appoint a Senate member who was affiliated with the

majority political party in the Senate; in making subsequent appointments, the Speaker and the President each were to alternate the political party affiliation of the members they appointed to the Commission.

Under the act, the number of ex officio, nonvoting members who are members of the General Assembly increases from two to four. Two ex officio members must be House members appointed by the Speaker and two ex officio members must be Senate members appointed by the President of the Senate. The Speaker must appoint one House member from among the representatives who are affiliated with the political party having a majority in the House and one House member from among the representatives who are affiliated with the political party having a minority in the House. Similarly, the President must appoint one Senate member from among the Senators who are affiliated with the political party having a majority in the Senate and one Senate member from among the senators who are affiliated with the political party having a minority in the Senate.

OHIO HOUSING FINANCE AGENCY (HFA)

- Requires the Ohio Housing Finance Agency (OHFA), in providing homeownership program assistance, to give preference to grants or loans for activities that provide housing and housing assistance to honorably discharged veterans.
- Creates the Grants for Grads Program, administered by OHFA, to provide grants or other financial assistance or down payment assistance and a reduced mortgage interest rate for the purchase of qualifying first homes to Ohio residents receiving an associate, baccalaureate, master's, doctoral, or other postgraduate degree.
- Creates a lien in the first home and allows for recovery of assistance amounts for failure of a recipient to comply with certain program criteria.

Housing assistance for honorably discharged veterans

(R.C. 175.052)

The act requires the Ohio Housing Finance Agency (OHFA), in providing homeownership program assistance, to give preference to grants or loans for activities that provide housing and housing assistance to honorably discharged veterans.

Grants for Grads Program

(R.C. 175.01 and 175.31(A))

The act creates the Grants for Grads Program, administered by OHFA using money available to it, to provide grants or other financial assistance or downpayment assistance to Ohio residents who have received an associate, baccalaureate, master's, doctoral, or other postgraduate degree.

The act defines "down payment assistance" as monetary assistance for down payment, closing costs, and pre-paid expenses directly related to the purchase of a home.[239] Grants or assistance made pursuant to this program must be used by a recipient to pay for the down payment or closing costs on the purchase of a first home.

The Grants for Grads program is not subject to income limits generally applicable to other OHFA programs. OHFA must allow participation in the program by any person who meets the eligibility requirements outlined below.

Program eligibility

(R.C. 175.30 and 175.31(B) and (C))

Under the act, a graduate is eligible to participate in the program if the graduate meets all of the following conditions:

(1) The graduate received an associate, baccalaureate, master's, doctoral, or other postgraduate degree from an institution of higher education within the 18 months immediately preceding the date of application for the program.

(2) The graduate is able to provide OHFA evidence documenting Ohio residency and graduation from a high school and institution of higher education.

(3) The graduate intends to live and work in Ohio for at least five years after graduation or completion of the degree.

(4) The graduate intends to purchase a first home in Ohio.[240]

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[239] The act retains use of the terms "grant" and "financial assistance" with regards to certain portions of the program and replaces "grantee" with "recipient" regarding the receipt of grants or assistance

[240] The act defines "graduate" as an individual who graduated from an institution of higher education and who is eligible for the program. It defines an "institution of higher education" as a state university or college located in Ohio, a private college or university located in Ohio that possesses a certificate of authorization issued by the Ohio Board of Regents, or an accredited college or university located outside

Ineligible graduates

The act specifies that a graduate who has been found by the state to be delinquent in the payment of individual income taxes is not eligible to receive a grant or other assistance. A graduate who is married to an individual who has previously received a grant or financial assistance or down payment assistance under the program is also not eligible to apply.

"First home" criteria

Under the act, a "first home" or "home" is the first residential real property located in Ohio to be purchased by a recipient who has not owned or had an ownership interest in a principal residence in the three years prior to the purchase.

"Ohio resident" criteria

Under the act, an "Ohio resident" is any of the following: (1) an individual who was a resident of Ohio at the time of the individual's graduation from an Ohio public or nonpublic high school that is approved by the State Board of Education, and who is a resident of Ohio when applying for the program, (2) an individual who was a resident of Ohio at the time of completing, through the 12th grade-level, a home study program approved by the State Board of Education, and who is a resident of Ohio when applying for the program, (3) an individual whose parent was a resident of Ohio at the time of the individual's graduation from high school, and who graduated from either an out-of-state high school that was accredited by a regional accrediting organization recognized by the U.S. Department of Education and met standards at least equivalent to those adopted by the State Board of Education for approval of nonpublic schools in Ohio or from a high school approved by the U.S. Department of Defense.

Receipt of assistance

(R.C. 175.31(D) and (E))

An eligible graduate is to receive down payment assistance and a reduction in the interest rate of the mortgage offered by OHFA. The down payment assistance must be provided to the recipient when the recipient obtains a qualifying mortgage loan from a participating lender in OHFA's first time home buyer program, which program is already in existence.

Ohio accredited by an accrediting organization or professional accrediting association recognized by the Board of Regents.

Lien on first home

(R.C. 175.32)

The act provides that at the time a first home is purchased under the program, OHFA must secure the amount of the down payment assistance by a lien on the home for a period of five years. Such a lien attaches, and may be perfected, collected, and enforced in the same manner as a mortgage lien on the home, and must otherwise have the same force and effect as a mortgage lien on the home. However, the act specifies that the OHFA lien is subordinate to a mortgage lien securing any money loaned by a financial institution for the purchase of the home.

Failure to comply with first home ownership criteria or use of fraudulent information

The act authorizes enforcement of the lien if OHFA finds that a recipient failed to comply with the first home ownership criteria of the act or otherwise applied for a grant using fraudulent information.

Failure to reside in first home for at least five years

The act provides that if a recipient becomes a resident of another state and does not reside at least five years in a first home purchased using grant money, OHFA may collect on the lien. The amount collectable in such a circumstance is a function of the time the recipient resided in the first home. If a recipient has resided in the first home for less than 12 months, the act allows collection of 100% of the down payment assistance amount. If a recipient has resided in the first home for 12 months and a day to 24 months the act allows collection of 80% of the down payment assistance amount. If a recipient has resided in the first home for 24 months and a day to 36 months, the act allows collection of 60% of the down payment assistance amount. If a recipient has resided in the first home for 36 months and a day to 48 months, the act allows collection of 40% of the grant amount. And if a recipient has resided in the first home for 48 months and a day to 60 months, the act allows collection of 20% of the down payment assistance amount.[241]

[241] The act uses the construction of "and a day" in demarking the periods of time for which different collectible amount percentages for grant recovery apply. Presumably, for example, the percentage applicable to "24 months and a day" would apply to someone who resided in the home for 24 months and three hours--simply because no other percentage would apply. The act could be made clearer, however, if "and a day" was replaced where appropriate with "or more."

Extinguishing the lien

The act provides that the five-year lien on the home secured by OHFA in the amount of the down payment assistance is extinguished if money is collected pursuant to the lien because a recipient becomes a resident of another state and does not reside at least five years in a first home purchased using grant money. Such a lien is also extinguished if the recipient, within the five-year period, moves to another residence in Ohio.

DEPARTMENT OF INSURANCE (INS)

- Transfers from the Director of Health to the Superintendent of Insurance authority to review a health insuring corporation's capability of providing the health care services for which the corporation is seeking a certificate of authority and other insurance review authority.

- Reduces the minimum number of employees or members of a trade or professional organization, labor union, or other association necessary to qualify for a sickness and accident insurance franchise plan with respect to long-term care insurance or disability income insurance.

- Increases the time period within which a person can request an external view for medical necessity after an internal review from a health insurance corporation and applies the same time limit to sickness and accident insurance and public employee benefit plans.

- Allows the Superintendent of Insurance to notify an "authorized person," instead of the insured person, of the result of the Superintendent's health care service denial review and requires health insuring corporations to cover services that the Superintendent determines are covered services.

- Shifts the burden of initiating an independent, external review of a health care service denial from the insured person to the health insuring corporation, sickness and accident insurer, or public employee benefit plan.

- Incorporates the previously existing Claims Processing Education Fund into the Department of Insurance Operating Fund as a separate account.

- Requires third party payers to pay claims for health care services to a provider electronically under Ohio's Prompt Payment Law when the third party payer receives the claim electronically.

- Clarifies that insurers must file the premium rates for small employer health benefit plans according to the requirements for group policies of a heath insuring corporation or sickness and accident insurer, as applicable.

- Clarifies that policies or certificates of sickness and accident insurance that are sold on the market to individuals are individual policies for the purposes of premium rate review regardless of whether those policies or certificates are issued through group policies.

- Creates the Health Care Coverage and Quality Council to advise the Governor, General Assembly, public and private entities, and consumers on strategies to expand affordable health insurance coverage to more individuals and improve the cost and quality of Ohio's health insurance system and health care system (PARTIALLY VETOED).

- Requires that all health care plans offered in the state that provide coverage for unmarried dependent children extend coverage at the request of the insured, under certain conditions, until the dependent child reaches at least 28 years of age and allows Ohio income tax deductions for coverage of those dependents (PARTIALLY VETOED).

- Makes changes to the open enrollment program, including changes to the number of people who must be accepted for health insurance coverage through open enrollment, the premium rates that can be charged for that coverage, and the effective dates of coverage.

- Reduces the maximum premium rates and contractual periodic prepayments that insurers and health insuring corporations may charge "federally eligible individuals" for individual health insurance contracts or policies that are converted from group contracts and policies.

- Prohibits insurers and health insuring corporations from using health status as a basis for refusing to renew a converted contract.

- Makes permanent the changes made by H.B. 2 of the 128th General Assembly (Transportation budget act) to the law regarding continuation of group health insurance coverage after termination of employment.

- Makes changes to the requirements concerning a sickness and accident insurer's aggregate administrative expenses and annual statement of the insurer's aggregate administrative expenses.

- Requires employers that employ ten or more employees to adopt and maintain a cafeteria plan that allows the employer's employees to pay for health insurance coverage by a salary reduction arrangement.

- Removes the statutory cap on homeowners insurance rates and basic property insurance rates that are established by the Ohio Fair Plan Underwriting Association for urban areas and instead requires that those rates be subject directly to the approval of the Superintendent of Insurance.

- Allows the Ohio Fair Plan Underwriting Association to approve payment of a percentage of the estimated annual premium due, instead of the entire estimated annual premium, before issuing a binder.

- Changes the effective date of a binder issued by the Ohio Fair Plan Underwriting Association from 15 days after the date of application to the day after the Association receives the application.

- Requires property and casualty insurance companies to annually submit to the Superintendent of Insurance specified actuarial documents.

- Places a moratorium on the Department of Insurance's designation of entities to provide investment options under alternative retirement plans established by public institutions of higher education until July 1, 2010.

Review of health insuring corporation's capability and availability of services--certificate of authority

(R.C. 1751.03, 1751.04, 1751.05, 1751.19, 1751.32, 1751.321, 1751.34, 1751.35, 1751.36, 1751.45, 1751.46, 1751.48, and 1753.09)

Under prior law, when the Superintendent of Insurance received an application for a health insuring corporation certificate of authority, the Superintendent had to give copies of the application and accompanying documents to the Director of Health. Within 90 days of receiving the application and accompanying documents, the Director of Health had to review the applications and accompanying documents and certify to the Superintendent whether or not the health insuring corporation did all of the following:

(1) Demonstrated the willingness and potential ability to ensure that all basic health care services and supplemental health care services described in the evidence of

coverage will be provided to all its enrollees as promptly as is appropriate and in a manner that assures continuity;

(2) Made effective arrangements to ensure that its enrollees have reliable access to qualified providers in those specialties that are generally available in the geographic area or areas to be served by the applicant and that are necessary to provide all basic health care services and supplemental health care services described in the evidence of coverage;

(3) Made appropriate arrangements for the availability of short-term health care services in emergencies within the geographic area or areas to be served by the applicant, 24 hours per day, seven days per week, and for the provision of adequate coverage whenever an out-of-area emergency arises;

(4) Made appropriate arrangements for an ongoing evaluation and assurance of the quality of health care services provided to enrollees, including, if applicable, the development of a quality assurance program, and the adequacy of the personnel, facilities, and equipment by or through which the services are rendered;

(5) Developed a procedure to gather and report statistics relating to the cost and effectiveness of its operations, the pattern of utilization of its services, and the quality, availability, and accessibility of its services.

If the Director found that the health insuring corporation did not meet those five requirements, the Director had to give the health insuring corporation the opportunity for a hearing. A health insuring corporation could not receive a certificate of authority from the Superintendent if the Director did not certify that the health insuring corporation met those five requirements.

Prior law also required the Director to review a health insuring corporation's plan of operation and make a certification to the Superintendent, as described above, every time the application was amended or a health insuring corporation made a request to expand its approved service area. The Director also had to make an examination of health insuring corporations as often as the Director considered it necessary, but not less than every three years, to determine whether the health insuring corporation still met the above five requirements.

The act transfers all of the Director's review authority, as described above, to the Superintendent of Insurance, and removes the 90-day period within which an application for a certificate of authority and accompanying documents must be reviewed to determine whether the applicant meets the five requirements listed above. Under the act, the Superintendent must complete that review and the application

review already under the Superintendent's authority within the Superintendent's continuing time limit of 135 days. Additionally, the act removes the requirement that examination be repeated every three years.

Under prior law, a health insuring corporation had to make copies of its complaints and responses available to the Director and the Superintendent. A health insuring corporation also had to file annual reports and annual audit reports with both the Director and the Superintendent. Under the act, a health insuring corporation would not need to make any records available to the Director or file any reports with the Director. Additionally, the act removes from Health Insuring Corporation Law all authority of the Director to enforce Health Insuring Corporation Law and any requirements that the Superintendent consider any recommendations received from the Director for enforcement of Health Insuring Corporation Law or adoption of rules.

Franchise plans

(R.C. 3923.11)

A franchise plan is a group of insurance policies issued to individuals in a group rather than to the group as a whole. Under law largely unchanged by the act sickness and accident insurers may issue franchise plans to either of the following:

(1) Five or more employees of any corporation, copartnership, or individual employer, or of any governmental corporation or agency or a department;

(2) Ten or more members of any trade or professional association, or labor union, or any other association having had an active existence for at least two years where the association or union has a constitution or bylaws and is formed in good faith for purposes other than that of obtaining insurance.

In order for the policies to be considered as issued on a franchise plan, under continuing law, the employees or members must be issued the same form of an individual policy, varying only in the amounts and kinds of coverage for which the employees or members apply. Additionally, the premiums may be paid to the insurer periodically by the employer or by the association for its members, or by some designated person acting on behalf of the employer or association.

The act reduces to two or more the number of employees or members of a trade or professional organization, labor union, or other association necessary to qualify for a sickness and accident insurance on a franchise plan with respect to long-term care insurance or disability income insurance.

Independent, external reviews of health care coverage decisions

(R.C. 1751.831, 1751.84, 1751.85, 3923.66, 3923.67, 3923.68, 3923.75, 3923.76, and 3923.77)

Under continuing law, health insuring corporations, sickness and accident insurers (insurers), and public employee benefit plans (plans) must provide for external reviews of certain health care coverage decisions made by those entities.

External reviews at the request of the insured person

If a health care coverage decision denies, reduces, or terminates coverage for a particular service on the basis that the service is not medically necessary, continuing law requires the health insuring corporation, insurer, or plan that makes that decision to afford the insured person who has been denied coverage an opportunity for an external review upon that person's request. The same is required if a decision denies, reduces, or terminates coverage for a drug, device, procedure, or other therapy for a terminal condition on the basis that the therapy is experimental or investigatory.

Under prior law, a health insuring corporation could deny an insured person's request for an external review if the request was not made within 60 days after the insured person receives notification of the results of the health insuring corporation's internal review (the internal review is required under continuing law after the initial denial of coverage and upon the insured person's request). Insurers and plans were not afforded this same authority under prior law. The act increases the time during which an insured person can request an external review of a health insuring corporation's adverse decision, from 60 days to 180 days. The act also gives insurers and plans the authority to deny an insured person's request for an external review of an adverse decision if the request is not made within 180 days after the insured person receives notice from the insurer or plan of the adverse decision.

Automatic external reviews

If a health insuring corporation, insurer, or plan denies, reduces, or terminates coverage for a particular service on the basis that the service is not one that is covered under the insurance contract, policy, or plan, continuing law allows an insured person, or a person authorized to act on behalf of the insured person, to request a review by the Superintendent of Insurance. Upon receiving the request, the Superintendent must consider the denial and determine whether the health care service is a service covered under the terms of the contract, policy, or plan. The Superintendent does not have to make a determination, however, if doing so requires resolution of a medical issue.

Under prior law, when a determination was made, or the Superintendent concluded that a determination could not be made because it required resolution of a

medical issue, the Superintendent had to notify the insured person and the insuring entity of that decision. The act allows the Superintendent to notify an "authorized person" of the decision, instead of the insured person and in addition to the insuring entity. For purposes of insurers and plans, continuing law defines an "authorized person" as a parent, guardian, or other person authorized to act on behalf of an insured person or plan member with respect to health care decisions. The term is not defined for purposes of health insuring corporations.

If the Superintendent determines that the service is not a covered service, continuing law does not require any further action from the health insuring corporation, insurer, or plan. If the Superintendent determines that the service is a covered service, continuing law is silent as to what insurers and plans must do, but prior law required health insuring corporations to either cover the service or afford the enrollee an opportunity for an external review. The act removes the latter option and simply requires that the health insuring corporation cover the service.

If the Superintendent could not make a determination because doing so required the resolution of a medical issue, prior law required the health insuring corporation, insurer, or plan to conduct an external review upon the insured person's request. A health insuring corporation could deny an enrollee's request for this type of external review under prior law if the request was not made within 60 days after the enrollee was first informed of the health insuring corporation's decision to deny the covered service (this decision was made during the health insuring corporation's internal review, which occurred before the Superintendent's review). An insurer or plan could deny an insured person's request for this type of external review if the request was not made within 60 days after the insured person received notice of the Superintendent's decision.

The act requires the health insuring corporation, insurer, or plan to initiate an independent, external review automatically, without a request from the insured person, upon receiving notification from the Superintendent that a determination cannot be made as to whether the service is a covered service under the contract, policy, or plan because that determination requires the resolution of a medical issue. Accordingly, the act removes any language that references an insurer's or plan's authority to deny this type of external review request on the basis that the insured person failed to make the request within a certain time period.

Insurance prompt payment fines--disposition

(R.C. 3901.3812)

Under continuing law the Superintendent of Insurance may impose monetary penalties for insurers that do not process claims payments to health care providers as required under Ohio's law regulating prompt payments to health care providers. Those fines must be paid into the state treasury as follows: 25% to the Department of Insurance Operating Fund; 65% to the General Revenue Fund; and 10% to the Claims Processing Education Fund. The Superintendent must use the money in the Claims Processing Education Fund to make technical assistance available to third-party payers, providers, and beneficiaries for effective implementation of Ohio's law regulating prompt payments to health care providers. The act eliminates the separate fund status of the Claims Processing Education Fund and instead incorporates it into the Department of Insurance Operating Fund as a separate account.

Electronic payment of claims

(R.C. 3901.381; Section 812.10)

The act requires third party payers to pay claims for health care services to a provider electronically under Ohio's Prompt Payment Law when the third party payer receives the claim electronically. The act also prohibits providers from refusing to accept those payments on the basis that they were transmitted electronically. Both of these changes become effective 12 months after the act's effective date.

Health insurance premium rate filing

(R.C. 3923.021 and 3924.06)

Under continuing law, prior to delivering or issuing for delivery a policy or certificate of sickness and accident insurance, insurers must file with the Superintendent of Insurance the policy or certificate, or any endorsement, rider, or application which becomes or which is designed to become a part of any policy or certificate and the premium rates and classification of risks of the policy or certificate. The Superintendent has 30 days to review the filing and determine if it contains any provision which is contrary to the law of Ohio, or contains inconsistent provisions or any question, provision, title, heading, backing, or other indication of its contents, which is ambiguous, misleading, or deceptive, or likely to mislead or deceive the policyholder, certificate holder or applicant. The Superintendent also has the option of withdrawing approval of the filing anytime after the 30 days have expired. (R.C. 3923.02, not in the act.)

Similarly, prior to delivering or issuing for delivery a group policy,[242] continuing law requires a health insuring corporation to file with the Superintendent the contractual periodic prepayment information for the group policy. The Superintendent may reject the filing at any time, with at least 30 days' written notice to a health insuring corporation, if the contractual periodic prepayment is not in accordance with sound actuarial principles or is not reasonably related to the applicable coverage and characteristics of the applicable class of enrollees. (R.C. 1751.12, not in the act.)

The act clarifies that insurers that offer plans to small employers must file their premium rates with the Superintendent in accordance to the requirements above for group policies of sickness and accident insurance or for group policies of a health insuring corporation, as applicable.

Under continuing law, if a policy is an individual policy of sickness and accident insurance, when the insurer files the policy with the Superintendent as required above, the Superintendent must specifically review the premium rates to determine whether the benefits provided are unreasonable in relation to the premium charged. If the Superintendent does not disapprove the filing within 30 days, it is deemed approved. Anytime after the Superintendent approves the filing, the Superintendent, after a hearing, may withdraw approval of the filing.

The act clarifies that policies or certificates of sickness and accident insurance that are sold on the market to individuals are individual policies of sickness and accident insurance for the purposes of the Superintendent's review of premium rates regardless of whether those policies or certificates are issued through group policies to one or more associations or entities.

Limiting age for dependent child coverage under a health care plan or insurance policy (PARTIALLY VETOED)

(R.C. 1739.05, 1751.14, 3923.24, and 3923.241; Section 803.10)

Continuing law specifically allows a health insurance policy offered by a sickness and accident insurer or a health insuring corporation that offers coverage for unmarried dependent children to place a "limiting age" upon that coverage. However, under continuing law, the attainment of that age may not operate to terminate coverage if the child continues to be both: (1) incapable of self-sustaining employment by reason of mental retardation or physical handicap, and (2) primarily dependent upon the

[242] Continuing law contains similar requirements for filing of contractual periodic prepayment and premium rate for nongroup and conversion policies of a health insuring corporation (R.C. 1751.12, not in the act).

subscriber for support and maintenance. The act expands that requirement to include public employee benefit plans and multiple employer welfare arrangements (hereafter, MEWA).

Additionally, the act stipulates that once an unmarried child has attained the limiting age for dependent children, as provided in the policy or plan, upon the request of the subscriber, the insurer must offer to cover the unmarried child until the child's 28th birthday if all of the following are true: (1) the child is the natural child, stepchild, or adopted child of the subscriber, (2) the child is not employed by an employer that offers the child any "health benefit plan," (3) the child is a resident of Ohio or a full-time student at an accredited public or private institution of higher education, and (4) the child is not eligible for Medicaid or Medicare. The act's requirements apply only to policies and plans delivered, issued for delivery, or renewed on or after July 1, 2010. The Governor vetoed a provision that would have additionally required that the child maintained continuous coverage under any health benefit plan after having attained the limiting age for dependent children in order to be eligible for this expanded coverage.

For the purposes of determining what type of health coverage offered by an employer would disqualify a person from qualifying as a dependent under the act, the act defines a "health benefit plan" as a public employee benefit plan, a health benefit plan as regulated under ERISA, or any hospital or medical expense policy or certificate or any health plan provided by a health insuring corporation, sickness and accident insurer, or MEWA that is delivered, issued for delivery, renewed, or used in Ohio on or after the date occurring six months after November 24, 1995. "Health benefit plan" does not include policies covering only accident, credit, dental, disability income, long-term care, hospital indemnity, medicare supplement, specified disease, or vision care; coverage under a one-time-limited-duration policy of no longer than six months; coverage issued as a supplement to liability insurance; insurance arising out of a workers' compensation or similar law; automobile medical-payment insurance; or insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

Exceptions

(R.C. 1751.14, 3923.24, and 3923.241)

The act specifies that it does not require insurers to offer dependent coverage in general and its requirements do not extend to dependents of dependents. Additionally, the act specifically does not require an employer to offer coverage to the dependents of any employee or to pay for any part of the premium for a dependent child that has already attained the normal limiting age for dependents that is specified in the policy or

plan. The act's requirements would not apply to specified supplemental health care services or specialty health care services.

Deduction for coverage for older children

(R.C. 5747.01(A)(11))

Federal income tax law excludes the value of employer-paid health coverage from an employee's gross income, so the value of the coverage is not taxable income under the federal or Ohio income tax.[243] But both the federal and Ohio exclusions apply only to plans covering the taxpayer and any spouse or dependents. Federal income tax law defines who qualifies as a "dependent," and Ohio previously applied the same definition in all cases. (The qualification criteria for dependents is described below.) If a child was covered by an employer-paid plan but did not qualify as a dependent under federal income tax law, the value of the policy to the extent of that coverage could not be excluded from taxable income; the coverage of the nondependent was imputed to the taxpayer as taxable income.

Continuing law also authorizes an income tax deduction for amounts paid for medical care insurance and long-term care insurance covering the taxpayer or the taxpayer's spouse or dependents. The medical care insurance deduction may be claimed only to the extent the premiums paid are not offset by premium refunds, reimbursements, or dividends related to the coverage. It is available only for individuals who are not eligible for coverage under an employer-subsidized health plan (either directly or through a spouse's employer) and who are not eligible for Medicare coverage.[244]

The act permits taxpayers to deduct the income imputed to a taxpayer on the basis of an employer-paid plan covering a child who, although not a "dependent" for tax purposes, nevertheless meets requirements for being a "qualifying relative" under the Internal Revenue Code (IRC Sec. 152(d)) except for the income and support requirements. This definition includes the taxpayer's child or descendent of a child, brother, sister, stepbrother, stepsister, father, mother, ancestor of father or mother, stepfather, stepmother, nephew, niece, uncle, aunt, son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, sister-in-law, or any other individual who has the same principal place of abode as the taxpayer and is a member of the taxpayer's household. The act also allows taxpayers to claim the medical care insurance deduction

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[243] Internal Revenue Code section 106, 26 U.S.C. 106.

[244] Coverage offered by a former employer--e.g., through a retirement plan--is treated as employer-subsidized coverage.

for coverage of the same qualifying relatives without requiring that those relatives meet any income or support requirements.

Mandated review by Superintendent of Insurance--exemption

(R.C. 1751.14(A), 3923.24(A), and 3923.241(A))

The act exempts its provisions that require expanded coverage for dependents from the review otherwise required by R.C. 3901.71, which requires the Superintendent of Insurance to hold a public hearing to consider any new health benefit mandate contained in a law enacted by the General Assembly. A new health benefit mandate may not be applied to policies and plans of insurance until the Superintendent determines that the mandate can be fully and equally applied to self-insured employee benefit plans subject to the regulation under the federal Employee Retirement Income Security Act of 1974 (ERISA), and to employee benefit plans established by the state or its political subdivisions, or their agencies and instrumentalities. ERISA generally precludes state regulation of benefits offered by private self-insured, employee benefit plans.

Mandatory open enrollment period for health insurance coverage

(R.C. 1751.15, 1751.18, 3923.58, 3923.581, and 3923.582)

Continuing law requires health insuring corporations, sickness and accident insurers (insurers), and multiple employer welfare arrangements (MEWAs) to hold an annual open enrollment period during which those carriers are required to accept applicants for health insurance in the order the applicants apply if the carrier issues health benefit plans to individuals or nonemployer groups. During open enrollment, all three types of carriers are required to accept "federally eligible individuals." A "federally eligible individual" is an uninsured person who is not eligible for a group health plan, Medicaid, or Medicare, and who has at least 18 months of previous coverage under a group, government, or church plan. The term is defined under continuing law by cross reference to federal regulations concerning portability, access, and renewability requirements for individual insurance coverage.

Continuing law also requires insuring corporations and insurers to accept non-federally eligible individuals for open enrollment coverage. Under prior law, sickness and accident insurers and MEWAs only had to accept non-federally eligible individuals if the insurer issued health benefit plans to individuals. Under the act, all carriers (health insuring corporation, sickness an accident insurers, and MEWAs must accept non-federally qualified individuals if the carrier offers health benefit plans to individuals and nonemployer groups with the exception of individual policies that are converted from group policies under Ohio law.

Additionally, the act conforms the requirements for health insuring corporation open enrollment coverage of non-federally eligible individuals to the requirements for sickness and accident insurers' and MEWAs' coverage of those individuals including requiring health insuring corporations to accept applicants up to the limits regardless of when they apply (prior law only health insuring corporations to accept non-federal eligible applicants during a one-month open enrollment period).

Maximum number of required enrollees

Prior law limited the number of people that carriers must accept during open enrollment. With regard to federally eligible individuals, prior law capped the number of those individuals that must be accepted annually for open enrollment at ½% of the carrier's total number of insured individuals and non-employer groups. Insurers were only required to accept non-federally eligible individuals for open enrollment to the extent the number of such individuals did not exceed ½% of the insurer's total number of insured individuals. For health insuring corporations, prior law capped the number of non-federally eligible individuals that must be accepted at 1% of the health insuring corporation's total number of subscribers.

The act phases in an increase in those caps to 4% for federally eligible individuals and 4% for non-federally eligible individuals for calendar years 2010 and 2011 and 8% for each for 2012 and every year thereafter, unless the Superintendent of Insurance determines that act's changes to the open enrollment program have resulted in the market-wide average medical loss ratio for coverage sold to individual insureds and nonemployer group insureds in this state, including open enrollment insureds, to increase by more than 5¼ percentage points during calendar year 2010. If the Superintendent makes that determination, the 2010 and 2011 enrollment limit remains in effect. The Superintendent's determination must be supported by a signed letter from a member of the American Academy of Actuaries.

Under prior law, once an insurer met the open enrollment cap for non-federally eligible individuals, the insurer would be exempt from the requirements for the rest of the calendar year. For federally eligible individuals, prior law required that once all insures met the limit, insurers would have to accept additional open enrollment enrollees up to ½% of the insurer's total individual and non-employer group insures in Ohio. The act allows carriers to be exempt only for as long as the carrier continues to meet the enrollment limit. If the total number of the carrier's current insureds with open enrollment coverage falls below the enrollment limit, the carrier must accept new applicants. The act also allows a carrier to establish a waiting list if the insurer has met the open enrollment limit and must notify the Superintendent if the carrier has a waiting list in effect. For federally eligible individuals, the act requires that once all

carriers meet the limit, carriers must accept additional enrollees up to half of the applicable percentage limit required under the act as described above.

Rates for open enrollment coverage

In addition to limiting the number of people who must be accepted during open enrollment, prior law limited the premiums that can be charged for open enrollment coverage. Under prior law carriers accepting federally eligible individuals for open enrollment coverage could not charge those individuals more than two times the midpoint rate charged other individuals for similar coverage. "Midpoint rate" was defined in prior law as the arithmetic average of the base premium rate and the corresponding highest premium rate charged to individuals with similar case characteristics and plan design. With regard to non-federally eligible individuals who are accepted for open enrollment, insurers were prohibited from charging more than two and one-half times the highest rate charged any other individual for similar coverage. There was no similar prohibition for health insuring corporations, meaning that health insuring corporations could charge higher premium rates.

The act phases in a reduction in the premium rates that can be charged by carriers for federally eligible and non-federally eligible individuals including applying those rate limitations to health insuring corporations. Under the act, the rate limit for calendar years 2010 and 2011 is an amount that is two times the base rate charged for coverage offered to any other individual to which the carrier is currently accepting new business, and for which similar copayments and deductibles are applied. The rate limit for calendar year 2012 and every calendar year thereafter is an amount that is one and one-half times the base rate for coverage offered to any other individual to which the carrier is currently accepting new business and for which similar copayments and deductibles are applied, unless the Superintendent determines that the act's changes to the open enrollment program have resulted in a market-wide average medical loss ratio for coverage sold to individual insureds and nonemployer group insureds in this state, including open enrollment insureds, to increase by more than 5¼ percentage points during calendar year 2010. If the Superintendent makes that determination, the premium limit for 2010 and 2011 remains in effect. The Superintendent's determination must be supported by a signed letter from a member of the American Academy of Actuaries.

For purposes of open enrollment coverage, the act defines "base rate" as the lowest premium rate for new or existing business prescribed by the carrier for the same or similar coverage under a plan or arrangement covering any individual with similar case characteristics.

Delay in open enrollment coverage

Under prior law, an insurer did not have to make open enrollment benefits available to non-federally eligible individuals for the first 90 days after enrollment. The act requires an immediate effective date for such benefits when the insured individual had other health care coverage that was terminated by a carrier because the carrier exited the market and the individual was accepted for open enrollment within 63 days of that termination. Under any other circumstance, the act continues to allow the 90-day delay.

Preexisting conditions

Under ongoing law, open enrollment health benefit plans issued to non-federally eligible individuals may establish preexisting conditions provisions that exclude or limit coverage for a period of up to 12 months following the individual's effective date of coverage and that may relate only to conditions during the six months immediately preceding the effective date of coverage. The act adds that in determining whether a preexisting condition provision applies to an insured or dependent, each plan must credit the time the insured or dependent was covered under a previous policy, contract, or plan if the previous coverage was continuous to a date not more than 63 days prior to the effective date of the new coverage, exclusive of any applicable service waiting period under the plan.

Under continuing law a health insuring corporation may apply a preexisting condition provision for any basic health care service related to a transplant of a body organ if the transplant occurs within one year after the effective date of a non-federally eligible enrollee's coverage under the open enrollment program except with respect to a newly born child. The act maintains this exception for health insuring corporations only.

Commissions for open enrollment contracts

Prior law required insurers to pay agents a 5% commission for initial open-enrollment health insurance contracts for non-federally eligible individuals and a 4% commission for renewals of those contracts. The act removes the mandatory character of those commissions and, instead, makes them optional while maintaining the Superintendent's rulemaking and enforcement authority. The act also allows health insuring corporations, insurers, and MEWAs issuing health insurance contracts through open enrollment to federally eligible individuals to pay those commissions and extends the Superintendent's rulemaking and enforcement authority to these types of arrangements.

Exceptions

Under continuing law sickness and accident insurers and MEWAs are not required to accept non-federally eligible individuals if the insurer that is currently in a state of supervision, insolvency, or liquidation. If an insurer demonstrates to the satisfaction of the Superintendent that those open enrollment requirements would place the insurer in a state of supervision, insolvency, or liquidation, the Superintendent may waive or modify either the requirement to accept non-federally eligible individuals or the cap on that number of those individuals the insurer must accept. The act adds the following to the circumstances that would allow the Superintendent to waive or modify those requirements: the requirements would otherwise jeopardize the carrier's economic viability overall or in the individual market. (Continuing law provides a similar exception for open enrollment coverage of federally eligible individuals.)

Additionally, under continuing law, if a carrier offers a health benefit plan in the individual market through a network plan, the carrier may limit the federally eligible individuals that may apply for such coverage to those who live, work, or reside in the service area of the network plan. Within the service area of the network plan, carriers also may deny the coverage to federally eligible individuals if the carrier has demonstrated both of the following to the Superintendent: (1) the carrier will not have the capacity to deliver services adequately to any additional individuals because of the carrier's obligations to existing group contract holders and individuals, (2) the carrier is applying that denial of coverage uniformly to all federally eligible individuals without regard to any health status-related factor of those individuals. A carrier that denies coverage to an individual in the service area of a network plan, may not offer coverage in the individual market within that service area for at least 180 days after the date the coverage is denied. The act applies this same exception to open enrollment coverage of non-federally qualified individuals.

Rules adopted by the Superintendent

The act allows the Superintendent to adopt rules in accordance with the Administrative Procedures Act (R.C. Chapter 119.) to implement the open enrollment program, including rules relating to both of the following: (1) requirements for adequate notice by carriers to consumers of the availability and premium rates of open enrollment coverage, (2) reporting and data collection requirements for implementation of the open enrollment program and to evaluate the performance of the open enrollment program and the individual health insurance market of this state.

Additionally, on or before June 30, beginning calendar year 2011 and continuing every year thereafter, the act requires the Superintendent to issue a report to the Governor and the General Assembly on the open enrollment program and the

performance of the individual health insurance market in this state. The report must include a determination by the Superintendent, supported by a signed letter from a member of the American Academy of Actuaries, as to whether the amendments by this act the open enrollment program, have caused the market-wide average medical loss ratio for coverage sold to individual insureds and nonemployer group insureds in this state, including open enrollment insureds, to increase and, if so, by how many percentage points.

Group-to-individual policy conversions

(R.C. 1751.16 and 3923.122)

Under continuing law, every group contract issued by a health insuring corporation or sickness and accident insurer must provide an option for conversion to an individual contract. When a federally eligible individual exercises that option to convert, continuing law, revised in part by the act, prohibits the health insuring corporation or insurer from charging periodic prepayments or premiums that exceed two times the midpoint of the standard rate charged any other individual for similar coverage. "Midpoint of the standard rate" was not a defined term under prior law.

The act phases in a reduction in the premium rates that can be charged by health insuring corporations and sickness and accident insurers carriers for converted policies covering federally eligible individuals including applying those rate limitations to health insuring corporations. Under the act, the rate limit for calendar years 2010 and 2011 is an amount that is two times the base rate charged for coverage offered to any other individual to which the carrier is currently accepting new business, and for which similar copayments and deductibles are applied. The rate limit for calendar year 2012 and every calendar year thereafter, is an amount that is one and one-half times the base rate for coverage offered to any other individual to which the carrier is currently accepting new business and for which similar copayments and deductibles are applied, unless the Superintendent determines that the act's changes to the open enrollment program have resulted in a market-wide average medical loss ratio for coverage sold to individual insureds and nonemployer group insureds in this state, including open enrollment insureds, to increase by more than 5¼ percentage points during calendar year 2010. If the Superintendent makes that determination, the premium limit for 2010 and 2011 remains in effect.

For purposes of converted policies, the act defines "base rate" as the lowest premium rate for new or existing business prescribed by the carrier for the same or similar coverage under a plan or arrangement covering any individual of a group with similar case characteristics.

Additionally, the act prohibits health insuring corporations and sickness and accident insurers from using health status as a basis for refusing to renew a converted policy.

Continuation of group health insurance coverage

(Section 105.10)

Am. Sub. H.B. 2 of the 128th General Assembly makes the following changes to the law regarding continuation of group health insurance coverage after termination of employment:

(1) The act lengthens the time that the employee would be eligible for continued coverage from six months to 12 months.

(2) The act also eliminates the requirement that an individual be eligible for unemployment compensation in order to be eligible for continued coverage under the individual's group contract after termination of employment and requires only that the individual's employment has not been terminated voluntarily or as a result of any gross misconduct on the part of the individual.

(3) The act removes prescription drug benefits from a list that specifies coverages that the continuation of coverage is not required to include.

(4) The act requires employees to notify the health insuring corporation or insurer if the employee elects continuing coverage and allows the health insuring corporation or insurer to require the employer to provide documentation if the employee elects continuation of coverage and is seeking premium assistance for the continuation of coverage under the American Recovery and Reinvestment Act of 2009. The "Director of Insurance" (presumably, this refers to the Superintendent of Insurance) must publish guidance for employers and health insuring corporations concerning the contents of that documentation.

However, Am. Sub. H.B. 2 also specified that its changes to this law automatically repeal on January 1, 2010, thereby reverting the law to the set of requirements that existed prior to the act's enactment. This act, however, removes the automatic repeal, thereby making the changes enacted in Am. Sub. H.B. 2 permanent.

Administrative expenses incurred by sickness and accident insurers

(R.C. 3923.022)

Continuing law limits the amount of aggregate administrative expenses an insurer licensed to do the business of sickness and accident insurance may have in any

year to no more than 20% of the premium income of the insurer, based on the premiums received in that year on the sickness and accident insurance business of the insurer. Under the act, the percentage of aggregate administrative expenses would be based upon the premiums "earned" rather than "received."

Prior law defined "administrative expense" as

> The amount resulting from the following: the amount of premiums received by the insurer for sickness and accident insurance business minus the sum of the amount of claims for losses paid; the amount of losses incurred but not reported; the amount paid for state fees, federal and state taxes, and reinsurance; and the costs and expenses related, either directly or indirectly, to the payment of commissions, measures to control fraud, and managed care. "Administrative expense" does not include any amounts collected, or administrative expenses incurred, by an insurer for the administration of an employee health benefit plan subject to regulation by the federal "Employee Retirement Income Security Act of 1974," 88 Stat. 832, 29 U.S.C.A. 1001, as amended.

The act additionally includes in the definition of administrative expenses for the purposes of the cap on sickness and accident insurer's administrative expenses premiums "earned" rather than just "received" (not necessarily equal amounts), the amount of losses recovered from reinsurance coverage, the amount "incurred" for state fees rather than "paid," and the "incurred" costs and expenses related to payment of commissions rather than the actual costs and expenses (not necessarily equal amounts).

Under continuing law, each insurer must submit to the Superintendent of Insurance an annual statement of the insurer's aggregate administrative expenses. However, the act specifies that the statement must itemize and separately detail all of the following information with respect to the insurer's sickness and accident insurance business:

(1) The amount of premiums earned by the insurer both before and after any costs related to the insurer's purchase of reinsurance coverage;

(2) The total amount of claims for losses paid by the insurer both before and after any reimbursement from reinsurance coverage;

(3) The amount of any losses incurred by the insurer but not reported by the insurer in the current or prior year;

(4) The amount of costs incurred by the insurer for state fees and federal and state taxes;

(5) The amount of costs incurred by the insurer for reinsurance coverage;

(6) The amount of costs incurred by the insurer that are related to the insurer's payment of commissions;

(7) The amount of costs incurred by the insurer that are related to the insurer's fraud prevention measures;

(8) The amount of costs incurred by the insurer that are related to managed care;

(9) Any other administrative expenses incurred by the insurer.

Additionally, the statement must include all of the above information separately detailed for the insurer's individual business, small group business, and large group business. However, the act specifies that the statement of aggregate expenses that separately details that information must be considered work papers resulting from the conduct of a market analysis meaning that the statement is not public record but the Superintendent may share aggregated market information that identifies all of the itemized information except for the amount of costs incurred by the insurer for reinsurance coverage. Under the act, "individual business" includes policies or certificates of sickness and accident insurance that are sold on the individual market to individuals regardless of whether those policies or certificates are issued through group policies to one or more associations or entities.

Under continuing law the Superintendent may suspend the license of an insurer if the insurer fails to meet the limits on aggregate administrative expenses. The act also allows the Superintendent to suspend the license of an insurer if the insurer fails to submit the required annual statement.

Employer-sponsored health insurance coverage

(R.C. 4113.11)

The act requires employers that employ ten or more employees to adopt and maintain a cafeteria plan that allows the employer's employees to pay for health insurance coverage by a salary reduction arrangement under the Internal Revenue Code (IRC). However, the act exempts employers that, through other means, offer health insurance coverage, reimburse for health insurance coverage, or provide employees

with opportunities to pay for health insurance with pre-tax dollars through other salary reduction arrangements. The act refers to the IRC for the definition of "cafeteria plan." The IRC defines a cafeteria plan as a written plan under which all participants are employees, and the participants may choose among two or more benefits consisting of cash and qualified benefits. With specified exceptions, under the IRC, a cafeteria plan does not include any plan that provides for deferred compensation. (IRC Sec. 125.)

Implementation

The act delays the date on which employers must adopt and maintain the required cafeteria plan as follows: (1) for employers that employ more than 500 employees, by not later than January 1, 2011, or six months after the Superintendent of Insurance adopts rules to implement and enforce the requirement, whichever is later, (2) for employers that employ 150 to 500 employees, by not later than July 1, 2011, or 12 months after the Superintendent adopts rules to implement and enforce the requirement, whichever is later, (3) for employers that employ 10 to 149 employees, by not later than January 1, 2012, or 18 months after the Superintendent adopts rules to implement and enforce the requirement, whichever is later.

Under the act, the Superintendent of Insurance must adopt rules in accordance with the Administrative Procedure Act (R.C. Chapter 119.) to implement and enforce the requirement that employers offer a cafeteria plan. Prior to adopting rules, the act requires the Superintendent to consult any federal agency that has oversight of cafeteria plans and employee welfare benefit plans, including the Internal Revenue Service and the United States Department of Labor, and receive written confirmation that the rules adopted will permit employers to establish cafeteria plans in accordance with federal law. The act, additionally, clarifies that its requirements for the adoption and maintenance of a cafeteria plan should not be construed as requiring an employer to establish a cafeteria plan in a manner that would violate federal law, including the Employee Retirement Income Security Act (ERISA) the Consolidated Omnibus Budget Reconciliation Act (COBRA) or the "Health Insurance Portability and Accountability Act (HIPAA).

Additionally, the Health Care Coverage and Quality Council must make recommendations to the Superintendent for the development of strategies to educate, assist, and conduct outreach to employers to simplify administrative processes with respect to creating and maintaining cafeteria plans, including, but not limited to, providing employers with model cafeteria plan documents and technical assistance on creating and maintaining cafeteria plans that conform with state and federal law. The Council also must make recommendations to the Superintendent for the development of strategies to educate, assist, and conduct outreach to employees with respect to finding, selecting, and purchasing a health insurance plan to be paid for through their

employer's cafeteria plan. The rules adopted by the Superintendent must include the strategies recommended by the Council.

Definitions

The act defines "employer" as "any person who has one or more employees. "Employer" includes an agent of an employer, the state or any agency or instrumentality of the state, and any municipal corporation, county, township, school district, or other political subdivision or any agency or instrumentality thereof."

The act defines "employee" as "an individual employed for consideration who works 25 or more hours per week or who renders any other standard of service generally accepted by custom or specified by contract as full-time employment, except for a public employee employed by a township or municipal corporation." In that case, "employee" means "an individual hired with the expectation that the employee will work more than one thousand five hundred hours in any year unless full-time employment is defined differently in an applicable collective bargaining agreement."

Health Care Coverage and Quality Council

(R.C. 3923.90 and 3923.91; Section 307.20)

The act creates the Health Care Coverage and Quality Council to advise the Governor, General Assembly, public and private sector entities, and consumers on strategies to expand affordable health insurance coverage to more individuals and improve the cost and quality of Ohio's health insurance system and health care system.

Council membership

The act provides that the Council is to consist of the following members:

(1) The Superintendent of Insurance or the Superintendent's designee;

(2) The Director of the Executive Medicaid Management Administration;

(3) The Director of Medicaid;

(4) The Director of Health;

(5) The Benefits Administrator of the Office of Benefits Administration in the Department of Administrative Services;

(6) Two members of the House of Representatives, one to be appointed by the Speaker of the House and one to be appointed by the Minority Leader of the House;

(7) Two members of the Senate, one to be appointed by the President of the Senate and one to be appointed by the Minority Leader of the Senate;

(8) The following members to be appointed by the Governor, with the advice and consent of the Senate:

(a) Two representatives of consumers of health care services;

(b) Two representatives of employers that provide health care coverage to their employees;

(c) Two representatives of medical facilities, at least one of whom is a representative of a research and academic medical center;

(d) Two physicians;

(e) Two individuals or representatives of individuals authorized to practice dentistry, optometry, podiatry, or chiropractic;

(f) Two representatives of sickness and accident insurers or health insuring corporations;

(g) Two representatives of organized labor;

(h) One representative of a nonprofit organization experienced in health care data collection and analysis;

(i) One individual with expertise in health information technology and exchange;

(j) One representative of a state retirement system;[245]

(k) One public health professional.

(9) Other members to be appointed by the Superintendent of Insurance.

Appointments to the Council must be made not later than 30 days after the effective date of this provision of the act. The initial legislative members are to be appointed for terms ending three years from the date of appointment.[246] The initial

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[245] The five state retirement systems are the Public Employees Retirement System (PERS), Ohio Police and Fire Pension Fund (OP&F), State Teachers Retirement System (STRS), School Employees Retirement System (SERS), and State Highway Patrol Retirement System (SHPRS).

[246] Legislative members cease to be Council members on ceasing to be members of the General Assembly.

members appointed by the Governor and the Superintendent of Insurance are to serve staggered terms of one, two, or three years, as selected by the Governor or Superintendent when making appointments to the Council. Thereafter, all appointed members are to serve terms of three years.

The Council is required to hold its first meeting not later than September 1, 2009. The Superintendent of Insurance or the Superintendent's designee is to serve as chairperson of the Council. Members are to serve without compensation, except to the extent that serving on the Council is considered part of their regular employment duties. The Superintendent is authorized by the act to provide staff and other administrative support for the Council to carry out its duties.

Duties and reports (PARTIALLY VETOED)

The act requires the Council to do all of the following:

(1) Advise the Governor and General Assembly on strategies to improve health care programs and health insurance policies and benefit plans;

(2) Monitor and evaluate implementation of strategies for improving access to health insurance coverage and improving the quality of Ohio's health care system, identify barriers to implementing those strategies, and identify methods for overcoming the barriers;

(3) Catalog existing health care data reporting efforts and make recommendations to improve data reporting in a manner that increases transparency and consistency in the health care and insurance coverage systems;

(4) Study health care financing alternatives that will increase access to health insurance coverage, promote disease prevention and injury prevention, contain costs, and improve quality;

(5) Evaluate systems that individuals use to obtain or otherwise become connected with health insurance and recommend improvements to those systems or the use of alternative systems;

(6) Recommend minimum coverage standards for basic and standard health insurance plans offered by insurance carriers;

(7) Recommend strategies, such as subsidies, to assist individuals in being able to afford health insurance coverage;

(8) Recommend strategies to implement health information technology to support improved access and quality and reduced costs in Ohio's health care system;

(9) Study alternative care management options for Medicaid recipients not required to participate in the Medicaid care management system;

(10) Perform any other duties specified in rules adopted by the Superintendent.

The act authorizes the Superintendent to adopt rules as necessary for the Council to carry out its duties. The rules must be adopted in accordance with the Administrative Procedure Act (R.C. Chapter 119.). In adopting the rules, the Superintendent may consider recommendations made by the Council.

On or before December 31 each year, the act requires the Council to prepare and issue an annual report, which may include recommendations. The Council may prepare and issue other reports and recommendations at other times that the Council finds appropriate.

The Governor vetoed a provision that would have required the Council to evaluate and recommend strategies pursuant to the recommendations of the former Ohio Medicaid Administrative Study Council[247] to establish an initiative conducted by clinicians in the Office of Ohio Health Plans in the Department of Job and Family Services to do all of the following:

(1) Adopt evidence-based protocols for the prevention and management of disease;

(2) Develop a centralized system for payment of Medicaid claims;

(3) Provide physicians, nurses, and allied health professionals with training on Medicaid claims procedures and payment reforms;

(4) Monitor results for preventive and primary care services.

The Council would have been required not later than June 30, 2010, to submit a report of its findings and recommendations to the Governor, the President of the Senate, and the Speaker of the House.

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[247] The Ohio Medicaid Administrative Study Council was created under Am. Sub. H.B. 66 of the 126th General Assembly, the main operating budget for fiscal years 2006 and 2007. The Council ceased to exist after issuing its final report to the Governor, Senate President, and House Speaker in December 2006. (Ohio Medicaid Administrative Study Council, *About the Council*, available at <http://www.medicaidstudycouncil.ohio.gov/description.asp>.)

Exemption from sunset requirements

Continuing law provides that a board or commission will cease to exist after four years unless legislation is enacted extending its existence. The act exempts the Council from this law.

The Ohio Fair Plan Underwriting Association

(R.C. 3929.43)

Under continuing law, the Ohio Fair Plan Underwriting Association is charged with making basic property insurance and homeowners insurance available in urban areas to people whose property is insurable in accordance with reasonable underwriting standards but who are unable to get insurance through normal channels. This task is accomplished through a plan of operation, which is approved by the Superintendent of Insurance and implemented by every insurer who is authorized to write basic property insurance in Ohio as members of the Association.

Rates for basic property insurance and homeowners insurance

Prior law specified that the rates for the basic property insurance offered under the Fair Plan could not exceed those filed with the Superintendent of Insurance by the major rating organization in Ohio. For homeowners insurance rates, the Association could file deviations from the rating organization's rates, but those deviations were subject to the Superintendent's approval. The act eliminates those limitations on rates and instead requires only that all filings of the rates for basic property insurance and homeowners insurance be subject to the approval of the Superintendent.

Binders for basic property insurance and homeowners insurance

When a person applies for basic property insurance or homeowners insurance under the Plan, continuing law requires issuance of a binder for the coverage sought. In practice, a binder is temporary insurance that is issued until a final agreement for insurance is made. Continuing law does not require issuance of a binder until the applicant has paid the amount of the annual premium due, as estimated by the Association, for the coverage sought. Under prior law, the binder took effect 15 days following the date of application.

The act allows the Association to determine an appropriate percentage of the estimated annual premium that can be paid, instead of the full amount, before a binder must be issued. Additionally, the act changes the binder's effective date to the day after the Association receives the application, provided that the application meets the underwriting standards of the Association.

Property and casualty insurance reporting requirements

(R.C. 3903.77)

The act requires property and casualty insurance companies that do business in Ohio annually to have a qualified actuary[248] prepare the following documents:

(1) A "Statement of Actuarial Opinion" (an actuarial opinion that certifies to the reasonableness of the insurance company's reserves);

(2) An "Actuarial Opinion Summary" (a summary in support of the Statement of Actuarial Opinion). Except, the act does not require an insurance company licensed but not domiciled in Ohio to include the Actuarial Opinion Summary in its submissions to the Superintendent of Insurance unless requested by the Superintendent.

The act requires insurers to submit those documents to the Superintendent in accordance with the National Association of Insurance Commissioners' (hereafter, NAIC) property and casualty annual statement instructions. However, the act allows the Superintendent to exempt property and casualty insurance companies from the requirement to prepare and submit these documents.

Additionally, the act requires insurers to prepare an actuarial report and underlying work papers to support those documents in accordance with the NAIC's property and casualty statement instructions. The insurance company must make the actuarial report and underlying work papers available to the Superintendent upon request. If an insurer fails to provide the actuarial report or work papers at the request of the Superintendent or the Superintendent determines that the actuarial report or work papers provided are unacceptable, the act allows the Superintendent to contract with a qualified actuary at the expense of the insurer to review the Statement of Actuarial Opinion provided by the insurer. The actuary may review the basis for that opinion and prepare a separate set of actuarial report and work papers.

Except in cases of fraud or willful misconduct on the part of the actuary, the act protects any actuary appointed by an insurer to prepare the Statement of Actuarial Opinion and Actuarial Opinion Summary from liability for damages to any person except the insurer and the Superintendent for any act, error, omission, decision, or conduct with respect to the actuary's opinion.

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[248] Under the act, "qualified actuary" means a person who is a member in good standing of the American Academy of Actuaries and who meets the requirements identified in the NAIC's property and casualty statement instructions.

Under the act, the Statement of Actuarial Opinion is a public document and a public record. However, the Actuarial Opinion Summary, actuarial report, work papers, and any documents, materials or other information provided in support of the Statement of Actuarial Opinion are privileged and confidential, are not a public record, are not subject to subpoena or to discovery, and are not admissible in evidence in any private civil action. The act prohibits the Superintendent, including any person who receives documents, materials, or other information required to be kept confidential while acting under the authority of the Superintendent, from testifying in any private civil action concerning any of the documents, materials, or other information. However, the act specifies that this confidentiality should not be construed to limit the Superintendent's authority to release documents to the Actuarial Board for Counseling and Discipline so long as the documents are necessary for the purpose of professional disciplinary proceedings and the Actuarial Board for Counseling and Discipline establishes procedures satisfactory to the Superintendent for preserving the confidentiality of the documents. Additionally, the act specifies that the confidentiality provisions should not be construed to limit the Superintendent's authority to use documents, materials, nor other information in furtherance of any regulatory or legal action brought as part of the Superintendent's official duties.

In order to assist in the performance of the Superintendent's duties, the act allows the Superintendent to do all of the following:

(1) Share documents, materials, or other information, including any documents, materials, or other information required to be kept confidential, with other state, federal, and international regulatory and law enforcement agencies and with the NAIC including its affiliates and subsidiaries if the recipient agrees to maintain the confidentiality and privileged status of the document, material, or other information and has the legal authority to maintain confidentiality;

(2) Receive documents, materials, or other information, including otherwise confidential and privileged documents, materials, and information from other state, federal, and international regulatory and law enforcement agencies and from the NAIC including its affiliates and subsidiaries. The act additionally specifies that the Superintendent must maintain the confidentiality and privileged status of any document, material, or other information received with notice of confidential and privileged status under the laws of the jurisdiction that is the source of the document, material, or information.

(3) Enter into agreements as described above for the sharing and use of information.

Providers of investment options under alternative retirement plans

(Section 739.10)

Continuing law requires the Department of Insurance to designate three or more entities to provide investment options under alternative retirement plans established by public institutions of higher education in accordance with Ohio's law governing alternative retirement plans (R.C. Chapter 3305.) and provides specific requirements that, if met, qualify an entity to be a designated provider. The act requires the Department to withhold from designating any additional entities that the Department has not designated prior to the effective date of this provision of the act until July 1, 2010. However, the act allows the Superintendent to approve additions, deletions, substitutions, and other changes to the investment options offered by an entity already designated by the Superintendent.

DEPARTMENT OF JOB AND FAMILY SERVICES (JFS)

I. General

- Permits federal grant funds that are obligated by the Ohio Department of Job and Family Services (ODJFS) for financial allocations to county family services agencies and local workforce investment boards to be available for expenditure for the duration of the federal grant period.

- Creates the ODJFS General Services Administration and Operating Fund.

- Provides for the Treasurer of State to transfer money in the Refunds and Audit Settlements Fund to the ODJFS General Services Administration and Operating Fund after completion of the reconciliation of all final transactions with the federal government regarding a federal grant for a program ODJFS administers and a final closeout for the grant.

- Provides for money in the ODJFS General Services Administration and Operating Fund to be used for expenses of the programs ODJFS administers and ODJFS's administrative expenses.

- Eliminates a requirement that ODJFS collaborate with county departments of job and family services (CDJFSs) to develop training for appropriate CDJFS employees regarding CDJFSs' duties under previous welfare reform legislation and, after the training is developed, collaborate with the CDJFSs on providing the training.

- Provides that a board of county commissioners, county children services board, or child support enforcement agency is not entitled to an administrative review when ODJFS, pursuant to its authority to take various actions against a county regarding a family services duty, performs or contracts with another entity to perform the family services duty if ODJFS determines that an emergency exists.

- Would have required ODJFS to reallocate certain funds to counties when ODJFS was informed that a county would not use the full amount allocated to it for fiscal year 2010 or 2011 or when ODJFS determined through an annual close out or reconciliation of funds that a county had not used the entire amount of the funds (VETOED).

- Revises the law governing the method by which cash assistance is provided under the Ohio Works First (OWF) and Disability Financial Assistance programs by (1) also applying the law to cash assistance provided under the Refugee Assistance Program, (2) eliminating law that permits a board of county commissioners to require a CDJFS to establish a voluntary or mandatory direct deposit system unless the ODJFS Director has provided for the cash assistance to be made by a state electronic benefit transfer system, (3) requiring a CDJFS to establish a direct deposit system and inform applicants for and recipients of the programs that they must choose whether to receive the cash assistance under the county direct deposit system or the state electronic benefit transfer system, (4) eliminating law that (a) requires a CDJFS to determine what type of account will be used for direct deposit, (b) requires a CDJFS to negotiate with financial institutions to determine the charges, if any, to be imposed, and (c) specifies whether a CDJFS must or may pay the charges, (5) eliminating law that permits a recipient to elect to receive cash assistance in the form of a paper warrant, and (6) eliminating law that requires a CDJFS to bear the full cost of the amount of a replacement warrant under certain circumstances.

II. Child Welfare and Adoption

- Eliminates the requirement that a public children services agency (PCSA) must enter into an agreement with a special needs child's adoptive parent, under certain circumstances, under which the agency must make state adoption maintenance subsidy payments, and instead permits the agency to enter into an agreement if state funds are available.

- Eliminates the requirement that if, after a child's adoption is finalized, a PCSA considers the child to be in need of public care or protective services, the agency must enter into an agreement with the child's adoptive parent under which the agency must make post adoption special services subsidy payments to the extent

state funds are appropriated, and instead permits the agency to enter into an agreement to the extent that state funds are available.

- Eliminates the required listing of all children who are in the permanent custody of an institution or association certified by ODJFS and the required listing of all persons who wish to adopt children and who are approved by an agency empowered to do so.

- Eliminates the requirement that ODJFS compile a report with conclusions regarding the effectiveness of the listing program and submit it to the General Assembly.

- Creates an 18-month pilot program in not more than ten counties, based on an "Alternative Response" approach to reports of child abuse, neglect, and dependency, to be developed and implemented by ODJFS.

- Would have extended from two to four years the period of time within which ODJFS must pass upon the fitness of an institution or association that receives children, or desires to receive and care for children, or places children in private homes, but would have retained the two-year period for individuals who, for compensation, receive or care for children for two or more consecutive weeks (VETOED).

III. Child Care

- Permits the ODJFS Director to adopt rules that establish a different system for the payment of publicly funded child care.

- Eliminates the requirement that CDJFSs specify the maximum number of days providers of publicly funded child care will be provided certificates of payment for days the provider would have provided publicly funded child care had the child been present.

- Eliminates the requirement that CDJFSs automatically review the fee paid by a caretaker parent for publicly funded child care every six months, and instead requires CDJFSs to adjust the fee if the parent reports changes in income, family size, or both.

- Reduces the number of mandatory inspections given to a child day-care center or type A family day-care home from twice to once during each 12-month period of operation and permits all inspections to be unannounced.

- Specifies that, if a center or type A home has been notified that it is in violation of the Day-care Laws and it fails to timely correct the violation, ODJFS's

commencement of an action to revoke the center's or home's license is sufficient notice that the correction has not been made.

- Requires the parent, guardian, or custodian of each child receiving child care from a type A or type B family day-care home that is not covered by liability insurance to sign a written statement, instead of an affidavit, provided by the licensee of the type A family day-care home or the provider of the type B family day-care home stating that the family day-care home does not carry liability insurance.

- Creates a committee to study publicly funded child care services, which must prepare a report of its findings by June 30, 2010, and provide a copy of the report to the Governor, the Speaker of the House of Representatives, and the President of the Senate.

IV. Child Support Enforcement

- Requires health insurance providers to send information to the Office of Child Support in ODJFS identifying policy holders and policy information upon request.

- Authorizes a court or child support enforcement agency to transmit a child support withholding or deduction notice to an obligor's payor by secure electronic format instead of by regular mail.

- Requires employers with more than 50 employees to send withholdings and deductions of child support to the Office of Child Support in ODJFS by electronic means.

- Requires payors who submit combined child support withholdings and deductions to the Office of Child Support in ODJFS to provide the case numbers from the income withholding or deduction notice.

- Requires the ODJFS Director to adopt rules for the compromise and waiver of child support arrearages owed to the state and federal governments, consistent with the federal Title IV-D program.

V. Temporary Assistance for Needy Families (TANF)

- Reenacts prior law that provides for a sanction under the Ohio Works First (OWF) program to continue for the longer of one to six months (depending on the number of previous sanctions) and the date the failure or refusal to comply with a self-sufficiency contract ceases.

- Requires ODJFS to provide an OWF assistance group member who causes a sanction a compliance form the member may complete to indicate willingness to come into full compliance with a provision of a self-sufficiency contract.

- Provides that an OWF member's failure or refusal to comply in full with a provision of a self-sufficiency contract is deemed to have ceased on the date a CDJFS receives the compliance form from the member if the compliance form is completed and provided to the CDJFS in the manner specified in ODJFS's rules.

- Provides that an OWF assistance group must reapply to participate in OWF before resuming participation following a sanction if a CDJFS does not receive the compliance form within a period of time specified in ODJFS rules.

- Eliminates a requirement that ODJFS include, with each cash assistance payment provided under OWF to an assistance group residing in a county in which the Support Enforcement Tracking System is in operation, a notice of the number of months the assistance group has participated in OWF and the remaining number of months the assistance group may participate in OWF under the program's time limits.

- Permits a CDJFS to amend its statement of policies governing its Prevention, Retention, and Contingency (PRC) Program to suspend operation of its PRC Program temporarily.

VI. Medicaid

- Provides that a parent is not required to undergo an eligibility redetermination for Medicaid more often than once every 12 months unless there are reasonable grounds to believe that circumstances have changed that may affect the parent's eligibility.

- Requires a third party against which ODJFS has a right of recovery for payment of a medical item or service provided to a Medicaid recipient to consider ODJFS's payment to be the equivalent of the recipient having obtained prior authorization for the item or service from the third party.

- Prohibits a third party from denying a claim described above solely on the basis of the Medicaid recipient's failure to obtain prior authorization for the medical item or service.

- Modifies the laws governing ODJFS's use of time-limited Medicaid provider agreements by (1) extending the phase-in period to January 1, 2015 (from January 1, 2011), (2) extending the duration of time-limited agreements to seven years (from

three), and (3) exempting hospitals from the requirement that provider agreements be time-limited.

- Provides that ODJFS is not required to issue an order pursuant to an adjudication conducted in accordance with the Administrative Procedure Act when doing any of the following: (1) denying, terminating, or not renewing a Medicaid provider agreement because a provider's owner, officer, authorized agent, associate, manager, or employee has been convicted of an offense that caused the provider agreement to be suspended, (2) terminating or not renewing a Medicaid provider agreement because the provider has not billed or otherwise submitted a Medicaid claim to ODJFS for at least two years, regardless of whether ODJFS has determined that the provider has moved from the address on record with ODJFS without leaving an active forwarding address, or (3) denying, terminating, or not renewing a Medicaid provider agreement because the provider fails to provide to ODJFS the National Provider Identifier assigned to the provider.

- Adds to the offenses that disqualify a person from being a Medicaid provider or employed by a Medicaid provider, and applies the same disqualifying offenses to a provider of home and community-based waiver services and any of its employees.

- Includes, among the additional disqualifying offenses, cruelty to animals, permitting child abuse, menacing, arson, and a violation of any municipal ordinance that is substantially equivalent to the new or existing disqualifying offenses.

- Specifies that the date a person was convicted of, entered a guilty plea to, or was found eligible for intervention in lieu of conviction for an offense that disqualifies the person from being a Medicaid provider, provider of home and community-based services, or an employee of such providers is irrelevant for purposes of determining the person's eligibility to be a provider or an employee.

- Requires ODJFS to prepare an annual Medicaid fraud, waste, and abuse report (PARTIALLY VETOED).

- Requires ODJFS to implement evidence-based, best practice guidelines or protocols and decision support tools for advanced diagnostic imaging services available under the fee-for-service component of the Medicaid program not later than January 1, 2010.

- Requires ODJFS to establish a two-year pilot program under which a CDJFS serving a county with at least 200,000 persons may contract with medical transportation management organizations to manage nonemergency medical transportation

services provided to groups of Medicaid recipients the CDJFS includes in the pilot program.

- Modifies the duties, administration, and membership of ODJFS's Pharmacy and Therapeutics Committee, and requires ODJFS to post certain information regarding the Committee on the ODJFS web site (PARTIALLY VETOED).

- Requires ODJFS, if it studies the issue of funding the Medicaid program through franchise permit fees on providers of health-care services, to submit a copy of a report regarding the study to the General Assembly.

- Terminates the assessment of a Medicaid franchise permit fee on Medicaid health insuring corporations after the calendar quarter ending September 30, 2009, and instead includes the premium rate payments provided under the Medicaid program to an insurance company, including a health insuring corporation, in the computation of the state's annual franchise tax on insurance companies.

- Creates a new formula for determining the franchise permit fee on nursing home beds and hospitals' long-term care beds that is based in part on 5.5% of net patient revenues and a base of $11.95.

- Requires ODJFS to recalculate the franchise permit fee if the amount assessed by the fee for a fiscal year exceeds 5.5% of the actual net patient revenue for all nursing homes and hospital long-term care units for that fiscal year and to credit nursing homes' and hospitals' franchise permit fees for the following fiscal year.

- Requires ODJFS to seek a federal waiver to (1) reduce the nursing home franchise permit fee to zero dollars for two groups of nursing homes and (2) reduce, for each nursing facility with more than 200 Medicaid-certified beds, the franchise permit fee for a number of the nursing facility's beds specified by ODJFS to the amount necessary to obtain approval of the waiver.

- Permits ODJFS to increase uniformly the franchise permit fee for each nursing home and hospital not qualifying for a reduction to an amount that will have the franchise permit fee raise an amount of money that does not exceed the amount the franchise permit fee would raise if not for the waiver.

- Requires ODJFS to determine the amount of the nursing home franchise permit fee for a fiscal year not later than the 15th day of September, rather than August, of that fiscal year and to mail each nursing home and hospital notice of the amount of the franchise permit fee not later than the first day of October, rather than September, of that fiscal year.

- Provides that the first installment payment of the nursing home franchise permit fee for a fiscal year is due not later than 45 days after the last day of October, rather than September, of that fiscal year.

- Creates a formula for determining how much of the money raised by the nursing home franchise permit fee is to be deposited into the Home- and Community-Based Services for the Aged Fund, in place of a statutorily specified percentage.

- Subjects intermediate care facilities for the mentally retarded (ICFs/MR) that the Ohio Department of Developmental Disabilities (ODODD) operates to the ICF/MR franchise permit fee effective August 1, 2009.

- Increases the ICF/MR franchise permit fee from $11.98 per bed per day to $14.75 for all but the first month of fiscal year 2010 and then decreases the fee to $13.55 for all of fiscal year 2011.

- Requires ODJFS to recalculate the ICF/MR franchise permit fee for a fiscal year if the amount assessed by the fee exceeds 5.5% of the actual net patient revenue for all ICFs/MR for that fiscal year and to credit the fee to ICFs/MR for the following fiscal year.

- Provides for the money generated by the ICF/MR franchise permit fee to be deposited as follows: (1) 84.2% in fiscal year 2010 and 79.12% in fiscal year 2011 and thereafter into the Home- and Community-Based Services for the Mentally Retarded and Developmentally Disabled Fund and (2) 15.8% in fiscal year 2010 and 20.88% in fiscal year 2011 and thereafter into a new fund created in the state treasury called the ODODD Operating and Services Fund.

- Provides for money in the ODODD Operating and Services Fund to be used for expenses of the programs that ODODD administers and ODODD's administrative expenses.

- Abolishes the Children with Intensive Behavioral Needs Programs Fund.

- Requires ODJFS to begin to use a new index when first redetermining the cost per case-mix unit for the purpose of nursing facilities' direct care costs and to begin to use a new index when first redetermining the rate for ancillary and support costs for the different peer groups used in the calculation of those costs.

- Revises the deadline for a nursing facility to submit corrections to assessment information by providing that ODJFS may not assign a quarterly average case-mix score due to late submission of the corrections unless the nursing facility fails to submit the corrections before the earlier of (1) the 46th (rather than 81st) day after

the end of the calendar quarter to which the information pertains or (2) the deadline established by federal Medicare and Medicaid regulations.

- Provides that the costs of oxygen, rather than only emergency oxygen, are reimbursable as part of a nursing facility's direct care costs.

- Adds the costs of over-the-counter pharmacy products, physical therapists, physical therapy assistants, occupational therapists, occupational therapy assistants, speech therapists, and audiologists to the costs that are reimbursable as part of a nursing facility's direct care costs.

- Adds wheelchairs and resident transportation to the costs that are reimbursable as part of a nursing facility's ancillary and support costs.

- Sets the Medicaid reimbursement rate paid to nursing facilities for the franchise permit fee at $6.25 per resident per day rather than, as under prior law, the amount of the franchise permit fee per resident per day.

- Prohibits persons, other than nursing facility providers, from billing the Medicaid program for a service provided to a nursing facility resident if the service is included in a Medicaid payment to the nursing facility's provider or in the reimbursable expenses reported on the provider's Medicaid cost report.

- Prohibits a nursing facility provider from submitting a separate Medicaid claim for a service provided to a resident if the service is included in a Medicaid payment made to the provider under the statutory price formula or in the reimbursable expenses on the provider's Medicaid cost report.

- Repeals law that provided, with an exception, that costs of therapy were not allowable costs for nursing facilities for purposes of calculating their reimbursement rate under the statutory price formula and law that established restrictions on nursing facilities' billing for covered therapy services.

- Adjusts the formula used to calculate nursing facilities' Medicaid reimbursement rates for fiscal years 2010 and 2011.

- Would have required ODJFS, not later than December 31, 2010, to issue a report with recommendations for developing a new system for reimbursing nursing facilities' capital costs under the Medicaid program (VETOED).

- Requires, for purposes of Medicaid reimbursement, that the costs of day programming be part of the direct care costs of an ICF/MR as off-site day programming if the area in which the day programming is provided is not certified

as an ICF/MR and regardless of whether (1) the area in which the day programming is provided is less than 200 feet away from the ICF/MR or (2) the provider of the day programming is a related party to the ICF/MR.

- Would have required the Medicaid program to cover oxygen services provided by a medical supplier to a medically fragile child residing in an ICF/MR regardless of certain circumstances (VETOED).

- Eliminates ODJFS's authorization to place limits on the costs for resident meals prepared and consumed outside an ICF/MR when determining whether an ICF/MR's direct care and indirect care costs are allowable.

- Provides for an ICF/MR to be paid for services provided during the period beginning July 17, 2009, and ending July 31, 2009, the rate that the ICF/MR was paid June 29, 2009.

- Adjusts the formula used to calculate ICFs/MR's Medicaid reimbursement rates for the last 11 months of fiscal year 2010 by (1) requiring ODJFS to reduce the Medicaid rates for ICFs/MR if the mean total per diem rate for all ICFs/MR, weighted by May 2009 Medicaid days and calculated as of August 1, 2009, exceeds $278.15, (2) prohibiting, for the remainder of fiscal year 2010, further adjustments otherwise authorized by law governing Medicaid payments to ICFs/MR, and (3) if the federal government requires that the franchise permit fee for ICFs/MR be reduced or eliminated, reducing the payments to ICFs/MR as necessary to reflect the loss of revenue and federal financial participation generated by the fee.

- Adjusts the formula used to calculate ICFs/MR's Medicaid reimbursement rates for fiscal year 2011 by (1) requiring ODJFS to reduce the fiscal year 2011 Medicaid rates for ICFs/MR if the mean total per diem rate for all ICFs/MR, weighted by May 2010 Medicaid days and calculated as of July 1, 2010, exceeds $278.15, (2) prohibiting, for the remainder of fiscal year 2011, further adjustments otherwise authorized by law governing Medicaid payments to ICFs/MR, and (3) if the federal government requires that the franchise permit fee for ICFs/MR be reduced or eliminated, reducing the payments to ICFs/MR as necessary to reflect the loss of revenue and federal financial participation generated by the fee.

- Would have created the ICF/MR Reimbursement Study Council and required the Council to submit a report, not later than July 1, 2010, on its review of the state system for Medicaid reimbursement of ICF/MR services (VETOED).

- Eliminates a requirement that a nursing facility refund to ODJFS the amount of excess depreciation paid to the facility under Medicaid if the facility is sold.

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

- Permits the ODJFS Director to adopt rules establishing procedures for both of the following: (1) identifying individuals who are eligible and on a waiting list for a Medicaid waiver program that provides home and community-based services, are receiving inpatient hospital services or residing in an intermediate care facility for the mentally retarded or nursing facility, and choose to be enrolled in the waiver program and (2) approving such individuals' enrollment in the waiver program.

- Permits the ODJFS Director to seek federal approval to have home care attendant services covered by the Ohio Home Care Medicaid waiver program and the Ohio Transitions II Aging Carve-Out Medicaid waiver program.

- Establishes requirements an individual must meet to be able to provide home care attendant services under either of the Medicaid waiver programs.

- Places restrictions on a home care attendant's authority to assist a consumer with nursing tasks and self-administration of medication.

- Permits the Director of Budget and Management to seek Controlling Board approval for certain fiscal actions, such as creating new funds and transferring appropriations, in support of any home and community-based services Medicaid waiver program.

- Creates the Money Follows the Person Enhanced Reimbursement Fund into which the Director of Budget and Management is to deposit the federal grant Ohio receives under the Money Follows the Person Demonstration Program.

- Requires the ODJFS Director to seek federal approval to establish a system under which community behavioral health boards obtain federal financial participation for the allowable administrative activities the boards perform in the administration of the Medicaid program (PARTIALLY VETOED).

- Would have provided that a community behavioral health board (1) was required to use state funds provided to the board for the purpose of funding community behavioral health services to pay a provider for Medicaid services administered by the Department of Mental Health or Department of Alcohol and Drug Addiction Services and (2) was permitted to use money raised by a county tax levy to make the payment if using the money for that purpose was consistent with the purpose for which the tax was levied (VETOED).

- Would have provided that the comprehensive annual plan was permitted, rather than required, to certify the availability of unencumbered community mental health local funds to match Medicaid reimbursement funds earned by community mental health facilities (VETOED).

- Imposes an annual assessment on hospitals based on their total facility costs.

- Permits ODJFS to audit a hospital to ensure that the hospital properly pays its assessment and requires ODJFS to take action to recover from a hospital any amount the audit reveals that the hospital should have paid but did not.

- Creates the Hospital Assessment Fund into which the hospital assessments are to be deposited and requires ODJFS to use the money in the fund to pay costs of the Medicaid program, including administrative costs.

- Requires the ODJFS Director to seek federal approval to create the Hospital Inpatient and Outpatient Supplemental Upper Payment Limit Program for the purpose of making supplemental Medicaid payments to hospitals.

- Specifies that portions of the money raised by the hospital assessment, and available federal matching funds, are to be used to fund the Hospital Inpatient and Outpatient Supplemental Upper Payment Limit Program.

- Requires ODJFS to take all necessary actions to cease implementation of the hospital assessment and the Hospital Inpatient and Outpatient Supplemental Upper Payment Limit Program if the United States Secretary of Health and Human Services determines that the assessment is an impermissible health-care related tax under federal Medicaid law.

- Repeals the law governing the hospital assessment effective October 1, 2011.

- For fiscal years 2010 and 2011, (1) requires the ODJFS Director to pay the full cost (100%) of Medicaid cost outlier claims for inpatient admissions at children's hospitals that are less than a threshold amount ($443,463 in 2002, adjusted annually for inflation), rather than just 85% of the cost, but (2) specifies that paying the full cost of such claims must cease and revert back to 85% of the estimated cost when the difference between the total amount the Director has paid at full cost for the outlier claims and the total amount the Director would have paid for such claims at the 85% level exceeds the sum of the state funds made available for the additional cost outlier payments in each fiscal year and the corresponding federal match.

- For fiscal years 2010 and 2011, requires the ODJFS Director to make supplemental Medicaid payments to children's hospitals for inpatient services under a program

modeled after the program that ODJFS was required to create under Am. Sub. H.B. 66 of the 126th General Assembly when the difference between the total amount the Director has paid at full cost for Medicaid outlier claims and the total amount the Director would have paid at the 85% level for the claims does not require the expenditure of all state and federal funds made available for the additional cost outlier payments in the applicable fiscal year.

- Prohibits the ODJFS Director from adopting, amending, or rescinding any rules that would result in decreasing the amount paid to children's hospitals for cost outlier claims.

- Increases, for the period between October 1, 2009 and June 30, 2011, the Medicaid reimbursement rate for hospital inpatient and outpatient services paid under a prospective payment system by 5% over the rate for such services provided on September 30, 2009.

- Requires ODJFS to postpone the recalibration of certain Medicaid rates for hospital services that were to occur on January 1, 2010, and January 1, 2011, to January 1, 2012, and January 1, 2013, respectively.

- Requires the ODJFS Director to reduce the Medicaid reimbursement rates for the following services by at least 3% effective January 1, 2010: advanced practice nursing services, ambulatory surgery center services, chiropractic services, durable medical equipment, home health services, ambulance and ambulette services, physician services, physical therapy services, podiatry services, private duty nursing services, vision services, clinic services (other than rural health clinics and federally qualified health centers), occupational therapy services, dental services, services provided under an ODJFS-administered home and community-based waiver program, and other services the ODJFS Director identifies (other than services for which an Ohio statute sets the Medicaid reimbursement rate).

- Sets the Medicaid dispensing fee for noncompounded drugs at $1.80 for the period beginning January 1, 2010, and ending June 30, 2011.

- Requires ODJFS to submit a report to the General Assembly on Medicaid expenditures for durable medical equipment and make recommendations on strategies to reduce the cost of such equipment.

- Would have created the Prompt Payment Policy Workgroup to research and make policy recommendations for the Medicaid program (VETOED).

VII. Hospital Care Assurance Program

- Delays the termination of the Hospital Care Assurance Program to October 16, 2011.

VIII. Children's Health Insurance Program

- Would have provided that a school-based health center could furnish health assistance services covered under the Children's Health Insurance Program if the center met the requirements applicable to other providers of those services (VETOED).

IX. Children's Buy-In Program

- Provides that an individual's countable family income must exceed 300% of the federal poverty guidelines rather than 250% for the individual to meet the income requirement for the Children's Buy-In Program.

- Revises the eligibility requirements for the Children's Buy-In Program regarding access to creditable coverage.

X. Disability Medical Assistance

- Abolishes the Disability Medical Assistance Program, which provided medical assistance to those who were medication dependent and ineligible for Medicaid.

XI. Supplemental Nutrition Assistance Program (Food Stamp Program)

- Consistent with a change made to federal law, renames the Food Stamp Program the Supplemental Nutrition Assistance Program (SNAP) for purposes of state law, but permits the ODJFS Director to refer to the program as the Food Stamp Program or Food Assistance Program in rules and documents.

- Requires ODJFS, immediately following a CDJFS's certification that a household in immediate need of nutrition assistance is eligible for SNAP, to provide for the household to be sent by regular United States mail an electronic benefit transfer card containing the amount of benefits the household is eligible to receive under the program, rather than requiring a CDJFS staff member to personally hand an authorization-to-participate card to a household member or authorized representative.

- Eliminates law that provides that food stamps and any document necessary to obtain food stamps are, except while in the custody of the United States Postal Service, the property of ODJFS from the time ODJFS receives the food stamps from

the federal agency responsible for their delivery until they are received by the household entitled to receive them or by that household's authorized representative.

XII. Workforce Development

- Includes reimbursements to a county public assistance fund for expenditures made for activities funded by the Workforce Investment Act in the requirement that all expenditures of workforce development activities be made from local workforce development funds.

XIII. Unemployment Compensation

- Requires unemployment compensation benefits otherwise payable for any week to be reduced by the amount of remuneration or other payments a claimant receives with respect to that week for the determinable value of cost savings days.

- Defines "cost savings day" as any unpaid day off from work in which employees continue to accrue employee benefits that have a determinable value including vacation, pension contribution, sick time, and life and health insurance.

- Specifies that remuneration for personal services includes cost savings days for which employees continue to accrue employee benefits that have a determinable value.

I. General

Expenditure of federal grant funds obligated by the Ohio Department of Job and Family Services (ODJFS) for financial allocations to county family services agencies and local workforce investment boards

(R.C. 131.33)

Continuing law generally requires that if an agency has unexpended balances of appropriations at the end of the period for which the appropriations are made, the balances revert to the funds from which the appropriations were made. The act creates an exception to this requirement for federal grant funds obligated by the Ohio Department of Job and Family Services (ODJFS) for financial allocations to county family services agencies and local workforce investment boards. Under the act, if the ODJFS Director so chooses, those federal grant funds may be available for expenditure for the duration of the federal grant period of obligation and liquidation, as follows:

(1) A the end of the state fiscal year, all unexpended county family services agency and local workforce investment board financial allocations obligated from federal grant funds may continue to be valid for expenditure during subsequent state fiscal years.

(2) The financial allocations described in (1), above, must be reconciled at the end of the federal grant period of availability or as required by federal law, regardless of the state fiscal year of the appropriation.

For purposes of this provision, "county family services agency" means a child support enforcement agency, a county department of job and family services (CDJFS), and a public children services agency. "Local workforce investment board" means a local workforce investment board established under the federal "Workforce Investment Act of 1998."

The act permits the ODJFS Director to adopt rules as necessary to implement this provision of the act. If adopted, the rules are to be adopted in accordance with procedures that do not require a public hearing and as if the rules were internal management rules.

ODJFS General Services Administration and Operating Fund

(R.C. 5101.073)

The act creates in the state treasury the ODJFS General Services Administration and Operating Fund. The ODJFS Director is permitted by the act to submit a deposit modification and payment detail report to the Treasurer of State after completion of the reconciliation of all final transactions with the federal government regarding a federal grant for a program ODJFS administers and a final closeout for the grant. On receipt of the report, the State Treasurer must transfer the money in the Refunds and Audit Settlements Fund[249] that is the subject of the report to the ODJFS General Services Administration and Operating Fund. Money in the ODJFS General Services Administration and Operating Fund is to be used to pay for expenses of the programs ODJFS administers and ODJFS's administrative expenses, including the costs of state hearings, required audit adjustments, and other related expenses.

[249] The Refunds and Audit Settlements Fund is a state fund used as a holding account for checks for which disposition cannot be determined at the time of receipt. The Fund was originally created by Am. Sub. H.B. 238 of the 116th General Assembly but it has never been codified in the Revised Code.

Collaboration on welfare reform training

(R.C. 5101.072 (repealed))

The General Assembly enacted various welfare reforms in the 1990s, including Sub. H.B. 167 of the 121st General Assembly and Sub. H.B. 408 of the 122nd General Assembly. H.B. 167 predated federal welfare reform legislation that, in part, replaced the Aid to Families with Dependent Children program with the Temporary Assistance for Needy Families (TANF) program. H.B. 408 was enacted after the federal legislation and updated Ohio's public assistance laws to reflect the federal changes.

The act eliminates a requirement for ODJFS to collaborate with CDJFSs to develop training for appropriate employees of the CDJFSs regarding the provisions of H.B. 408 (and of H.B. 167 that were not superseded by H.B. 408) that impose duties on the CDJFSs. Also eliminated is a requirement for ODJFS to collaborate with the CDJFSs on providing the training.

Action against a county regarding family services duties

(R.C. 5101.24)

Under certain circumstances, continuing law authorizes ODJFS to take various actions against a board of county commissioners, county children services board, or child support enforcement agency (referred to in statute as the responsible county grantee). For example, ODJFS may take over a family services duty, or contract with another to perform the duty, until ODJFS is satisfied that the responsible county grantee ensures that the duty will be performed satisfactorily. (A family services duty is a duty, other than a duty funded by the U.S. Department of Labor, that state law requires or allows a child support enforcement agency, CDJFS, or public children services agency to assume, including financial and general administrative duties.[250]) With certain exceptions, the responsible county grantee may request an administrative review of an action ODJFS proposes to take.

The act creates an additional exception to the right of a responsible county grantee to request an administrative review. Under this exception, an administrative review is not to be available when ODJFS proposes to perform, or contract with another entity to perform, a family services duty if ODJFS determines that an emergency exists.

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[250] R.C. 307.981.

Reallocation of unused county funds (VETOED)

(Section 309.45.90)

The Governor vetoed a provision that would have required ODJFS to reallocate certain funds when ODJFS was informed that a county would not use the entire amount allocated to it for fiscal year 2010 or 2011 or when ODJFS determined through an annual close out or reconciliation of funds that a county had not used the entire amount of any of the funds allocated to the county for either fiscal year. The following funds would have been subject to reallocation:

(1) Funds ODJFS allocated to a county to meet matching fund requirements or reimburse a county for administrative expenses incurred in the administration of the Disability Financial Assistance Program, Disability Medical Assistance Program,[251] Medicaid, or Supplemental Nutrition Assistance Program (i.e., the Food Stamp Program). Collectively, these funds were referred to as "income maintenance funds."

(2) Funds ODJFS allocated to a county for programs funded with the TANF block grant, such as the Ohio Works First Program and the Prevention, Retention, and Contingency Program. The vetoed provision referred to these funds as "TANF funds."

(3) Funds ODJFS allocated to a county from funds under the TANF block grant that were transferred for use for social services under Title XX of the Social Security Act. The vetoed provision referred to these funds as "TANF Title XX transfer funds."

(4) Funds ODJFS allocated to a CDJFS for social services under Title XX of the Social Security Act. These funds were referred to as "Title XX social services funds."

With respect to the reallocation, ODJFS would have been required to reallocate the portion of the funds the county would or had not used to other counties for the remainder of the fiscal year in which the funds were reallocated or the next fiscal year. In reallocating the funds, ODJFS would have been required to do both of the following:

(1) For each group of funds separately, rank each county by the percentage reduction in allocations of the funds from the fiscal year preceding the fiscal year in which the reallocation was made to the fiscal year in which the reallocation was made, with the county that had the greatest reduction percentage placed at the top of the ranking;

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[251] The act abolishes the Disability Medical Assistance Program. (See "**Disability Medical Assistance Program**" below.)

(2) Reallocate each group of funds separately to counties in the order in which they were ranked in a manner that provided, to the extent funds were available for reallocation, for each county to be, as a result of the reallocation, allocated the same amount of the funds that the county was allocated the previous year, other than the counties that would or had not used the full amount of their allocation of the funds.

Direct deposit system for cash assistance

(R.C. 329.03 (primary) and 126.35)

Continuing law authorizes ODJFS to make payment or delivery of benefits under programs ODJFS administers, including the Ohio Works First Program (OWF) and Disability Financial Assistance Program, through a state electronic benefit transfer system. Under the state electronic benefit transfer system, ODJFS contracts with an agent to supply debit cards to be used in accessing the programs' benefits.[252]

Prior law permitted the ODJFS Director to require that cash assistance payments under OWF and the Disability Financial Assistance Program be made under the state electronic benefit transfer system. If the ODJFS Director did not require that, a board of county commissioners could adopt a resolution requiring its CDJFS to establish a direct deposit system to distribute the cash assistance payments. The resolution had to specify whether use of the direct deposit system was voluntary or mandatory.

A CDJFS that was required to establish a direct deposit system had to determine what type of account would be used and negotiate with financial institutions to determine the charges, if any, to be imposed by a financial institution for establishing and maintaining the accounts. A CDJFS was permitted to pay the charges under a voluntary direct deposit system and was required to pay the charges under a mandatory system.

An OWF or Disability Financial Assistance applicant or recipient residing in a county with a voluntary direct deposit system was permitted to elect to receive cash assistance payments in the form of a paper warrant. An applicant or recipient residing in a county with a mandatory direct deposit system was allowed to request to receive payments in the form of a paper warrant under certain circumstances.

A CDJFS was required to bear the full cost of the amount of any replacement warrant issued to an OWF or Disability Financial Assistance recipient for whom an authorization form for direct deposit was not obtained within 180 days after the later of (1) the date the board of county commissioners adopted the resolution regarding direct

[252] R.C. 5101.33.

deposit or (2) the date of application for the program. The CDJFS's responsibility to bear the full cost of each replacement warrant continued until the board of county commissioners required the CDJFS to obtain an authorization form from each recipient.

The act eliminates these provisions regarding county direct deposit systems and the option to receive OWF and Disability Financial Assistance cash assistance payments in the form of a paper warrant. Instead, the act requires each CDJFS to establish a direct deposit system under which cash assistance payments to OWF and Disability Financial Assistance recipients who agree to direct deposit are made by electronic transfer to an account in a financial institution the recipient designates. The act also makes this applicable to cash assistance provided under the Refugee Assistance Program.

Each CDJFS is required by the act to inform each OWF, Disability Financial Assistance, and Refugee Assistance applicant or recipient that the applicant or recipient must choose whether to receive cash assistance payments under the county direct deposit system or under the state electronic benefit transfer system. A CDJFS must obtain from each applicant or recipient who is to receive cash assistance payments through direct deposit an authorization form designating a financial institution and account into which the payments are to be made. The act requires a CDJFS to receive from an applicant or recipient who chooses the state electronic benefit transfer system a signed form to that effect. Each CDJFS must inform the applicants and recipients of the conditions under which an applicant or recipient may change the system used to receive the cash assistance payments.

The act retains a requirement that a recipient's designation of a financial institution and account remain in effect until withdrawn in writing or dishonored by the financial institution. Prior law, however, provided that no designation change could be made until the recipient's next eligibility redetermination unless the department[253] felt that good grounds existed for an earlier change. The act provides instead that no designation change may be made until the next eligibility redetermination unless the CDJFS determines that good cause exists for an earlier change or the financial institution dishonors the recipient's account.

An applicant or recipient who does not have an account but is to receive cash assistance payments through a county direct deposit system must designate an account suitable for direct deposit within ten days of receiving the authorization form. Prior law required the department[254] to designate a financial institution and help the recipient

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[253] The statute used the term "department" in this context making it ambiguous as to whether it referred to ODJFS or a CDJFS.

[254] *Id.*

to open an account if the designation was not made by the deadline or the recipient requested that the department make the designation. The act provides instead that a recipient is to receive cash assistance payments under the state electronic benefit transfer system if the recipient fails to make the designation by the deadline.

The act makes changes to the law governing how the Director of Budget and Management makes cash assistance payments to reflect the changes the act makes regarding county direct deposit systems.

II. Child Welfare and Adoption

State adoption maintenance subsidy and post adoption special services subsidy

(R.C. 5153.163)

Former law required a PCSA, prior to the finalization of a child's adoption, to enter into an agreement with the child's adoptive parent under which the agency must make state adoption maintenance subsidy payments as needed on behalf of the child when all of the following apply:

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

(2) The child was placed in the adoptive home by a PCSA or a private child placing agency (PCPA) and may legally be adopted.

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

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

(5) 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.

(6) The gross income of the adoptive parent's family does not exceed 120% 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. 1397, as amended.

(7) 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. 671, as amended.

The act eliminates the requirement that a PCSA *must* enter into an agreement with a special needs child's adoptive parent, under the circumstances listed above, under which the agency must make state adoption maintenance subsidy payments, and instead *permits* the agency to enter into an agreement to the extent state funds are available.

Former law also permitted a PCSA that considers a child residing in the county served by the agency to be in need of public care or protective services, to the extent state funds are *appropriated* for this purpose, to enter into an agreement with the child's adoptive parent under which the agency must make post adoption special services subsidy payments on behalf of the child as needed when the child has a physical or developmental handicap or mental or emotional condition that either existed before the adoption petition was filed or developed after the adoption petition was filed and can be directly attributed to factors in the child's preadoption background, medical history, or biological family's background or medical history, and the agency determines the expenses necessitated by the child's handicap or condition are beyond the adoptive parent's economic resources.

The act eliminates this requirement and instead permits the agency to enter into an agreement to the extent that state funds are *available.*

Listing of children available for adoption and prospective adoptive parents

(R.C. 5103.154 and 5153.163)

Former law required information concerning all children who are in the permanent custody of an institution or association certified by ODJFS to be listed with the Department within 90 days after permanent custody is effective, unless the child had been placed for adoption or unless an application for placement was initiated.

Former law also required all persons who wished to adopt children, and who were approved by an agency empowered to do so, to be listed with the Department within 90 days of approval, unless a person requested in writing that that person's name not be so listed, or previously had a child placed in that person's home in preparation for adoption, or had filed a petition for adoption. Additionally, all persons who wished to adopt a child with special needs and who were approved by an agency empowered to do so, had to be listed separately by the Department within 90 days of approval, unless a person requested in writing that that person's name not be so listed, or previously had a child with special needs placed in that person's home in preparation for adoption, or had filed a petition for adoption.

ODJFS was required to forward information on such children and listed persons at least quarterly to all PCSAs and all certified agencies. The appropriate listed names

were removed when a child was placed in an adoptive home or when a person withdrew an application for adoption.

The act eliminates the required listing of all children who are in the permanent custody of an institution or association certified by ODJFS and the required listing of all persons who wish to adopt children and who are approved by an agency empowered to do so.

Former law also required that, no later than six months after the end of each fiscal year, the Department must compile a report of its conclusions regarding the effectiveness of its actions and of certain restrictions on placement in increasing adoptive placements of children with special needs, together with its recommendations, and submit a copy of the report to the chairpersons of the principal committees of the Senate and the House of Representatives who consider welfare legislation. The act eliminates the requirement that ODJFS compile this report with conclusions regarding the effectiveness of the listing program and submit it to the General Assembly.

Alternative Response pilot program

(Section 309.45.10)

The act requires ODJFS to develop, implement, oversee, and evaluate a pilot program based on an "Alternative Response" approach to reports of child abuse, neglect, and dependency. The pilot program must be implemented in not more than ten counties that are selected by ODJFS and that agree to participate in the pilot program. The pilot program will last 18 months, not including time expended in preparation for the implementation of the pilot program and any post-pilot program evaluation activity. After the 18-month period, the ten sites may continue to administer the Alternative Response approach uninterrupted, unless ODJFS determines otherwise.

ODJFS is required to assure that the Alternative Response pilot program is independently evaluated with respect to outcomes for children and families, costs, worker satisfaction, and any other criteria ODJFS determines will be useful in the consideration of statewide implementation of an Alternative Response approach to child protection. The measure associated with the 18-month pilot program will, for the purposes of the evaluation, be compared with those same measures in the pilot counties during the 18-month period immediately preceding the beginning of the pilot program period. If the independent evaluation of the pilot program recommends statewide implementation of an Alternative Response approach to child protection, ODJFS may expand the Alternative Response approach statewide through a schedule determined by ODJFS. Prior to statewide implementation, ODJFS must adopt rules, in accordance with the Administrative Procedure Act, as necessary to carry out the purposes of the

Alternative Response program. Until that time, ODJFS may adopt rules, as if they were internal management rules, as necessary to carry out the purposes of the Alternative Response pilot program.

ODJFS review of associations and institutions (VETOED)

(R.C. 5103.02 and 5103.03)

Under continuing law, except for facilities under the control of the Department of Youth Services, places of detention for children, and child day-care centers, ODJFS is required to pass upon the fitness of every institution and association that receives, or desires to receive and care for children, or places children in private homes every *two* years.

The act would have required ODJFS to pass upon the fitness of every institution and association that receives, or desires to receive and care for children, or places children in private homes every *four* years, but would have retained the two-year period for individuals who, for hire, gain, or reward, receive or care for children for two or more consecutive weeks, unless the individual is related to them by blood or marriage.

III. Publicly Funded Child Care

Reimbursements for providers of publicly funded child care

(R.C. 5104.30, 5104.32, 5104.39, and 5104.42)

Continuing law requires the ODJFS Director to adopt rules establishing a payment procedure for publicly funded child care. The rules may provide that ODJFS will either reimburse CDJFSs for payments made to providers of publicly funded child care or make direct payments to providers pursuant to an agreement entered into with a county board of commissioners.

Under the act, these rules may provide that ODJFS will reimburse CDJFSs for payments made to providers of publicly funded child care, make direct payments to providers, or establish another system for the payment of publicly funded child care.

Certificates of payment for days a child has been absent

(R.C. 5104.32)

Under continuing law, CDJFSs must give individuals eligible for publicly funded child care the option of obtaining certificates for payment that the individual may use to purchase that care. Continuing law states that for each six-month period a provider of

publicly funded child care provides publicly funded child day-care to the child of an individual given certificates for payment, the individual must provide the provider certificates for days the provider would have provided publicly funded child care to the child had the child been present. Under prior law CDJFSs were required to specify the maximum number of days providers would be provided certificates of payment for days the provider would have provided publicly funded child care had the child been present. Under continuing law, the maximum number of days cannot exceed ten days in a six-month period during which publicly funded child care is provided to the child regardless of the number of providers that provide publicly funded child care to the child during that period.

The act eliminates the requirement that CDJFSs specify the maximum number of days providers of publicly funded child care will be provided certificates of payment for days the provider would have provided publicly funded child care had the child been present.

Eligibility determinations for publicly funded child care

(R.C. 5104.341)

Under former law, the CDJFS had to redetermine the appropriate level of a fee charged to a caretaker parent for publicly funded child care every six months, unless the caretaker parent requested that the fee be reduced due to changes in income, family size, or both and the CDJFS approved the reduction.

The act eliminates the automatic review of this fee every six months, and instead the CDJFS must adjust the level of the fee if the caretaker parent reports changes in income, family size, or both.

Child day-care center and home inspections and day-care law violations

(R.C. 5104.04)

Former law required ODJFS to inspect a child day-care center or type A family day-care home at least twice during every 12-month period of operation. At least one inspection was required to be unannounced. The act reduces the number of mandatory inspections from twice to once during each 12-month period of operation, and permits all inspections to be unannounced.

The act also makes the Department's commencement of an action to revoke the license of a child day-care center or type A family day-care home for a violation of the Day-care Laws sufficient notice that the correction has not yet been made, and no other notice regarding the correction is required.

Liability insurance for type A and type B family day-care homes

(R.C. 5104.041)

Former law required the parent, guardian, or custodian of each child receiving child care from a type A or type B family day-care home that is not covered by liability insurance to sign an affidavit, provided by the licensee of the type A family day-care home or the provider of the type B family day-care home, stating that the family day-care home does not carry liability insurance.

Under the act, the parent, guardian, or custodian must only sign a written statement, instead of an affidavit, provided by the licensee of the type A family day-care home or the provider of the type B family day-care home, stating that the family day-care home does not carry liability insurance.

Committee to study publicly funded child care services

(Section 309.40.70)

The act creates a committee to study publicly funded child care services, including the Early Learning Initiative enacted pursuant to the act and pursuant to changes in the administrative rules governing reimbursement and eligibility for publicly funded child day-care. The study must include the following subjects:

(1) The effects of changing the definitions of full-time and part-time care on children, families, and providers of care, including the effects on the quality of care; the number of children served and the availability and accessibility of subsidized care to caregivers with full-time and part-time jobs; the availability of full-time and part-time care in areas with a high incidence of poverty; private pay rates; closure of centers and center programs; and loss of jobs in the child care industry.

(2) The effects of changes to the Early Learning Initiative on families and children, including the distribution and use of program slots across the state;[255] the effect of mandatory participation in the voluntary child day-care center quality-rating program on program quality; outcomes in terms of school readiness, and other related factors for children who participate in the program.

The committee must consist of the following members:

[255] The Early Learning Initiative (Section 309.40.60) was vetoed.

(1) Three members of the House of Representatives, two appointed by the Speaker of the House of Representatives and one appointed by the Minority Leader of the House of Representatives;

(2) Three members of the Senate, two appointed by the President of the Senate and one appointed by the Minority Leader of the Senate;

(3) One parent of a child receiving publicly funded child care services, appointed by the President of the Senate;

(4) Two representatives of licensed child care centers serving low-income areas, one appointed by the Speaker of the House of Representatives and one appointed by the President of the Senate;

(5) One representative from the Ohio Association of Child Care Providers, appointed by the President of the Senate;

(6) One representative from the Ohio State Alliance of Young Men's Christian Associations, appointed by the Speaker of the House of Representatives;

(7) One representative from the Department of Job and Family Services, appointed by the Speaker of the House of Representatives; and

(8) One representative from the Department of Education, appointed by the President of the Senate.

The Department of Education must provide the committee meeting space and clerical assistance. The act requires the committee to prepare a report of its findings by June 30, 2010, and to provide a copy of the report to the Governor, the Speaker of the House of Representatives, and the President of the Senate, at which time the committee will cease to exist.

IV. Child Support Enforcement

Office of Child Support requests for medical insurance information

(R.C. 3119.371)

The act requires a health insurance provider, upon request of the Office of Child Support in ODJFS and for the purpose of establishing and enforcing orders to provide health insurance coverage, to provide the following information to the Office of Child Support: (1) an individual's name, address, date of birth, and social security number, (2) the group or plan number or other identifier assigned by a health insurance provider to a policy held by an individual or a plan in which the individual participates and the

nature of the coverage, and (3) any other data specified by the ODJFS Director in rules adopted to regulate the enforcement of orders to provide health insurance. For the purposes of this provision, "health insurance provider" means: (1) a person authorized to engage in the business of sickness and accident insurance in Ohio, (2) a person or government entity providing coverage for medical services or items to individuals on a self-insurance basis, (3) a health insuring corporation, (4) a group health plan, (5) any organization, business, or association described in the federal law regulating state grants for medical assistance programs (42 U.S.C. 1396a(a)(25)), or (6) a managed care organization.

Issuance of income withholding notices

(R.C. 3121.03 and 3121.035)

Continuing law requires a court or child support enforcement agency to issue a child support withholding or deduction notice to an obligor's payor by regular mail. The act authorizes the court or child support enforcement agency to transmit the notice by secure federally managed electronic format instead of by regular mail.

Mandatory electronic remittance of child support by certain payors

(R.C. 3121.037, 3121.0311, and 3121.19)

Continuing law requires an employer to submit the entire amount withheld from an obligor's income pursuant to a child support withholding or deduction notice to the Office of Child Support in ODJFS immediately, but not later than seven business days, after the withholding or deduction. The act requires an employer who employs more than 50 employees to submit these funds to the Office of Child Support in ODJFS by electronic transfer.

Remittance of combined child support payments

(R.C. 3121.20)

Under continuing law, a payor or financial institution required to withhold or deduct a specified amount from the income or savings of more than one obligor under a withholding or deduction notice may combine all of the payments to be forwarded to the Office of Child Support in ODJFS into one payment, if the payment is accompanied by a list that clearly identifies: (1) the name of each obligor covered by the payment, and (2) the portion of the payment attributable to each obligor.

The act requires the payor or financial institution forwarding a combined payment to include a list that clearly identifies all of the following: (1) the name of each

obligor covered by the payment, (2) each child support case, numbered as provided on the withholding or deduction notice, that is covered by the payment, and (3) the portion of the payment attributable to each obligor and each case number. The act also requires an employer who employs more than 50 employees and who is thus required to submit any withholdings or deductions by electronic transfer to submit multiple withholdings or deductions in a combined payment, with the same list as described above.

Waiver and compromise of assigned child support arrearages

(R.C. 3125.25)

The act requires the rules adopted under the Administrative Procedure Act by the ODJFS Director governing the operation of support enforcement by child support enforcement agencies to include provisions for the compromise and waiver of child support arrearages owed to the state and federal government, consistent with Title IV-D of the "Social Security Act," 88 Stat. 2351 (1975), 42 U.S.C. 651 *et seq.*, as amended.

V. Temporary Assistance for Needy Families (TANF)

Title IV-A of the Social Security Act authorizes the Temporary Assistance for Needy Families (TANF) block grant. States may receive federal funds under the TANF block grant to operate programs designed to meet one or more of the following purposes:

(1) Provide assistance to needy families so that children may be cared for in their own homes or in the homes of relatives;

(2) End the dependence of needy parents on government benefits by promoting job preparation, work, and marriage;

(3) Prevent and reduce the incidence of out-of-wedlock pregnancies and establish annual numerical goals for preventing and reducing the incidence of these pregnancies;

(4) Encourage the formation and maintenance of two-parent families.

Persons who receive assistance funded in part with federal TANF funds are subject to a number of federal requirements, including time limits and work requirements. Federal regulations define "assistance" as including cash, payments, vouchers, and other forms of benefits designed to meet a family's ongoing basic needs for such things as food, clothing, shelter, utilities, household goods, personal care items, and general incidental expenses. It includes such benefits even when they are provided in the form of payments to individual recipients and conditioned on participation in

work experience, community service, or other work activities provided by federal TANF law. Unless specifically excluded, "assistance" also includes supportive services such as transportation and child care provided to unemployed families.

Ohio has a number of different programs funded with TANF funds, including Ohio Works First (OWF) and the Prevention, Retention, and Contingency (PRC) program. Participants of OWF receive TANF-funded assistance and are therefore subject to the federal TANF requirements applicable to assistance such as time limits and work requirements. Each county is required to develop its own PRC program to provide benefits and services, but not assistance, that individuals need to overcome immediate barriers to achieving or maintaining self sufficiency and personal responsibility.

Ohio Works First (OWF) sanctions

(R.C. 5107.05, 5107.16, 5107.17, and 5111.01)

Continuing law modified by the act requires a CDJFS to sanction an OWF assistance group if a member fails or refuses, without good cause, to comply in full with a provision of the assistance group's self-sufficiency contract.

The sanctions for not complying with a self-sufficiency contract are tiered. For a first failure or refusal to comply, a CDJFS was required by prior law to deny or terminate the assistance group's eligibility to participate in OWF for one payment month. A second failure or refusal resulted in ineligibility for three payment months. A third or subsequent failure or refusal resulted in ineligibility for six payment months. The act modifies the duration of the sanctions by providing that they are not to end before the failure or refusal ceases. Thus, the sanction for a first failure or refusal is to last one payment month or until the failure or refusal ceases, whichever is longer. The sanction for a second failure or refusal is to last three payment months or until the failure or refusal ceases, whichever is longer. The sanction for a third or subsequent failure or refusal is to last six payment months or until the failure or refusal ceases, whichever is longer. This is how long the sanctions lasted before Am. Sub. H.B. 119 of the 127th General Assembly modified the durations. In other words, the act restores prior law governing the duration of the sanctions.

The act establishes a procedure for a member of an assistance group to indicate willingness to come into full compliance with a provision of a self-sufficiency contract. The ODJFS Director is required to establish in rules a compliance form to be used for this purpose. The ODJFS Director is to provide a compliance form to an assistance group member who fails or refuses, without good cause, to comply in full with a provision of a self-sufficiency contract. The member's failure or refusal to comply in full

with the provision is to be deemed to have ceased on the date a CDJFS receives the compliance form from the member if the compliance form is completed and provided to the CDJFS in a manner the ODJFS Director is to specify in rules.

An assistance group that resumes participation in OWF following a sanction is not required to reapply to participate unless it is the assistance group's regularly scheduled time for an eligibility redetermination. The act provides that an assistance group is also required to reapply following a sanction if a CDJFS does not receive a completed compliance form within a period of time the ODJFS Director is to specify in rules.

Notices of number of months of OWF Participation

(R.C. 5107.78)

As discussed above, there is a time limit for participating in OWF. In general, an assistance group is ineligible to participate in OWF if the assistance group includes an individual who has participated in OWF for 36 months as an adult head of household, minor head of household, or spouse of an adult or minor head of household. An assistance group that loses eligibility after the 36-month period may reapply for OWF after having been off the program for at least 24 months and, if good cause exists, resume participation for up to an additional 24 months. There are exceptions to both the initial 36-month time limit and the additional 24-month time limit.

The act eliminates a requirement that ODJFS include, with each cash assistance payment provided under OWF to an assistance group residing in a county in which the Support Enforcement Tracking System is in operation, a notice of the number of months the assistance group has participated in OWF and the remaining number of months the assistance group may participate in OWF under the program's time limits.

Prevention, Retention, and Contingency (PRC) Program Suspensions

(R.C. 5108.04 and 5108.07)

Continuing law requires each CDJFS to adopt a written statement of policies governing the PRC Program for the county it serves. A CDJFS is permitted to amend its statement of policies to modify, terminate, and establish new policies for its PRC Program. The act permits a CDJFS to also amend its statement of policies to suspend operation of its PRC Program temporarily.

Continuing law requires a PRC statement of policies to include the board of county commissioners' certification that the CDJFS complied with state law governing PRC in adopting the statement of policies. A board of county commissioners is to revise

its certification if an amendment to the statement of policies that the board considers to be significant is adopted. The act requires a board of county commissioners to revise its certification if a CDJFS adopts an amendment to the statement of policies to suspend operation of its PRC Program temporarily.

VI. Medicaid

Medicaid is a health-care program for low-income children and families and for aged, blind, and disabled persons. The program is funded with federal, state, and county funds and was established by Congress in 1965 as Title XIX of the Social Security Act. ODJFS is responsible for the administration of Medicaid. ODJFS, however, contracts with other entities to administer parts of the Medicaid program on ODJFS's behalf and perform certain administrative functions.

Annual Medicaid eligibility redeterminations for parents

(R.C. 5111.0121 (primary) and 5111.0120)

Continuing law requires the ODJFS Director to seek federal approval to make an individual eligible for Medicaid if the individual is the residential parent of a child under age 19, has family income not exceeding 90% of the federal poverty guidelines, and meets all other eligibility requirements established by ODJFS rules. The act provides that an individual who qualifies for Medicaid under this provision is not required to undergo a redetermination of eligibility for the Medicaid program more often than once every 12 months unless there are reasonable grounds to believe that circumstances have changed that may affect the individual's Medicaid eligibility.

Medicaid third party liability

Background

Congress intended that Medicaid be the payer of last resort; if a Medicaid recipient has another source of payment for health services, that source is to pay instead of Medicaid.[256] Consistent with federal law reflecting this intent, the U.S. Secretary of Health and Human Services has promulgated regulations[257] requiring states to have plans to (1) identify Medicaid recipients' other sources of health coverage, (2) determine the extent of the liability of third parties, (3) avoid payment of third party claims, and

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[256] U.S. Government Accountability Office. *Medicaid Third Party Liability: Federal Guidance Needed to Help States Address Continuing Problems* (Sept. 2006), available at <http://www.gao.gov/new.items/d06862.pdf>, at p. 1.

(4) seek reimbursement from third parties for claims paid if the state can reasonably expect to recover more than it spends in seeking the reimbursement.

Duties of liable third parties

Federal law

To enhance states' ability to identify and obtain payments from liable third parties, the Deficit Reduction Act of 2005[258] made several changes to the third party liability provisions of federal Medicaid law.[259] Under the federal act, states are required to enact laws requiring health insurers to do all of the following: (1) provide states with coverage, eligibility, and claims data needed to identify potentially liable third parties, (2) honor the assignment to states of Medicaid recipients' rights to payment by insurers for health care items or services, and (3) not deny assignment or refuse to pay claims submitted by state Medicaid agencies based on procedural reasons such as the failure of a recipient to present an insurance card at the point of sale or a state's failure to submit an electronic, as opposed to a paper, claim.[260]

Ohio law

(R.C. 5101.573)

Consistent with the Deficit Reduction Act's requirements, continuing Ohio law requires a third party to do all or the following: accept ODJFS's right of recovery against third parties and its assignment of rights; not later than three years after the date of provision of a Medicaid item or service, respond to an inquiry by ODJFS regarding a claim for the item or service; pay a claim submitted by ODJFS to the third party within the three-year time frame; and not deny a claim submitted in a timely fashion solely on the basis of the date of submission of the claim, type or format of the claim form, or a failure by the Medicaid recipient to present proper documentation of coverage at the time of service.

In addition to the requirements in continuing law, the act (1) requires a third party to consider ODJFS's payment of a claim for a medical item or service to be the equivalent of the Medicaid recipient having obtained prior authorization for the item or service from the third party and (2) prohibits a third party from denying a claim paid by

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[257] 42 C.F.R. Part 433, subpart D (2005).

[258] Pub. L. 109-171.

[259] Letter from Dennis G. Smith, Director, Center for Medicaid and State Operations, Centers for Medicare & Medicaid Services, U.S. Department of Health & Human Services, to State Medicaid Directors (SMD #06-026) (dated Dec. 15, 2006), available at <http://www.cms.hhs.gov/smdl/downloads/SMD121506.pdf>.

[260] Discussed in letter from Dennis G. Smith, *supra*.

ODJFS solely on the basis of the Medicaid recipient's failure to obtain prior authorization for the medical item or service.

Time-limited Medicaid provider agreements

(R.C. 5111.028)

Continuing law requires, with some exceptions, that Medicaid provider agreements be "time-limited" in accordance with procedures established in rules adopted by the ODJFS Director. Formerly, ODJFS was to phase in the use of time-limited provider agreements during a period commencing not later than January 1, 2008, and ending three years later on January 1, 2011.

The act extends the phase-in period by four years, moving the end date to January 1, 2015. The act also extends the duration of a time-limited provider agreement from three to seven years. Finally, the act adds hospitals to the list of Medicaid providers that are exempt from the requirement that provider agreements be time-limited.

Administrative actions relative to Medicaid provider agreements

(R.C. 5111.06)

Generally, ODJFS is required to issue an order pursuant to an adjudication conducted in accordance with the Administrative Procedure Act (R.C. Chapter 119.) when refusing to enter into a Medicaid provider agreement or suspending, terminating, or refusing to renew an existing Medicaid provider agreement. There are several exceptions to this requirement however. The act amends two of the exceptions and adds a new exception.

Exception related to conviction of offense

One exception is that ODJFS is not required to issue an order pursuant to an adjudication when denying, terminating, or not renewing a Medicaid provider agreement because the provider has been convicted of an offense for which continuing law requires a Medicaid provider agreement to be suspended. But, a Medicaid provider agreement must be suspended due to such an offense not only when the offense is committed by the provider but also when an owner, officer, authorized agent, manager, or employee of the provider commits the offense. The act provides that the exception is also to apply when the owner, officer, authorized agent, associate, manager, or employee is convicted of the offense.

Exception related to not billing for two years

Another exception is that ODJFS is not required to issue an order pursuant to an adjudication when terminating or not renewing a Medicaid provider agreement because the provider has not billed or otherwise submitted a Medicaid claim to ODJFS for two years and ODJFS has determined that the provider has moved from the address on record with ODJFS without leaving an active forwarding address with ODJFS. The act provides that the exception applies without the need for ODJFS to have determined that the provider has moved without leaving an active forwarding address.

Exception related to National Provider Identifier (PARTIALLY VETOED)

The act creates a new exception that provides for ODJFS to deny, terminate, or not renew a Medicaid provider agreement without issuing an order pursuant to an adjudication when the provider fails to provide ODJFS the National Provider Identifier assigned the provider by the National Provider System under federal law. ODJFS is permitted to deny, terminate, or not renew a Medicaid provider agreement in such a case by sending a notice explaining the proposed action to the provider. The notice must be sent to the provider's address on record with ODJFS. The Governor vetoed a provision that would have required that the notice be sent by certified mail.

Disqualifying offenses--Medicaid providers and home and community waiver services providers

(R.C. 109.572, 5111.032, 5111.033, and 5111.034)

Except in circumstances specified in rules ODJFS is permitted to adopt under law unchanged by the act, ODJFS is required to terminate a Medicaid provider agreement or independent provider agreement, or deny issuance of such an agreement, if the provider or applicant is subject to a criminal records check and has been convicted of, pleaded guilty to, or been found eligible for intervention in lieu of conviction for any of a specified list of offenses ("disqualifying offenses"). Similarly, a provider is prohibited from allowing a person to be an employee, owner, officer, or board member of the provider if the person is subject to a criminal records check and has been convicted of, pleaded guilty to, or been found eligible for intervention in lieu of conviction for a disqualifying offense. Further, a home and community-based waiver services agency is prohibited from employing a person in a position that involves providing home and community-based waiver services if the person has been convicted of, pleaded guilty to, or been found eligible for intervention in lieu of conviction for any of the same offenses.

The act adds the following crimes as disqualifying offenses: cruelty to animals, permitting child abuse, menacing by stalking, menacing, aggravated arson, arson, disrupting public services, vandalism, soliciting or providing support for an act of

terrorism, making a terroristic threat, terrorism, telecommunications fraud, criminal simulation, defrauding a rental agency or hostelry, tampering with records, personating an officer, unlawful law enforcement emblem display, defrauding creditors, illegal use of food stamps or Women, Infant, and Children (WIC) program benefits, inciting to violence, aggravated riot, riot, inducing panic, interference with custody, intimidation, perjury, escape, aiding escape or resistance to lawful authority, conspiracy, complicity, ethnic intimidation, and any municipal ordinance that is substantially equivalent to the new or existing disqualifying offenses.

The act also specifies that the date a person was convicted of, entered a guilty plea to, or was found eligible for intervention in lieu of conviction for an offense that disqualifies the person from being a Medicaid provider, provider of home and community-based services, or an employee of such providers is irrelevant for purposes of determining the person's eligibility to be a provider or an employee.

Medicaid fraud, waste, and abuse report (PARTIALLY VETOED)

(R.C. 5111.092)

The act requires ODJFS to prepare an annual report on its efforts to minimize fraud, waste, and abuse in the Medicaid program. The Governor vetoed a provision that would have required each report to include goals and objectives to minimize fraud, waste, and abuse and performance measures for monitoring all state and local activities related to minimizing fraud, waste, and abuse.

The annual reports are to be available on ODJFS's web site and ODJFS is to make copies of the report available to the public on request. In addition, ODJFS is to submit a copy of the reports to the Governor and General Assembly.[261] The first report is to be prepared no later than January 1, 2010.

Prior authorization for high-technology radiological services

(R.C. 5111.0210)

The act requires ODJFS to implement, not later than January 1, 2010, evidence-based, best practice guidelines or protocols and decision support tools for advanced diagnostic imaging services available under the fee-for-service component of the Medicaid program. "Advanced diagnostic imaging services" is defined as magnetic

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

resonance imaging services, computed tomography services, positron emission tomography services, cardiac nuclear medicine services, and similar imaging services.

Medicaid nonemergency medical transportation management

(Section 309.32.45)

The act requires ODJFS to establish a Medicaid nonemergency medical transportation pilot program. The pilot program is to be operated for two years.

A CDJFS serving a county with a population exceeding 200,000 persons is allowed to participate in the pilot program. A CDJFS that participates in the pilot program must identify which groups of Medicaid recipients residing in the county are required to participate in the pilot program. A participating CDJFS must also contract with one or more medical transportation management organizations to have the organizations manage Medicaid-covered nonemergency medical transportation services to the groups required to participate. To be eligible to contract with a participating CDJFS, a medical transportation management organization must have experience in coordinating nonemergency medical transportation services.

The act requires a medical transportation management organization that contracts with a participating CDJFS to report monthly to the CDJFS. Each report must contain (1) a description of the transportation services provided to Medicaid recipients participating in the pilot program, including details on the varying modes of transportation used in providing the services and the frequency at which the services were provided, (2) the number of times nonemergency medical transportation providers failed to arrive for an appointment to transport a pilot program participant, (3) the number of times the providers were late for such an appointment and the lengths of the delays, (4) the cost of the services provided in the pilot program, and (5) other quality indicators the CDJFS requests be included in the report.

ODJFS is required, on conclusion of the pilot program, to submit a report regarding the pilot program to the Governor and General Assembly.[262] CDJFSs that participate in the pilot program are to assist with the report. The report must specify the amount of savings, if any, the Medicaid program realized as a result of the pilot program.

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

ODJFS Pharmacy and Therapeutics Committee (PARTIALLY VETOED)

(R.C. 5111.084)

Continuing law establishes the ODJFS Pharmacy and Therapeutics Committee. The act specifies that the Committee must assist ODJFS with developing and maintaining a preferred drug list for the Medicaid program. The Committee must review and recommend, by a majority of a quorum (five members), to the ODJFS Director the drugs that should be included on the preferred drug list. The recommendations must be based on the evaluation of competent evidence regarding the relative safety, efficacy, and effectiveness of prescription drugs within a class or classes of prescription drugs. In the case of a tie, the chairperson must decide the outcome.

The act requires the ODJFS Director to (1) act on the Committee's recommendations not later than 30 days after a Committee recommendation is posted on the ODJFS web site (see below), and (2) if the ODJFS Director does not accept a recommendation, present the basis for this determination not later than 14 days after making the determination or at the next scheduled committee meeting, whichever is sooner. It appears that the Governor intended to veto these requirements. However, the Governor's veto message does not explicitly describe his intention to do so, thus, future amendments are necessary to confirm the Governor's intent.

Administration

The act requires the Committee to establish guidelines necessary for the committee's operation. The act also permits the Committee to establish one or more subcommittees to investigate and analyze issues consistent with the Committee's duties. The subcommittees may submit proposals regarding the issues to the Committee and the Committee may adopt, reject, or modify the proposals. It appears that the Governor intended to veto these provisions. However, the Governor's veto message does not explicitly describe his intention to do so, thus, future amendments are necessary to confirm the Governor's intent.

The act permits an interested party to make a presentation or submit written materials during a Committee meeting relevant to an issue under consideration by the Committee. Any written material, including a transcript of testimony to be given on the day of the meeting, may be submitted to the Committee in advance of the meeting.

Membership

Continuing law requires the ODJFS Director to appoint ten members consisting of the following: (1) three licensed pharmacists, (2) two medical doctors and two osteopathic doctors, (3) a licensed registered nurse, (4) a pharmacologist holding a

doctoral degree, and (5) a psychiatrist. The Committee is to elect from one of its members a chairperson.

When selecting the members, the act requires the ODJFS Director to seek recommendations for membership from relevant professional organizations. However, the candidate must have professional experience working with Medicaid recipients. The act also specifies that of the four physician members, one must be a family practice physician.

The Governor vetoed a provision that would have prohibited the ODJFS Director from appointing a member who is employed by ODJFS.

ODJFS web site

Under the act, ODJFS must post the following on its web site:

--Committee guidelines;[263]

--Detailed committee agendas not later than 14 days prior to the date of a regularly scheduled meeting and not later than 72 hours prior to the date of a special meeting;

--Committee recommendations not later than seven days after the meeting at which the recommendation was approved;

--The ODJFS Director's final determination as to the Committee recommendations.[264]

Study of Medicaid provider franchise permit fees

(Section 309.31.55)

The act requires ODJFS, if it conducts a study on the issue of funding the Medicaid program through franchise permit fees on providers of health-care services, to submit a copy of a report regarding the study to the General Assembly.[265]

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[263] Future amendment of this provision may be necessary to conform to any amendments confirming the Governor's intent to veto related provisions, as described above.

[264] Future amendment of this provision may be necessary to conform to any amendments confirming the Governor's intent to veto related provisions, as described above.

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

Medicaid health insuring corporation franchise permit fee

(R.C. 5111.176)

Each health insuring corporation participating in the state's Medicaid care management system is required to pay a franchise permit fee each calendar quarter beginning January 1, 2006. Unless increased or decreased by rule, the fee is equal to 4.5% of the managed care premiums the health insuring corporation receives in the applicable quarter, excluding any amount of any managed care premiums returned or refunded to enrollees, members, or premium payers. ODJFS may adopt rules to decrease the fee or to increase it to not more than 6% of managed care premiums received.

The act terminates the assessment of a Medicaid franchise permit fee on Medicaid health insuring corporations after the calendar quarter ending September 30, 2009, and instead subjects premium amounts received under the Medicaid program to the state's insurance corporation franchise tax (see "**Taxation of Medicaid health insuring corporations**") in the Taxation section. Under the act, insurance corporations participating in the state's Medicaid managed care program are not subject to the Medicaid franchise permit fee, but are subject to the state's insurance corporation franchise tax.

Nursing home and ICF/MR franchise permit fees

Nursing homes; hospitals with skilled nursing facility, long-term care, or nursing home beds; and intermediate care facilities for the mentally retarded (ICFs/MR) are required to pay an annual franchise permit fee.

Funds

The money generated by the franchise permit fee on nursing homes and hospitals is required to be deposited into two funds: the Home and Community-Based Services for the Aged Fund and the Nursing Facility Stabilization Fund. ODJFS and the Department of Aging are required to use the money in the Home and Community-Based Services for the Aged Fund for the Medicaid program, including the PASSPORT component of the Medicaid program, and the Residential State Supplement program.[266] ODJFS is required to use money in the Nursing Facility Stabilization Fund to make Medicaid payments to nursing facilities.[267]

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[266] R.C. 3721.56.

[267] R.C. 3721.561.

Money generated by the ICF/MR franchise permit fee is also to be deposited into two funds. One of the funds is named the Home and Community-Based Services for the Mentally Retarded and Developmentally Disabled Fund. ODJFS and the Ohio Department of Developmental Disabilities (ODODD) are required to use money in the Home and Community-Based Services for the Mentally Retarded and Developmentally Disabled Fund for the Medicaid program and home and community-based services to persons with mental retardation or a developmental disability. Under prior law, the other fund was the Children with Intensive Behavioral Needs Programs Fund. Prior law required that the money in the Children with Intensive Behavioral Needs Programs Fund be used for programs the ODODD Director is to establish for individuals under 21 years of age who have intensive behavioral needs. The act abolishes the Children with Intensive Behavioral Needs Programs Fund and creates a new fund named the ODODD Operating and Services Fund.[268] The new fund is to receive a portion of the money generated by the ICF/MR franchise permit fee and the money in the fund is to be used for the expenses of the programs ODODD administers and ODODD's administrative expenses.

Changes to nursing home and hospital franchise permit fee

(R.C. 3721.51 (primary), 3721.50, 3721.511, 3721.512, 3721.513, 3721.53, 3721.55, and 3721.56)

Change in fee

Prior law set the franchise permit fee for nursing homes and hospitals at $6.25 per bed per day. Instead of specifying a specific dollar amount for the fee, the act creates a five-step formula to be used to determine the fee. The fee is to be determined as follows:

(1) Determine the difference between (a) the total net patient revenue, less Medicaid per diem payments, of all nursing homes and hospital long-term care units[269] as shown on Medicaid cost reports for the calendar year immediately preceding the fiscal year for which the fee is assessed and (b) the total net patient revenue, less Medicaid per diem payments, of all nursing homes and hospital long-term care units as

[268] Although the act abolishes the Children with Intensive Behavioral Needs Programs Fund, the act maintains a requirement for the ODODD Director to establish one or more programs for individuals under age 21 who have intensive behavioral needs which, under prior law, were funded with money in the Children with Intensive Behavioral Needs Programs Fund.

[269] The act defines "hospital long-term care unit" as any distinct part of a hospital in which any of the following are located: (1) beds registered with the Department of Health as skilled nursing facility beds or long-term care beds and (2) beds licensed as nursing home beds.

shown on Medicaid cost reports for the calendar year immediately preceding the calendar year that immediately precedes the fiscal year for which the fee is assessed.

(2) Multiply the amount determined under (1) by 5.5%.

(3) Divide the amount determined under (2) by the total number of days in the fiscal year for which the fee is assessed.

(4) Subtract $11.95 from the amount determined under (3).

(5) Add $11.95 to the amount determined under (4).

If the total amount of the franchise permit fee assessed for a fiscal year using the formula exceeds 5.5% of the actual net patient revenue for all nursing homes and hospital long-term care units for that fiscal year, ODJFS is required by the act to recalculate the assessments using a per bed per day rate equal to 5.5% of actual net patient revenue for all nursing homes and hospital long-term care units for that fiscal year. If ODJFS makes such a recalculation for a fiscal year, ODJFS must refund the difference between the amount of the fee assessed for that fiscal year and the amount so recalculated as a credit against the assessments imposed for the subsequent fiscal year.

Waiver to reduce fee

The act requires ODJFS to seek a federal waiver to (1) reduce the franchise permit fee to zero dollars for two groups of nursing homes meeting certain requirements and (2) reduce the franchise permit fee for a number of nursing facility beds located in a nursing facility with more than 200 Medicaid-certified beds. ODJFS must apply for the waiver not later than four months after the effective date of this provision of the act. The waiver's effective date is to be the first day of the calendar quarter beginning after the United States Secretary of Health and Human Services approves the waiver.

The first group that is eligible to have its franchise permit fee reduced to zero consists of nursing homes that (1) are exempt from state taxation, (2) are exempt from federal income taxation, (3) do not participate in Medicaid or Medicare, and (4) provide services for the life of each resident without regard to the resident's ability to secure payment for the services. The second group to have its franchise permit fee reduced to zero consists of nursing homes that (1) have had a written affiliation agreement with a university in Ohio for education and research related to Alzheimer's disease for each of the 20 years preceding the effective date of this provision of the act and have such an agreement on the effective date of this provision of the act, (2) were constructed

pursuant to a certificate of need granted under a provision of legislation from the 116th General Assembly,[270] and (3) do not participate in Medicaid or Medicare.

The amount of the reduction in the franchise permit fee for a nursing facility with more than 200 Medicaid-certified beds is to be the amount necessary to obtain the waiver. ODJFS is to specify the number of such a nursing facility's beds that are to be subject to the reduced franchise permit fee.

ODJFS is required, if the United States Secretary approves the waiver, to reduce the franchise permit fee for each nursing home and hospital that qualifies for a reduction in its franchise permit fee under the waiver. ODJFS is to reduce the franchise permit fee in accordance with the waiver's terms. For purposes of the first fiscal year during which the waiver takes effect, ODJFS must determine the amount of the reduction not later than the waiver's effective date and mail to each nursing home and hospital qualifying for the reduction notice of the reduction not later than the last day of the first month of the calendar quarter that begins after the waiver is approved. For purposes of subsequent fiscal years, ODJFS is to make the determinations and mail the notices in accordance with state law governing regular determinations and notices of the franchise permit fee.

ODJFS is permitted by the act to increase the franchise permit fee for nursing homes and hospitals that do not qualify for the reduction if the United States Secretary approves the waiver. In increasing the franchise permit fee, ODJFS is required to determine how much money the franchise permit fee would have raised in a fiscal year if not for the waiver and uniformly increase the amount of the franchise permit fee for each nursing home and hospital subject to the increase to an amount that will have the franchise permit fee raise an amount of money that does not exceed the amount the franchise permit fee would have raised. If ODJFS increases the franchise permit fee for the first fiscal year during which the waiver takes effect, ODJFS must determine the amount of the increase not later than the waiver's effective date and mail to each nursing home and hospital subject to the increase notice of the increase not later than the last day of the first month of the calendar quarter that begins after the waiver is approved. If ODJFS increases the franchise permit fee for a subsequent fiscal year, ODJFS must make the determinations and mail the notices in accordance with state law governing regular determinations and notices of the franchise permit fee.

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[270] Section 3 of Am. Sub. S.B. 256 of the 116th General Assembly required a certificate of need application for long-term care to be granted if the application met a number of requirements, including a requirement that the application be for the construction or conversion of a nursing home, nursing home wing, or licensed rest home designed to be specially adapted exclusively to care for and treat persons having or suspected of having Alzheimer's disease and to conduct research related to Alzheimer's disease.

Deadlines

The act revises various deadlines associated with the franchise permit fee. Prior law required ODJFS to determine the fee for a year not later than August 15th and to mail the notice to each nursing home and hospital not later than September 1st. The act requires ODJFS to determine the fee not later than September 15th and to mail the notice not later than October 1st. Whereas prior law required nursing homes and hospitals to pay the first installment of the fee not later than 45 days after the last day of September, the act sets the deadline as 45 days after the last day of October.

Distribution of money into funds

Whereas prior law specified what percentage of the money raised by the franchise permit fee is to be deposited into the Home and Community-Based Services for the Aged Fund (16%), the act creates a formula to be used to determine the percentage. The percentage is to be determined by dividing one by the franchise permit fee rate or, if ODJFS recalculates the amount of the assessments for a fiscal year, the amount of the per bed per day rate so recalculated for that fiscal year. The Nursing Facility Stabilization Fund is to continue to get the remainder.

Changes to ICF/MR franchise permit fee

(R.C. 5112.30, 5112.31, 5112.37, and 5112.371)

Prior law excluded ICFs/MR that ODODD operates (i.e., developmental centers) from the ICF/MR franchise permit fee. The act makes developmental centers subject to the ICF/MR franchise permit fee effective August 1, 2009.

Under prior law, the ICF/MR franchise permit fee was to be increased effective July 1, 2009, from $11.98 to an amount determined in accordance with a composite inflation factor established in rules. Under the act, the fee is to remain at $11.98 until August 1, 2009. The fee is to be raised to $14.75 for the period beginning August 1, 2009, and ending June 30, 2010. For fiscal year 2011, the fee is to be lowered to $13.55. For each subsequent fiscal year, the fee is to be the rate used for the immediately preceding fiscal year as adjusted in accordance with the composite inflation factor. However, the act provides that if the total amount of the fee assessed for a fiscal year exceeds 5.5% of actual net patient revenue for all ICFs/MR for that fiscal year, ODJFS is required to recalculate the assessments using a rate equal to 5.5% of actual net patient revenue for all ICFs/MR for that fiscal year. If ODJFS must recalculate the assessments for a fiscal year, ODJFS is to refund the difference between the amount of the fee assessed for that fiscal year and the amount recalculated as a credit against the assessments imposed for the subsequent fiscal year.

The following table shows how the money generated by the fee is to be divided among the funds.

	[illegible]	[illegible]	[illegible]
Home and Community-Based Services for the Mentally Retarded and Developmentally Disabled Fund	94.28%	84.2%	79.12%
Children with Intensive Behavioral Needs Programs Fund	5.72%	N/A	N/A
ODODD Operating and Services Fund	N/A	15.8%	20.88%

Medicaid rates for nursing facilities

The formula for determining the rate nursing facilities are to be paid under the Medicaid program is included in the Revised Code. The formula is divided into several parts sometimes referred to as cost centers or price centers. The price centers in the nursing facility reimbursement formula are direct care costs, ancillary and support costs, tax costs, capital costs, and franchise permit fees.[271] A nursing facility is paid a rate for each price center; there is a separate formula for determining each rate. There is also a quality incentive payment included in the formula. A nursing facility's total rate is the sum of all of the rates and quality incentive payment.

Direct care costs include costs for nurses, direct care staff, medical directors, respiratory therapists, quality assurance, employee benefits, and other costs. A nursing facility's rate for direct care costs is determined in part by calculating a cost per case-mix unit for the nursing facility's peer group.[272]

Ancillary and support costs include costs for activities, social services, pharmacy consultants, habilitation supervisors, incontinence supplies, food, laundry, security,

[271] See "**Nursing home and ICF/MR franchise permit fees**," above.

[272] Nursing facilities are placed in one of three peer groups as part of the process of determining their rate for direct care costs. The peer group in which a nursing facility is placed depends on the county in which it is located. For example, the first peer group consists of nursing facilities located in Brown, Butler, Clermont, Clinton, Hamilton, or Warren county. (R.C. 5111.20 and 5111.231.)

travel, dues, subscriptions, and other costs not included with direct care costs or capital costs.[273]

Tax costs are costs for real estate taxes, personal property taxes, corporate franchise taxes, and commercial activity taxes.[274]

Capital costs are a nursing facility's costs of ownership, which is the actual expense incurred for (1) depreciation and interest on capital assets costing $500 or more per item, (2) amortization and interest on land improvements and leasehold improvements, (3) amortization of financing costs, and (4) lease and rent of land, building, and equipment.[275]

The quality incentive payment is based on the number of points a nursing facility earns for such factors as having no health deficiencies on its most recent standard survey and a resident satisfaction above the statewide average. The mean quality incentive payment for fiscal year 2007, weighted by Medicaid days,[276] was set at $3 per Medicaid day.[277]

Inflation adjustments used in nursing facility rates

(R.C. 5111.231 and 5111.24)

The formulas used to determine nursing facilities' direct care and ancillary and support costs include provisions regarding inflation adjustments. Prior law required ODJFS to use the Employment Cost Index for Total Compensation, Health Services Component, as published by the United States Bureau of Labor Statistics, in calculating the inflation adjustment for direct care costs. ODJFS was required to use the Consumer Price Index for all items for all urban consumers for the North Central Region, as published by the United States Bureau of Labor Statistics, in calculating the inflation adjustment for ancillary and support costs.

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[273] R.C. 5111.20 and 5111.24.

[274] R.C. 5111.242.

[275] R.C. 5111.20 and 5111.25.

[276] "Medicaid days" is defined as all days during which a resident who is a Medicaid recipient eligible for nursing facility services occupies a bed in a nursing facility that is included in the facility's Medicaid-certified capacity. Therapeutic or hospital leave days for which payment is made are considered Medicaid days proportionate to the percentage of the nursing facility's per resident per day rate paid for those days. (R.C. 5111.20.)

[277] R.C. 5111.244.

Under the act, ODJFS is to begin to use the Employment Cost Index for Total Compensation, Nursing and Residential Care Facilities Occupational Group, published by the United States Bureau of Labor Statistics, when it first redetermines the cost per case-mix unit that is used in part of the calculation of direct care costs.[278] If the Bureau ceases to publish that index, ODJFS is to use the index the Bureau subsequently publishes that covers nursing facilities' staff costs.

In the case of ancillary and support costs, the act requires ODJFS to use the Consumer Price Index for All Items for All Urban Consumers for the Midwest Region, published by the United States Bureau of Labor Statistics, the first time it redetermines the rate for ancillary and support costs for the different peer groups used in the calculation of those costs.[279] If the Bureau ceases to publish that index, ODJFS is required to use the index the Bureau subsequently publishes that covers urban consumers' prices for items for the region that includes Ohio.

Deadline for nursing facility to submit corrections

(R.C. 5111.232)

ODJFS is required to determine average case-mix scores for nursing facilities as part of the process of determining the facilities' direct care costs. Direct care costs are among the costs included in the total rate paid nursing facilities under the Medicaid program.

Nursing facilities are required to provide the state information used in calculating their case-mix scores. The information must be provided quarterly. If a nursing facility fails to submit the information in time for ODJFS to be able to calculate the nursing facility's case-mix score, or submits incomplete or inaccurate information, ODJFS is authorized to assign the nursing facility a case-mix score that is 5% less than its case-mix score for the previous quarter. The reduced score may be used in calculating the nursing facility's rate for direct care costs for one or more months of the quarter for which the rate will be paid. However, before taking such action, ODJFS must permit the nursing facility a reasonable period of time to correct the information. The act reduces the amount of time by which the information may be corrected before ODJFS may assign the reduced case-mix score.

Prior law provided that ODJFS could not assign the reduced case-mix score unless the nursing facility failed to submit corrected information before the earlier of (1)

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[278] ODJFS is not required to redetermine the cost per case-mix unit more often than once every ten years.

[279] ODJFS is not required to redetermine peer groups' rates for ancillary and support costs more often than once every ten years.

the 81st day after the end of the quarter to which the information pertained or (2) the deadline for submission of corrections established by federal Medicare and Medicaid regulations. This meant that the nursing facility had at most 80 days after the end of a quarter to submit the corrections. The act reduces this to at most 45 days.

Nursing facilities' direct care costs

(R.C. 5111.20)

The act revises the list of costs that are included in nursing facilities' direct care costs. Whereas prior law included only emergency oxygen, the act includes any oxygen. The act also includes the costs of over-the-counter pharmacy products, physical therapists, physical therapy assistants, occupational therapists, occupational therapy assistants, speech therapists, and audiologists.

Nursing facilities' ancillary and support costs

(R.C. 5111.20)

The act includes the costs of wheelchairs and resident transportation among the costs included in nursing facilities' ancillary and support costs.

Nursing facilities' franchise permit fee rates

(R.C. 5111.243)

As discussed above, the costs of the franchise permit fee on nursing homes is one of the price centers included in the formula for determining nursing facilities' Medicaid rates. Prior law provided that the rate a nursing facility was to be paid for the franchise permit fee was an amount equal to the fee the facility paid. The act provides instead that the rate is to equal $6.25 per resident per day.

Prohibitions on certain Medicaid billings

(R.C. 5111.262)

The act prohibits anyone, other than a nursing facility, from submitting a claim for Medicaid reimbursement for a service provided to a nursing facility resident if the service is included in a Medicaid payment made to the nursing facility or in the reimbursable expenses reported on a Medicaid cost report for the facility. The act also prohibits nursing facilities from submitting a separate claim for Medicaid reimbursement for a service provided to a resident if the service is included in a Medicaid payment made to the nursing facility or in the reimbursable expenses on the facility's Medicaid cost report.

Costs of therapy and covered therapy services

(R.C. 5111.263 (repealed))

The act repeals a law regarding Medicaid coverage of therapy services provided to nursing facility residents. The law that is repealed generally provided that the costs of therapy were not allowable costs for the purpose of determining nursing facilities' Medicaid reimbursement rates. (A nursing facility's reasonable costs for rehabilitative, restorative, or maintenance therapy services rendered to residents by nurses or nurse aides, and the facility's overhead costs to support therapy services provided to nursing facility residents, were allowable costs for the purposes of establishing nursing facilities' Medicaid reimbursement rates.) The repealed law also restricted ODJFS's ability to process a claim for covered therapy services rendered to a nursing facility resident. "Covered therapy services" was defined as physical therapy, occupational therapy, audiology, and speech therapy services that were provided by appropriately licensed therapists or therapy assistants and that were covered for nursing facility residents either by Medicare or Medicaid.

FY 2010 and FY 2011 Medicaid reimbursement rates for nursing facilities

(Sections 309.30.20 and 309.30.25)

Continuing law requires ODJFS to adjust the rates determined under the formulas included in the Revised Code for direct care costs, ancillary and support costs, tax costs, and capital costs as directed by the General Assembly through the enactment of law governing Medicaid payments to nursing facilities.[280] ODJFS must also annually adjust the mean quality incentive payment by the same adjustment factors.[281]

Initial adjustments

The act establishes adjustments to the fiscal year 2010 and fiscal year 2011 Medicaid rates for nursing facilities that have a valid Medicaid provider agreement on the day preceding the first day of the fiscal year and a valid Medicaid provider agreement during the fiscal year for which the rate is paid.

A nursing facility's cost per case-mix unit calculated as part of direct care costs, rate for ancillary and support costs, rate for tax costs, and rate for capital costs are to be adjusted as follows:

(1) Increase the cost and rates by 2%.

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[280] R.C. 5111.222.

[281] R.C. 5111.244.

(2) Increase the amount calculated above by another 2%.

(3) Increase the amount calculated above by 1%.

Instead of adjusting the mean quality incentive payment by the same adjustment factors, the act provides that the mean payment is to be $3.03 per Medicaid day and weighted by Medicaid days.

Franchise permit fee-related adjustment

After making the initial adjustments discussed above, a nursing facility's rate is to be further adjusted by a percentage ODJFS is to determine in consultation with the Ohio Health Care Association; Ohio Academy of Nursing Homes; and the Association of Ohio Philanthropic Homes, Housing, and Services for the Aging. The percentage is to be based on expending an amount equal to the amount determined as follows:

(1) Determine how much of the revenue to be generated by the nursing home franchise permit fee for the fiscal year for which the rate is paid reflects the first four steps of the calculation of the fee (see "**Changes to nursing home and hospital franchise permit fee**" above);

(2) From the amount determined under (1), subtract the portion to be expended in making Medicaid payments to nursing facilities for the fiscal year that reflects the second step in the calculation regarding the part of the rate known as the consolidated services rate (see "**Consolidated services rate**" below).

Stop loss and gain

A nursing facility's rate, as determined with the adjustments discussed above, is then compared to a certain amount to determine whether a downward or upward adjustment is to be made.

For fiscal year 2010, a downward adjustment is to be made if the rate determined for that fiscal year is more than 101.75% of the nursing facility's June 30, 2009 rate. The downward adjustment is to be such that the nursing facility's rate is not more than 101.75% of the nursing facility's June 30, 2009 rate. An upward adjustment is to be made for fiscal year 2010 if the nursing facility's rate is less than 99% of its June 30, 2009 rate. The upward adjustment is to be such that the nursing facility's rate is not less than 99% of its June 30, 2009 rate. The downward or upward adjustment applies only if the nursing facility's rate as determined with the initial adjustments discussed above is more than 101.75% or less than 99% of its June 30, 2009 rate. The nursing facility's rate is not subject to the downward or upward adjustment if another adjustment made during fiscal year 2010 in accordance with the statutory formula governing nursing

facilities' Medicaid rates causes the nursing facility's rate to become more than 101.75% or less than 99% of its June 30, 2009 rate.

For fiscal year 2011, a downward adjustment is to be made if the rate determined for that fiscal year is more than 102.25% of a portion of the nursing facility's June 30, 2010 rate. The portion of the nursing facility's June 30, 2010 rate to which its preliminary fiscal year 2011 rate is compared is the amount of its total June 30, 2010 rate less the portion of that total rate that equals the sum of the parts of the total rate known as the workforce development incentive payment and consolidated services rate (see "**Workforce development incentive payment**" and "**Consolidated services rate**" below). The downward adjustment is to be such that the nursing facility's rate is not more than 102.25% of that portion of the nursing facility's June 30, 2010 rate. An upward adjustment is to be made for fiscal year 2011 if the nursing facility's rate is less than 99% of that portion of its June 30, 2010 rate. The upward adjustment is to be such that the nursing facility's rate is not less than 99% of that portion of its June 30, 2010 rate. However, neither the downward nor the upward adjustment is to be made to the nursing facility's fiscal year 2011 rate if the nursing facility's fiscal year 2010 rate was not subject to a downward or upward adjustment even though its fiscal year 2011 rate, as determined with the initial adjustments discussed above, is more than 102.25% or less than 99% of the applicable portion of its June 30, 2010 rate. As with the fiscal year 2010 rate, the upward or downward adjustment applies only with regard to the initial determination of the rate and not if another adjustment made during fiscal year 2011 in accordance with the statutory formula governing nursing facilities' Medicaid rates causes the nursing facility's rate to become more than 102.25% or less than 99% of the applicable portion of its June 30, 2009 rate.

Workforce development incentive payment

Following a stop loss or gain adjustment, if any, a nursing facility's rate is to be increased by a workforce development incentive payment in an amount of $5.70 per Medicaid day. The total amount of the workforce development incentive payment must be used to improve the nursing facility's employee retention and direct care staffing levels, including by increasing wages paid to direct care staff. For fiscal years 2010 and 2011 each, ODJFS is required to issue a report detailing the impact that the workforce development incentive payments have on nursing facilities' employee retention, direct care staffing levels, and direct care staff wages. The fiscal year 2010 report is to be submitted to the Governor and General Assembly not later than September 30, 2011. The fiscal year 2011 report is due by September 30, 2012.

Consolidated services rate

A nursing facility's rate is to be further increased by the consolidated services rate. The consolidated services rate is to equal the sum of the following: (1) $3.91 and (2) the amount calculated under the first four steps of the calculation of the nursing home franchise permit fee for the fiscal year for which the rate is paid (see "**Changes to nursing home and hospital franchise permit fee**" above).

Deadline for determining rates

ODJFS is required to determine the fiscal year 2010 rates to be paid nursing facilities not later than October 1, 2009. The deadline for fiscal year 2011 is one year later -- October 1, 2010. Until the rates are determined, ODJFS must continue to pay a nursing facility the rate it was paid on the last day of the previous fiscal year. When the rates for a fiscal year are determined, ODJFS is required to pay the rates retroactive to the first day of the fiscal year.

Reduction in payments if franchise permit fee is reduced or eliminated

If the United States Centers for Medicare and Medicaid Services requires that the franchise permit fee for nursing facilities be reduced or eliminated, ODJFS is required to reduce the amount it pays nursing facilities for fiscal year 2010 and fiscal year 2011 as necessary to reflect the loss to the state of the revenue and federal financial participation generated from the franchise permit fee.

Adjustments to be implemented notwithstanding contrary statutes

The act requires that ODJFS implement the rate adjustments in determining nursing facilities' fiscal year 2010 and fiscal year 2011 Medicaid rates notwithstanding anything to the contrary in the Revised Code governing nursing facilities' Medicaid rates.

Nursing facility capital costs study (VETOED)

(Section 309.30.30)

The Governor vetoed a provision that would have required ODJFS to issue a report with recommendations for developing a new system for reimbursing nursing facilities' capital costs under the Medicaid program. The report would have been due December 31, 2010. ODJFS would have been required to prepare the report in consultation with the Ohio Academy of Nursing Homes; the Association of Ohio Philanthropic Homes, Housing, and Services for the Aging; and the Ohio Health Care Association. The report would have been submitted to the Governor and General Assembly.

The report's recommendations would have had to focus on (1) resulting in a statewide average per diem rate, weighted by Medicaid days, for capital costs for the first fiscal year the system was implemented that was budget neutral compared to the statewide average per diem rate, weighted by Medicaid days, for capital costs as calculated under continuing law and (2) appropriately recognizing increased costs incurred by nursing facilities for capital improvements to, and replacement of, existing nursing facilities. The report could have included recommendations for changes to other parts of the Medicaid reimbursement system for nursing facilities.

Medicaid rates for ICFs/MR

The formula for determining the rate ICFs/MR are to be paid under the Medicaid program is also included in the Revised Code. As is the case with the formula for nursing facilities, the formula for ICF/MR rates is divided into several cost centers. The cost centers for the ICF/MR formula differ from the price centers used in the nursing facility formula. The cost centers in the ICF/MR reimbursement formula are direct care costs, other protected costs, capital costs, and indirect care costs. An ICF/MR is paid a rate for each cost center; there is a separate formula for determining each rate. An ICF/MR's total rate is the sum of all of the rates.

Direct care costs include costs for nurses, direct care staff, medical directors, respiratory therapists, quality assurance, employee benefits, and other costs. An ICF/MR's rate for direct care costs is determined in part by calculating a cost per case-mix unit for the ICF/MR.[282]

Other protected costs are costs incurred by an ICF/MR for such things as medical supplies; real estate, franchise, and property taxes; utilities and water; sewage; and refuse.[283]

Capital costs are an ICF/MR's costs of ownership and nonextensive renovation. "Costs of ownership" is defined as the actual expense incurred for (1) depreciation and interest on capital assets costing $500 or more per item, (2) amortization and interest on land improvements and leasehold improvements, (3) amortization of financing costs, and (4) lease and rent of land, building, and equipment. "Costs of nonextensive renovation" is defined as the actual expense incurred by an ICF/MR for depreciation or amortization and interest on renovations that are not extensive renovations.[284]

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[282] R.C. 5111.20(H) and 5111.23.

[283] R.C. 5111.20(R).

[284] R.C. 5111.20(C).

Indirect care costs are all reasonable costs incurred by an ICF/MR that are not direct care costs, other protected costs, or capital costs. Indirect care costs include such costs as habilitation supplies, medical and habilitation records, incontinence supplies, food, housekeeping, security, administration, human resources, dues, license fees, legal services, accounting services, minor equipment, maintenance and repairs, and employee benefits.[285]

ICF/MR off-site day programming

(R.C. 5111.233)

The act requires that the costs of day-programming be part of the direct care costs of an ICF/MR as off-site day programming if the area in which the day programming is provided is not certified by the Director of Health as an ICF/MR and regardless of either of the following: (1) whether or not the area in which the day programming is provided is less than 200 feet away from the ICF/MR or (2) whether or not the day programming is provided by an individual who, or organization that, is a related party to the provider of the ICF/MR.[286]

Medicaid coverage of oxygen services for ICF/MR residents (VETOED)

(R.C. 5111.236)

The ODJFS Director has adopted a rule limiting when Medicaid covers oxygen services. Under the rule, oxygen services are covered only for Medicaid recipients with significant hypoxemia in the chronic stable state and only when certain conditions are met, including blood gas or oxygen saturation levels indicating the need for oxygen services. A Medicaid recipient's oxygen saturation levels indicate the need for oxygen services if the recipient has (1) an arterial oxygen saturation at or below 88% when at rest while awake, (2) an arterial oxygen saturation at or below 88% during sleep if the recipient demonstrates an arterial oxygen saturation at or above 89% while awake, (3) a decrease in arterial oxygen saturation of more than 5% during sleep that is associated with symptoms or signs reasonably attributable to hypoxemia, or (4) an arterial oxygen saturation at or below 88% during exercise if the recipient demonstrates an arterial oxygen saturation at or above 89% during the day while at rest.[287]

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[285] R.C. 5111.20(K).

[286] Continuing law defines "related party" as an individual or organization that, to a significant extent, has common ownership with, is associated or affiliated with, has control of, or is controlled by, the provider (R.C. 5111.20).

[287] O.A.C. 5101:3-10-13.

The Governor vetoed a provision that would have required the Medicaid program to cover oxygen services that a medical supplier with a valid Medicaid provider agreement provided to a Medicaid recipient who is a medically fragile child[288] and resides in an ICF/MR. The Medicaid program would have had to cover such oxygen services regardless of any of the following:

(1) The percentage of the Medicaid recipient's arterial oxygen saturation at rest, exercise, or sleep;

(2) The type of system used in delivering the oxygen to the Medicaid recipient;

(3) Whether the ICF/MR in which the Medicaid recipient resides purchased or rented the equipment used in the delivery of the oxygen to the recipient.

The vetoed provision also would have required a medical supplier of an oxygen service to bill ODJFS directly for oxygen services the Medicaid program covers due to this part of the act. An ICF/MR would have been prohibited from including the cost of such an oxygen service in its Medicaid cost report unless it was the medical supplier of the oxygen service.[289]

Limits on costs of outside ICF/MR resident meals

(R.C. 5111.261)

ODJFS is generally prohibited from placing limits on specific categories of reasonable costs when determining whether the direct care and indirect care costs of an ICF/MR are allowable for purposes of its Medicaid rate. ODJFS may place limits on only the following categories: compensation of owners, compensation of relatives of owners, and compensation of administrators.

Under prior law, ODJFS was also permitted to place limits on costs for resident meals prepared and consumed outside an ICF/MR. The act removes that authority. Thus, ODJFS is no longer authorized to place a limit on such costs when determining whether the direct care and indirect care costs of an ICF/MR are allowable.

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[288] The vetoed provision would have defined "medically fragile child" as an individual under age 18 who requires (1) the services of a physician at least once a week due to instability of the individual's medical condition and (2) the services of a registered nurse on a daily basis.

[289] The Governor's veto message indicates an intent to veto the enactment of R.C. 5111.236 in its entirety and the Governor clearly vetoes the reference to the section in the act's title and enacting clause. However, the veto only shows division (C) of the section, which concerns the billing for oxygen services, as being vetoed.

FY 2010 Medicaid reimbursement rate for ICFs/MR

(Section 309.30.60)

The act establishes limits on the fiscal year 2010 Medicaid rates for ICFs/MR to which either of the following apply:

(1) There is a valid Medicaid provider agreement for the ICF/MR on June 30, 2009, and a valid Medicaid provider agreement during fiscal year 2010.

(2) The ICF/MR undergoes a change of operator effective July 1, 2009, the exiting (i.e., former) operator has a valid Medicaid provider agreement for the ICF/MR on June 30, 2009, and the entering (i.e., new) operator has a valid Medicaid provider agreement for the ICF/MR during fiscal year 2010.

The Medicaid rate to be paid to such an ICF/MR during fiscal year 2010 is the rate calculated for the ICF/MR in accordance with the formula included in the Revised Code. However, such an ICF/MR is to be paid for services provided during the period beginning July 17, 2009, and ending July 31, 2009, the rate that the ICF/MR was paid June 29, 2009. Also, if the mean total per diem rate for all such ICFs/MR for the period beginning August 1, 2009, and ending July 30, 2010, weighted by May 2009 Medicaid days and calculated as of August 1, 2009, exceeds $278.15, ODJFS must reduce the total per diem rate for each such ICF/MR for that period by a percentage that is equal to the percentage by which the mean total per diem rate exceeds $278.15.

The act provides that the rate so set for an ICF/MR is not subject to any adjustments otherwise authorized by state law governing ICF/MR Medicaid rates during the remainder of fiscal year 2010. And, ODJFS must reduce ICF/MRs' fiscal year 2010 rate as necessary to reflect the loss to the state of the revenue and federal financial participation generated from the ICF/MR franchise permit fee if the United States Centers for Medicare and Medicaid Services requires that the franchise permit fee be reduced or eliminated.

ODJFS is to implement the rate limits notwithstanding anything to the contrary in the Revised Code governing Medicaid rates for ICFs/MR.

FY 2011 Medicaid reimbursement rate for ICFs/MR

(Section 309.30.70)

The act establishes similar limits for the fiscal year 2011 Medicaid rates for ICFs/MR. The limits are to apply to ICFs/MR to which either of the following apply:

(1) There is a valid Medicaid provider agreement for the ICF/MR on June 30, 2010, and a valid Medicaid provider agreement during fiscal year 2011.

(2) The ICF/MR undergoes a change of operator effective July 1, 2010, the exiting (i.e., former) operator has a valid Medicaid provider agreement for the ICF/MR on June 30, 2010, and the entering (i.e., new) operator has a valid Medicaid provider agreement for the ICF/MR during fiscal year 2011.

The Medicaid rate to be paid to such an ICF/MR during fiscal year 2011 is the rate calculated for the ICF/MR in accordance with the formula included in the Revised Code. However, if the mean total per diem rate for all such ICFs/MR for fiscal year 2011, weighted by May 2010 Medicaid days and calculated as of July 1, 2010, exceeds $278.15, ODJFS must reduce the total per diem rate for each such ICF/MR by a percentage that is equal to the percentage by which the mean total per diem rate exceeds $278.15.

The act provides that the rate so set for an ICF/MR is not subject to any adjustments otherwise authorized by state law governing ICF/MR Medicaid rates during the remainder of fiscal year 2011. And, ODJFS must reduce ICF/MRs' fiscal year 2011 rate as necessary to reflect the loss to the state of the revenue and federal financial participation generated from the ICF/MR franchise permit fee if the United States Centers for Medicare and Medicaid Services requires that the franchise permit fee be reduced or eliminated.

ODJFS is to implement the rate limits notwithstanding anything to the contrary in the Revised Code governing Medicaid rates for ICFs/MR.

ICF/MR Reimbursement Study Council (VETOED)

(Section 309.30.71)

The Governor vetoed a provision that would have created the ICF/MR Reimbursement Study Council, which would have consisted of the following:

(1) The ODJFS Director;

(2) The Deputy Director of ODJFS's Office of Ohio Health Plans;

(3) The ODODD Director;

(4) One representative of Medicaid recipients residing in ICFs/MR, appointed by the Governor;

(5) Two representatives, each appointed by their respective governing bodies, of the Ohio Provider Resource Association, the Ohio Health Association, and the Ohio Association of County Boards of Mental Retardation and Developmental Disabilities.

The ODJFS Director would have been required to serve as the Council's chairperson. Council members would have served without compensation. The Council would have been required to review the system for reimbursing ICF/MR services under the Medicaid program. When reviewing the system, the Council would have had to use the following principles:

(1) The system should appropriately account for differences in acuity and service needs among individuals in ICFs/MR.

(2) The system should support and encourage quality services, including both of the following elements:

(a) A high level of coverage of direct care costs.

(b) Pay for performance mechanisms.

(3) The system should reflect appropriate recognition that virtually all individuals served in ICFs/MR are Medicaid recipients.

(4) The system should encourage cost-effective service delivery.

(5) The system should encourage innovation in service delivery.

(6) The system should encourage appropriate maintenance, improvement, and replacement of facilities.

The Council would have been required to submit a report of its activities, findings, and recommendations to the Governor, the Speaker of the House of Representatives, and the President of the Senate no later than July 1, 2010.

Nursing facility refund of excess depreciation

(R.C. 5111.25)

The act repeals a requirement that a nursing facility, after the date on which a transaction of sale is closed, refund to ODJFS the amount of excess depreciation that ODJFS paid to the facility for each year it operated under a Medicaid provider agreement. The amount of the refund was to be prorated according to the number of Medicaid patient days for which the nursing facility received payment. "Excess depreciation" was defined as a nursing facility's depreciated basis, which was the

facility's cost less accumulated depreciation, subtracted from the purchase price net of selling costs but not exceeding the amount paid to the facility for capital costs less any amount paid for interest costs, amortization of financing costs, and lease expenses.[290]

Medicaid debt collection process (VETOED)

(R.C. 5111.65, 5111.651, 5111.68, 5111.681, 5111.685, 5111.686, 5111.688, 5111.689, 5111.874, and 5111.875)

Continuing law establishes requirements for a nursing facility or ICF/MR that undergoes a change of operator,[291] facility closure,[292] voluntary termination,[293] or voluntary withdrawal of participation.[294] The requirements concern the state collecting debts a nursing facility or ICF/MR owes under the Medicaid program. The Governor vetoed provisions that would have revised these requirements.

Estimate of Medicaid debt

An operator is required to notify ODJFS of an impending change of operator, facility closure, voluntary termination, or voluntary withdrawal of participation.[295] On receipt of the notice, ODJFS must determine the amount of any overpayments made under the Medicaid program to the operator, including overpayments the operator disputes, and other actual and potential debts the operator owes or may owe under the Medicaid program.[296] A vetoed provision would have clarified that ODJFS was to estimate, rather than determine, this amount and provided that the amount of the

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[290] The act also repeals a requirement that a nursing facility that is sold or that voluntarily terminates participation in the Medicaid program refund any other amount that ODJFS properly finds to be due after an audit. However, continuing law establishes a debt collection process for nursing facilities that undergo a change of operator or cease to participate in Medicaid.

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

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

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

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

[295] R.C. 5111.66 and 5111.67.

[296] R.C. 5111.68.

estimated debt included any franchise permit fee the operator owes or may owe under the Medicaid program. ODJFS would have been required to use a debt estimation methodology in estimating the operator's actual and potential Medicaid debts. The debt estimation methodology was to be established in rules. A vetoed provision would have eliminated a requirement that ODJFS, if it was unable to determine the amount of Medicaid debts for any period of time before the effective date of the new provider's Medicaid provider agreement in the case of a change of operator or the effective date of a facility closure, voluntary termination, or voluntary withdrawal of participation, make a reasonable estimate of the Medicaid debts for the period using information available to ODJFS, including prior determinations of Medicaid debts.

ODJFS would have been required to provide the operator written notice of ODJFS's estimate of the operator's Medicaid debt not later than 30 days after ODJFS received the notice of the change of operator, facility closure, voluntary termination, or voluntary withdrawal of participation. The notice would have had to include the basis for the estimate.

Withholding

With a certain exception, ODJFS must withhold a specified amount from payment due the operator under the Medicaid program. A vetoed provision would have permitted rather than required ODJFS to make the withholding, changed the amount to be withheld, eliminated the existing exception to the withholding requirement, and created new circumstances under which the withholding would not occur or be reduced.

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

ODJFS is permitted to choose not to make the withholding in the case of a change of operator if the new operator (1) enters into a nontransferable, unconditional, written agreement with ODJFS to pay ODJFS the former operator's Medicaid debt and (2) provides ODJFS a copy of the new operator's balance sheet that assists ODJFS in

determining whether to make the withholding. A vetoed provision would have eliminated this provision and established circumstances applicable to a change of operator under which the withholding was not to occur or be reduced and circumstances applicable to a facility closure, voluntary termination, or voluntary withdrawal of participation under which the withholding was not to occur or to be reduced.

In the case of a change of operator, a vetoed provision would have prohibited ODJFS from making the withholding if the new operator or a qualified affiliated operator executed a successor liability agreement to assume liability for the entire amount of the former operator's Medicaid debt as specified in ODJFS's notice to the former operator.[297] ODJFS would have been required to reduce the amount of the withholding if the new operator or qualified affiliated operator executed such a successor liability agreement to assume liability for the portion of the former operator's Medicaid debt that represents the franchise permit fee the former operator owes. The amount of the reduction was to equal that portion of the former operator's Medicaid debt.

In the case of a facility closure, voluntary termination, or voluntary withdrawal of participation, a vetoed provision would have prohibited ODJFS from making the withholding if the former operator or a qualified affiliated operator executed a successor liability agreement to assume liability for the entire amount of the former operator's Medicaid debt. ODJFS would have been required to reduce the amount of the withholding if the former operator or qualified affiliated operator executed a successor liability agreement to assume liability for the portion of the former operator's Medicaid debt that represents the franchise permit fee the former operator owes. The amount of the reduction was to equal that portion of the former operator's Medicaid debt.

A provision vetoed by the Governor would have provided that execution of a successor liability agreement did not waive the former operator's right to contest the amount that ODJFS specified in its notice to the former operator that the operator owes under the Medicaid program.

A vetoed provision would have defined "qualified affiliated operator" as a nursing facility or ICF/MR operator to whom all of the following applied:

(1) The operator was affiliated with either the former operator for whom the affiliated operator was to assume liability for all or part of the former operator's

[297] A successor liability agreement would have had to be executed in a manner ODJFS was to prescribe.

Medicaid debt or the new operator involved in a change of operator with the former operator;

(2) The operator had one or more valid Medicaid provider agreements;

(3) During the 12-month period preceding the month in which ODJFS received notice of the change of operator, facility closure, voluntary termination, or voluntary withdrawal of participation, the average monthly Medicaid payment made to the operator equaled at least 90% of the average monthly Medicaid payment made to the former operator.

Determination of actual Medicaid debt

ODJFS is required to determine the actual amount of an operator's Medicaid debt by completing all final fiscal audits not already completed and performing all other appropriate actions ODJFS determines to be necessary. ODJFS must issue a debt summary report not later than 90 days after the operator files a properly completed cost report with ODJFS or, if ODJFS waives the requirement for the operator to file a cost report, not later than 90 days after the date ODJFS waives the cost report requirement. A provision the Governor vetoed would have provided for this report to be issued as an initial debt summary report and reduced the number of days ODJFS had to issue it to 60 days following the date the operator filed a properly completed cost report or ODJFS waived the cost report requirement.

The operator and a qualified affiliated operator who executes a successor liability agreement would have been permitted to request an informal settlement conference to contest any of ODJFS's findings included in the initial debt summary report. The request was to be submitted to ODJFS not later than 30 days after the date ODJFS issued the initial debt summary report. If ODJFS had withheld money from payment due the operator under the Medicaid program, ODJFS would have been required to conclude the conference not later than 60 days after the date ODJFS received the timely request unless ODJFS and the operator or qualified affiliated operator agreed to a later conclusion date. The operator and qualified affiliated operator would have been permitted to submit information to ODJFS explaining what was contested before and during the conference, including documentation of the amount of any debt ODJFS owes the operator. ODJFS would have been required to issue a revised debt summary report after the conference's conclusion. If ODJFS had made a withholding, the revised debt summary report was to be submitted not later than 60 days after the conference's conclusion. The revised debt summary was to include ODJFS's findings and the amount of debt ODJFS determined the operator owes under the Medicaid program. ODJFS would have been required to explain its findings and determination in the revised debt summary report.

Only the parts of a debt summary report that are subject to an adjudication under another provision of state Medicaid law are subject to an adjudication under the Administrative Procedure Act (R.C. Chapter 119.).[298] A vetoed provision would have provided instead that the operator or qualified affiliated operator could request an adjudication regarding any part of an initial or revised debt summary report. The adjudication was to be consolidated with any other uncompleted adjudication that concerned a matter addressed in the initial or revised debt summary report. ODJFS would have been required to complete the adjudication not later than 60 days after receiving the request for the adjudication if ODJFS had made a withholding.

Release of withholding

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

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

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

A vetoed provision would have revised the deadlines for ODJFS to release the amount of the withholding that was to be released. The following would have been the deadlines:

(1) If ODJFS failed to release the initial debt summary report within the required time, 61 days after the date the operator filed the properly completed cost report or ODJFS waived the cost report requirement;

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

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

(a) Thirty days after the later of the deadline for requesting an informal settlement conference and the deadline for requesting an adjudication regarding the initial debt summary report if the operator and a qualified affiliated operator who executed a successor liability agreement failed to request both the conference and adjudication on or before the deadline;

(b) Thirty days after the deadline for requesting an adjudication regarding a revised debt summary report if the operator or a qualified affiliated operator who executed a successor liability agreement requested an informal settlement conference on or before the deadline but failed to request an adjudication on or before the deadline;

(c) Thirty days after the completion of an adjudication of the initial or revised debt summary report if the operator or a qualified affiliated operator who executed a successor liability agreement requested the adjudication on or before the deadline.

Medicaid Payment Withholding Fund

A provision vetoed by the Governor would have required that all amounts withheld from a nursing facility or ICF/MR operator be deposited into the existing Medicaid Payment Withholding Fund. Money in the fund would have had to be used to pay an operator when a withholding was released and to pay ODJFS and the federal government the amount an operator owes under the Medicaid program. Amounts paid to ODJFS or the federal government from the fund would have had to be deposited into the appropriate ODJFS fund.

Home first rules for home and community-based services

(R.C. 5111.85 (primary), 5111.705, and 5111.851)

Continuing law permits the ODJFS Director to adopt rules regarding components of the Medicaid program authorized by a waiver granted by the United States Department of Health and Human Services (i.e., a Medicaid waiver component). For example, the ODJFS Director may adopt rules establishing eligibility requirements for a Medicaid waiver component and rules establishing the type, amount, duration, and scope of services a Medicaid waiver component provides.

The act permits the Director to adopt additional rules regarding Medicaid waiver components under which home and community-based services are provided as an alternative to hospital, nursing facility, or intermediate care facility for the mentally retarded services. The rules may establish procedures for identifying individuals who (1) are eligible for such a Medicaid waiver component and on a waiting list for the component, (2) are receiving inpatient hospital services or residing in a nursing facility or ICF/MR (as appropriate for the component), and (3) choose to be enrolled in the

component. The rules may also establish procedures for approving the enrollment of individuals so identified into a Medicaid waiver component providing home and community-based services. These procedures are popularly known as "home first." Any such home first procedures established in rules for the Medicaid waiver components known as the PASSPORT Program and the Assisted Living Program must be consistent with state law governing home first procedures for those Medicaid waiver components.

Home care attendant services

(R.C. 5111.88, 5111.881, 5111.882, 5111.883, 5111.884, 5111.885, 5111.886, 5111.887, 5111.888, 5111.889, 5111.8810, and 5111.8811)

The act permits the ODJFS Director to submit requests to the United States Secretary of Health and Human Services to amend the federal Medicaid waivers authorizing the Ohio Home Care program and the Ohio Transitions II Aging Carve-Out program to have those programs cover home care attendant services. Home care attendant services are personal care aide services, assistance with self-administration of medication, and assistance with nursing tasks. If the Secretary approves the waiver amendments, home care attendant services are to be available to consumers enrolled in the Ohio Home Care program or Ohio Transitions II Aging Carve-Out program to whom all of the following apply:

(1) The consumer has a medically determinable physical impairment that is expected to last for a continuous period of not less than 12 months and causes the consumer to require assistance with activities of daily living, self-care, and mobility, including assistance with self-administration of medication, the performance of nursing tasks, or both.

(2) In the case of a consumer who is at least 18 years of age, the consumer is mentally alert and is, or has an authorized representative[299] who is, capable of selecting, directing the actions of, and dismissing a home care attendant.

(3) In the case of a consumer under 18 years of age, the consumer has an authorized representative[300] who is capable of selecting, directing the actions of, and dismissing a home care attendant.

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[299] A consumer who is at least 18 is permitted by the act to select an individual to act on the consumer's behalf for purposes regarding home care attendant services. The individual selected is referred to as an authorized representative. (See "**Selection of authorized representative**" below.)

[300] The parent, custodian, or guardian of a consumer under 18 years of age is to serve as the consumer's authorized representative for purposes related to home care attendant services.

Requirements for home care attendant service providers

The act requires the ODJFS Director to enter into a Medicaid provider agreement with a qualifying individual to authorize the individual to provide home care attendant services to eligible consumers if the Secretary of Health and Human Services approves a waiver amendment regarding home care attendant services. To qualify to be a provider of home care attendant services, an individual would have to agree to comply with the act's requirements regarding home care attendant services, and any rules the Director adopts regarding the services, and provide the ODJFS Director evidence satisfactory to the Director of all of the following:

(1) That the individual either meets personnel qualifications specified in federal regulations for home health aides[301] or has successfully completed at least (a) a competency evaluation program or training and competency evaluation program approved or conducted by the Director of Health for nurse aides or (b) a training program approved by ODJFS that includes training in certain subjects[302] and provides training equivalent to a training and competency program approved or conducted by the Director of Health for nurse aides or meets requirements set in federal regulations.

(2) That the individual has obtained a certificate of completion of a course in first aid from a first aid course that (a) is not provided solely through the Internet, (b) includes hands-on training provided by a first aid instructor who is qualified to provide such training according to standards set in rules the ODJFS Director is authorized to adopt, and (c) requires the individual to demonstrate successfully that the individual has learned the first aid taught in the course.

(3) That the individual meets any other requirements for the Medicaid provider agreement specified in rules the ODJFS Director is authorized to adopt.

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[301] To meet the personnel qualifications specified in the federal regulations, an individual must have successfully completed (1) a state-established or other training program that meets certain requirements and a competency evaluation program or state licensure program meeting certain requirements or (2) a competency evaluation program or state licensure program meeting certain requirements. An individual is not considered to have completed a training and competency evaluation program or a competency evaluation program if, since the individual's most recent completion of the program, there has been a continuous period of 24 consecutive months during which the individual has not furnished home health services for compensation. (42 C.F.R. 484.4.)

[302] The training program must include training in at least all of the following: (1) basic home safety, (2) universal precautions for the prevention of disease transmission, including hand-washing and proper disposal of bodily waste and medical instruments that are sharp or may produce sharp pieces if broken, (3) personal care aide services, and (4) the labeling, counting, and storage requirements for schedule II, III, IV, and V medications.

An individual issued a Medicaid provider agreement to provide home care attendant services under the Ohio Home Care program or Ohio Transitions II Aging Carve-Out program is required to complete not less than 12 hours of in-service continuing education regarding health care attendant services each year. The individual must provide the ODJFS Director evidence satisfactory to the Director that the individual has satisfied this requirement. The evidence must be submitted to the ODJFS Director not later than the annual anniversary of the issuance of the individual's Medicaid provider agreement.

The act requires that a home care attendant maintain a clinical record for each consumer to whom the attendant provides home care attendant services. The clinical record must be maintained in a manner that protects the consumer's privacy. A home care attendant must also participate in a face-to-face visit every 90 days with each consumer to whom the attendant provides health care attendant services, the consumers' authorized representatives (if any), and a registered nurse. The purpose of the visit is to monitor the consumers' health and welfare. The registered nurse must agree to answer any questions that the home care attendant, consumer, or authorized representative has about consumer care needs, medications, and other issues. The home care attendant is required to document the activities of each visit in the consumer's clinical record with the registered nurse's assistance.

Assisting with nursing tasks and self-administration of medication

The act places restrictions on a home care attendant assisting a consumer with nursing tasks or self-administration of medication. A home care attendant may provide such assistance only after completing consumer-specific training in how to provide the assistance. The training must be provided by a physician or registered nurse who authorizes the assistance or the consumer or consumer's authorized representative in cooperation with the authorizing physician or registered nurse. A home care attendant may provide the assistance only after successfully demonstrating that the attendant has learned how to provide the assistance to the consumer if the consumer, consumer's authorized representative, or physician or registered nurse who authorizes the assistance requests the demonstration. Also, a home care attendant must comply with both of the following when assisting a consumer with nursing tasks or self-administration of medication:

(1) The written consent of the consumer or consumer's authorized representative;

(2) The written authorization of a physician or registered nurse, including a registered nurse who is an advanced practice nurse.

To consent to a home care attendant assisting a consumer with nursing tasks or self-administration of medication, the consumer or consumer's authorized representative must provide the ODJFS Director a written statement signed by the consumer or authorized representative under which the consumer or authorized representative consents to (1) having the attendant assist the consumer with the nursing tasks or self-administration of medication and (2) assuming responsibility for directing the attendant when the attendant assists the consumer with nursing tasks or self-administration of medication.

To authorize a home care attendant to assist a consumer with nursing tasks or self-administration of medication, a physician or registered nurse must provide the ODJFS Director a written statement signed by the physician or registered nurse that includes all of the following:

(1) The consumer's name and address;

(2) A description of the nursing tasks or self-administration of medication with which the attendant is to assist the consumer, including, in the case of assistance with self-administration of medication, the name and dosage of the medication;

(3) The times or intervals when the attendant is to assist the consumer with the self-administration of each dosage of the medication or nursing tasks;

(4) The dates the attendant is to begin and cease providing the assistance;

(5) A list of severe adverse reactions the attendant must report to the physician or registered nurse should the consumer experience one or more of the reactions;

(6) At least one telephone number at which the attendant can reach the physician or registered nurse in an emergency;

(7) Instructions the attendant is to follow when assisting the consumer with nursing tasks or self-administration of medication, including instructions for maintaining sterile conditions and for storage of task-related equipment and supplies;

(8) The physician or registered nurse's attestation that (a) the consumer or consumer's authorized representative has demonstrated to the physician or registered nurse the ability to direct the attendant and (b) the attendant has demonstrated the ability to provide the assistance and the consumer or authorized representative has indicated to the physician or registered nurse that the consumer or authorized representative is satisfied with the attendant's demonstration.

A physician or registered nurse, when authorizing a home care attendant to assist a consumer with nursing tasks or self-administration of medication, is not permitted to authorize the attendant to do any of the following:

(1) Perform a task that is outside the physician or registered nurse's scope of practice;

(2) Assist the consumer with the self-administration of a medication unless the medication is administered orally, topically, or via a gastrostomy tube[303] or jejunostomy tube;[304]

(3) Assist the consumer with the self-administration of a medication unless the medication is in its original container and the label attached to the container displays (a) the consumer's full name in print, (b) the medication's dispensing date, which must not be more than 12 months before the date the attendant assists the consumer with self-administration of medication, and (c) the exact dosage and means of administration that match the physician or registered nurse's authorization to the attendant;

(4) Assist the consumer with the self-administration of a schedule II, III, IV, or V medication unless (a) the medication has a warning label on its container, (b) the attendant counts the medication in the consumer's or authorized representative's presence when the medication is administered to the consumer and records the count on a form used for the count as specified in rules the act authorizes the ODJFS Director to adopt, (c) the attendant recounts the medication in the consumer's or authorized representative's presence at least monthly and reconciles the recount on a log located in the consumer's clinical record, and (d) the medication is stored separately from all other medications and is secured and locked at all times when not being administered to the consumer to prevent unauthorized access;

(5) Perform an intramuscular injection;

(6) Perform a subcutaneous injection unless it is for a routine dose of insulin;

(7) Program a pump used to deliver a medication unless the pump is used to deliver a routine dose of insulin;

(8) Insert, remove, or discontinue an intravenous access device;

(9) Engage in intravenous medication administration;

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[303] A gastrostomy tube is a percutaneously inserted catheter that terminates in the stomach.

[304] A jejunostomy tube is a percutaneously inserted catheter that terminates in the jejunum, which is the middle portion of the small intestine.

(10) Insert or initiate an infusion therapy;

(11) Perform a central line dressing change.

Use of a metered dose inhaler is permitted when assisting a consumer with self-administration of a medication that is administered orally. Use of an eye, ear, or nose drop or spray or a vaginal or rectal suppository is permitted when assisting a consumer with self-administration of a medication that is administered topically. Transdermal medication is included as a topical medication. A home care attendant may assist with the self-administration of a medication that is administered via a gastrostomy tube or jejunostomy tube only when a pre-programmed pump is used.

Practice of nursing without a license

The act provides that a home care attendant who provides home care attendant services to a consumer in accordance with a physician or registered nurse's authorization does not engage in the practice of nursing as a registered nurse or in the practice of nursing as a licensed practical nurse in violation of continuing law that generally prohibits persons from engaging in such activities without a license from the Board of Nursing. However, a consumer or consumer's authorized representative is required to report to the ODJFS Director if a home care attendant engages in the practice of nursing as a registered nurse or the practice of nursing as a licensed practical nurse beyond the physician or registered nurse's authorization. The ODJFS Director must forward a copy of each report to the Board of Nursing.

Selection of authorized representative

An adult consumer is permitted to select an individual to act on the consumer's behalf for purposes regarding home care attendant services. To make a selection, the consumer is to submit a written notice of the selection to the ODJFS Director. The notice must specifically identify the individual the consumer selects. The notice may limit what the authorized representative may do on the consumer's behalf. A consumer is prohibited from selecting the consumer's home care attendant to be the consumer's authorized representative.

Rules

The act requires the ODJFS Director to adopt rules as necessary for the implementation of the act's provisions regarding home care attendant services. The rules are to be adopted in accordance with the Administrative Procedure Act (R.C. Chapter 119.) and must be consistent with federal and state law.

Fiscal activities related to Medicaid waiver programs

(Section 309.30.90)

The act permits the Director of Budget and Management to seek Controlling Board approval to do any of the following in support of any home and community-based services Medicaid waiver program:

(1) Create new funds and account appropriation items associated with a unified long-term care budget;

(2) Transfer cash between funds used by affected agencies;

(3) Transfer appropriation between appropriation items within a fund and used by the same state agency.

Money Follows the Person Enhanced Reimbursement Fund

(Section 309.31.10)

Background

The Deficit Reduction Act of 2005 authorizes the United States Secretary of Health and Human Services to award grants to states for Money Follows the Person demonstration projects.[305] The projects are to be designed to achieve the following objectives with respect to institutional and home and community-based long-term care services under a state's Medicaid program:

(1) Increase the use of home and community-based, rather than institutional, long-term care services;

(2) Eliminate barriers or mechanisms that prevent or restrict the flexible use of Medicaid funds to enable Medicaid-eligible individuals to receive support for appropriate and necessary long-term services in the settings of their choice;

(3) Increase the ability of a state's Medicaid program to assure continued provision of home and community-based long-term care services to eligible individuals who choose to transition from an institution to a community setting;

(4) Ensure that procedures are in place to provide quality assurance for eligible individuals receiving Medicaid home and community-based services and to provide for continuous quality improvement in such services.

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[305] Section 6071 of the Deficit Reduction Act of 2005, Public Law No. 109-171.

The Deficit Reduction Act includes federal appropriations for Money Follows the Person grants through federal fiscal year 2011 (ending September 30, 2011). A state seeking a grant is required to apply to the Secretary. ODJFS submitted an application for a grant in November 2006. Ohio learned in January 2007 that its application was approved.

The act

The act creates the Money Follows the Person Enhanced Reimbursement Fund in the state treasury. This is a continuation of the Fund as created by Am. Sub. H.B. 562 of the 127th General Assembly. The federal payments made to Ohio under federal law governing Money Follows the Person demonstration projects are to be deposited in the Fund. ODJFS is required to use the money in the Fund for system reform activities related to the demonstration project.

Community behavioral health boards' administrative costs (PARTIALLY VETOED)

(Section 309.32.40)

The act requires the ODJFS Director to seek federal approval to establish a system under which boards of alcohol, drug addiction, and mental health services, community mental health boards, and alcohol and drug addiction services boards (i.e., community behavioral health boards) obtain federal financial participation for the allowable administrative activities the boards perform in the administration of the Medicaid program. The Governor vetoed a provision that would have required the ODJFS Director to seek federal approval not later than October 1, 2009. The ODJFS Director must implement the system on receipt of federal approval. The ODJFS Director is required by the act to work with the Directors of Alcohol and Drug Addiction Services and Mental Health and representatives of community behavioral health boards when implementing this provision of the act.

Funding of Medicaid-covered behavioral health services (VETOED)

(Section 309.32.43)

The Department of Mental Health, Department of Alcohol and Drug Addiction Services, and community behavioral health boards are required to pay the nonfederal share of any Medicaid payment to a provider for Medicaid services administered by the Department of Mental Health or Department of Alcohol and Drug Addiction Services pursuant to an interagency agreement with ODJFS. The Governor vetoed a provision that would have required a community behavioral health board to use state funds provided to the board for the purpose of funding community behavioral health services

to make the required payments. The vetoed provision would have permitted a community behavioral health board to use money available to the board that is raised by a county tax levy to make such a payment if using the money was consistent with the purpose for which the tax was levied.

The Medicaid program is required to cover certain mental health services provided by community mental health facilities.[306] The comprehensive annual plan must certify the availability of sufficient unencumbered community mental health state subsidy and local funds to match federal Medicaid reimbursement funds earned by community mental health facilities. The Governor vetoed a provision that would have provided that the comprehensive annual plan[307] was permitted, rather than required, to certify the availability of sufficient unencumbered community mental health local funds.

Hospital assessments

(R.C. 5112.40, 5112.41, 5112.42, 5112.43, 5112.44, 5112.45, 5112.46, 5112.47, and 5112.48; Sections 125.10 and 309.30.17)

The act imposes an annual assessment on hospitals. A hospital, other than a federal hospital and a hospital that does not charge any of its patients for its services, is to be subject to the assessment if any of the following apply to the hospital:

(1) It is registered with the Department of Health as a general medical and surgical hospital or a pediatric general hospital and provides inpatient hospital services.

(2) It is recognized under the Medicare program as a cancer hospital and is exempt from the Medicare prospective payment system.

(3) It is a psychiatric hospital licensed by the Department of Mental Health.

The assessment is in addition to the assessment imposed under the Hospital Care Assurance Program (HCAP).[308]

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[306] A community mental health facility is a community mental health facility with a quality assurance program accredited by the Joint Commission on Accreditation of Healthcare Organizations or that is certified by the Department of Mental Health or ODJFS.

[307] Continuing law does not specify what is meant by the "comprehensive annual plan."

[308] See "**Hospital Care Assurance Program (HCAP)**" below for a discussion of that program.

Amount of assessment

The amount of a hospital's assessment for a year is to equal a percentage of the hospital's total facility costs for a certain period of time. A hospital's total facility costs are the hospital's total costs for all care provided to all patients, including the direct, indirect, and overhead costs to the hospital of all services, supplies, equipment, and capital related to the care of patients, regardless of whether patients are enrolled in a health insuring corporation. However, total facility costs exclude all of the following costs: skilled nursing services provided in distinct-part nursing facility units; home health services; hospice services; ambulance services; renting durable medical equipment; and selling durable medical equipment.[309] And, the ODJFS Director is permitted to adopt rules to exclude any of the following from a hospital's total facility costs for the purpose of the assessment: (1) a hospital's costs associated with providing care to Medicaid recipients, Medicare beneficiaries, Disability Financial Assistance Program recipients, Disability Medical Assistance Program recipients,[310] recipients of the Program for Medically Handicapped Children, and recipients of services provided under the federal Maternal and Child Health Services Block Grant and (2) any other category of hospital costs the Director deems appropriate under federal law and regulations governing the Medicaid program. The amount of a hospital's total facility costs is to be derived from cost-reporting data for the hospital submitted to ODJFS for purposes of HCAP. The cost-reporting data used to determine a hospital's assessment is subject to the same type of adjustments made to the data under HCAP.

The percentage of a hospital's total facility costs that is to be the hospital's assessment for the first year of the assessment is 1.52%. The percentage to be used for the second and successive years is 1.61% unless ODJFS obtains federal approval to establish a tiered assessment. The period of time for which a hospital's total facility costs are counted for purposes of the assessment is the hospital's cost reporting period[311] that ends in the state fiscal year that ends in the federal fiscal year that precedes the federal fiscal year that precedes the year for which the assessment is imposed. For the first assessment to be imposed, this means that the period of time for which a hospital's total facility costs is counted will be the period covered by its cost reporting period that ended in state fiscal year 2008 (July 1, 2007, to June 30, 2008). This is because state fiscal year 2008 ended during federal fiscal year 2008 (October 1, 2007, to November 30, 2008),

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[309] These costs are to be shown on cost-reporting data ODJFS is to use for purposes of determining the hospital's assessment.

[310] The act abolishes the Disability Medical Assistance Program. (See "**Disability Medical Assistance Program**" below.)

[311] A cost reporting period is the period of time used by a hospital in reporting costs for purposes of the Medicare program.

federal fiscal year 2008 preceded federal fiscal year 2009, and federal fiscal year 2009 precedes the year (i.e., the period from October 1, 2009, to November 30, 2010) for which the first assessment is to be imposed.

Notice of assessments

ODJFS is required to mail to each hospital the preliminary determination of the amount that the hospital is assessed for a year. The notice must be sent by certified mail, return receipt requested before or during each assessment program year. An assessment program year is the 12-month period beginning the first day of October of a calendar year and ending that last day of September of the following calendar year.

Unless a hospital requests that ODJFS reconsider the preliminary determination, the preliminary determination becomes the final determination 15 days after the preliminary determination is mailed to the hospital. To request a reconsideration, a hospital must submit to ODJFS a written request not later than 14 days after the preliminary determination is mailed. The request must be accompanied by written materials setting forth the basis for the reconsideration. On receipt of the timely request, ODJFS must 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.

ODJFS must mail to each hospital a written notice of the final determination of its assessment. A hospital may appeal the final determination to the Franklin County Court of Common Pleas. While a judicial appeal is pending, the hospital must pay any amount of its assessment that is not in dispute.

Paying assessments

Unless the ODJFS Director adopts rules establishing a different payment schedule, each hospital is to pay its assessment as follows:

(1) 28% of a hospital's assessment for a year is due on the last business day of October;

(2) 31% is due on the last business day of February;

(3) 41% is due on the last day of May.

Hospital audits

The act permits ODJFS to audit a hospital to ensure that the hospital properly pays the amount it is assessed. ODJFS must take action to recover from a hospital any amount the audit reveals that the hospital should have paid but did not pay.

Hospital Assessment Fund

The act creates in the state treasury the Hospital Assessment Fund. All installment payments that hospitals make in paying the assessment and all recoveries ODJFS makes pursuant to an assessment-related audit are to be deposited into the fund. The fund's investment earnings are to be credited to the fund. ODJFS is required to use money in the fund to pay for costs of the Medicaid program, including the program's administrative costs.

Hospital Inpatient and Outpatient Supplemental UPL Program

The ODJFS Director is required by the act to seek federal approval to create the Hospital Inpatient and Outpatient Supplemental Upper Payment Limit Program. If federal approval is obtained, the program is to make supplemental Medicaid payments to hospitals for Medicaid-covered inpatient and outpatient services. Children's hospitals are excluded from the program. A portion of the money raised by the hospital assessment, and federal matching funds available for the program, are to be used for the program. The act specifies that 9.16% of the money raised by the hospital assessment for the first year of the assessment is to be used for the program. Of the money raised by the hospital assessment for the second year, 10.29% is to be used for the program.

Federal issues

Federal law places restrictions on federal financial participation for the Medicaid program when a state receives revenue generated by health-care related taxes.[312] A health-care related tax is a licensing fee, assessment, or other mandatory payment that is related to (1) health care items or services, (2) the provision of, or the authority to provide, health care items or services, or (3) the payment for health care items or services.[313] The federal financial participation that a state receives for its Medicaid program is to be reduced by the sum of any revenue received during a fiscal year from health-care related taxes that are deemed impermissible.[314] To avoid being deemed

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[312] 42 U.S.C. 1396b(w).

[313] 42 C.F.R. 433.55.

[314] 42 U.S.C. 1396b(w)(1)(A).

impermissible, a health-care related tax must meet three requirements: it must be broad based, it must be uniformly imposed, and it cannot violate a hold harmless prohibition.[315] A state may obtain a federal waiver of aspects of the broad-based and uniform requirements but not the hold harmless prohibition.[316]

The act requires the ODJFS Director to implement the hospital assessment in a manner that does not cause a reduction in federal financial participation for the Medicaid program. However, if the United States Secretary of Health and Human Services determines that the hospital assessment is an impermissible health care-related tax under federal Medicaid law, the ODJFS Director is required to take all necessary actions to cease implementation of the assessment and the Hospital Inpatient and Outpatient Supplemental Upper Payment Limit Program. Additionally, the ODJFS Director must promptly refund to each hospital the amount of money in the Hospital Assessment Fund at the time the refund is to be made that the hospital paid, plus any corresponding investment earnings on that amount.

Rules

The act authorizes the ODJFS Director to adopt, amend, and rescind rules as necessary to implement the hospital assessment. The ODJFS Director is to follow the Administrative Procedure Act (R.C. Chapter 119.) when adopting, amending, or rescinding the rules.

Sunset

The act repeals the law governing the hospital assessment (i.e., sunsets) effective October 1, 2011.

Cost outlier and supplemental payments to children's hospitals

(Section 309.30.15)

Background

Ohio pays hospitals for Medicaid inpatient admissions under a prospective payment system that includes pre-established, fixed amounts for each admission based on diagnosis-related group (DRG) codes. ODJFS makes additional payments to hospitals, called "cost outlier payments" and "exceptional outlier payments," to supplement base DRG payments for certain high- and extraordinarily high-cost inpatient admissions. The outlier payment policy is intended to promote access to care

[315] 42 C.F.R. 433.68(b).

[316] 42 U.S.C. 1396b(w)(3)(E) and 42 C.F.R. 433.72(b)(3).

for patients with more costly claims.[317] The reimbursement methodology for cost outlier and exceptional outlier cases is in an administrative rule adopted by the ODJFS Director (Ohio Administrative Code 5101:3-2-07.9).

The act

Am. Sub. H.B. 119 of the 127th General Assembly, the biennial appropriations act, created an alternative outlier payment methodology for children's hospitals during fiscal years 2008 and 2009. The act re-establishes this methodology for fiscal years 2010 and 2011.

Under the act, notwithstanding continuing law's cost outlier payment, the ODJFS Director must pay the full cost (100%) of Medicaid cost outlier claims for inpatient admissions at children's hospitals[318] that are less than a threshold amount ($443,463 in 2002, adjusted annually for inflation), rather than just 85% of the cost, as under continuing law. The act requires that the practice of paying the full cost of such claims cease and revert back to 85% of the estimated cost when the difference between the total amount the Director has paid at full cost for the outlier claims and the total amount the Director would have paid children's hospitals for such claims at the 85% level exceeds the sum of the state funds made available for the additional cost outlier payments in each fiscal year and the corresponding federal match. The amount of state funds made available for this purpose for fiscal year 2010 is $6 million plus an additional $4.4 million from funds in the Hospital Assessment Fund.[319] In fiscal year 2011, a total of $10 million of state funds is made available for this purpose, of which $4 million is to come from funds in the Hospital Assessment Fund.

In addition, the act requires the ODJFS Director, for fiscal years 2010 and 2011, to make supplemental Medicaid payments to children's hospitals for inpatient services under a program modeled after the program that ODJFS was required to create under

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[317] U.S. Department of Health and Human Services, Office of Inspector General. *Review of Ohio's Medicaid Hospital Outlier Payments for State Fiscal Years 2000 through 2003* (March 2006) (last visited April 10, 2009), available at <http://oig.hhs.gov/oas/reports/region5/50400064.pdf>.

[318] The act defines "children's hospital" as a hospital that primarily serves patients 18 years of age and younger and is excluded from Medicare prospective payment in accordance with federal regulations (42 U.S.C. 412.23(d)).

Under continuing law, the cost for an inpatient case is determined by multiplying the allowed charges for the claim by the hospital-specific cost-to-charge ratio. As directed by paragraph (A)(6) of O.A.C. 5101:3-2-07.9, ODJFS pays the full estimated cost (100%) for a case where the cost exceeds an amount ($443,463) that is adjusted annually for inflation. For cases where the cost does not meet or is equal to $443,463 adjusted annually for inflation, ODJFS pays 85% of the estimated cost.

[319] See "**Hospital assessments**," above.

Section 206.66.79 of Am. Sub. H.B. 66 of the 126th General Assembly when the difference between the total amount the Director has paid at full cost for Medicaid outlier claims and the total amount the Director would have paid at the 85% level for the claims does not require the expenditure of all state and federal funds made available for the additional cost outlier payments in the applicable fiscal year. The program may be the same as the program the Director used for making supplemental payments to children's hospitals for fiscal years 2008 and 2009 under Am. Sub. H.B. 119 of the 127th General Assembly.

Further, the act prohibits the ODJFS Director from adopting, amending, or rescinding any rules that would result in decreasing the amount paid to children's hospitals for cost outlier claims.

Increase in Medicaid rates for hospital inpatient and outpatient services

(Section 309.30.73)

The act requires the ODJFS Director to amend Medicaid rules as necessary to increase, for the period beginning October 1, 2009, and ending June 30, 2011, the Medicaid reimbursement rates for Medicaid-covered hospital inpatient and outpatient services that are paid under a prospective payment system. The rates are to be increased to rates that result in an amount that is 5% higher than the amount resulting from the rates in effect on September 30, 2009.

Postponement of recalibration for hospitals

(Section 309.30.18)

The ODJFS Director has adopted rules regarding a Medicaid prospective payment system for hospital inpatient services. Included in the rules is a provision regarding weights that are applied in setting rates under the payment system. One of the rules requires, effective for discharges on or after January 1, 2010, and every calendar year thereafter, that relative weights be determined on an annual basis.[320] The act requires the ODJFS Director to amend this rule to postpone to January 1, 2012, the recalibration that otherwise would occur on January 1, 2010, and to postpone to January 1, 2013, the recalibration that otherwise would occur on January 1, 2011.

[320] O.A.C. 5101:3-2-07.3.

Reduction in Medicaid rates for community provider services

(Section 309.30.75)

The act requires the ODJFS Director to amend rules governing Medicaid services as necessary to reduce, effective January 1, 2010, the Medicaid reimbursement rates for certain Medicaid-covered services to rates that result in an amount that is at least 3% lower than the amount resulting from the rates in effect on December 31, 2009. The rate reduction applies to the following services:

(1) Advanced practice nursing services;

(2) Ambulatory surgery center services;

(3) Chiropractic services;

(4) Durable medical equipment;

(5) Home health services;

(6) Ambulance and ambulette services;

(7) Physician services;

(8) Physical therapy services;

(9) Podiatry services;

(10) Private duty nursing services;

(11) Vision services;

(12) Clinic services, other than rural health clinics and federally qualified health centers;

(13) Occupational therapy services;

(14) Dental services;

(15) Services provided under a Medicaid waiver program of home and community-based services administered by ODJFS;

(16) Other services the ODJFS Director identifies, other than services for which an Ohio statute sets the Medicaid reimbursement rate.

Medicaid dispensing fee for noncompounded drugs

(Section 309.30.76)

The act sets the Medicaid dispensing fee for each noncompounded drug covered by the Medicaid program at $1.80 for the period beginning January 1, 2010, and ending June 30, 2011.

Durable medical equipment study

(Section 309.32.70)

The act requires ODJFS to prepare and submit a report on expenditures for durable medical equipment by the Medicaid program to the Speaker and Minority Leader of the House of Representatives and the President and Minority Leader of the Senate. ODJFS is to do all of the following in preparing the report:

(1) Identify the types of durable medical equipment that represent, in total, greater than 50% of the state's total Medicaid expenditures for durable medical equipment;

(2) Consult with durable medical equipment suppliers to identify cost-saving strategies;

(3) Evaluate opportunities for competitive purchasing procedures for durable medical equipment.

The report is to include recommendations on strategies to reduce the Medicaid program's costs for durable medical equipment and must be submitted not later than July 1, 2010.

Prompt Payment Policy Workgroup (VETOED)

(Section 751.30)

The Governor vetoed a provision that would have created the Prompt Payment Policy Workgroup and given the Workgroup the following duties: (1) to recommend one set of regulations to govern prompt payment policies for Medicaid managed care plans, (2) to research and analyze prompt payment policies related to aged medical claims within the health insurance industry and the Medicaid program, (3) to review general payment rules, payment policies related to electronic and paper claims, definitions of clean and unclean claims, late payment penalties, auditing requirements, and any other issues related to Medicaid prompt payment policy identified by the Workgroup, and (4) to review statistical data on the compliance rates of current policies.

The Workgroup would have been made up of the following members: (1) one representative of the Office of Budget and Management, appointed by the Director of Budget and Management, (2) three representatives of the Department of Insurance, appointed by the Superintendent of Insurance, (3) four representatives of the Office of Ohio Health Plans in ODJFS, appointed by the ODJFS Director, (4) two representatives of Ohio's Medicaid managed care plans, appointed by the Executive Director of Ohio's Care Coordination Plans, (5) two representatives from the community of provider associations, one appointed by the Speaker of the House of Representatives and one appointed by the President of the Senate, (6) two members of the Ohio House of Representatives, one appointed by the Speaker of the House of Representatives and one appointed by the Minority Leader, and (7) two members of the Ohio Senate, one appointed by the President of the Senate and one appointed by the Minority Leader.

The act would have designated the ODJFS Director, or the Director's designee, as chairperson of the Workgroup and specified that members of the Workgroup are to serve without compensation, except to the extent that serving on the Workgroup is considered part of the members' regular employment duties.

Not later than February 1, 2010, the act would have required the Workgroup to submit a report containing prompt payment policy recommendations for Ohio's Medicaid program to the Governor and the majority and minority leadership in both Houses of the Ohio General Assembly. The Workgroup would have ceased to exist on February 28, 2010.

VII. Hospital Care Assurance Program (HCAP)

Under the Hospital Care Assurance Program (HCAP), (1) hospitals are annually assessed an amount based on their total facility costs and (2) government hospitals make annual intergovernmental transfers to ODJFS. ODJFS distributes to hospitals money generated by the assessments and intergovernmental transfers along with federal matching funds generated by the assessments and transfers. A hospital compensated under HCAP must provide, without charge, basic, medically necessary, hospital-level services to Ohio residents who are not recipients of Medicare or Medicaid and whose income does not exceed the federal poverty guidelines.

Delay of termination of HCAP

(Sections 640.10 and 640.11)

Under prior law, HCAP was scheduled to terminate on October 16, 2009. The act delays the termination date of the program until October 16, 2011.

VIII. Children's Health Insurance Program

The Children's Health Insurance Program (CHIP) is a health-care program for uninsured, low-income children. It is funded with federal, state, and county funds and was established by Congress in 1997 as Title XXI of the Social Security Act. ODJFS administers the program. Federal and state law permits ODJFS to implement CHIP as a separate program, as part of the Medicaid program, or a combination of both. ODJFS has chosen to implement CHIP as part of the Medicaid program. State law provides for CHIP to have three parts. CHIP Part I covers uninsured individuals under age 19 with family incomes not exceeding 150% of the federal poverty guidelines. CHIP Part II covers uninsured individuals under age 19 with family incomes above 150% but not exceeding 200% of the federal poverty guidelines. CHIP Part III is to cover individuals under age 19 with family incomes above 200% but not exceeding 300% of the federal poverty guidelines. ODJFS has not implemented CHIP Part III to date.

School-based health centers as CHIP providers (VETOED)

(R.C. 5101.504, 5101.5110, and 5101.5210 (primary); 173.71, 5101.26, 5101.50, 5101.5111, and 5101.571)

The federal "Children's Health Insurance Program Reauthorization Act of 2009"[321] provided that nothing in federal law is to be construed to limit the ability of states to furnish health assistance services covered under the Children's Health Insurance Program through school-based health centers.[322] The Governor vetoed a provision that would have specified that a school-based health center was permitted to furnish health assistance services that CHIP Part I, II, or III covers if the center met the requirements applicable to other providers providing those services. The vetoed provision would have permitted the ODJFS Director to adopt rules pertaining to the billing, reimbursement, and data collection for school-based health centers.

IX. Children's Buy-In Program

The Children's Buy-In Program is a state-funded health care program for individuals under 19 years of age who have countable family income exceeding a certain amount and meet other eligibility requirements, including requirements

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[321] Public Law 111-3.

[322] Under federal law, a "school-based health center" is defined as a health clinic that (a) is located in or near a school facility of a school district or board or of an Indian tribe or tribal organization, (b) is organized through school, community, and health provider relationships, (c) is administered by a sponsoring facility, (d) provides through health professionals primary health services to children in accordance with state and local law, and (e) satisfies other requirements as a state may establish for the operation of a health clinic (42 U.S.C. 1397jj (c)(9).

regarding access to creditable coverage. Individuals participating in the program are subject to premiums and co-payments.

Eligibility requirements

(R.C. 5101.5212 and 5101.5213)

Prior law provided that an individual's countable family income must have exceeded 250% of the federal poverty guidelines to meet the income requirement for the Children's Buy-In Program. The act raises this to 300% of the federal poverty guidelines.

Other eligibility requirements for the Children's Buy-In Program concern access to creditable coverage. "Creditable coverage" is a federal term meaning all of the following: (1) a group health plan, (2) health insurance coverage, (3) Medicare parts A and B, (4) Medicaid, (5) medical care available through the United States Armed Forces (10 U.S.C. Chapter 55), (6) a medical care program of the Indian Health Service or of a tribal organization, (7) a state health benefits risk pool, (8) health insurance available to federal employees (5 U.S.C. Chapter 89), (9) a public health plan, or (10) a health plan available under the Peace Corps (22 U.S.C. 2504(e)). For purposes of state law governing the Children's Buy-In Program, medical assistance available under the Children's Buy-In Program or the Program for Medically Handicapped Children is not considered to be creditable coverage.

The act revises the eligibility requirements for the Children's Buy-In Program regarding access to creditable coverage. Under prior law, an individual was ineligible for the program unless the individual had not had creditable coverage for at least six months before enrolling in the program, unless the individual lost the only creditable coverage available to the individual because the individual exhausted a lifetime benefit limitation. Also, one or more of the following had to apply to the individual:

(1) The individual must have been unable to obtain creditable coverage due to a preexisting condition of the individual;

(2) The individual must have lost the only creditable coverage available to the individual because the individual exhausted a lifetime benefit limitation;

(3) The premium for the only creditable coverage available to the individual must have been greater than 200% of the premium applicable to the individual under the Children's Buy-In Program;

(4) The individual must have participated in the Program for Medically Handicapped Children.

Instead of those eligibility requirements regarding access to creditable coverage, the act provides that an individual must not have had creditable coverage for at least three, rather than six, months before enrolling in the Children's Buy-In Program. And, the three-month requirement does not apply if at least one of the requirements from Column I and at least one of the requirements from Column II apply:

Column I	Column II
The individual's parents must be involuntarily unemployed.	The cost of the least expensive creditable coverage available to the individual must be greater than 10% of the individual's countable family income.
At least one of the individual's parents must be unable to find work due to a disabling condition.	The premium for the creditable coverage with the lowest premium available to the individual must be greater than 150% of the premium applicable to the individual under the Children's Buy-In Program.
At least one of the individual's parents must have involuntarily lost creditable coverage for the individual.	The individual must be unable to obtain creditable coverage due to a preexisting condition of the individual.
The individual must have creditable coverage under COBRA continuation coverage.	The individual must have lost the only creditable coverage available to the individual because the individual exhausted a lifetime benefit limitation.
	The individual must participate in the Program for Medically Handicapped Children.

X. Disability Medical Assistance Program

Disability Medical Assistance Program abolished

(R.C. 5115.10 to 5115.14 (primary), 9.24, 127.16, 131.23, 173.71, 173.76, 323.01, 329.04, 329.051, 2305.234, 2744.05, 3111.04, 3119.54, 3702.74, 4123.27, 4731.65, 4731.71, 5101.16, 5101.181, 5101.26, 5101.31, 5101.36, 5101.571, 5101.58, 5112.03, 5112.08, 5112.17, 5115.20, 5115.22, and 5115.23)

Under former law, ODJFS was required to establish and administer the Disability Medical Assistance Program, a state-funded program that generally provided medical assistance to persons who were medication dependent and not eligible for Medicaid. For a person to be considered "medication dependent," a licensed physician had to

certify that the person was subject to ongoing treatment for a chronic medical condition of sufficient severity (including severe pain) such that the absence of continuous prescription medication could reasonably be expected to result in placing the patient's health in serious jeopardy, serious impairment to bodily functions, serious dysfunction of any bodily organ or part, or death. The medical condition could include physical or mental impairment and must have lasted or could have been expected to last for a continuous period of at least 12 months. In addition to being medication dependent and ineligible for Medicaid, the applicant had to meet certain residency, income, and citizenship requirements. Covered services included certain inpatient and outpatient physician services, prescription drugs, certain medical supplies, certain laboratory and x-ray services, and dental extractions and related x-rays.[323]

The act abolishes the Disability Medical Assistance Program.

XI. Supplemental Nutrition Assistance Program (Food Stamp Program)

Name of Food Stamp Program changed

(R.C. 176.05, 329.042, 329.06, 955.201, 2913.46, 3119.01, 3121.898, 3123.952, 3770.05, 4141.162, 5101.11, 5101.16, 5101.162, 5101.33, 5101.47, 5101.54, 5101.541, 5101.542, 5101.544, 5101.84, 5502.01, 5502.14, 5502.15, and 5739.02; Section 309.40.20)

The Food, Conservation, and Energy Act of 2008 (Pub. Law 110-246) renamed the Food Stamp Program the Supplemental Nutrition Assistance Program (SNAP). The act also renamed the federal law that authorizes the program. Previously, the federal law was called the Food Stamp Act of 1977. Now it is called the Food and Nutrition Act of 2008.

The act makes corresponding changes to state law. References to the Food Stamp Program are replaced with references to SNAP and references to the Food Stamp Act of 1977 are replaced with references to the Food and Nutrition Act of 2008. References to food stamps and food stamp coupons are replaced with references to SNAP benefits. However, the act permits the ODJFS Director to refer to the program as the Food Stamp Program or the Food Assistance Program in rules and documents of ODJFS. ODJFS is not required to amend rules regarding the program to change its name to SNAP.

[323] O.A.C. 5101:1-42-01 and 5101:3-23-01.

Issuance of SNAP benefits

(R.C. 5101.54)

Prior law required that when a household was determined to be in immediate need of food assistance, the document referred to as the "authorization to participate card" (the card that shows the face value of the benefits an eligible household is entitled to receive) had to be issued immediately upon certification. A CDJFS staff member was required to personally hand the card to the member of the household in whose name application was made or that member's authorized representative. The act requires instead that, immediately following a CDJFS's certification that a household determined to be in immediate need of nutrition assistance is eligible for SNAP, ODJFS must provide for the household to be sent by regular United States mail an electronic benefit transfer card containing the amount of benefits the household is eligible to receive. The card must be sent to the member of the household in whose name application for the program was made or that member's authorized representative.

The act eliminates law that provides that food stamps and any document necessary to obtain food stamps are, except while in the custody of the United States Postal Service, the property of ODJFS from the time ODJFS receives the food stamps from the federal agency responsible for their delivery until they are received by the household entitled to receive them or by that household's authorized representative.

XII. Workforce Development

(R.C. 6301.03)

Continuing law requires all expenditures for activities funded by the Workforce Investment Act (29 U.S.C. § 2801, *et seq.*) to be made from the workforce development funds established by local areas and subrecipients of local areas. The act includes reimbursements to a county public assistance fund for expenditures made for activities funded by the Workforce Investment Act in the expenditures that must be made from the local workforce development funds.

XIII. Unemployment Compensation

Reduction of unemployment compensation benefits

(R.C. 4141.01 and 4141.31)

Under continuing law, an individual is "partially unemployed" in any week if, due to involuntary loss of work, the total remuneration payable to the individual for that week is less than the individual's weekly benefit amount. The Director of Job and Family Services calculates unemployment compensation benefits for partial

unemployment in accordance with a formula specified in continuing law (R.C. 4141.30, not in the act). Additionally, continuing law reduces unemployment compensation benefits otherwise payable for any week by the amount of remuneration or other payments a claimant receives with respect to such week as follows:

- Remuneration in lieu of notice;
- Compensation for wage loss under Ohio's Workers' Compensation Law (R.C. 4123.56, not in the act) or a similar provision under the workers' compensation law of any state or the United States;
- Payments in the form of retirement, or pension allowances as provided under the Unemployment Compensation Law (R.C. 4141.312, not in the act);
- Except for specified types of military benefits, remuneration in the form of separation or termination pay paid to an employee at the time of the employee's separation from employment;
- Vacation pay or allowance payable under the terms of a labor-management contract or agreement, or other contract of hire, which payments are allocated to designated weeks.

The act adds an additional reason by which an individual's unemployment compensation benefits may be reduced as described above: the determinable value of cost savings days. Under the act, a "cost savings day" means any unpaid day off from work in which employees continue to accrue employee benefits which have a determinable value including, but not limited to, vacation, pension contribution, sick time, and life and health insurance. Additionally, under the act, remuneration for personal services includes cost savings days, as defined under the act, for which employees continue to accrue employee benefits that have a determinable value. Any unemployment compensation benefits that may be payable as a result of cost savings days must be reduced as provided under the act and continuing law. These provisions appear to apply to both private and public sector employees.

JOINT LEGISLATIVE ETHICS COMMITTEE (JLE)

- Creates the Joint Legislative Ethics Committee Investigative Fund and requires that all receipts that the Joint Legislative Ethics Committee receives from the payment of financial disclosure statement filing fees be deposited into the fund.

- Requires a state agency that employs an officer or employee who actively advocates in a fiduciary capacity as a representative of that agency to pay the officer's or employee's registration fee as a legislative agent.

Creation of the Joint Legislative Ethics Committee Investigative Fund

(R.C. 101.34 and 102.02)

Prior law required that the Joint Legislative Ethics Committee (JLEC) deposit into the state General Revenue Fund all money it receives as regular and late filing fees from public officers and employees who must file annual financial disclosure statements with JLEC. The act requires instead that JLEC deposit these fees into the Joint Legislative Ethics Committee Investigative Fund, which the act creates in the state treasury. Money in the fund must be used solely for the operations of JLEC in conducting investigations. Investment earnings of the fund must be credited to the fund.

Payment of legislative agent registration fees by the state agency that employs legislative agents

(R.C. 101.72)

Continuing law generally requires the payment of a registration fee of $25 for filing an initial registration statement with JLEC as a legislative agent, but not if the registrant is an officer or employee of a state agency who actively advocates in a fiduciary capacity as a representative of that state agency. The act eliminates this exemption from paying the registration fee, but requires the state agency that employs the officer or employee who actively advocates in a fiduciary capacity as a representative of that state agency to pay the officer's or employee's registration fee.

JUDICIARY, SUPREME COURT (JSC)

- Specifies that scheduled, increased salaries are payable to the Supreme Court Chief Justice and justices, appeals court judges, common pleas court judges, full- and part-time municipal court judges, and county court judges, not each calendar year, but each year.

- Eliminates the requirement that the Supreme Court reimburse a county for the compensation of a substitute municipal court judge who is not appointed by the Chief Justice of the Supreme Court and for the compensation of a substitute county court judge.

- Changes the pay period for the clerks of municipal courts other than those of Auglaize, Brown, Hamilton, Holmes, Lorain, Portage, and Wayne counties to either semimonthly or biweekly, as determined by the payroll administrator.

- Provides that, as of September 29, 2009, the judge of the Lorain County Court of Common Pleas, Division of Domestic Relations, whose term began on February 9, 2009, is the probate judge of the Lorain County Probate Court and that the successors to that judge must be elected as the judge of the probate division of that court.

- Provides that in Lorain County, all proceedings that are within the jurisdiction of the Lorain County Probate Court that are pending before a judge of the Domestic Relations Division of the Lorain County Court of Common Pleas on the effective date of the act will remain with that judge of the Domestic Relations Division of the Lorain County Court of Common Pleas.

- Provides that in Lorain County, all proceedings that are within the jurisdiction of the Domestic Relations Division of the Lorain County Court of Common Pleas that are pending before the probate judge of the Lorain County Probate Court on September 29, 2009, remain with that probate judge of the Lorain County Probate Court.

- Increases from $40 to $100 the filing fee charged by the Clerk of the Supreme Court for each case entered upon its docket.

- Provides that the filing fees so charged and collected are in full for each case filed in the Supreme Court under the Rules of Practice of the Supreme Court, instead of listing the types of cases or motions filed and the types of court functions covered by the fees under prior law.

- Precludes charging a filing fee or security deposit to an indigent party upon the Supreme Court's determination of indigency pursuant to the Rules of Practice of the Supreme Court.

- Repeals provisions specifically exempting a prosecutor under specified circumstances from being charged the filing fee upon its motion to dismiss an indigent defendant's appeal for lack of prosecution.

- Requests the Supreme Court to modify its Rules of Practice regarding filing fees and security deposits to be consistent with the act's provisions.

- Provides that the additional filing fees collected by the clerks of the municipal court, county court, and court of common pleas in each new civil action or proceeding for the charitable public purpose of providing financial assistance to legal aid societies

that operate within the state and to support the office of the State Public Defender and that must be transmitted to the State Treasurer do not include an amount equal to up to 1% of those moneys retained to cover administrative costs.

- Provides that if the court fails to transmit to the State Treasurer the moneys the court collects for the additional filing fees described in the preceding dot point in a manner prescribed by the State Treasurer or the Ohio Legal Assistance Foundation the court must forfeit the moneys the court retains to cover administrative costs and must transmit to the State Treasurer all moneys collected, including the forfeited amount retained for administrative costs, for deposit in the Legal Aid Fund.

- Expands the definition of "peace officer" that applies to the prohibition against impersonating a peace officer and the provision allowing a peace officer to file a request with the BMV to prohibit the disclosure of the officer's residence address contained in BMV motor vehicle records.

- Expands the definition of "law enforcement officer" that applies to the prohibition against an insurer considering the circumstance that an applicant or policyholder has been involved in a motor vehicle accident while in the pursuit of the applicant's or policyholder's official duties as a law enforcement officer, and applies that prohibition to an investigator of BCII.

- Would have allowed a gasoline purchase card with a value not exceeding $10 to be awarded as a prize for playing a skill-based amusement machine even if the machine was not located at a gasoline station or if the card was not redeemable at the location of, or at the time of playing, the machine (VETOED).

- Changes from mandatory to permissive the requirement that the cost of electronic monitoring for indigents subject to a protection order under R.C. 2903.14 be paid out of the Reparations Fund, limits the amount that may be paid out of the Fund for such purposes, and authorizes the Attorney General to adopt rules governing these payments.

- Would have specified that the *perfection* of an appeal, *including an administrative-related appeal,* does not operate as a stay of execution until a stay of execution has been obtained pursuant to the Rules of Appellate Procedure or in another applicable manner, and a supersedeas bond is executed under continuing law subject to the next dot point (VETOED).

- Would have required that an appellant who obtains a stay of execution pending the appeal of a final order, adjudication, or decision of any officer, tribunal, authority, board, bureau, commission, department, or other division of any political

subdivision of the state, simultaneously execute a supersedeas bond to the appellee, with sufficient sureties and in a sum equal to specified costs and expenses or the reasonable value of the matter at issue in the final order, adjudication, or decision, and would have required that bond to be conditioned as provided in continuing law (VETOED).

- Would have specified that an appellant is not required to give a supersedeas bond in connection with the *perfection of* an appeal by certain persons specified in continuing law, or the *perfection of* an administrative-related appeal of a final order that is not for the payment of money (VETOED).

Annual compensation of judges

(R.C. 141.04)

Continuing law provides for the payment from the state treasury of all or a portion of the annual salaries of the Supreme Court Chief Justice, Supreme Court justices, appeals court judges, common pleas court judges, full- and part-time municipal court judges, and county court judges. These payments are made in equal monthly installments, except that the Supreme Court Chief Justice, Supreme Court justices, appeals court judges, and common pleas court judges must be paid biweekly if they deliver a written request for biweekly payment to the Administrative Director of the Supreme Court.

Prior law provided that increased salaries were payable to the justices and judges mentioned above each calendar year from 2002 through 2008. The act specifies instead that the increased salaries are payable, not each "calendar year," but each "year" from 2002 through 2008. Generally in statutory usage, a "calendar year" is the 12-month period January through December; a "year," by contrast, is a period of 12 consecutive months.

Reimbursement of compensation of substitute judges in municipal and county courts

(R.C. 1901.121 and 1907.14)

Continuing law provides that a judge appointed as substitute judge under certain specified circumstances, a judge of another municipal court or county court designated as an additional judge of a municipal court because of the volume of cases pending in the municipal court, and a retired judge who has been assigned to active duty on the municipal court is entitled, on a per diem basis, to the compensation paid to

the incumbent judge of the municipal court in which the judge is appointed or designated to serve. Continuing law requires the treasurer of the county in which a municipal court is located to pay the compensation to which those judges are entitled. Continuing law requires the treasurer of a county that is required to pay any compensation to which the acting judges, judges, or retired judges are entitled to submit to the Administrative Director of the Supreme Court quarterly requests for reimbursements of the per diem amounts so paid. The administrative Director must then cause reimbursements for those amounts to be paid to the county. The act limits those reimbursements to reimbursements paid for judges who are appointed or designated by the Chief Justice of the Supreme Court.

Continuing law also provides that when a judge of a county court is temporarily absent, incapacitated, or otherwise unavailable, the judge may appoint a substitute having the qualifications required by law or may appoint a retired judge of a court of record in the state who is a qualified elector and a resident of the county court district. Prior law required the treasurer of a county that is required to pay any compensation to which the acting judges, judges, or retired judges are entitled to submit to the Administrative Director of the Supreme Court quarterly requests for reimbursements of the per diem amounts so paid. The reports had to include verifications of the payment of those amounts. The Administrative Director was required to cause the reimbursements of those amounts to be issued to the county if the Administrative Director verified that those amounts were, in fact, so paid. The act removes this procedure for the reimbursement of the county of amounts paid for those acting judges, judges, or retired judges who serve in county courts.

Pay period for certain municipal court clerks

(R.C. 1901.31)

Under prior law, the clerks of municipal courts other than those of Auglaize, Brown, Hamilton, Holmes, Lorain, Portage, and Wayne counties were paid in semimonthly installments. The act changes the pay period for the clerks of municipal courts other than those of Auglaize, Brown, Hamilton, Holmes, Lorain, Portage, and Wayne counties to either semimonthly or biweekly, as determined by the payroll administrator, and reiterates the continuing provision in R.C. 1901.31(A)(2)(d) that the clerk of the Columbiana County Municipal Court be paid either semimonthly or biweekly, as determined by the payroll administrator.

Lorain County Court of Common Pleas

(R.C. 2101.01, 2301.02, and 2301.03)

Under prior law, the Lorain County Court of Common Pleas had ten judges that are elected pursuant to R.C. 2301.02: six judges of the general division and four judges of the domestic relations division. The four judges of the domestic relations division, and their successors, have the same qualifications, exercise the same powers and jurisdiction, and receive the same compensation as the other judges of Lorain County Court of Common Pleas and are elected and designated as the judges of the Court of Common Pleas, Domestic Relations Division. They have all of the powers relating to the juvenile courts, and all cases under R.C. Chapters 2151. and 2152., all parentage proceedings over which the juvenile court has jurisdiction, and all divorce, dissolution of marriage, legal separation, and annulment cases are assigned to them, except cases that for some special reason are assigned to some other judge of the court of common pleas. Under the act, from February 9, 2009, through *September 28, 2009*, the judge of the Lorain County Court of Common Pleas whose term begins on February 9, 2009, has all the powers relating to juvenile courts, and cases under R.C. Chapters 2151. and 2152., parentage proceedings over which the juvenile court has jurisdiction, and divorce, dissolution of marriage, legal separation, and annulment cases are assigned to that judge, except cases that for some special reason are assigned to some other judge of the Court of Common Pleas. Under the act, the other three judges of the Domestic Relations Division retain the above-described jurisdiction without limitation.

Prior law provided that on and after January 1, 2006, the judges of the Court of Common Pleas, Division of Domestic Relations, in addition to the powers and jurisdiction described above, had jurisdiction over matters that are within the jurisdiction of the probate court. Prior law also provided that on and after February 9, 2009, "probate court" meant the Domestic Relations Division of the Court of Common Pleas, and "probate judge" meant each of the judges of the Court of Common Pleas who are judges of the Domestic Relations Division. The act provides that from January 1, 2006, through *September 28, 2009*, the judges of the Court of Common Pleas, Division of Domestic Relations, have jurisdiction over matters that are within the jurisdiction of the probate court. The act also provides that the above-described definitions of "probate court" and "probate judge" are operative from February 9, 2009, through *September 28, 2009*, that the judge of Lorain County Court of Common Pleas, Division of Domestic Relations, whose term begins on February 9, 2009, and successors, is the probate judge beginning September 29, 2009, and is elected and designated as judge of the Court of Common Pleas, Probate Division, and specifies that there are nine judges of the Lorain County Court of Common Pleas that are elected pursuant to R.C. 2301.02 and one judge elected pursuant to R.C. 2101.01.

Prior law also provided that the judge of the Court of Common Pleas, Division of Domestic Relations, whose term began on February 9, 2009, was the successor to the probate judge who was elected in 2002 for a term that began on February 9, 2003. On and after February 9, 2009, with respect to Lorain County, all references in law to the probate court was required to be construed as references to the Court of Common Pleas, Division of Domestic Relations, all references to the probate judge were required to be construed as references to the judges of the Court of Common Pleas, Division of Domestic Relations, and all references in law to the clerk of the probate court were required to be construed as references to the judge who is serving pursuant to Rule 4 of the Rules of Superintendence for the Courts of Ohio as the administrative judge of the Court of Common Pleas, Division of Domestic Relations (R.C. 2301.03(C)(2)(b) and (c).) Prior law specified that the judges of the Domestic Relations Division of the Lorain County Court of Common Pleas elected pursuant to R.C. 2301.02 also perform the duties and functions of the judge of the probate division. The act provides that after September 28, 2009, the judge of the Lorain County Court of Common Pleas, Division of Domestic Relations, whose term begins on February 9, 2009, is the probate judge, that the references in law to the probate court, probate judge, and the clerk of the probate court that are described above are operative from February 9, 2009 through *September 28, 2009*, and that the judges of the Domestic Relations Division of the Lorain County Court of Common Pleas also perform the duties and functions of the judge of the probate division *from February 9, 2009, through September 28, 2009*.

The act specifies in uncodified law that in Lorain County, all proceedings that are within the jurisdiction of the Probate Court under R.C. Chapter 2101. and other provisions of the Revised Code that are pending before a judge of the Domestic Relations Division of the Lorain County Court of Common Pleas on the effective date of the act remain with that judge of the Domestic Relations Division of the Lorain County Court of Common Pleas. It also specifies that all proceedings that are within the jurisdiction of the Domestic Relations Division of the Lorain County Court of Common Pleas under R.C. Chapter 2301. and other provisions of the Revised Code that are pending before the probate judge of the Lorain County Probate Court on September 29, 2009, remain with that probate judge of the Lorain County Probate Court and that the successors to the judge of the Lorain County Court of Common Pleas who was elected pursuant to R.C. 2301.02 in 2008 for a term that began on February 9, 2009, must be elected in 2014 and thereafter pursuant to R.C. 2101.02 as judges of the Probate Division of the Lorain County Court of Common Pleas.

Supreme Court filing fee

(R.C. 2503.17)

General provision

Former law generally required the Clerk of the Supreme Court to charge and collect $40, as a filing fee, for each case entered upon the *minute book, including, but not limited to, original actions in the Court, appeals filed as of right, and cases certified by the courts of appeals for review on the ground of conflict of decisions; and for each motion to certify the record of a court of appeals or for leave to file a notice of appeal in criminal cases docket.* The filing fees so charged and collected were in full for *docketing the cases or motions, making dockets from term to term, indexing and entering appearances, issuing process, filing papers, entering rules, motions, orders, continuances, decrees, and judgments, making lists of causes on the regular docket for publication each year, making and certifying orders, decrees, and judgments of the court to other tribunals, and the issuing of mandates.* The party invoking the action of the Court was required to pay the filing fee to the Clerk before the case *or motion* was docketed. Continuing law requires the filing fee to be taxed as costs and recovered from the other party if the party invoking the action of the court succeeds, unless the court otherwise directs.

The act requires the Clerk of the Supreme Court to charge and collect $100 (instead of $40) for each case entered in the *docket* (instead of minute book). The filing fees so charged and collected are in full for each case filed in the Supreme Court under the Rules of Practice of the Supreme Court (henceforth Rules of Practice). The act deletes all of the italicized language in the discussion of former law above, retains the last sentence in the preceding paragraph. It further provides that no filing fee or security deposit may be charged to an indigent party upon determination of indigency by the Supreme Court pursuant to the Rules of Practice.[324]

Exception

Prior law precluded the Clerk of the Supreme Court from charging to and collecting from a prosecutor the $40 filing fee described above when all of the following circumstances applied:

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[324] Under existing Rule XV, section 3 of the Rules of Practice of the Supreme Court, an affidavit of indigency may be filed in lieu of filing fees or security deposits. The party on whose behalf the affidavit is filed must execute it within six months prior to it being filed in the Supreme Court. The affidavit must state the specific reasons for the party not having sufficient funds to pay the filing fees or security deposit. The Supreme Court may review and determine the sufficiency of the affidavit at any stage in the proceeding. Counsel appointed by a trial or appellate court to represent an indigent party may file a copy of the entry of appointment in lieu of an affidavit of indigency.

(1) In accordance with the Rules of Practice, an indigent defendant in a criminal action or proceeding files in the appropriate court of appeals a notice of appeal within 30 days from the date of the entry of the judgment or final order that is the subject of the appeal.

(2) The indigent defendant fails to file or offer for filing in the Supreme Court within 30 days from the date of the filing of the notice of appeal in the court of appeals, a copy of the notice of appeal supported by a memorandum in support of jurisdiction and other documentation and information as required by the Rules of Practice.

(3) The prosecutor or a representative of the prosecutor associated with the criminal action or proceeding files a motion to docket and dismiss the appeal of the indigent defendant for lack of prosecution as authorized by the Rules of Practice.

(4) The prosecutor states in the motion that the $40 filing fee does not accompany the motion because of the applicability of this provision, and the Clerk of the Supreme Court determines that this provision applies.

The act repeals the above provisions.

Modification of Rules of Practice

(Section 313.20)

The act states in temporary law that the General Assembly respectfully requests the Supreme Court to modify Rule XV of the Rules of Practice of the Supreme Court pursuant to its authority under the Ohio Constitution to make that Rule consistent with the amendments made by this act to R.C. 2503.17.[325]

Administrative costs for collecting additional filing fees to assist legal aid societies

(R.C. 1901.26(C), 1907.24(C), and 2303.201(C))

Continuing law states that the municipal court, in all its divisions except the small claims division, the county court, in all its divisions except the small claims division, and the court of common pleas must collect the sum of $26 as additional filing

[325] Existing Rule XV, section 1 provides for the $40 filing fee imposed under preexisting R.C. 2503.17 and requires the fee to be paid before a case is filed for each of the following: filing a notice of appeal, filing a notice of cross-appeal, filing an order of a court of appeals certifying a conflict, and instituting an original action. Section 2 of Rule XV provides that original actions also require a deposit of $100 as security for costs. The security deposit must be paid before the case is filed. In extraordinary circumstances, the Supreme Court may require an additional security deposit at any time during the action.

fees in each new civil action or proceeding for the charitable public purpose of providing financial assistance to legal aid societies that operate within the state and to support the office of the State Public Defender. The clerk of the court must transmit the moneys collected on or before the 20th day of the following month to the State Treasurer in a manner prescribed by the State Treasurer or by the Ohio Legal Assistance Foundation.

The act provides that the moneys collected by the clerk of the court that must be transmitted to the State Treasurer do not include an amount equal to up to 1% of those moneys retained to cover administrative costs. The act also provides that if the court fails to transmit to the State Treasurer the moneys the court collects in a manner prescribed by the State Treasurer or by the Ohio Legal Assistance Foundation, the court must forfeit the moneys the court retains to cover the administrative costs, including the hiring of any additional personnel necessary to implement this provision, and must transmit to the State Treasurer all moneys collected under R.C. 1901.26(C), 1907.24(C), and 2303.201(C), including the forfeited amount retained for administrative costs, for deposit in the Legal Aid Fund.

Impersonating a peace officer--definition of "peace officer"

(R.C. 2921.51)

Continuing law prohibits the following: (1) any person from impersonating a "peace officer," private police officer, federal law enforcement officer, or investigator of BCII, (2) any person, by impersonating a "peace officer," private police officer, federal law enforcement officer, or investigator of BCII, from arresting or detaining any person, searching any person, or searching the property of any person, (3) any person, with purpose to commit or facilitate the commission of an offense, from impersonating a "peace officer," private police officer, federal law enforcement officer, officer, agent, or employee of the state, or investigator of BCII, and (4) any person from committing a felony while impersonating a "peace officer," private police officer, federal law enforcement officer, officer, agent, or employee of the state, or investigator of BCII. Prohibition (1) is a misdemeanor of the fourth degree. Prohibition (2) is a misdemeanor of the first degree. Prohibition (3) is a misdemeanor of the first degree or a felony of the fourth degree. Prohibition (4) is a felony of the third degree. For each prohibition, the term "peace officer" means a sheriff, deputy sheriff, marshal, deputy marshal, member of the organized police department of a municipal corporation, or township constable, who is employed by a political subdivision of Ohio, a member of a police force employed by a metropolitan housing authority, a member of a police force employed by a regional transit authority, a state university law enforcement officer, a veterans' home police officer, a special police officer employed by a port authority, or a state highway patrol trooper whose primary duties are to preserve the peace, to protect life and

property, and to enforce the laws, ordinances, or rules of the state or any of its political subdivisions.

The act expands the definition of "peace officer" described in the preceding paragraph to include an officer, agent, or employee of the state or any of its agencies, instrumentalities, or political subdivisions, upon whom, by statute, a duty to conserve the peace or to enforce all or certain laws is imposed and the authority to arrest violators is conferred, within limits of that statutory duty and authority.

Disclosure of peace officer's residence address in BMV records--definition of "peace officer"

(R.C. 4501.271)

Continuing law provides that a "peace officer," correctional employee, or youth services employee may file a written request with the Bureau of Motor Vehicles to prohibit disclosure of the officer's or employee's residence address as contained in motor vehicle records of the Bureau, provide a business address to be displayed on the officer's or employee's driver's license or certificate of registration, or both. Procedures regarding the filing and granting of this request are specified in R.C. 4501.271. Continuing law defines "peace officer" to mean those persons described in R.C. 109.71(A)(1), (2), (4), (5), (6), (9), (10), (12), or (13), the house sergeant at arms appointed under R.C. 101.311(B)(1), and any assistant sergeant at arms appointed under R.C. 101.311(C)(1). "Peace officer" includes state highway patrol troopers but does not include the sheriff of a county or a supervisory employee who, in the absence of the sheriff, is authorized to stand in for, exercise the authority of, and perform the duties of the sheriff.

The act expands the definition of "peace officer" described in the preceding paragraph to include a member of a police force employed by a regional transit authority under R.C. 306.35(Y), an officer, agent, or employee of the state or any of its agencies, instrumentalities, or political subdivisions, upon whom, by statute, a duty to conserve the peace or to enforce all or certain laws is imposed and the authority to arrest violators is conferred, within the limits of that statutory duty and authority, and an investigator of the Bureau of Criminal Identification and Investigation as defined in R.C. 2903.11.

Prohibition against insurers considering certain motor vehicle accidents of specified employees

(R.C. 3937.41)

Continuing law provides that an insurer may not consider the circumstance that an applicant or policyholder has been involved in a motor vehicle accident while in the pursuit of the applicant's or policyholder's official duties as a "law enforcement officer," firefighter, or operator of an emergency vehicle or ambulance, while operating a vehicle engaged in mowing or snow and ice removal as a county, township, or Department of Transportation employee, or while operating a vehicle while engaged in the pursuit of the applicant's or policyholder's official duties as a member of the motor carrier enforcement unit of the state highway patrol under R.C. 5503.34, as a basis for doing either of the following: (1) refusing to issue or deliver a policy of insurance upon a private automobile, or increasing the rate to be charged for such a policy, or (2) increasing the premium rate, canceling, or failing to renew an existing policy of insurance upon a private automobile. Continuing law also sets forth an appeal procedure that any applicant or policyholder affected by an action of an insurer in violation of the prohibition described above may utilize. It also sets forth procedures by which the employer of a person protected by the prohibition must certify to the appropriate office or agency that the person was engaged in the performance of the person's official duties at the time of the accident.

The act applies the prohibitions and procedures explained in the preceding paragraph to an investigator of the Bureau of Criminal Identification and Investigation as defined in R.C. 2903.11. Additionally, the act redefines "law enforcement officer" for purposes of the preceding two paragraphs. Under continuing law, "law enforcement officer" is defined as a sheriff, deputy sheriff, constable, marshal, deputy marshal, municipal or township police officer, state highway patrol trooper, police officer employed by a qualified nonprofit police department pursuant to R.C. 1702.80, or police officer employed by a proprietary police department or security department of a hospital operated by a public hospital agency or nonprofit hospital agency pursuant to R.C. 4973.17. The act expands this definition to also include (1) a police officer of a joint township police district, (2) a member of a police force employed by a metropolitan housing authority under R.C. 3735.31(D), (3) an officer, agent, or employee of the state or any of its agencies, instrumentalities, or political subdivisions, upon whom, by statute, a duty to conserve the peace or to enforce all or certain laws is imposed and the authority to arrest violators is conferred, within the limits of that statutory duty and authority, (4) a veterans' home police officer appointed under R.C. 5907.02, and (5) a member of a police force employed by a regional transit authority under R.C. 306.35(Y).

Award of a gasoline purchase card for playing a skill-based amusement machine (VETOED)

(R.C. 2915.01)

A person is prohibited from establishing, promoting, or operating, or from knowingly engaging in conduct that facilitates, any scheme of chance and punishes a violation as a first degree misdemeanor (R.C. 2915.02(A)(2) and (F), not in the act). "Scheme of chance" means a slot machine, lottery, numbers game, pool conducted for profit, or other scheme in which a participant gives a valuable consideration for a chance to win a prize, but does not include bingo, a skill-based amusement machine, or a pool not conducted for profit. Thus, playing a skill-based amusement machine does not violate the prohibition described above.

A "skill-based amusement machine" is a mechanical, video, digital, or electronic device that rewards the player or players, if at all, only with merchandise prizes or with redeemable vouchers redeemable only for merchandise prizes, provided that, with respect to rewards for playing the game, all of the following apply:

(1) The wholesale value of a merchandise prize awarded as a single play of a machine does not exceed $10.

(2) Redeemable vouchers awarded for any single play of a machine are not redeemable for a merchandise prize with a wholesale value of more than $10.

(3) Redeemable vouchers are not redeemable for a merchandise prize that has a wholesale value of more than $10 times the fewest number of single plays necessary to accrue the redeemable vouchers required to obtain that prize.

(4) Any redeemable vouchers or merchandise prizes are distributed at the site of the skill-based amusement machine at the time of play.

The Governor vetoed a provision that would have specified that a card for the purchase of gasoline is a redeemable voucher for purposes of the definition above even if the skill-based amusement machine for the play of which the card is awarded is located at a place where gasoline may not be legally distributed to the public or the card is not redeemable at the location of, or at the time of playing, the skill-based amusement machine.

Cost of electronic monitoring devices

(R.C. 2903.214)

Under prior law, if a court ordered electronic monitoring of a respondent in response to a request for a protection order under R.C. 2903.214 (menacing by stalking protection order or sexually oriented offense protection order) and determines that the respondent is indigent, the cost of the installation and monitoring of the electronic monitoring device was required to be paid out of funds from the Reparations Fund created under R.C. 2743.191.

The act changes the requirement that the cost of installing and monitoring an electronic monitoring device for indigent respondents be paid out of the Reparations Fund from mandatory to permissive. The act limits the total amount of costs paid under this provision for the installation and monitoring of electronic monitoring devices to $300,000 per year. The act permits the Attorney General to promulgate rules to govern such payments from the Reparations Fund and provides that the rules may include reasonable limits on the total cost paid per respondent, the amount of the $300,000 allocated to each county, and how invoices may be submitted by a county, court, or other entity.

Appeals

(R.C. 2505.09, 2505.12, and 2505.122)

Execution of supersedeas bond (VETOED)

Under the Appeals Law, with certain exceptions, an appeal does not operate as a stay of execution until a stay of execution has been obtained pursuant to the Rules of Appellate Procedure or in another applicable manner, and a supersedeas bond is executed by the appellant to the appellee, with sufficient sureties and in a sum that is not less than, if applicable, the cumulative total for all claims covered by the final order, judgment, or decree and interest involved, except that the bond cannot exceed $50 million excluding interest and costs, as directed by the court that rendered the final order, judgment, or decree that is sought to be superseded or by the court to which the appeal is taken. The act would have specified that the above provision applies to *the perfection of* an appeal, *including an administrative-related appeal.*[326] It would have provided that the amount of the bond is subject to the following paragraph.

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[326] An "administrative-related appeal" means an appeal to a court of the final order of an administrative officer, agency, board, department, tribunal, commission, or other instrumentality (R.C. 2505.01(B)--not in the act).

The act would have required that an appellant who obtains a stay of execution pending the appeal of a final order, adjudication, or decision of any officer, tribunal, authority, board, bureau, commission, department, or other division of any political subdivision of the state simultaneously execute a supersedeas bond to the appellee, with sufficient sureties and in a sum equal to the cost of delay, increased cost of construction, legal expenses, loss of anticipated revenues, or the reasonable value of the matter at issue in the final order, adjudication, or decision, including any reasonable investment-backed expectations of the appellee. That bond would have been conditioned as provided in R.C. 2505.14 (the condition that the appellant must abide and perform the appellate court's order, judgment, or decree and pay all money, costs, and damages that may be required of or awarded against the appellant upon the final determination of the appeal and any other conditions that the court provides).

Exceptions to execution of supersedeas bond (VETOED)

Under continuing law, an appellant is not required to give a supersedeas bond in connection with any of the following: (1) an appeal by an executor, administrator, guardian, receiver, trustee, or trustee in bankruptcy who is acting in that person's trust capacity and who has given bond in this state, with surety according to law, by the state or any political subdivision of the state, or by any public officer of the state or of any of its political subdivisions who is suing or is sued solely in the public officer's representative capacity as that officer, or (2) an administrative-related appeal of a final order that is not for the payment of money. The act would have specified that an appellant is not required to give a supersedeas bond in connection with the *perfection of* an appeal by the persons described in (1), above, or the *perfection of* an administrative-related appeal of a final order that is not for the payment of money.

LEGAL RIGHTS SERVICE COMMISSION (LRS)

- Requires the Legal Rights Service Commission to study the potential transition of the Legal Rights Service from a public entity to a nonprofit organization.

Legal Rights Service Commission Transition Study

(Section 317.20)

The Ohio Legal Rights Service (OLRS) is Ohio's designated protection and advocacy system and client assistance program for children and adults with mental disabilities. For Ohio to receive federal funds for services to persons who are mentally