Sub. H.B. 33
As Passed by the Senate
MCDCD30, MCDCD60,
MCDCD61, MCDCD62,
MCDCD64 MCDCD65,
DOHCD45

_____ moved to amend as follows:

In line 29 of the title, after "173.21," insert "173.24,"

In line 111 of the title, after "3721.026," insert "3721.08, 3721.17, 3721.99,"

In line 189 of the title, after "5165.152," insert "5165.157,"

In line 190 of the title, after "5165.192," insert "5165.23,"

In line 194 of the title, after "5168.26," insert "5168.40,"

In line 273 of the title, after "5164.913," insert "5165.158,"

In line 783, after "173.21," insert "173.24,"

In line 844, after "3721.026," insert "3721.08, 3721.17, 3721.99,"

In line 900, after "5165.152," insert "5165.157,"; after "5165.192," insert "5165.23,"

In line 903, after "5168.26," insert "5168.40,"

In line 962, after "5164.913," insert "5165.158,"

After line 19661, insert:

"**Sec. 173.24.** (A) As used in this section:

(1) "Employee" and "employer" have the same meanings as in section 4113.51 of the Revised Code.

(2) "Retaliatory action" includes physical, mental, or verbal abuse; change of room assignment; withholding of services; failure to provide care in a timely manner; discharge; and termination of employment.

(B) An employee providing information to or participating in good faith in registering a complaint with the office of the state long-term care ombudsman program or participating in the investigation of a complaint or in administrative or judicial proceedings resulting from a complaint registered with the office shall have the full protection against disciplinary or retaliatory action provided by division ~~(G)~~(E) of section 3721.17 and by sections 4113.51 to 4113.53 of the Revised Code.

(C) No long-term care provider or other entity, no person employed by a long-term care provider or other entity, and no other individual shall knowingly subject any resident, recipient, employee, representative of the office of the state long-term care ombudsman program, or another individual to any form of retaliation, reprisal, discipline, or discrimination for doing any of the following:

(1) Providing information to the office;

(2) Participating in registering a complaint with the office;

(3) Cooperating with or participating in the investigation of a complaint by the office or in administrative or judicial

proceedings resulting from a complaint registered with the office."

In line 65380, delete "The director"

Delete lines 65381 and 65382

In line 65385, delete "Full and complete disclosure" and insert "Disclosure"

In line 65388, after "of" insert "the building or buildings in which"; after "home" insert "is housed"; after the second "owner" insert "of the building or buildings"

In line 65390, after "(iii)" insert "The owner of the legal rights associated with the ownership and operation of the nursing home beds, if the owner is a different person from the applicant;

(iv)"; delete "manager of" and insert "management firm or business employed to manage"; delete the second "manager" and insert "management firm or business employed to manage the nursing home"

In line 65392, delete "(iv)" and insert "(v)"

In line 65393, delete "whether"; delete the second "the"

In line 65394, delete "applicant, owner, or manager of the nursing home" and insert "any party identified in division (A)(1)(a) of this section"

In line 65395, delete "Full and complete disclosure" and insert "Disclosure"

In line 65411, after "(c)" delete the balance of the line

Delete lines 65412 and 65413

In line 65414, delete "(d)"

In line 65475, delete "submits copies of the nursing"

In line 65476, delete "home's policies and procedures, including" and insert "attests that the applicant has"

In line 65477, delete "that are required"

In line 65479, delete "submits" and insert "attests that the applicant has"

In line 65483, delete "demonstrates that" and insert "attests that the applicant has"

In line 65484, after "experience," insert "who"

In line 65528, after "(D)" insert "(1) The director shall investigate an allegation that a change of operator has occurred and the entering operator failed to submit an application in accordance with this section or an application was filed but the information was fraudulent. The director may request the attorney general's assistance with an investigation under this section.

(2)"; after "aware" insert ", by means of an investigation or otherwise,"

In line 65332, after "1396r(f)(10)" insert ".

(14) "Real and present danger" means immediate danger of serious physical or life-threatening harm to one or more occupants of a home"

After line 65546, insert:

"**Sec. 3721.08.** (A) ~~As used in this section, "real and present danger" means imminent danger of serious physical or life-threatening harm to one or more occupants of a home.~~

~~(B)~~ The director of health may petition the court of common pleas of the county in which the home is located for an order enjoining any person from operating a home without a license or

enjoining a county home or district home that has had its license revoked from continuing to operate. The court shall have jurisdiction to grant such injunctive relief upon a showing that the respondent named in the petition is operating a home without a license or that the county home or district home named in the petition is operating despite the revocation of its license. The court shall have jurisdiction to grant such injunctive relief against the operation of a home without a valid license regardless of whether the home meets essential licensing requirements.

~~(C)~~(B) Unless the department of medicaid or contracting agency has taken action under section 5165.77 of the Revised Code to appoint a temporary manager or seek injunctive relief, if, in the judgment of the director of health, real and present danger exists at any home, the director may petition the court of common pleas of the county in which the home is located for such injunctive relief as is necessary to close the home, transfer one or more occupants to other homes or other appropriate care settings, or otherwise eliminate the real and present danger. The court shall have the jurisdiction to grant such injunctive relief upon a showing that there is real and present danger.

~~(D)(1)~~(C)(1) If the director determines that real and present danger exists at a home and elects not to immediately seek injunctive relief under division ~~(C)~~(B) of this section, the director may give written notice of proposed action to the home. The notice shall specify all of the following:

(a) The nature of the conditions giving rise to the real and present danger;

(b) The measures that the director determines the home must take to respond to the conditions;

(c) The date on which the director intends to seek injunctive

relief under division ~~(C)~~(B) of this section if the director determines that real and present danger exists at the home.

(2) If the home notifies the director, within the time specified pursuant to division ~~(D)(1)(c)~~(C)(1)(c) of this section, that it believes the conditions giving rise to the real and present danger have been substantially corrected, the director shall conduct an inspection to determine whether real and present danger exists. If the director determines on the basis of the inspection that real and present danger exists, the director may petition under division ~~(C)~~(B) of this section for injunctive relief.

~~(E)(1)~~(D)(1) If in the judgment of the director of health conditions exist at a home that will give rise to real and present danger if not corrected, the director shall give written notice of proposed action to the home. The notice shall specify all of the following:

(a) The nature of the conditions giving rise to the director's judgment;

(b) The measures that the director determines the home must take to respond to the conditions;

(c) The date, which shall be no less than ten days after the notice is delivered, on which the director intends to seek injunctive relief under division ~~(C)~~(B) of this section if the conditions are not substantially corrected and the director determines that a real and present danger exists.

(2) If the home notifies the director, within the period of time specified pursuant to division ~~(E)(1)(c)~~(D)(1)(c) of this section, that the conditions giving rise to the director's determination have been substantially corrected, the director

shall conduct an inspection. If the director determines on the basis of the inspection that the conditions have not been corrected and a real and present danger exists, the director may petition under division ~~(C)~~(B) of this section for injunctive relief.

~~(F)(1)~~(E)(1) A court that grants injunctive relief under division ~~(C)~~(B) of this section may also appoint a special master who, subject to division ~~(F)(2)~~(E)(2) of this section, shall have such powers and authority over the home and length of appointment as the court considers necessary. Subject to division ~~(F)(2)~~(E)(2) of this section, the salary of a special master and any costs incurred by a special master shall be the obligation of the home.

(2) No special master shall enter into any employment contract on behalf of a home, or purchase with the home's funds any capital goods totaling more than ten thousand dollars, unless the special master has obtained approval for the contract or purchase from the home's operator or the court.

~~(G)~~(F) If the director takes action under division ~~(C)~~(B), ~~(D)~~(C), or ~~(E)~~(D) of this section, the director may also appoint employees of the department of health to conduct on-site monitoring of the home. Appointment of monitors is not subject to appeal under Chapter 119. or any other section of the Revised Code. No employee of a home for which monitors are appointed, no person employed by the home within the previous two years, and no person who currently has a consulting contract with the department or a home, shall be appointed under this division. Every monitor shall have the professional qualifications necessary to monitor correction of the conditions that give rise to or, in the director's judgment, will give rise to real and present danger. The number of monitors present at a home at any given time shall not exceed one for every fifty residents, or fraction thereof.

~~(H)~~(G) On finding that the real and present danger for which injunctive relief was granted under division ~~(C)~~(B) of this section has been eliminated and that the home's operator has demonstrated the capacity to prevent the real and present danger from recurring, the court shall terminate its jurisdiction over the home and return control and management of the home to the operator. If the real and present danger cannot be eliminated practicably within a reasonable time following appointment of a special master, the court may order the special master to close the home and transfer all residents to other homes or other appropriate care settings.

~~(I)~~(H) The director of health shall give notice of proposed action under divisions ~~(D)~~(C) and ~~(E)~~(D) of this section to both of the following:

(1) The home's administrator;

(2) If the home is operated by an organization described in subsection 501(c)(3) and tax exempt under subsection 501(a) of the "Internal Revenue Code of 1986," 100 Stat. 2085, 26 U.S.C.A. 1, as amended, the board of trustees of the organization; or, if the home is not operated by such an organization, the owner of the home.

Notices shall be delivered by certified mail or hand delivery. If notices are mailed, they shall be addressed to the persons specified in divisions ~~(I)(1)~~(H)(1) and (2) of this section, as indicated in the department of health's records. If they are hand delivered, they shall be delivered to persons who would reasonably appear to the average prudent person to have authority to accept them.

~~(J)~~(I) If ownership of a home is assigned or transferred to a different person, the new owner is responsible and liable for

compliance with any notice of proposed action or order issued under this section prior to the effective date of the assignment or transfer.

Sec. 3721.17. (A) Any resident who believes that the resident's rights under sections 3721.10 to 3721.17 of the Revised Code have been violated may file a grievance under procedures adopted pursuant to division (A)(2) of section 3721.12 of the Revised Code.

When the grievance committee determines a violation of sections 3721.10 to 3721.17 of the Revised Code has occurred, it shall notify the administrator of the home. If the violation cannot be corrected within ten days, or if ten days have elapsed without correction of the violation, the grievance committee shall refer the matter to the department of health.

(B) Any person who believes that a resident's rights under sections 3721.10 to 3721.17 of the Revised Code have been violated may report or cause reports to be made of the information directly to the department of health. No person who files a report is liable for civil damages resulting from the report.

(C)(1) ~~Within thirty days of receiving a complaint under this section, the~~ The department of health shall investigate any complaint referred to it by a home's grievance committee and any complaint from any source that alleges that the home provided substantially less than adequate care or treatment, or substantially unsafe conditions, or~~, within seven days of receiving a complaint,~~ refer it to the attorney general~~, if the attorney general agrees to investigate within thirty days~~.

(2) ~~Within thirty days of receiving a complaint under this section, the~~ The department of health may investigate any alleged

violation of sections 3721.10 to 3721.17 of the Revised Code, or of rules, policies, or procedures adopted pursuant to those sections, not covered by division (C)(1) of this section, or it may~~, within seven days of receiving a complaint,~~ refer the complaint to the grievance committee at the home where the alleged violation occurred, or to the attorney general ~~if the attorney general agrees to investigate within thirty days~~.

(D) If, after an investigation, the department of health finds probable cause to believe that a violation of sections 3721.10 to 3721.17 of the Revised Code, or of rules, policies, or procedures adopted pursuant to those sections, has occurred ~~at a home that is certified under the medicare or medicaid program~~, it shall cite one or more findings or deficiencies ~~under sections 5165.60 to 5165.89 of the Revised Code. If the home is not so certified, the department shall hold an adjudicative hearing within thirty days under Chapter 119. of the Revised Code~~, and, if necessary, take action under section 3721.99 of the Revised Code.

(E) ~~Upon a finding at an adjudicative hearing under division (D) of this section that a violation of sections 3721.10 to 3721.17 of the Revised Code, or of rules, policies, or procedures adopted pursuant thereto, has occurred, the department of health shall make an order for compliance, set a reasonable time for compliance, and assess a fine pursuant to division (F) of this section. The fine shall be paid to the general revenue fund only if compliance with the order is not shown to have been made within the reasonable time set in the order. The department of health may issue an order prohibiting the continuation of any violation of sections 3721.10 to 3721.17 of the Revised Code.~~

~~Findings at the hearings conducted under this section may be appealed pursuant to Chapter 119. of the Revised Code, except that an appeal may be made to the court of common pleas of the county~~

~~in which the home is located.~~

~~The department of health shall initiate proceedings in court to collect any fine assessed under this section that is unpaid thirty days after the violator's final appeal is exhausted.~~

~~(F) Any home found, pursuant to an adjudication hearing under division (D) of this section, to have violated sections 3721.10 to 3721.17 of the Revised Code, or rules, policies, or procedures adopted pursuant to those sections may be fined not less than one hundred nor more than five hundred dollars for a first offense. For each subsequent offense, the home may be fined not less than two hundred nor more than one thousand dollars.~~

~~A violation of sections 3721.10 to 3721.17 of the Revised Code is a separate offense for each day of the violation and for each resident who claims the violation.~~

~~(G)~~ No home or employee of a home shall retaliate against any person who:

(1) Exercises any right set forth in sections 3721.10 to 3721.17 of the Revised Code, including, but not limited to, filing a complaint with the home's grievance committee or reporting an alleged violation to the department of health;

(2) Appears as a witness in any hearing conducted under ~~this section or~~ section 3721.162 of the Revised Code;

(3) Files a civil action alleging a violation of sections 3721.10 to 3721.17 of the Revised Code, or notifies a county prosecuting attorney or the attorney general of a possible violation of sections 3721.10 to 3721.17 of the Revised Code.

If, under the procedures outlined in this section, a home or its employee is found to have retaliated, the ~~violator may be fined up to one thousand dollars~~ <u>department of health may take</u>

action under section 3721.99 of the Revised Code.

~~(H)~~(F) When legal action is indicated, any evidence of criminal activity found in an investigation under division (C) of this section shall be given to the prosecuting attorney in the county in which the home is located for investigation.

~~(I)(1)(a)~~(G)(1)(a) Any resident whose rights under sections 3721.10 to 3721.17 of the Revised Code are violated has a cause of action against any person or home committing the violation.

(b) An action under division ~~(I)(1)(a)~~(G)(1)(a) of this section may be commenced by the resident or by the resident's legal guardian or other legally authorized representative on behalf of the resident or the resident's estate. If the resident or the resident's legal guardian or other legally authorized representative is unable to commence an action under that division on behalf of the resident, the following persons in the following order of priority have the right to and may commence an action under that division on behalf of the resident or the resident's estate:

(i) The resident's spouse;

(ii) The resident's parent or adult child;

(iii) The resident's guardian if the resident is a minor child;

(iv) The resident's brother or sister;

(v) The resident's niece, nephew, aunt, or uncle.

(c) Notwithstanding any law as to priority of persons entitled to commence an action, if more than one eligible person within the same level of priority seeks to commence an action on behalf of a resident or the resident's estate, the court shall determine, in the best interest of the resident or the resident's

estate, the individual to commence the action. A court's determination under this division as to the person to commence an action on behalf of a resident or the resident's estate shall bar another person from commencing the action on behalf of the resident or the resident's estate.

(d) The result of an action commenced pursuant to division ~~(I)(1)(a)~~(G)(1)(a) of this section by a person authorized under division ~~(I)(1)(b)~~(G)(1)(b) of this section shall bind the resident or the resident's estate that is the subject of the action.

(e) A cause of action under division ~~(I)(1)(a)~~(G)(1)(a) of this section shall accrue, and the statute of limitations applicable to that cause of action shall begin to run, based upon the violation of a resident's rights under sections 3721.10 to 3721.17 of the Revised Code, regardless of the party commencing the action on behalf of the resident or the resident's estate as authorized under divisions ~~(I)(1)(b)~~(G)(1)(b) and (c) of this section.

(2)(a) The plaintiff in an action filed under division ~~(I)(1)~~(G)(1) of this section may obtain injunctive relief against the violation of the resident's rights. The plaintiff also may recover compensatory damages based upon a showing, by a preponderance of the evidence, that the violation of the resident's rights resulted from a negligent act or omission of the person or home and that the violation was the proximate cause of the resident's injury, death, or loss to person or property.

(b) If compensatory damages are awarded for a violation of the resident's rights, section 2315.21 of the Revised Code shall apply to an award of punitive or exemplary damages for the violation.

(c) The court, in a case in which only injunctive relief is granted, may award to the prevailing party reasonable attorney's fees limited to the work reasonably performed.

(3) Division ~~(I)(2)(b)~~(G)(2)(b) of this section shall be considered to be purely remedial in operation and shall be applied in a remedial manner in any civil action in which this section is relevant, whether the action is pending in court or commenced on or after July 9, 1998.

(4) Within thirty days after the filing of a complaint in an action for damages brought against a home under division ~~(I)(1)(a)~~(G)(1)(a) of this section by or on behalf of a resident or former resident of the home, the plaintiff or plaintiff's counsel shall send written notice of the filing of the complaint to the department of medicaid if the department has a right of recovery under section 5160.37 of the Revised Code against the liability of the home for the cost of medicaid services arising out of injury, disease, or disability of the resident or former resident.

Sec. 3721.99. (A) ~~Whoever violates section 3721.021, division (B), (D), or (E) of section 3721.05, division (A), (C), or (D) of section 3721.051, section 3721.06, division (A) of section 3721.22, division (A) or (B) of section 3721.24, division (E) or (F) of section 3721.30, or section 3721.65 of the Revised Code shall be fined one hundred dollars for a first offense. For each subsequent offense, the violator shall be fined five hundred dollars~~ If the director of health determines that a violation of sections 3721.01 to 3721.17 of the Revised Code has occurred, the director may do any of the following:

(1) Request a licensee to submit an acceptable plan of

correction to the director stating all of the following:

(a) The actions being taken or to be taken to correct the violation;

(b) The time frame for completion of the plan of correction;

(c) The means by which continuing compliance with the plan of correction will be monitored.

(2) In accordance with Chapter 119. of the Revised Code, impose a civil monetary penalty as follows:

(a) For violations that result in no actual harm with the potential for more than minimal harm that is not a real and present danger to one or more residents, that are cited more than once during a fifteen-month period from the exit of an inspection, a civil penalty of not less than two thousand dollars and not more than three thousand dollars.

(b) For violations that result in actual harm that is not a real and present danger to one or more residents, a civil penalty of not less than three thousand one hundred dollars and not more than six thousand dollars.

(c) For violations that result in a real and present danger to one or more residents, a civil penalty of not less than six thousand one dollars and not more than ten thousand dollars.

(d)(i) For violations of sections 3721.10 to 3721.17 of the Revised Code, other than a violation of division (E) of section 3721.17 of the Revised Code, a civil penalty of not less than one thousand dollars and not more than five thousand dollars for a first offense. For each subsequent offense, the violator may be fined not less than two thousand dollars and not more than ten thousand dollars.

(ii) For violations of division (E) of section 3721.17 of the Revised Code, a civil penalty up to five thousand dollars for each offense.

~~(B) Whoever violates~~(e) For violations of division (A) or (C) of section 3721.05 or division (B) of section 3721.051 of the Revised Code shall be fined five thousand dollars for a first offense. For each subsequent offense, the violator shall be fined ten thousand dollars.

(3) In accordance with section 3721.03 of the Revised Code, revoke a license to operate.

(B) All monies collected by the director under division (A) of this section shall be deposited into the state treasury to the credit of the general operations fund created in section 3701.83 of the Revised Code for use only in administering and enforcing this chapter and the rules adopted under it.

(C) In determining a civil monetary penalty under division (A)(2) of this section, the director shall consider all of the following:

(1) The number of residents directly affected by the violation;

(2) The number of staff involved in the violation;

(3) Any actions taken by the home to correct or mitigate the violation, including the timeliness and sufficiency of the home's response to the violation and the outcome of that response;

(4) Any concurrent federal penalties being imposed for the same violations by the United States centers for medicare and medicaid services, which shall reduce any civil monetary penalty imposed under this section by the same amount;

(5) The home's history of compliance.

(D) If the director determines the need for a civil monetary penalty under this section, the director may enter into settlement negotiations with the affected home. Settlements may include any of the following:

(1) A lesser civil monetary penalty than initially proposed;

(2) Allowing the home to invest an amount equal to or less than the proposed civil monetary penalty on remedial measures or quality improvement initiatives designed to reduce the likelihood of similar violations occurring in the future, which, unless authorized by the director, shall be conducted or undertaken by a third party;

(3) Other penalties warranted by the deficient practice and negotiations between the director and the home.

(E) Whoever violates division (D) of section 3721.031 or division (E) of section 3721.22 of the Revised Code is guilty of registering a false complaint, a misdemeanor of the first degree.

~~(D)~~(F) Whoever violates section 3721.66 of the Revised Code is guilty of tampering with an electronic monitoring device, a misdemeanor of the first degree."

In line 105907, after "operator" insert "or there is a change in owner of a nursing facility"

In line 105910, after "operator's" insert "or owner's"

In line 105915, after "operator" insert "or owner"

In line 105918, after "operator" insert "or owner"

In line 105919, after the first "operator's" insert "or owner's"; after the second "operator's" insert "or owner's"

In line 105921, after "operator" insert "or owner"

In line 105925, after "operator" insert "or owner"

In line 105935, after "operator" insert "or owner"

In line 105940, delete "manage" and insert "assume control of the operations and cash flow of"

In line 105941, after "operator's" insert "or owner's"; after "agent" insert";

(h) A change in control of the owner of the real property associated with the nursing facility if, within one year of the change of control, there is a material increase in lease payments or other financial obligations of the operator to the owner"

In line 105949, strike though "A" and insert "Except as provided in division (J)(1) of this section, a

In line 105953, after "operator" insert "or owner"

In line 105957, after "operator" insert "or owner"

In line 105961, after "operator" insert "or owner"

After line 106186, after "(NN)" insert ""Private room" means a nursing facility bedroom that meets all of the following criteria:

(1) It has four permanent, floor-to-ceiling walls and a full door.

(2) It contains one licensed or certified bed that is occupied by one individual.

(3) It has access to a hallway without traversing another bedroom.

(4) It has access to a toilet and sink shared by not more than one other resident without traversing another bedroom.

(5) It meets all applicable licensure or other standards pertaining to furniture, fixtures, and temperature control.

(OO)"

In line 106187, delete "(OO)" and insert "(PP)"

In line 106192, delete "(PP)" and insert "(QQ)"

In line 106196, delete "(QQ)" and insert "(RR)"

In line 106203, delete "(RR)" and insert "(SS)"

In line 106216, delete "(SS)" and insert "(TT)"

In line 106250, delete "(TT)" and insert "(UU)"

In line 106262, delete "(UU)" and insert "(VV)"

In line 106264, delete "(VV)" and insert "(WW)"

In line 106267, delete "(WW)" and insert "(XX)"

In line 106269, delete "(XX)" and insert "(YY)"

After line 106270, insert:

"(ZZ) "Surrender" has the same meaning as in section 5168.40 of the Revised Code."

In line 106271, delete "(YY)" and insert "(AAA)"

In line 106274, delete "(ZZ)" and insert "(BBB)"

In line 106276, delete "(AAA)" and insert "(CCC)"

In line 106278, delete "(BBB)" and insert "(DDD)"

In line 106372, strike through "5165.157" and insert "5165.158"

After line 106401, insert:

"(D) If the nursing facility qualifies as a low occupancy nursing facility, subtract from the sum determined under division

(C) of this section the nursing facility's low occupancy deduction determined under section 5165.23 of the Revised Code."

After line 106477, insert:

"**Sec. 5165.157.** (A) As used in this section, "SFF list" and "CMS" have the same meanings as in section 5165.26 of the Revised Code.

(B) The medicaid director shall establish an alternative purchasing model for nursing facility services provided by designated discrete units of nursing facilities to medicaid recipients with specialized health care needs. The director shall do all of the following with regard to the model:

(1) Establish criteria that a discrete unit of a nursing facility must meet to be designated as a unit that, under the alternative purchasing model, may admit and provide nursing facility services to medicaid recipients with specialized health care needs~~;~~. Beginning July 1, 2023, the director shall not approve an application for a discrete unit of a nursing facility that provides ventilator services if, at the time of the application, the nursing facility is listed on table A or table D of the SFF list or is designated as having a one-star overall rating in CMS's nursing facility five-star rating system known as care compare.

(2) Specify the health care conditions that medicaid recipients must have to have specialized health care needs, which may include dependency on a ventilator, severe traumatic brain injury, the need to be admitted to a long-term acute care hospital or rehabilitation hospital if not for nursing facility services, and other serious health care conditions;

(3) For each fiscal year, set the total per medicaid day

payment rate for nursing facility services provided by designated discrete units of nursing facilities under the alternative purchasing model at either of the following:

(a) Thirty-four per cent of the statewide average of the total per medicaid day payment rate for long-term acute care hospital services as of the first day of the fiscal year;

(b) Another amount determined in accordance with an alternative methodology that includes improved health outcomes as a factor in determining the payment rate.

(4) Require, to the extent the director considers necessary, a medicaid recipient to obtain prior authorization for admission to a long-term acute care hospital or rehabilitation hospital as a condition of medicaid payment for long-term acute care hospital or rehabilitation hospital services.

~~(B)~~(C) The criteria established under division ~~(A)(1)~~(B)(1) of this section shall provide for a discrete unit of a nursing facility to be excluded from the alternative purchasing model if the unit is paid for nursing facility services in accordance with section 5165.153, 5165.154, or 5165.156 of the Revised Code. The criteria may require the provider of a nursing facility that has a discrete unit designated for participation in the alternative purchasing model to report health outcome measurement data to the department of medicaid.

~~(C) A~~(D) Except as provided in division (E) of this section, a discrete unit of a nursing facility that provides nursing facility services to medicaid recipients with specialized health care needs under the alternative purchasing model shall be paid for those services in accordance with division ~~(A)(3)~~(B)(3) of this section instead of the total per medicaid day payment rate determined under section 5165.15, 5165.153, 5165.154, or 5165.156

of the Revised Code.

(E) Beginning January 1, 2024, a discrete unit of a nursing facility that provides ventilator services and that is listed on table A or table D of the SFF list or is designated as having a one-star overall rating by CMS under CMS's nursing facility five-star rating system known as care compare shall be paid the total per medicaid day payment rate determined under section 5165.15, 5165.153, 5165.154, or 5165.156 of the Revised Code for those services instead of the rate determined in accordance with division (B)(3) of this section. The rate determined under this division applies to any resident who was admitted to the discrete unit on or after the later of January 1, 2024, or the date on which the nursing facility is added to table A or table D or receives a one-star overall rating. If the nursing facility is removed from table A or table D or no longer has a one-star overall rating, it shall be paid the rate determined in accordance with division (B)(3) of this section for ventilator residents in the discrete unit on or after the date on which the nursing facility is removed from table A or table D or no longer has a one-star overall rating. The director may waive the requirements of this division for a discrete unit of a nursing facility if the director determines that the waiver is necessary to ensure access to ventilator services in the area served by the discrete unit.

Sec. 5165.158. (A) As used in this section:

(1) "Category one private room" means a private room that has unshared access to a toilet and sink.

(2) "Category two private room" means a private room that has shared access to a toilet and sink.

(B) Beginning six months following approval by the United

States Ccenters for medicare and medicaid services or on the effective date of applicable department of medicaid rules, whichever is later, but not sooner than April 1, 2024, the total per medicaid day payment rate for nursing facility services provided on or after that date in private rooms approved by the department of medicaid under division (C) of this section shall be the sum of both of the following:

(1) The total per medicaid day payment rate determined for the nursing facility under section 5165.15 of the Revised Code;

(2) The private room incentive payment. The private room incentive payment shall be thirty dollars per day for a category one private room and twenty dollars per day for a category two private room, beginning in state fiscal year 2024. The department may increase the payment amount for subsequent fiscal years.

(C)(1) The department shall approve rooms in nursing facilities to qualify for the rate described in division (B) of this section. A nursing facility provider shall apply for approval of its private rooms by submitting an application in the form and manner prescribed by the department. The department shall begin accepting applications for approval of category one private rooms on January 1, 2024, and category two private rooms on March 1, 2024. The department may specify evidence that an applicant must supply to demonstrate that a room meets the definition of a private room under section 5165.01 of the Revised Code and may conduct an on-site inspection of the room to verify that it meets the definition. Subject to division (C)(2) of this section, the department shall approve an application if the rooms included in the application meet the definition of a private room under section 5165.01 of the Revised Code.

(2) The department shall only consider applications that meet

the following criteria:

(a) Private rooms that are in existence on July 1, 2023, in facilities where all of the licensed beds are in service on the application date;

(b) Private rooms created by surrendering licensed beds from its licensed capacity, or, if the facility does not hold a license, surrendering beds that have been certified by CMS. A nursing facility where the beds are owned by a county and the facility is operated by a person other than the county may satisfy this requirement by removing beds from service.

(c) Private rooms created by adding space to the nursing facility or renovating nonbedroom space, without increasing the total licensed bed capacity;

(d) A nursing facility licensed after July 1, 2023, in which all licensed beds are in service on the application date or in which private rooms were created by surrendering licensed beds from its licensed capacity.

(3) The department may specify evidence that an applicant must supply to demonstrate that it meets the conditions specified in division (C)(2) of this section and may conduct an on-site inspection to verify that the conditions are met.

(4) The department may deny an application if the department determines that any of the following circumstances apply:

(a) The rooms included in the application do not meet the definition of a private room under section 5165.01 of the Revised Code;

(b) The rooms included in the application do not meet the criteria specified in division (C)(2) of this section;

(c) The applicant created private rooms by reducing the number of available beds without surrendering the beds, and surrender of the beds is required by this section;

(d) Approval of the room would cause projected expenditures for private room incentive payments under this section for the fiscal year to exceed forty million dollars in fiscal year 2024 or one hundred sixty million dollars in fiscal year 2025 or subsequent fiscal years. In projecting expenditures for private room incentive payments, the department shall use a medicaid utilization percentage of fifty per cent. If the department determines that there are more approvable eligible applications submitted than can be accommodated within the applicable spending limit specified in this division, the department shall prioritize category one private rooms.

(e) On the application date, the nursing facility is listed on table A or table D of the SFF list, as defined in section 5165.01 of the Revised Code or is designated as having a one-star overall rating in the United States centers for medicare and medicaid services nursing facility five-star quality rating system known as care compare.

(5) Beginning July 1, 2025, to retain eligibility for private room rates, a nursing facility must do both of the following:

(a) Have a policy in place to prioritize placement in a private room based on the medical and psychosocial needs of the resident;

(b) Participate in the resident or family satisfaction survey performed pursuant to section 173.47 of the Revised Code.

(6) The department shall hold all applications for a private room incentive payment in a pending status until the United States

centers for medicare and medicaid services approves private room incentive payments and the department determines a facility is qualified for the payment. An application in pending status shall be included in the payment cap described in division (C)(4)(d) of this section as if the application were approved.

(7) An applicant may request reconsideration of a denial under division (C) of this section."

In line 106629, strike through "twenty-fifth" and insert "seventieth"

In line 106696, reinsert "June 30, 1999"; delete "October 1, 2019"

In line 106748, reinsert all after "(b)"

Reinsert lines 106749 and 106750

In line 106751, reinsert "(c)"

In line 106755, reinsert "(d)"; delete "(c)"

In line 106757, reinsert all after "(i)"

Reinsert lines 106758 through 106760

In line 106761, reinsert "(iii)"

In line 106762, reinsert "June"

In line 106763, reinsert "30, 1999"; delete "October 1, 2019"

In line 106764, reinsert "(iv)"; delete "(ii)"

In line 106766, reinsert "(e)"; delete "(d)"

In line 106769, reinsert "(f)"; delete "(e)"

In line 106775, reinsert "(g)"; delete "(f)"

After line 106786, insert:

"**Sec. 5165.23.** (A) Each state fiscal year, the department of medicaid shall determine the critical access incentive payment for each nursing facility that qualifies as a critical access nursing facility. To qualify as a critical access nursing facility for a state fiscal year, a nursing facility must meet all of the following requirements:

(1) The nursing facility must be located in an area that, on December 31, 2011, was designated an empowerment zone under the "Internal Revenue Code of 1986," section 1391, 26 U.S.C. 1391.

(2) The nursing facility must have an occupancy rate of at least eighty-five per cent as of the last day of the calendar year immediately preceding the state fiscal year.

(3) The nursing facility must have a medicaid utilization rate of at least sixty-five per cent as of the last day of the calendar year immediately preceding the state fiscal year.

(B) A critical access nursing facility's critical access incentive payment for a state fiscal year shall equal five per cent of the portion of the nursing facility's total per medicaid day payment rate for the state fiscal year that is the sum of the rates identified in divisions (A)(1) to (4) of section 5165.15 of the Revised Code.

(C) Each state fiscal year, the department shall determine the low occupancy deduction for each nursing facility that qualifies as a low occupancy nursing facility. To qualify as a low occupancy nursing facility for a state fiscal year, a nursing facility must have an occupancy rate lower than sixty-five per cent. For purposes of this division, the department shall utilize a nursing facility's occupancy rate for the licensed beds reported on the facility's cost report for the calendar year preceding the

fiscal year for which the rate is determined, or if the facility is not required to be licensed, the facility's occupancy rate for its certified beds. If the facility surrenders licensed or certified beds before the first day of July of the calendar year in which the fiscal year begins, the department shall calculate a nursing facility's occupancy rate by dividing the inpatient days reported on the facility's cost report for the calendar year preceding the fiscal year for which the rate is determined by the product of the number of days in the calendar year and the facility's number of licensed, or if applicable, certified beds on the first day of July of the calendar year in which the fiscal year begins.

A low occupancy nursing facility's low occupancy deduction for a state fiscal year shall equal five per cent of the nursing facility's total per medicaid day payment rate for the state fiscal year identified in division (D) of section 5165.15 of the Revised Code, for the state fiscal year.

This division does not apply to any of the following:

(1) A nursing facility where the beds are owned by a county and the facility is operated by a person other than the county;

(2) A nursing facility that opened during the calendar year preceding the fiscal year for which the rate is determined or the preceding fiscal year;

(3) A nursing facility that underwent a renovation during the calendar year preceding the fiscal year for which the rate is determined if both of the following apply:

(a) The renovation involved a capital expenditure of one hundred fifty thousand dollars or more, excluding expenditures for equipment;

(b) The renovation included one or more rooms housing beds that are part of the nursing facility's licensed capacity and that were taken out of service for at least thirty days while the rooms were being renovated."

In line 106801, after "~~(6)~~" insert "(5)" and reinsert the balance of the line

Reinsert lines 106802 and 106803

In line 106804, after "~~(7)~~" insert "(6)" and reinsert the balance of the line

Reinsert lines 106805 through 106807

In line 106809, reinsert "divisions"; delete "division"; after the first stricken comma insert "and"; reinsert "(E),"

In line 106810, delete "(E)" and insert "(F)"

In line 106827, delete "(D)(2)" and insert "(E)(2)"

In line 106834, strike through "division" and insert "divisions"; after "(C)(2)" insert "and (3)"

In line 106860, delete "Two" and insert "Seven"; after "points" insert "for fiscal year 2024 and three points for fiscal year 2025 and subsequent fiscal years"

In line 106861, delete "but not more than" and insert "per cent."

Delete lines 106862 through 106864

In line 106865, delete all before "For"

In line 106871, delete "May" and insert "July"

In line 106878, delete "May" and insert "July"

After line 106893, after "medication" insert ";

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

In line 106904, reinsert "or (c)"

In line 106910, reinsert all before "~~for~~"; after "~~points~~" insert "calculated"; reinsert "for" and insert "or during a"

In line 106911, reinsert "state fiscal year"; reinsert "for all of"

In line 106912, reinsert "the quality metrics specified in" and insert "divisions (C)(1)(a), and if applicable, division (C)(1)(c)"; reinsert "of this section"

Reinsert line 106913

In line 106914, reinsert all before the comma; after "~~facilities~~" insert "calculated using the points for the July 1 rate setting of that fiscal year"; reinsert "reduce the nursing"

In line 106915, reinsert "facility's points to zero" and insert "until the next point calculation. If a facility's recalculated points under division (C)(3) of this section are below the number of points determined to be the twenty-fifth percentile for that fiscal year, the facility shall receive zero points for the remainder of that fiscal year."

In line 106916, reinsert all before "~~zero~~" and insert "recalculated"; reinsert "for" and insert "the second half of the"

In line 106917, reinsert "state fiscal year"

In line 106919, after "~~section~~" insert "based on the most recent four quarter average data, or the average data for fewer quarters in the case of successor metrics, available in the database maintained by CMS and known as the care compare, in the

most recent month of the calendar year during which the fiscal year for which the rate is determined begins. The metrics specified by division (C)(1)(b) of this section shall not be recalculated"; reinsert the stricken period and insert "In redetermining the quality payment for each facility based on the recalculated points, the department shall use the same per point value determined for the quality payment at the start of the fiscal year."

In line 106976, after "~~(E)~~" insert "(D)" and reinsert the balance of the line

In line 106977, reinsert "payment"; reinsert "if"

Reinsert lines 106978 and 106979

In line 106980, reinsert "facility is listed in table A"; reinsert "on the first"

Reinsert lines 106981 and 106982

In line 106983, delete "(D)" and insert "(E)"

In line 106993, delete "sum of the"

Delete lines 106994 through 106999

In line 107000 delete "(ii) The"

In line 107003, delete "for state"

In line 107004, delete "fiscal year 2024"

In line 107006, delete "(D)(1)(a)" and insert "(E)(1)(a)"

In line 107010, delete "(D)(1)(b)" and insert "(E)(1)(b)"

In line 107013, delete "(D)(2)" and insert "(E)(2)"

In line 107015, reinsert "twenty-five"

In line 107016, delete "(E)(1)" and insert "(F)(1)"

In line 107026, delete all after "(2)" and insert "A"

In line 107028, delete "April" and insert "July"

Delete lines 107037 through 107046

In line 107048, reinsert "at least"

In line 107049, reinsert "five"; delete "two"; strike through "a" and insert "the"

In line 107051, strike through ", ancillary and support,"

After line 108152, insert:

"**Sec. 5168.40.** As used in sections 5168.40 to 5168.56 of the Revised Code:

(A) "Bed surrender" means the following:

(1) In the case of a nursing home, the removal of a bed from a nursing home's licensed capacity in a manner that reduces the total licensed capacity of all nursing homes and makes it impossible for the bed to ever be a part of any nursing home's licensed capacity;

(2) In the case of a hospital, the removal of a hospital bed from registration under section 3701.07 of the Revised Code as a skilled nursing facility bed or long-term care bed in a manner that reduces the total number of hospital beds registered under that section as skilled nursing facility beds or long-term care beds and makes it impossible for the bed to ever be registered as a skilled nursing facility bed or long-term care bed.

(B) "Change of operator" ~~means an entering operator becoming the operator of a nursing home or hospital in the place of the exiting operator.~~

~~(1) Actions that constitute a change of operator include the~~

~~following:~~

~~(a) A change in an exiting operator's form of legal organization, including the formation of a partnership or corporation from a sole proprietorship;~~

~~(b) A transfer of all the exiting operator's ownership interest in the operation of the nursing home or hospital to the entering operator, regardless of whether ownership of any or all of the real property or personal property associated with the nursing home or hospital is also transferred;~~

~~(c) A lease of the nursing home or hospital to the entering operator or the exiting operator's termination of the exiting operator's lease;~~

~~(d) If the exiting operator is a partnership, dissolution of the partnership;~~

~~(e) If the exiting operator is a partnership, a change in composition of the partnership unless both of the following apply:~~

~~(i) The change in composition does not cause the partnership's dissolution under state law.~~

~~(ii) The partners agree that the change in composition does not constitute a change in operator.~~

~~(f) If the operator is a corporation, dissolution of the corporation, a merger of the corporation into another corporation that is the survivor of the merger, or a consolidation of one or more other corporations to form a new corporation.~~

~~(2) The following, alone, do not constitute a change of operator:~~

~~(a) A contract for an entity to manage a nursing home or hospital as the operator's agent, subject to the operator's~~

~~approval of daily operating and management decisions;~~

~~(b) A change of ownership, lease, or termination of a lease of real property or personal property associated with a nursing home or hospital if an entering operator does not become the operator in place of an exiting operator;~~

~~(c) If the operator is a corporation, a change of one or more members of the corporation's governing body or transfer of ownership of one or more shares of the corporation's stock, if the same corporation continues to be the operator~~ has the same meaning as in section 5165.01 of the Revised Code.

(C) "Effective date of a change of operator" means the day an entering operator becomes the operator of a nursing home or hospital.

(D) "Entering operator" means the person or government entity that will become the operator of a nursing home or hospital on the effective date of a change of operator.

(E) "Exiting operator" means an operator that will cease to be the operator of a nursing home or hospital on the effective date of a change of operator.

(F) "Franchise permit fee rate" means the rate determined in accordance with section 5168.41 of the Revised Code.

(G) "Hospital" has the same meaning as in section 3727.01 of the Revised Code.

(H) "Hospital long-term care unit" means any distinct part of a hospital in which any of the following beds are located:

(1) Beds registered pursuant to section 3701.07 of the Revised Code as skilled nursing facility beds or long-term care beds;

(2) Beds licensed as nursing home beds under section 3721.02 or 3721.09 of the Revised Code.

(I) "Indirect guarantee percentage" means the percentage specified in the "Social Security Act," section 1903(w)(4)(C)(ii), 42 U.S.C. 1396b(w)(4)(C)(ii), that is to be used in determining whether a class of providers is indirectly held harmless for any portion of the costs of a broad-based health-care-related tax. If the indirect guarantee percentage changes during a fiscal year, the indirect guarantee percentage is the following:

(1) For the part of the fiscal year before the change takes effect, the percentage in effect before the change;

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

(J) "Medicaid days" and "nursing facility" have the same meanings as in section 5165.01 of the Revised Code.

(K)(1) "Nursing home" means all of the following:

(a) A nursing home licensed under section 3721.02 or 3721.09 of the Revised Code, including any part of a home for the aging licensed as a nursing home;

(b) A facility or part of a facility, other than a hospital, that is certified as a skilled nursing facility under Title XVIII;

(c) A nursing facility, other than a portion of a hospital certified as a nursing facility.

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

(a) A county home, county nursing home, or district home operated pursuant to Chapter 5155. of the Revised Code;

(b) A nursing home maintained and operated by the department of veterans services under section 5907.01 of the Revised Code.

(L) "Operator" means the person or government entity responsible for the daily operating and management decisions for a nursing home or hospital.

(M) "Title XIX" means Title XIX of the "Social Security Act," 42 U.S.C. 1396 et seq.

(N) "Title XVIII" means Title XVIII of the "Social Security Act," 42 U.S.C. 1395 et seq."

In line 124606, after "173.21," insert "173.24,"

In line 124668, after "3721.026," insert "3721.08, 3721.17, 3721.99,"

In line 124724, after "5165.152," insert "5165.157,"; after "5165.192," insert "5165.23,"

In line 124727, after "5168.26," insert "5168.40,"

In line 272722, delete "$5,267,359,400 $6,004,894,000" and insert "$5,381,259,400 $6,165,694,000"

In line 272723, delete "$13,997,454,600 $15,249,073,000" and insert "$14,210,154,600 $15,534,873,000"

In line 272724, delete "$19,264,814,000 $21,253,967,000" and insert "$19,591,414,000 $21,700,567,000"

In line 272727, add $113,900,000 to fiscal year 2024 and $160,800,000 to fiscal year 2025

In line 272728, add $212,700,000 to fiscal year 2024 and $285,800,000 to fiscal year 2025

In line 272729, add $326,600,000 to fiscal year 2024 and $446,600,000 to fiscal year 2025

In line 272755, add $326,600,000 to fiscal year 2024 and $446,600,000 to fiscal year 2025

In line 273413, delete "the sum of"

In line 273414, delete all before "the" and insert "due to"

In line 281791, after "3701.021," insert "3721.08, 3721.17, 3721.99, 5165.01, 5165.15, 5165.151, 5165.152, 5165.157, 5165.158, 5165.16, 5165.19, 5165.192, 5165.23, 5165.26, 5165.36, 5165.771, 5168.40,"

The motion was _____ agreed to.

SYNOPSIS

Medicaid day payment rate

R.C. 5165.15, 5165.16, 5165.19, and 5165.23

Restores House-added provisions removed by the Senate, with changes, that include a new formula deduction for low occupancy nursing facilities and establish a formula to calculate the deduction amount.

Modifies the calculation of direct care costs in the rate formula to use the 70th percentile rate among nursing facilities, instead of the 25th percentile rate as under current law, or the median rate as in the House.

Eliminates ancillary and support costs from House provisions requiring ODM to use only 40% of the increase from the FY 2024 rebasing when calculating certain cost centers during the biennium and makes the requirement apply to the increase in its base rate instead of the sum of the increase, so that requirement only applies to direct care costs.

Nursing facility private room payment

R.C. 5165.01, 5165.15, and 5165.158

Restores House-added provisions removed by the Senate, with changes, that establish a private room per day payment rate for services provided to residents in private rooms of nursing facilities.

Quality incentive payments

R.C. 5165.26

Restores House-added provisions, with changes, modified by the Senate, that make changes to the nursing facility quality incentive payment rate formula.

Restores House-added new quality metrics for FY 2025, removed by the Senate, and adds a metric for adjusted total nurse staffing hours per resident per day.

Removes the Senate payment tiers and instead establishes an occupancy rate add-on of 7.5 points in FY 2024 if the facility's occupancy rate is greater than 75% and 3 points in subsequent fiscal years.

Adds a new provision requiring quality incentive payments to be recalculated in the second half of each fiscal year based on the most recent data.

Restores to $125 million in each fiscal year the House cap to the add-on (the Senate reduced the total to $100 million in each fiscal year).

Restores provisions of current law, eliminated in the House and Senate versions, that disqualify a nursing facility from a quality incentive payment if it is on the SFF list or, with some modifications from former law, if its number of quality points is less than the bottom 25% of nursing facilities.

Removes House-added provisions that would have adjusted a facility's quality incentive payment amount by the per diem amount its ancillary and support costs changed as a result of the FY 2024 rebasing.

Removes House-added provisions that addressed quality incentive payments for nursing facilties that undergo a change of operator when the entering operator owns the physical assets of or has majority ownership of the facility.

Case-mix scores

R.C. 5165.192

Removes Executive provisions, removed by the House and restored by the Senate, that would have changed the method to calculate nursing facility case-mix scores, while retaining the bill's terminology update from "low resource utilization resident" to "low case-mix resident."

Rebasing

R.C. 5165.36

Removes House and Senate provisions modifying the rate of rebasing to at least every two years or every two years, respectively, and restores current law requiring rebasing to occur at least once every five fiscal years.

Adds ancillary and support costs to the current prohibition on rebasing capital costs.

Nursing home change of operator

R.C. 3721.01, 3721.026, 3721.08, 3721.17, 3721.99, 5165.01, 5168.40; conforming changes R.C. 173.24

Modifies a House-added provision regarding the nursing home change of operator application to do all of the following:

- Require the ODH Director to investigate allegations that an entering operator failed to submit a change of operator application or provided fraudulent information on a submitted application.

- Require a change of operator applicant to attest that the applicant has (rather than requiring the applicant to submit) evidence of (1) nursing home policies and procedures, (2) general and professional liability insurance, and (3) sufficient numbers of qualified staff.

- Removes a requirement that the ODH Director make the change of operator application available on its web site.

Modifies a House-added provision to add another event that constitutes a change of operator.

Nursing home violations

R.C. 3721.99

Adds a new provision that eliminates the time frame in which ODH must initiate an investigation after receiving a complaint that the rights of a resident of a nursing home have been violated.

Adds a provision that modifies the actions that the Director may take following a violation committed by a nursing home.

Department of Medicaid

Section 333.10

Increases GRF line item 651525, Medicaid Health Care Services, by $326,600,000 ($113,900,000 state share) in FY 2024 and by $446,600,000 ($160,800,000 state share) in FY 2025.